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RIDA

JOURNAL OF THE RHODE ISLAND DENTAL ASSOCIATION

MEMBER SPOTLIGHT

COVID-19 LEGAL UPDATE

SELLING A DENTAL PRACTICE

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DENTAL ASSOCIATION

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On the cover: Karyn Ward, DDS, receives her COVID-19 vaccine from her sister and fellow dentist, Lynne Ward, DDS

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MEMBER SPOTLIGHT
DR. JOSEPH G. SAMARTANO JR.

Anyone involved in the local dental community knows it doesn't get much better than Dr. Joseph G. Samartano. This past January, Dr. Samartano announced his retirement from clinical practice at St. Joseph Health Center and Our Lady of Fatima (although rumor has it he still makes regular appearances in both hospitals). We thought there was no more appropriate time to shine the spotlight on his 50+ year career as a dentist and member of the Rhode Island Dental Association.

Joe is a man of character who loves and cares about people. He always wants to hear everyone's story. I am most grateful to have worked with him and very thankful for his contribution to dentistry.
– Marian Royer, DMD

Dr. Joe Samartano was born in Meridan, CT, went to high school in Providence, RI and graduated from Providence College with a degree in Biology in 1963. From there, he went on to graduate from Georgetown University School of Dentistry, followed by an Internship and a Residency at Buffalo General Hospital, both in Oral and Maxillofacial Surgery. Dr. Samartano then came back to Rhode Island to enter private practice as an Oral Surgeon in Cranston from 1970-2005. After retiring from private practice, he began working as the attending Oral and Maxillofacial Surgeon at the St. Joseph Health Services Pediatric Dental Residency Program in Providence. At Our Lady of Fatima, he has held nearly every position possible, from staff to Chief of the Division of Dentistry and of Oral and Maxillofacial Surgery. His presence has been integral in keeping dentistry alive in both hospitals.

What his curriculum vitae doesn't tell you is how much Dr. Samartano loves the annual Christmas Party for the Kids at St. Joseph Hospital. Or that for many years he has helped lead the CharterCARE team in the Rhode Island Alzheimer's Walk. To know Dr. Samartano, you have to know that his generosity extends far beyond dentistry.

Dr. Samartano's affiliations also reach well beyond dentistry. He is Past President of the American Cancer Society RI Unit, Past President of the Jamestown RI Shores Association, and a Past Volunteer with RI Emergency Services in Jamestown, just to name a few.

On top of many years of recognition and awards for his guidance and dedication, this year Dr. Samartano is the recipient of the Rhode Island Dental Association Dr. A. James Kershaw Award. This award is presented to that member of the Rhode Island Dental Association who has

When thinking of Dr. Samartano, the phrase, "They don't make them like they used to," comes to mind. Dr. Sam's selfless commitment to his family, patients, colleagues and peers is truly unparalleled. I've been fortunate to have some wonderful mentors throughout my career and Dr. Sam is the gold standard to which I aspire.

Dr. Sam, thank you for the countless lessons in Oral Surgery, and more importantly, thank you for always setting the example of what a true gentleman should be. Congratulations on the award as it is more than well deserved.
– John Kiang, DDS

One of the things that Dr. Sam said often to the potential AEGD residents at their interviews was : " we have some great faculty here, you will learn how to do many things with proficiency , but also very importantly I will also try and teach you when you should refer a patient out!"
– Jeffrey Dodge, DMD

demonstrated honesty, integrity, and who has made an outstanding contribution to the community while representing the goodwill of the dental profession. We certainly think Dr. Samartano has done just that.

While his reputation as an Oral Surgeon is exemplary, it's the impact that Dr. Samartano has left on his peers and the community that tells you everything you need to know about the man himself.

Dr. Samartano, we want to thank you for your many years of dedicated service to the community and to dentistry. We wish you the very best during your retirement! ■

I first met Joe Samartano back in the early 80's when I was working a couple days a week at the state general hospital/IMH. Even back then he was known as Dr. Sam to everyone.

As the Chief, Division of Dentistry and Oral and Maxillofacial Surgery at Fatima/St. Joseph's Hospitals, I had the opportunity to work directly with him again, almost 35 years later, as a clinical attending in the AEGD NYU/Langone School of Dental Medicine residency program at St. Joseph's/Fatima Hospital. Not only did he diligently teach our AEGD residents, he also worked directly with all the pediatric residents. There are many young Doctors who are better clinicians because of his genuine dedication.

He was always available for the residents and strongly committed to improving their clinical skills in both the outpatient clinic and the Hospital OR's, located at Fatima Hospital. Everyone there knew and had great respect for Dr. Samartano.

I wish Dr. Samartano well. He has earned his retirement, now he can spend a little more time on the hobby he loves and relax a little. I will miss my discussions with him.

Sincerely,

Wayne B. Mollohan, D.M.D.

FROM YOUR OUTGOING PRESIDENT
LIFE DURING COVID...AND BLESSINGS

BY KARYN WARD, DDS
RIDA PRESIDENT 2020-2021

Last spring, on the a day before my 50th birthday, I was inducted as President of the Rhode Island Dental Association during the House of Delegates meeting. The meeting was virtual for the first time and things were different, but somehow the same. For me, this was a good thing in the midst of uncertainty. Much has happened since then, including many other GOOD THINGS.

The outpouring of caring and kindness in the dental community has been overwhelming. Rather than me asking patients "how are you?", patients are asking me how I am. Many have commented at the end of their appointment to "stay safe". Others have come bearing gifts of fabric masks and face shields. It's comforting knowing our patients care about us as much as we do about them.

I also find happiness is knowing I have contributed to the slowing of the spread. We all have in the way we practice, educate our patients, and promote a culture of safety in our offices and in our private lives. Additionally, many dentists have donated time and resources. No matter the size, every contribution helps move us further forward.

Since last March 2020, life has taken on a slower pace. It's been a nice change and has freed up time for other things. On October 31st with a full "blue moon", my husband and I adopted a "little sister" kitten to join our 7 year old cat. We would not have considered this pre-covid, due to our schedules. They have brought much joy and peace into our lives over the winter.

These are a few positive impacts of COVID. I hope everyone can find their own silver lining amidst the pandemic. No one knows what the future holds but kindness, happiness, and a slower lifestyle are mine.

As my year as president draws closer to a close, I can say that being RIDA President has been great. Seeing first hand the benefits of membership and the dedication of Christy and Madeline is something I wish everyone could experience. There is no manual and a "how to" search on google comes up empty. I am blessed to work with John, Greg, Fred, Steve, Jen, and Martin. Many thanks to George Gettinger who asked me years ago to join the Board. I am proud of our dental community for their flexibility, patience, and commitment to safe dental care. We continue to shine and are stronger together. ■

- Karyn Ward, DDS

Did you know? Nearly 70% of smokers want to Quit.[1]

QUITWORKS℠-RI

We can provide your patients with FREE evidence-based tobacco cessation and nicotine addiction treatment services to help optimize their oral health outcomes:

- **FREE phone-based counseling and virtual support tools**
- **FREE FDA-approved nicotine replacement therapy (NRT) gum, patches, and lozenges mailed direct to your patients**
- **Any staff member can make a simple and quick referral by an online form or faxed form**
- **Follow-up reports for providers**

QuitWorks-RI tobacco cessation services are provided free of charge for all patients covered by private pay health insurance or Medicaid, and for anyone without health insurance. Medical, dental, behavioral health, and mental health providers may refer patients ages 13 and older.

Connect your practice and patients today.
Visit: www.QuitworksRI.org

[1] www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm

Dental Lifeline Network • Rhode Island

Program Highlights

Dental Lifeline Network. • Rhode Island
More than Dentistry. Life.

Dental Lifeline Network is grateful for the Rhode Island Dental Association's partnership in developing a Donated Dental Services (DDS) program in 1989 and long-time support to help people with disabilities or who are elderly or medically fragile and have no other access to dental care.

During these ever-changing times, we are especially thankful to the Rhode Island dentists and labs who have donated over $7.4 million worth of comprehensive donated treatment for 3,149 people. We appreciate the dentists who continue to provide care to vulnerable DDS patients, who have no other resources for treatment they desperately need. If you are interested in helping a patient go to WillYouSeeOne.org.

Henry, DDS patient

The Story

The DDS program restores the oral health and often transforms the lives of the patients we serve, like Henry, 80, who lives alone in Providence County. Last year, he underwent treatment for colon cancer and just recently completed treatment for bladder cancer that is now in remission. Sadly, cancer wasn't Henry's only challenge. He hadn't been to a dentist in more than a decade and his dental health had deteriorated: he had no remaining bottom teeth and some of his remaining top teeth were broken. Surviving on only a minimal Social Security benefit, Henry struggled to make ends meet. With a limited fixed income, he was unable to afford the treatment he needed to address his dental problems.

Thankfully, two generous DDS volunteers came to his aid, a general dentist and a volunteer lab. Thanks to these caring volunteers, Henry received thousands in donated treatment that restored his dental health and gave him a brand new smile!

The Rhode Island DDS program is part of a network in which services are available in all 50 states. DLN volunteers provided over $23 million in donated treatment nationwide in fiscal year 2019-2020.

DDS Fiscal Year 2019-2020 Totals

Patients Served[1] = 151
Patients on Wait-list = 135
Volunteer Dentists = 206
Volunteer Labs in RI = 24
Participating Labs outside RI = 8
Value of Care to Patients Treated[2] = $369,196
Average Value of Treatment/Case[3] = $4,242
Value of Donated Lab Services = $31,363

[1]Number of Patients Served includes: patients who completed their treatment plan; patients who received services but treatment plan is not yet complete; and patients who are linked with a volunteer but haven't yet received treatment.
[2]Value of care to patients treated includes value of donated lab services.
[3]Average value is based on patients that have completed comprehensive treatment; does not include active patients, or patients who continue to receive ongoing care from their DDS volunteer.

Get Involved

Please Visit: DentalLifeline.org
Or Contact: Matt McLaren, DDS Coordinator
401.821.8656 (local)
833.392.1849 (fax)
mmclaren@DentalLifeline.org

Volunteer

Please Visit: WillYouSeeOne.org

Connect with us

@DentalLifeline

Patient Treatment (DS Program Totals 7/1/20 to 2/28/21)

Patients Served

Patients on Wait List

Volunteer Dentists

Volunteer Labs

Financial

Value of Care to Patients Treated $191,896

Average Value of Treatment/Case $4,339

Value of Donated Lab Services $19,844

Since Program Inception (1989)

Total Patients Treated 3,149

Total Value of Care to Patients Treated $7,439,406

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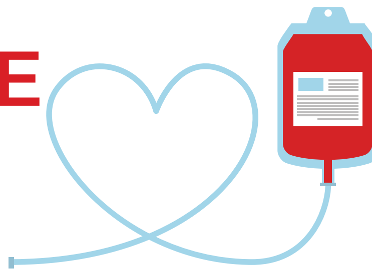
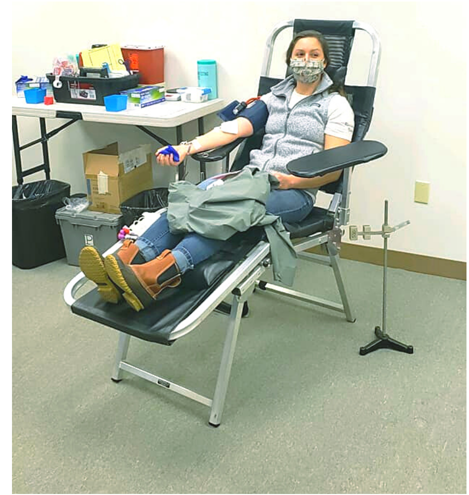
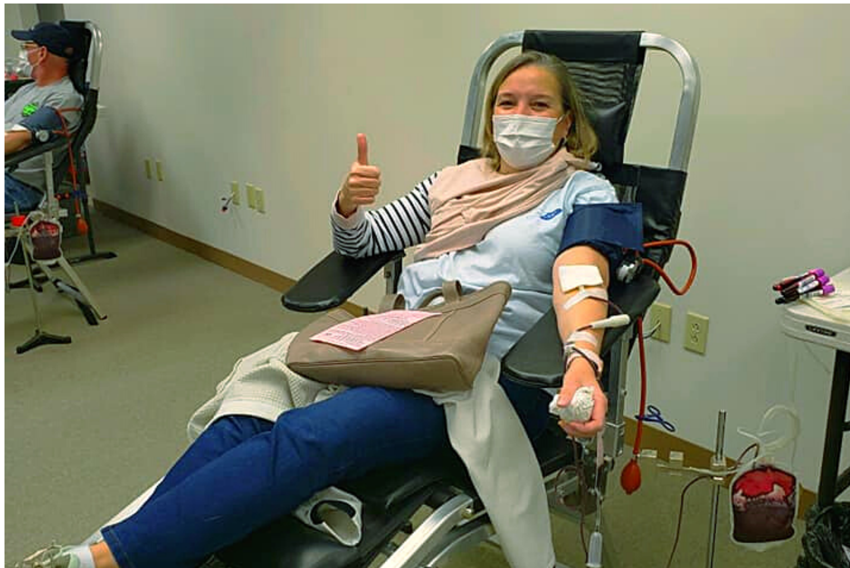


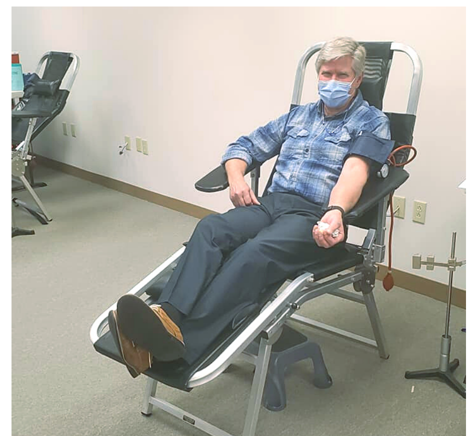


55 DONATIONS - HELPING TO SAVE 165 LIVES!



In the past few months, RIDA has sponsored two blood drives with the RI Blood Center. We could not be more proud of all our members and their families who came out to donate! All together, we have had 55 donations and were able to save 165 lives!

Keep an eye on your email for future RIDA Blood Drive dates!



Chronic blood shortages threaten healthcare systems more now than ever. The pandemic has created chronic blood shortages across the country that show no sign of improving as we head further into the winter months. The healthcare systems RI Blood Center supports require over 280 blood products *each day* to treat patients ranging from trauma victims to newborn babies and their mothers to cancer patients.

According to America's Blood Centers, mobile blood drive donations nationally are down by 30% compared to the same time last year. Please consider donating either at the next RIDA sponsored Blood Drive or at a location convenient to you by using the QR code below!

Scan the code to schedule your blood donation appointment!

Just open your camera and point!

COVID-19 Legal Update: Where Do Employers Stand in 2021?

BY: MATTHEW H. PARKER AND CAROLINE R. THIBEAULT, ESQ.

Introduction

On December 11, 2020, the U.S. Food and Drug Administration issued emergency use authorization for the first COVID-19 vaccine. Almost immediately thereafter, on December 16, 2020 the Equal Employment Opportunity Commission issued guidance to employers regarding vaccinations in the workplace, including guidance on mandatory workplace vaccination policies.

Then, just before the new year, the federal government passed legislation extending various provisions of the CARES Act, including provisions relating to unemployment assistances. Finally, on December 31, 2020, the Families First Coronavirus Relief Act ("FFCRA"), which required most employers to provide paid leave to employees for reasons related to COVID-19, expired.

Needless to say, many employers are unsure how these end-of-year developments will affect the workplace in 2021. This "Q&A" style article is intended to provide a brief overview of the employment laws affecting employers as they navigate the on-going pandemic.

Questions & Answers

1. Can employers require employees to get a COVID-19 vaccine?

With certain exceptions, yes – employers can require their employees to get a COVID-19 vaccine. Any vaccination requirement, however, must provide exemptions for employees who cannot get the vaccine due to a disability and for employees who object to the vaccine based on a sincerely held religious belief, practice, or observance.(1)

In light of the legal constraints applicable to any mandatory vaccination policy, as well as the potential negative effect such a policy could have on employee morale, employers should first consider ways to encourage employees to get the vaccine on a voluntary basis. Indeed, the Equal Employment Opportunity Commission ("EEOC") recommends that "employers should consider simply encouraging employees to get the [vaccine] rather than requiring them to take it."

Employers should also keep in mind that a vaccination requirement may apply to at-will employees, but it cannot be unilaterally imposed on employees covered by employment contracts or collective bargaining agreements. Such a requirement would need to be written into the contract or agreement to be enforceable.

2. What is a "disability" and how will an employer know if an employee has one?

Under the Americans with Disabilities Act ("ADA"), an employee has a "disability" if the employee has "[a] physical or mental impairment that substantially limits one or more of the major life activities of such individual."(2) Major life activities include things like caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, and walking. The term also includes "working."(3)

If an employer's employee (or prospective employee) has a disability, the ADA requires the employer to provide reasonable accommodations to the employee (or prospective employee), except when such accommodation would cause undue hardship to the employer.(4)

The ADA places the burden on employees to notify their employers of the need for a reasonable accommodation. Once an employee does so, the burden then shifts to the employer to identify potential reasonable accommodations.

3. Can employers ask for documentation of an employee's disability?

If an employee's disability or need for accommodation is not obvious to the employer, the employer is permitted to ask for "reasonable documentation" about the employee's disability and functional limitations – in other words, documentation that the employee has the claimed disability and that the disability necessitates a reasonable accommodation. Broad requests for an employee's complete medical record, however, are generally not considered "reasonable."(5)

For example, the employer may ask for a note from the employee's doctor or other health care professional. Alternatively, the employer may simply discuss with the employee the nature of the disability and its functional limitations.

4. What is a "sincerely held religious belief, practice, or observance"?

Under Title VII of the Civil Rights Act of 1964, "religion" includes "all aspects of religious observance and practice as well as belief" – ranging from traditional, organized religions like Christianity, Judaism, and Islam to religious beliefs that are "new, uncommon, not part of a

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1. See WHAT YOU SHOULD KNOW ABOUT COVID-19 AND THE ADA, THE REHABILITATION ACT, AND OTHER EEO LAWS, U.S. Equal Employment Opportunity Commission (Updated Dec. 16, 2020), available at https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws (last accessed February 2, 2021).
2. 29 C.F.R. § 1630.2(g). The definition also covers employees who have "a record of such an impairment," or who are "regarded as having" such an impairment.
3. Id. at § 1630.2(i).
4. See ENFORCEMENT GUIDANCE: REASONABLE ACCOMMODATION AND UNDUE HARDSHIP UNDER THE AMERICANS WITH DISABILITIES ACT, U.S. Equal Employment Opportunity Commission (Updated October 17, 2002), available at https://www.eeoc.gov/laws/guidance/enforcement-guidance-reasonable-accommodation-and-undue-hardship-under-ada (last accessed February 2, 2020).
5. See supra note 4 at Q. 6.

continued from page 6
formal church or sect, only subscribed to by a small number of people, or that seem illogical or unreasonable to others."(6)

Whether a person's belief is "religious" and "sincerely held" hinges on many factors. And because the definition of "religion" is so broad, the EEOC advises that employers "should ordinarily assume that an employee's request for religious accommodation is based on a sincerely held religious belief."(7)

5. What is a reasonable accommodation?
A reasonable accommodation is "any change in the work environment or in the way things are customarily done" that enables a person to enjoy equal employment opportunities.(8)

Examples of reasonable accommodations may include:

- Providing an employee with additional personal protective equipment;
- Allowing an employee to work from home;
- Reassignment to a vacant position;
- Part-time or modified work schedules; or
- Adjustment or modification to employer policies.

An employer is not required to grant a specific accommodation requested by an employee; rather, the employer must engage in a "informal, interactive process" with the employee to identify any accommodations that are reasonable and that would not cause an undue hardship to the employer. This process ordinarily involves discussing the request with the employee and asking clarifying questions where needed.

Employers are not required to provide accommodations that are not reasonable. Indefinite leaves of absence, for example, are not considered "reasonable" and therefore employers generally do not have to provide them. Other accommodations may be considered reasonable for some positions but not for others.

Likewise, employers are not required to provide a reasonable accommodation if doing so would cause an undue hardship to the employer.

6. What is an undue hardship?

Under the ADA, an undue hardship means the accommodation would require a "significant" difficulty or expense, or would be unduly disruptive to the nature or operation of the business.(9) Among the factors to consider in determining whether an accommodation is an undue hardship are the cost of the accommodation, the size and financial resources of the employer's business, and the nature and structure of its operation.

Under Title VII, which applies to religious accommodations, "undue hardship" means simply that the accommodation imposes more than a "de minimis" cost upon the employer.

7. Under what circumstances can an employer exclude an employee who cannot get the vaccination due to a disability or for religious reasons?

An employer may exclude an employee from the workplace if that employee would pose a "direct threat" to health or safety. A "direct threat" means a "significant risk of substantial harm" to the employee or to others in the workplace.

According to the EEOC, employers must make an "individualized" assessment to determine if an individual would pose a direct threat, and the decision must be "based on a reasonable medical judgment that relies on the most current medical knowledge rather than on speculation."(10) The analysis involves four factors: (1) the duration of the risk; (2) the nature and severity of the potential harm; (3) the likelihood that the potential harm will occur; and (4) the imminence of the potential harm.(11)

If an employer determines that an unvaccinated employee will expose others in the workplace to COVID-19, for example, the unvaccinated employee would constitute a "direct threat."(12) If, on the other hand, an unvaccinated employee can work from home or rarely comes into contact with others during the work day, the employee might not pose a "direct threat."

Before excluding an employee on the basis that they are a "direct threat," an employer must be satisfied that there is no way to provide a reasonable accommodation that would eliminate or reduce the threat. For example, if the employer can provide additional protective measures, such as masking or other personal protective equipment, and these measures reduce or eliminate the threat posed by the unvaccinated employee, then the employer may not exclude that employee absent undue hardship.

Finally, even if an employer determines that an employee poses a direct threat, and the direct threat cannot be reduced to an acceptable level, the employer can exclude the employee from physically entering the workplace, but that does not necessarily mean that they can terminate the employee.

8. Can employers share information with their clients or patients about which employees received the vaccine?

No. The ADA requires employers to keep medical information about their employees confidential – and that includes information about whether an employee received the COVID-19 vaccine. Therefore, employers should not reveal to their clients or patients whether an

6. See Compliance Manual on Religious Discrimination, U.S. Equal Employment Opportunity Commission (Updated January 15, 2021), available at https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination#h_92641543316651610748773227 (last accessed February 2, 2020).
7. See supra note 6.
8. See supra note 4.
9. See Health Care Workers and the Americans with Disabilities Act, U.S. Equal Employment Opportunity Commission at Q. 7 (Updated February 26, 2007), available at https://www.eeoc.gov/laws/guidance/health-care-workers-and-americans-disabilities-act (last accessed February 2, 2021).
10. See supra note 9 at Q. 8.
11. See supra note 1 at K. 5.
12. See supra note 1 at K. 5.

individual employee is vaccinated or not. Employers may, however, communicate generally about their employees – for example, by indicating that all of their employees received the vaccine.

If an employer cannot truthfully state that all of their employees are vaccinated, the employer should state that they encourage vaccinations and that they follow all applicable guidance from the CDC and the Rhode Island Department of Health.

9. Can employers require their employees who do not get the vaccine to sign a waiver of liability?

No. An employee who contracts COVID-19 in the workplace will likely be covered by the workers' compensation statute, which prohibits employees from waiving claims in advance.

If the employer has a voluntary vaccination program, the better practice would be to document in writing (via e-mail, letter, or memorandum to all employees) that the employer encourages employees to get vaccinated and that the employer will pay for all costs to the employee associated with getting vaccinated.

10. Can employers still test and/or screen employees for COVID-19 as a condition of entering the workplace?

Yes. If an employee has COVID-19, their presence in the workplace is considered a "direct threat" to the health and safety of others.(13) Therefore, employers are permitted to require their employees to get tested for COVID-19 before entering the workplace, and to exclude employees who test positive, as a means of keeping the workplace safe. In ADA terms, COVID-19 tests are "job related and consistent with business necessity."

If an employer requires testing, the employer must pay for the costs associated with such testing. This includes paying for the test itself if the employee's health insurance plan does not cover the cost. It also includes paying hourly, nonexempt employees for the time they spend getting tested, including travel time to and from the testing site.

Employers are also permitted to use certain screening techniques to minimize the likelihood of a person with COVID-19 entering the workplace. According to current EEOC guidance, permissible screening techniques include:

- taking an employee's temperature upon entering the workplace;
- asking employees if they are experiencing any of the COVID-19 symptoms;
- asking employees if they have been diagnosed with or tested for COVID-19; and
- asking employees if they have come into contact with anyone diagnosed with COVID-19 or who may have symptoms associated with the disease.(14)

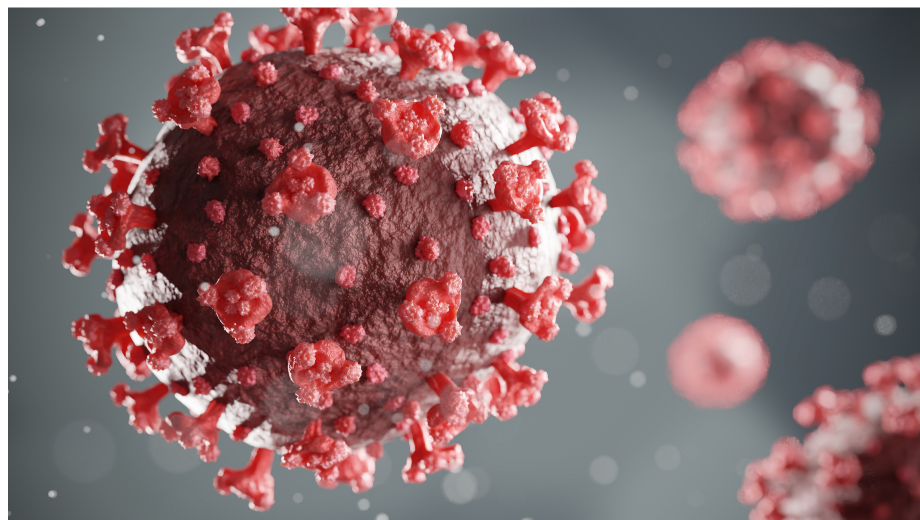
Keep in mind that mandatory testing requirements and screening protocols apply to employees who are actually entering the workplace. Employees who perform their jobs remotely, or who do not physically interact with others, would not pose the same "direct threat" to others if they tested positive. As such, employers should consider whether it is truly "job related and consistent with business necessity" to apply these protective measures to such employees.

Employers must also remember to keep any information they collect about an employee's symptoms or diagnosis as a confidential medical record in compliance with the ADA.

Finally, certain testing and screening measures are not permitted. For example, employers may not require employees to get an antibody test as a condition of entering the workplace, nor may they ask employees if any of their family members have COVID-19 or related symptoms.(15)

11. Can employers require an employee to stay home if they test positive for or have symptoms of COVID-19?

The EEOC encourages employers to follow guidance from the CDC regarding employees who test positive or who have symptoms. Currently, the CDC guidance states that employees who test positive or who have symptoms of COVID-19 should leave (or not come into) the workplace. Requiring employees who are positive or who have symptoms of COVID-19 to stay home is not a "disability-related action" under the ADA.



12. Can employers require an employee to quarantine for reasons related to COVID-19?

Employers can require their employees to follow quarantine guidance from the CDC and the Rhode Island Department of Health. For example, an employer may require an employee who travels

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13. See Pandemic Preparedness in the Workplace and the Americans with Disabilities Act, U.S. Equal Employment Opportunity Commission (Updated March 21, 2020), available at https://www.eeoc.gov/laws/guidance/pandemic-preparedness-workplace-and-americans-disabilities-act (last accessed February 2, 2020).
14. See supra notes 1, 13.
15. See supra note 1.

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to a high-risk state or who was exposed to a person with COVID-19 to quarantine in accordance with applicable guidelines.

Employers are also permitted to require employees to quarantine for longer periods of time than the CDC or Rhode Island Department of Health require.

13. What should an employer do if an employee refuses a temperature screening or refuses to answer legitimate screening questions about their symptoms or contact with positive cases?

According to the current EEOC guidance, an employer is permitted to bar the employee from entering the workplace. Before doing so, the EEOC recommends asking the employee the reasons for their refusal and offering to discuss or explain the reasons for the employer's policy.(16)

14. Do employers still have to provide paid leave under the emergency coronavirus legislation?

In April 2020, Congress passed the "Families First Coronavirus Relief Act" (the "FFCRA"), which required small employers (defined as employers with fewer than 500 employees) to provide two kinds of paid leave to employees impacted by COVID-19: emergency paid sick leave and emergency family and medical leave. Under the FFCRA, employers were required to provide paid leave to any employee who was unable to work because the employee:

1. was subject to a quarantine or isolation order related to COVID-19;
2. was advised by a health care provider to self-quarantine;
3. was experiencing COVID-19 symptoms and seeking a medical diagnosis;
4. was caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. was caring for a child whose school or place of care had closed for reasons related to COVID-19; or
6. was experiencing any other "substantially-similar condition."

The law expired on December 31, 2020, meaning that employees are no longer entitled to either type of FFCRA leave – even if the employee never used FFCRA leave, or only used some of it, while the law was in effect.

Nevertheless, an employer can voluntarily choose to provide FFCRA leave in 2021, and if they do so, the federal government will continue to issue tax credits for the leave through March 31, 2021.

15. What about regular FMLA leave?

Employers with 50 or more employees must comply with the Family and Medical Leave Act ("FMLA") and its state law equivalent, the Rhode Island Parental and Family Medical Leave Act ("RIPFMLA"). These laws require covered employers to provide up to 12 weeks or 13 weeks of unpaid job-protected leave, respectively, to eligible employees who need time to address their own serious health condition or that of a family member (among other reasons).

A "serious health condition" under the FMLA includes:

- Any condition requiring an overnight stay in a hospital or other medical care facility;
- Any incapacitating condition that lasts for more than three consecutive days and requires ongoing medical treatment;
- Any chronic condition that causes occasional periods of incapacitation requiring treatment; and
- Pregnancy.(17)

Under the RIPFMLA, it includes any "disabling physical or mental illness, injury, impairment, or condition that involves inpatient care in a hospital, a nursing home, or a hospice, or outpatient care requiring continuing treatment or supervision by a healthcare provider."(18)

Thus, employees may be entitled to FMLA/RIPFMLA for certain reasons relating to COVID-19. For example, an employee who has COVID-19, or who has a family member with COVID-19, may qualify for FMLA/RIPFMLA if the condition is incapacitating. Unlike the FFCRA, however, employers are not required to provide FMLA/RIPFMLA leave to employees who need to stay home to care for a child whose school or day care closed due to COVID-19; or to quarantine; or to seek preventative medical care related to COVID-19. Similarly, employers are not required to provide FMLA/RIPFMLA leave to employees who want to stay home for the purpose of avoiding exposure to COVID-19.

Notwithstanding the fact that the FMLA/RIPFMLA cover only some circumstances related to COVID-19, the U.S. department of Labor, which administers and interprets the FMLA, encourages employers to consider "flexible leave policies" for employees during the pandemic.

16. Do employers have to grant sick leave to employees for COVID-19-related reasons?

Even though the FFCRA is expired, employees in Rhode Island still have the right to accrue and use sick leave under the "Rhode Island Health and Safe Families and Workplaces Act," also known as the Rhode Island sick leave law.(19) Under the sick leave law, employers must provide a minimum of 40 hours of sick leave to each full-time employee per year, and a pro-rated amount of sick leave for employees who work less than 40 hours per week.

If the employer has fewer than 18 employees, the sick leave does not need to be paid. If an employer has 18 or more employees, the sick leave must be paid at the same hourly rate and with the same benefits, including healthcare benefits, as the employee normally earns.

16. See supra note 1.
17. See 29 U.S.C. § 2611(11).
18. See R.I. Gen. Laws § 28-48-1(7).
19. See R.I. Gen. Laws § 28-57-1 et seq.

Employees are entitled to use sick leave for any of the following reasons:

- The employee's own mental or physical illness, injury, or health condition;
- The employee's need for medical diagnosis, care, or treatment; or
- The need for preventative medical care.

Employees are also entitled to use sick leave to care for a family member with a mental or physical illness, injury, or health condition, or who needs medical diagnosis, care, treatment, or preventative medical care. The term "family member" is broadly defined to include the employee's child, parent, spouse, in-law, grandparent, grandchild, domestic partner, and sibling. It also covers a care recipient of the employee or a member of the employee's household.

The sick leave law also entitles employees to use sick leave due to:

- the closure of the employee's place of business by order of a public official due to a public health emergency;
- the need to care for a child whose school or place of care has been closed by order of a public official due to a public health emergency; or
- the need to care for oneself or a family member whose presence in the community may jeopardize the health of others because of their exposure to a communicable disease, as determined by the health authorities or a healthcare provider.

Thus, the sick leave law covers many common scenarios related to COVID-19, including, for example:

- An employee who is experiencing symptoms of COVID-19 and needs to get tested or seen by a medical professional;
- An employee who is positive for COVID-19 or whose family member tested positive;
- An employee who is subject to a quarantine order due to exposure to COVID-19;
- An employee who needs time off to receive the COVID-19 vaccination; and
- An employee who needs to stay home to care for a child whose school is closed due to COVID-19, or a child who was exposed to COVID-19 at school and is required to self-quarantine.

17. What is the status of state and federal unemployment laws applicable to COVID-19-related unemployment?

In March 2020, the federal government enacted the Coronavirus Aid, Relief and Economic Security Act (the "CARES Act"), which provided for expanded unemployment insurance benefits for individuals who were out of work for reasons related to COVID-19. It allowed individuals to collect a $600 "supplemental" unemployment payment on top of their ordinary benefits for each week of unemployment through July 31, 2020. It also expanded the range of individuals who could collect unemployment insurance benefits to include gig economy workers and others who do not ordinarily qualify for such benefits. Finally, it increased the number of weeks that an individual could collect unemployment insurance to 39 weeks.

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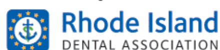

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The federal government updated and extended various provisions of the CARES Act related to unemployment insurance benefits on December 27, 2020. First, eligible individuals will receive a $300 supplemental payment on top of their ordinary unemployment benefits for each week of unemployment through March 14, 2021. Second, gig economy workers and others who previously did not qualify for unemployment insurance benefits remain covered. And third, the number of weeks an individual can collect unemployment insurance increased to 50 weeks, minus any weeks an individual already received regular unemployment insurance benefits and extended benefits.

Individual states are responsible for administering these federal unemployment benefits in addition to ordinary state unemployment benefits. The Rhode Island Department of Labor and Training, which administers Rhode Island's unemployment insurance program, has stated that it will automatically issue the $300 supplemental payments to each eligible claimant for the period running from January 2, 2021 through March 13, 2021. Extended benefits will run through April 10, 2021 (although some claimants may exhaust their benefits before that date).

18. Can employees use TCI for reasons related to COVID-19?

Rhode Island's Temporary Caregiver Insurance program ("TCI") allows eligible employees to collect up to four weeks of benefits while out on leave to care for child, spouse, domestic partner, parent, parent-in-law, or grandparent with a serious health condition.(20) Benefits are based on the employee's wages, with the current maximum weekly benefit set at $887 per week.(21)

An employee's family member is considered to have a "serious health condition" if they have any illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, residential healthcare facility, or continued treatment or continuing supervision by a licensed healthcare provider.(22) This definition likely covers an individual who has symptoms or a diagnosis of COVID-19.

TCI leave may be taken concurrently with FMLA/RIPFMLA leave. TCI benefits may also be collected on top of any sick or vacation pay the employee receives while out. Employers may require employees to provide at least 30 days' notice of the need to use leave, although employers must make an exception if an employee's need to take leave is unforeseeable. An unexpected positive COVID-19 test result, for example, would likely create an unforeseeable need to take leave.

Conclusion

The ever-evolving nature of the COVID-19 pandemic requires employers to stay on top of numerous laws and legal updates. Employers with additional questions about any of the topics discussed in this article, or about employment law generally, can contact the authors of this article using the following contact information:

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20. See R.I. Gen. Laws § 28-41-35.
21. See 2021 UI and TCI Quick Reference Guide, Rhode Island Department of Labor and Training (Issued Jan. 1, 2021), available at https://dlt.ri.gov/documents/pdf/quickref.pdf (last accessed Feb. 2, 2021).
22. See R.I. Gen. Laws § 28-41-34(11).

Understand Your Finances and Grow Your Business

CONTRIBUTED BY LANA M. GLOVACH, US SMALL BUSINESS ADMINISTRATION (SBA) IN RI
AUTHORED BY MARK MADRID ON APRIL 16, 2021 ON WWW.SBA.GOV

Understanding your finances is key to small business success. With small businesses across America still recovering from the impacts of the pandemic, financial literacy is more important now than ever.

Financial Literacy Month¹ was first established in 2004 to encourage Americans to learn about finance best practices and to boost their financial well-being. It can also serve as a reminder to take stock of your overall financial outlook and set finance-related goals - whether that's to obtain a loan, increase your revenue, or learn more about business taxes. Chances are, there's an SBA resource that can help you take the next steps toward achieving your goal.

To highlight three immediate educational resources to tap into, please consider the following:

A local business advisor –

SBA resource partners[2] can also help you get a clearer picture of your finances. One topic many small business owners work with resource partners on is preparing to apply for a small business loan. Resource partners can help you review your business plan, organize tax return documents and bank statements, and complete other important tasks before your loan application is sent to your lender.

Free online classes –

For training on any small business topic, the SBA's Learning Center[3] and new Ascent[4] platform provide readily available expert insights. An essential course for early-stage businesses is the Financing Your Business[5] course. This course outlines various funding options, including loans, grants, venture capital, and crowdfunding, and concludes with a downloadable worksheet to help you assess your own financial needs.

Financial advice for every area of life –

SBA is a proud member of the Financial Literacy and Education Commission[6], and fully supports the well-being of all individuals and small business employers. While special projects like Money Smart for Small Business (MSSB)[7] (a joint curriculum of SBA and FDIC) provides an introduction to topics related to starting and managing a business, the FLEC-sponsored website MyMoney.gov is full of financial literacy resources for students, retirees, and more.

SBA-Guaranteed Loans and Lender Match

SBA-guaranteed loans[8] are often an ideal funding option for small business owners who are creditworthy but don't qualify for conventional financing. SBA works with participating lenders to reduce their risk, increasing the likelihood your loan will be approved with the terms that work best for you.

If you decide SBA-guaranteed loans are a good fit for your business, SBA makes it easy for you to connect with lenders via our Lender Match[9] tool. Lender Match is SBA's free online referral program that connects small businesses with more than 800 participating SBA-approved lenders.

To get started, just answer a few questions about your business. Then, you'll receive an email with contact information from lenders who have expressed interest in your loan. From there, you'll be able to compare rates, terms, fees, and more.

Community Navigators being launched soon!

In the immediate future, we are expanding our reach through an even more expansive network of business coaches, called "Community Navigators." Navigators will accelerate information, education, training, and mentoring for small businesses in rural, underserved, and tribal communities. Please stay up-to-date by visiting **sba.gov/navigators**.

Whatever your financial goals for your business, SBA is here to help you get to your next step with personalized guidance and tested tools and resources. Learn more at **sba.gov**.

1. https://www.whitehouse.gov/briefing-room/presidential-actions/2021/03/31/a-proclamation-on-national-financial-capability-month-2021/
2. https://www.sba.gov/local-assistance
3. https://learn.sba.gov/dashboard
4. https://ascent.sba.gov/
5. https://learn.sba.gov/learning-center-launch/learning-center-financing-your-business
6. https://home.treasury.gov/policy-issues/consumer-policy/financial-literacy-and-education-commission
7. https://www.sba.gov/page/money-smart-small-business
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Did you know that 1 in 4 Rhode Island households lack adequate food? To help feed our hungry neighbors, please visit www.rifoodbank.org to see the many different ways to give.

Dr. Frederick McMillen

Dr. Frederick McMillen & David Laborde, Assistant General Manager, Costco

Dr. Frederick McMillen & Sean McKendry, General Manager, Costco

FILLING THE GAPS IN CHRONIC DISEASE PREVENTION:

Hypertension and Diabetes Screening Practices Among Rhode Island's Dental Providers

BY: SAMANTHA PEREZ, BA; MEGAN FALLON-SHERIDAN, MS, RD; SADIE DECOURCY, JD; SAMUEL ZWETCHKENBAUM, DDS, MPH

Abstract

Dental providers can contribute to chronic disease prevention efforts by screening in their offices, but current practice may be limited. In Rhode Island, screening practices within dental offices remain unknown. This article attempts to quantify and describe results from a 26-question survey distributed to dental providers in Rhode Island. The survey responses indicate that only one-quarter of oral health professionals screen for hypertension on all patients and only one-fifth screen for diabetes on all patients. These and other findings reveal opportunities for education and development of protocols within the practice to enhance chronic disease screening.

Background and Introduction

Rhode Island is confronted with a substantial chronic disease burden: 55.8% of all Rhode Island adults have at least one chronic disease, and more than one in four have multiple chronic conditions.(1) Diabetes alone has increased to an age-adjusted rate of 8.4%, compared to 5.3% in the late 1990s.(1) About one in three adults (32.4%) have been diagnosed with hypertension.(1) There are links between these chronic health issues and poor oral health(2,3) yet links between dental and medical healthcare systems are not robust.(4)

Knowing that oral health professionals have the capacity to provide care that extends beyond the oral cavity, several states have sought to remove barriers and foster integrated collaborations between medical and dental providers. A recent survey of Rhode Island dentists found many recognized the importance of screening, but most had liability concerns in providing limited preventive primary care.(5) Other studies have evaluated current screening practices before instituting programs and approaches for hypertension and diabetes screening. A Michigan survey found that 41% of oral health professionals screened for hypertension and 30% screened for diabetes on all adults.(6) While inconsistent use of parameters that define hypertension and diabetes when screening for these conditions was noted by researchers, most of the oral health professionals reported that they informed patients when screenings revealed high readings and some even provided patient education.6 Very few dental providers referred patients with elevated screening results to a primary care provider.(6) A Wisconsin study found that only 16% of dental providers frequently referred patients to medical providers for a

diabetes assessment, while 42% frequently made referrals for hypertension.(7) In contrast to the Michigan survey, 69% of the dental providers who participated in Wisconsin's survey reported that they infrequently provided patients with education on the connection between chronic diseases and poor oral health.(7) By the end of 2020, the Iowa Department of Health intends to conduct a similar survey evaluating the use of chronic disease assessments and referrals to treatment
(tobacco screening and referral, blood pressure screening, etc.).(8)

Based on the research done to prepare for this survey and report, only one different approach was found to have been tested in Rhode Island to evaluate the feasibility of chronic disease screening within dental offices. A collaborative project spear-headed by Delta Dental of Rhode Island recruited 11 general and periodontal dental offices and one dental clinic located within a community health center to determine whether point-of-care measurement of hemoglobin A1c from a finger-prick blood sample, in combination with the use of the American Diabetes Association Diabetes Risk Test9; demographic and health data; and periodontal evaluation, would be useful in establishing a feasible method of screening for undiagnosed diabetes and pre-diabetes within dental practices.(9) Researchers sought to train at least one existing staff member as a clinical coordinator to implement the Diabetes Risk and A1cNow+ tests.(9) However, all members of the dental offices played a role in identifying patients appropriate for screening.(9) Results from this study show that new procedures can be reasonably implemented and accepted by dental staff if sufficient training is provided, but a foundational collaboration between dental and medical providers remains important.(9)

Expanding upon these findings, the Rhode Island Department of Health (RIDOH) sought to better coordinate its oral health activities with work being conducted by its chronic disease program. RIDOH's Diabetes, Heart Disease and Stroke Prevention Program and Oral Health Program collaborated to assess chronic disease screening practices across dental providers in Rhode Island, highlighting gaps in care, provide education, and identify training needs.

Methods

Survey questions used in prior assessments were adapted for the needs of this project.(6) Additional questions were collaboratively developed. Overall, the 26-question survey included questions about the dental health provider and their practice, the use of hypertension/diabetes screening practices, comfort level when screening, knowledge of hypertension/diabetes parameters, the practice's current care process (i.e., referral to primary care is made when a patient is identified with high blood pressure), and resource needs. For the purposes of this survey, screening for hypertension is defined as taking blood pressure. Screening for diabetes was left open to interpretation (e.g., periodontal exam for oral signs of disease, health assessment questionnaire, point-of-care finger stick fasting plasma glucose, point-of-care finger stick hemoglobin A1 test), given that a standard of care for diabetes screening within dental settings remains unclear. A copy of the survey can be viewed by visiting were adapted for the needs of this project.(6) Additional questions were collaboratively developed. Overall, the 26-question survey included questions about the dental health provider and their practice, the use of hypertension/diabetes screening practices, comfort level when screening, knowledge of hypertension/diabetes parameters, the practice's current care process (i.e., referral to primary care is made when a patient is identified with high blood pressure), and resource needs. For the purposes of this survey, screening for hypertension is defined as taking blood pressure. Screening for diabetes was left open to interpretation (e.g., periodontal exam for oral signs of disease, health assessment questionnaire, point-of-care finger stick fasting plasma glucose, point-of-care finger stick hemoglobin A1 test), given that a standard of care for diabetes screening within dental settings remains unclear. A copy of the survey can be viewed by visiting health.ri.gov/publications/chronicdiseasesurvey.pdf.

Following pilot testing with 13 dental hygienists, the survey was disseminated through email in July 2019 and was open for one month. For the purposes of this data brief, screening practices were stratified by number of years in service, role, and type of practice setting.

Results

A variety of dental care providers (N=137) responded to the survey (Table 1). The number of respondents account for 9.5% of all oral health professionals in Rhode Island. Most respondents are experienced, with 62% having practiced for 21 years or longer.

Table 1. *Description of Surveyed Dental Providers*

Characteristics	N (%)
Role in Practice	
Dentist	63 (46.3%)
Dental Hygienist	69 (50.7%)
Dental Assistant	4 (3%)
No Answer	1 (0.7%)
Years in Practice	
Less than 1 year	2 (1.5%)
1-5 years	5 (3.7%)
6-10 years	10 (7.4%)
11-15 years	14 (10.4%)
16-20 years	19 (14.1%)
21 years or longer	85 (62.9%)
No Answer	2 (1.5%)
Type of Practice Setting	
Solo general dental practice	60 (44.4%)
Solo specialty practice	11 (8.2%)
Group practice	39 (28.9%)
Hospital-based clinic	5 (3.7%)
Federally Qualified Health Center	12 (8.9%)
Other	8 (5.9%)
No Answer	2 (1.5%)

Initially, findings from this survey indicate that 26% of respondents screen for hypertension on all patients they treat (Figure 1). Conversely, 25% reported that they did not screen for hypertension at all, with the top reason (75%) being that there was no protocol in place (Table 2). Eighty-nine percent (89%) of respondents report being comfortable or very comfortable with taking blood pressure. When assessing for hypertension parameter knowledge, most (79%) correctly identified 120/80mmHg as a normal blood pressure reading, while one-third (35%) recognized 130/80 mmHg as a hypertensive reading (Table 3).

Findings also indicate that only 20% of respondents screen for diabetes on *all* patients (Figure 1). A large majority of respondents (74%) do not screen for diabetes at *all*, with the top reason (54%) being that there is no protocol in place (Table 4). Given an array of possible screening methods for diabetes, 77% feel most comfortable doing a periodontal screen to look for

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oral signs of disease and 82% feel comfortable with a health assessment questionnaire. In the case of point-of-care finger stick recordings of fasting plasma glucose or a hemoglobin A1c test more than half (55%) report not using these methods. Knowledge on diabetes parameters varied (Table 3). Nearly one-third (31%) correctly identified an A1c less than 5.7% as normal or healthy. More than half of the respondents (53%) correctly identified an A1C of 6.5% or higher as diabetic. Nearly half (45%) correctly identified less than 100mg/dl as a normal fasting plasma glucose (FPG) and FPG of 126 mg/dl or higher as diabetic (47%).

Figure 1: *Respondents report different screening practices for hypertension and diabetes*

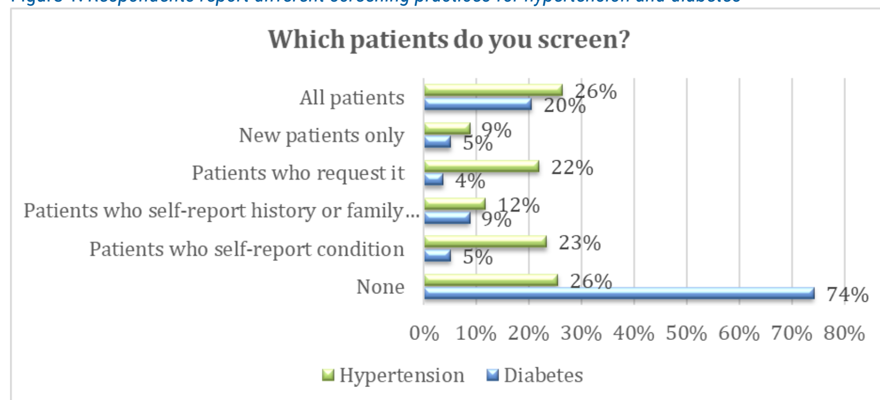


Table 2: *Identified or perceived barriers affecting hypertension screening*

Barriers to Hypertension Screening (n=24)	
Too little time in appointment	38%
Do not see the need	8%
Uncomfortable with skill to do this task	4%
Equipment not available	17%
Unable to refer to care	0%
No protocol in place	75%
No reimbursement or incentive to perform this procedure	21%
Other	17%

Notes:

- Of the 25 respondents that responded none when asked which patients they screened for hypertension, 24 respondents gave explanation as to why.
- Respondents were asked to choose all that apply from given responses.

Table 3: *Proportion of respondents correctly identifying normal and abnormal parameters for hypertension and diabetes*

	Hypertension - Blood Pressure	Diabetes - FPG	Diabetes - A1c
Normal (Correct)	79%	45%	31%
Abnormal (Correct)	35%	47%	53%

Table 4: *Identified or perceived barriers affecting diabetes screening*

Barriers to Diabetes Screening (n=75)	
I consider it outside my scope of practice.	19%
I treat the dental condition and suggest they contact their primary care provider.	37%
I do not have additional equipment needed for follow-up.	33%
The oral signs can indicate too many other medical conditions.	5%
Unable to refer for care	7%
No protocol in place	55%
No reimbursement or incentive for procedure	20%
Other	13%

Notes: All 75 of the respondents that responded none when asked which patients they screened for diabetes gave an explanation as to why. Respondents were asked to choose all that apply from given responses.

Most respondents reported that they instruct the patient to follow up with their primary care provider when a screening reveals high blood pressure, high A1C, or elevated fasting plasma glucose, but less than 15% of the dental providers contact the physician's office directly. If a referral to a primary care provider is made, less than 20% of respondents follow up with the physician's office to see if the patient made contact. The preferred resources on hypertension and diabetes are webinars or online continuing education (CE) courses (62%), followed by live lectures (55%), informational pamphlets (53%), and reference cards (48%).

Screening practices for hypertension and diabetes were then evaluated by characteristics of the survey respondents. Respondents were categorized into screening all, some, or none. The all category has the respondents that explicitly indicated screening all patients. The some category is classified as those who responded to screening any of the following: new patients only, patients who request it, report history or family history, or specified which patients in the other section. The none category includes those who explicitly indicated none and those respondents who did not provide an answer.

While sample size was low, results indicate that the proportion screening all patients between dentists and dental hygienists is 30% or less (Figure 2). A glimpse at private practice screening methods reveals that the proportion of screening all patients is about 20% or less (Figure 3). Overall screening practices of respondents that have more than 21 years in service (62% of total respondents) further highlights the gap in screening for diabetes (Figure 4).

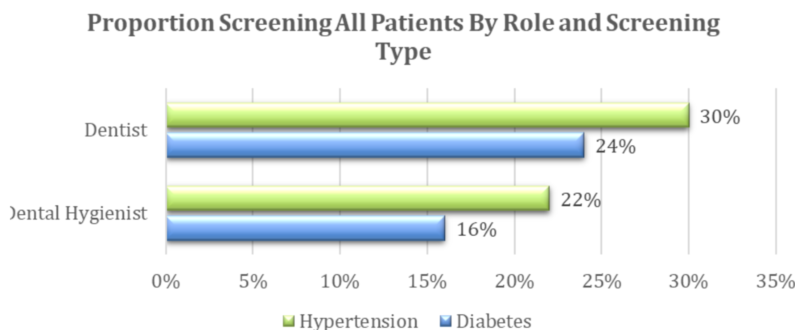
Discussion

Training for both dentists and dental hygienists has routinely included hypertension screening by taking of blood pressure; (10) (likely as a risk-management strategy) however, it may not be viewed as a way to improve overall health for patients. Dental professionals are well-aware of the potential oral side effects of anti-hypertensive medications and their impact on treatment and risks of drug-drug interactions with those associated with dental care;11 however, in most situations, hypertension has little impact on the oral health of the patient or their ability to receive dental treatment. In contrast to hypertension screening training, few providers receive training regarding diabetes screening. Unfortunately, diabetes is significantly more likely to impact the oral health of the patient, and the oral health of the patient is likely to impact their glycemic control.

This survey has shown us that current screening practices for hypertension and diabetes by dental care providers in

Rhode Island are limited and may not be ideal for effective medical dental integration. Current barriers to screening for both chronic diseases are a lack of protocol, inconsistent knowledge of parameters, and additionally for diabetes, unfamiliarity with screening techniques. Furthermore, the current referral systems available between medical and dental providers is limited or non-existent in most offices.

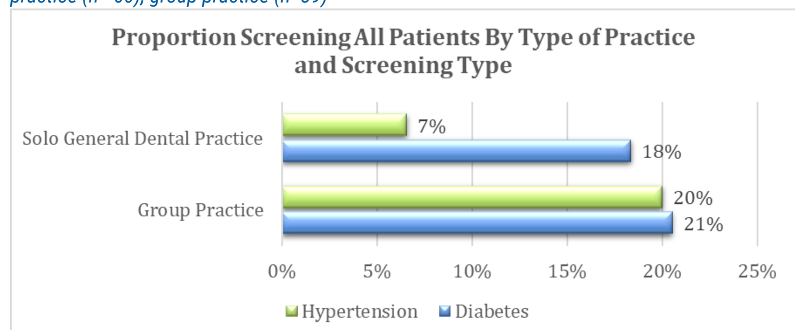
Figure 2: *Comparison between dentists (n=63) and dental hygienists (n= 69) screening all patients for hypertension and diabetes*



Notes:

- Dental assistants (n = 4) were excluded due to small sample size.
- Dentists reported that they are about three times more likely to screen some for hypertension than diabetes and about six times more likely to screen none for diabetes than hypertension.
- Dental hygienists reported that they are about two and a half times more likely to screen some for hypertension than diabetes and about two times more likely to screen none for diabetes than hypertension.

Figure 3: *Screening of all patients for most reported private practice type: solo general dental practice (n= 60), group practice (n=39)*



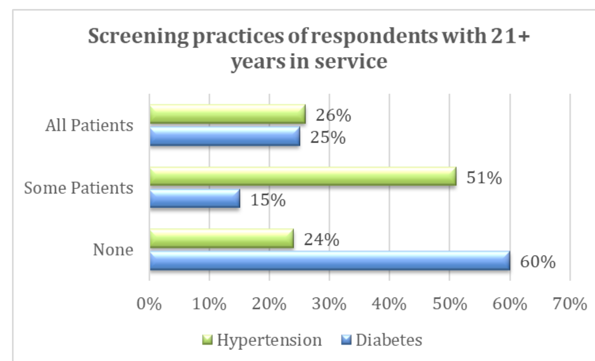
Notes: Solo specialty practice, Federally Qualified Health Center, hospital-based clinic, and other were excluded due to small sample size. Solo general dental practices reported they are about three times more likely to screen some for hypertension than diabetes and about two times more likely to screen none for diabetes than hypertension.

Group practices reported they are about three times more likely to screen some for hypertension than diabetes and about three times more likely to screen none for diabetes than hypertension.

Dental professionals are comfortable with the idea of screening for hypertension through the recording of blood pressure but may not do it for a number of reasons. It is easy to do and likely fits in well with the cadence of the appointment. Depending on how diabetes screening is done will determine how well it fits in. Asking key questions around risk factors and looking for oral signs fits in more easily than performing a finger stick and testing hemoglobin A1c. Developing a protocol for diabetes screening that results in a visit to a primary care physician would be an easier ask. Performing a hemoglobin A1c test takes time, requires supplies, and even with the new ADA code D0411 is unlikely to get covered by most dental insurers.

By utilizing a multi-level collaborative approach between RIDOH's Oral Health Program, Diabetes, Heart Disease and Stroke Prevention Program, and dental health providers, it is

Figure 4: *Comparison of screening all patients, some patients, or none for hypertension and diabetes and most reported years in service: 21 or more years (n = 85)*



Notes: *Respondents with less than 21 years of service were excluded due to small sample size.*

possible to successfully implement a standardized chronic disease screening protocol within dental settings in Rhode Island.

Current Rhode Island dentists show an interest in expanding their roles by providing limited preventive primary care, especially with older dental care providers.(5) Another Rhode Island study has shown the feasibility of implementing diabetes screenings with proper training.(9) The Models of Collaboration in Maryland also highlights that dental practices, with proper guidance and support, successfully incorporated hypertension screening into their workflow.(4) Thus, with a willing dental provider population and strong direction from RIDOH, there is potential to have screening for chronic diseases within the dental setting become standard practice.

New guidelines on hypertension have lowered a hypertensive blood pressure reading from 140/90 mm Hg to 130/80 mm Hg.(12) Our findings suggest that most Rhode Island dental providers are not aware of this change, as 52.15% of respondents chose 140/90 mm Hg. Similarly, less than half are knowledgeable on diabetes parameters. There is a clear need for education and training on proper evidence-based guidelines and screening methods for both hypertension and diabetes. The majority of respondents surveyed prefer continuing education webinars, live trainings, informational pamphlets, and reference cards. With adequate funding, possible options for RIDOH are to incorporate these trainings into its annual dental mini-residency or offer academic detailing with a PharmD through a lunch and learn. Another useful tool to consider was one that was implemented by the Maryland Department of Health—a social marketing campaign that raised awareness about the connection between oral and general health to both providers and patients.(4)

We have noted opportunities for communication between dental and medical providers. Although most of our respondents inform patients to go to a primary care provider, less than one-fifth will contact the physician themselves and follow up after the referral was made. Trainings and informational tools on when to refer a patient for care and the referral process could be utilized to fill this gap. Just as performance measures are now in place for physicians to make referrals to dentists, we should consider the same for dentists who make referrals to physicians. Previous studies also suggest that implementing a shared electronic health record could improve referrals and follow through. (4)

Limitations

Limitations of this study include a small sample size and a skew toward older providers; thus, the participants were not representative of dental professionals in Rhode Island overall. As a voluntary survey, there was also potential for a self-selection bias. The concept of screening, especially in the

continued on page 17

continued from page 16
case of diabetes, may have different meaning depending on the dental practice; there was no clarification in the survey as to whether screening for diabetes in a dental setting is asking health questions, performing a periodontal exam, or doing a blood test - leaving it up to interpretation may have influenced results.

Conclusion

The bidirectional relationship between oral health and systemic health cannot be over emphasized, as the mouth often mirrors systemic health and can be the initial site of an underlying disease. Dental providers have an opportunity to improve both the oral health and general health of their patients. Specifically, screening for chronic diseases within the dental setting and early intervention can impact chronic disease outcomes, especially those at high risk who would otherwise be missed through the medical setting. This brings attention to the critical need of increased collaboration between medical and dental health providers. ■

About the Authors

Samantha Perez graduated from Brown University in May 2019 and served as a Public Health Scholar through RIDOH's Academic Institute.
Megan Fallon-Sheridan is the Acting Program Administrator in the Diabetes, Heart Disease and Stroke Program in RIDOH's Division of Community Health and Equity.
Sadie DeCourcy is the Program Manager and **Dr. Samuel Zwetchkenbaum** is the Dental Director, both in the Oral Health Program in RIDOH's Division of Community Health and Equity.

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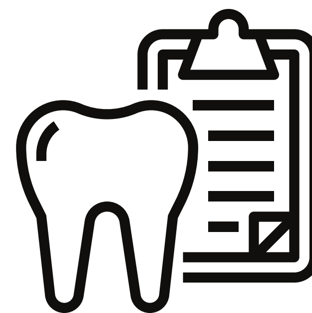
SCHOOL BASED SCREENING IN THE MIDST OF COVID-19



This past year has tested the resourcefulness of the dental community to find new methods of dental screenings in schools. Despite dentists' willingness to find a reasonable alternative method of conducting school-based screenings, virtual classrooms and increasingly high numbers of positive COVID tests made it almost impossible to logistically coordinate efforts. Dr. Pedro Ochoa at Blackstone Valley Community Health Center continued to maintain communication with several of the elementary schools' nurses in Central Falls and Pawtucket. He continued to monitor distance learning, State and CDC guidelines. When it became evident that Ella Risk Elementary School in Central Falls would be Rapid COVID testing students within the school, discussions began in earnest with the school nurse, school principal and with the UnitedHealthcare community coordinator to develop a plan on how to safely conduct dental screenings at the same time as COVID testing.

The COVID testing room located inside the school was evaluated and determined that it was large enough to set up student chairs 3 feet apart, has sufficient air flow-with an open window, and an air purifier to provide a safe environment for students, school and dental staff. A dental screening area with supplies and a chair for screenings to meet distance requirements was also set up in the room. Permission was obtained through an opt out consent form supplied through the school. Screening dates were scheduled for end of April and first week of May. Three hundred students were screened, assessed and identified based on degree of dental need. Parents/Guardians will be notified of the screening results, and every attempt will be made to schedule the students with a dental provider if the child does not have a dental home. Assessment will be done to determine the feasibility of in school sealant application program.

If you are interested in additional information contact: Marie Jones-Bridges, UnitedHealthcare community coordinator at 401-486-9794 or email at: marie_jones-bridges@uhc.com.

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SELLING A DENTAL PRACTICE

BY: JON ALMEIDA, PARTNER, TAX & BUSINESS SERVICES WITH MARCUM ACCOUNTANTS AND ADVISORS

Selling a business is a huge step in the life of any business owner. If you are considering selling your dental practice, there are many considerations you'll want to address to ensure the transaction goes smoothly and with the intended results. Your initial thoughts will range from "what am I going to do when I retire?" and "how long do I want to continue working?" to "what is my practice worth?" "how am I going to get the deal done?" and, of course, "how much tax am I going to pay?"

Although dental practices have been significantly impacted by the COVID-19 crisis in the short term, the demand for dental services was expected to increase prior to the crisis (the Bureau of Labor Statistics expected industry jobs to rise 19% from 2016-2026), and it stands to reason that this demand will continue and resume growing once the impact of the virus has been more fully addressed and absorbed by healthcare systems in the United States.

BACKGROUND

There are approximately 136,000 dental practices in the United States, and the great majority (90%) operate as general dentistry practices. The average practice generates $1 million in revenue annually and employs 7-8 workers. More than 80% of practices in the U.S are structured as partnerships, sole proprietorships and small business corporations ("S-Corporations"). Dental practices are considered highly marketable, in that they generate many transactions annually, and the goodwill of a dental practice generally is transferable to a buyer. There has been a trend over the past several years of dental service organizations increasing their share of the dental practice market through acquisitions.

VALUATION CONSIDERATIONS

General dentistry practices derive value from their existing patient base as compared to specialist practices, which derive value primarily from referrals. Practices with strong hygiene businesses derive significant additional value due to the recurring nature of the service and the low involvement required from the owner/practitioner to maintain this revenue stream. For a specialty practice, it may be more difficult for a potential buyer to maintain the goodwill or continuing cash flows, with the existing dental practitioner no longer in place.

When valuing a dental practice for a potential sale, it is important to consider not just the profits and revenue of the dental practice but the owner's compensation and benefits, in deriving the cash flows available to the owner. A prospective buyer will want to adjust the practice's cash flows to fair market value for compensation to the owner that is either too low, which would require a higher replacement cost to the buyer, or too high, which would result in greater cash flows to the business. Some discretionary expenses not vital to generating cash flow to the practice may be added back to cash flow in a valuation, effectively increasing the practice value.

Since the value of a business is often assessed based on the cash flows available to the owner(s), a dental practice owner may want to take a hard look at any inefficiencies, starting with how the business's overhead cost rates compare to the industry in general. Efforts to shore up operational inefficiencies, such as overpaying for certain expenses, prior to marketing the practice for sale may result in more money in the seller's pocket at closing. Not addressing inefficiencies in advance may result in a discounted selling price, to the buyer's advantage, with the inefficiencies surely being addressed by the buyer post-sale.

A dental practice owner may also want to consider engaging a business valuation professional to make an assessment prior to marketing it for sale or in negotiating a successor buy-in.

TRANSACTION AND TAX CONSIDERATIONS

Most dental practice sales are structured as asset sales, meaning the acquirer is buying specific assets of the company rather than its stock. This is done for several reasons, primarily the acquirer's ability to expense the payments for the assets purchased more quickly, versus company stock, as well as avoiding potential legal liabilities of the acquired company. Depending on the type of assets being sold, tax rates on gains can be very different if ordinary income rates apply, up to as much as 37%, versus capital gains rates, which range from 15% to 20%.

Due to tax considerations, of importance is agreement between the parties on the asset allocation statement, which should be included in an asset purchase agreement. When the parties to the sale report the transaction in their respective tax returns, the reporting on Form 8594, Asset Acquisition Statement, must be consistent on each return as to the sales price of assets and the fair market value of the respective asset classes. In a dental practice sale, the separate classes will most likely include accounts receivable, inventory, fixed assets (furniture and fixtures, equipment, vehicles), and goodwill.

Other than the obvious importance of identifying which assets are to be included or not included in the sale, the asset purchase agreement should identify the relative fair market value of the assets to be included as part of total sales price. For the seller, an increase in the allocation of the sales price to goodwill is generally beneficial, as lower capital gains tax rates would apply. An increase in the allocation of the sales price to equipment would not be beneficial to the seller, due to potential recapture of depreciation deductions previously taken on the equipment, in which case higher ordinary income tax rates would apply.

There are many other transactional considerations to be addressed when negotiating the sale of a dental practice, including responsibility for collecting accounts receivable and assumption of payables, the timing of the payment of the sales price, and any contingencies affecting the ultimate payment. Additionally, an employment agreement with the seller during a transition period subsequent to the sale may be a necessary aspect of the deal. Working through these issues with the help of a professional team, including a certified public accountant and an attorney, will help in achieving desired results and avoiding later conflicts.

CONCLUSION

Dental practice owners will have many questions and concerns when considering taking the big step of selling their practice. Just as great care should be taking in treating the patients of a continuing practice, similar care should be taken in addressing the multiple considerations of selling a dental practice, including valuation, taxation and transactional elements. A good first step in navigating these considerations is engaging qualified accounting and legal professionals to assist in guiding the transaction from initial stages to a close. ■

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THE RHODE ISLAND ORAL HEALTH COMMISSION BECOMES A COALITION!

Over the past year, the Rhode Island Oral Health Commission, which began is 2001, has transitioned to become the state's first Oral Health Coalition. This move ensures the foundation on which the organization was formed remains, while evolving into a stronger, unified Coalition of Oral Health Advocates. To maintain its relevancy and to ensure long-term sustainability, the newly branded RI Oral Health Coalition (RIOHC) is now the first section under the umbrella of the non-profit, Rhode Island Public Health Association.

This union provides the Coalition with unique opportunities to enhance its statewide reach and advance the organization's mission to provide leadership to formulate and promote sound oral health policy; increase awareness of oral health issues; and assist in promotion of initiatives for the prevention and control of oral diseases.

Most recently, the RIOHC approved new Bylaws and elected an Interim Executive Board of Directors until a full election is conducted this fall for the 2022-2024 term. The Interim Executive Board includes:Chair: Martha Dellapenna, RDH, MEd, Vice-Chair: Ann Cadoret, RDH, MSDH, MPH, Treasurer: Marie Jones-Bridges, CDA, RDH, PHDH, BS and Secretary: Susan Perlini, RDH, PHDH, BS.

RIOHC welcomes new members interested in advancing the oral health of Rhode Islanders and will be ready to launch membership registration soon. Watch for updates in the coming weeks!

NEW DENTIST NEWS
10 UNDER 10:
Dr. Elizabeth Benz's dental journey to working with vulnerable populations

Dr. Elizabeth Benz, of Providence, Rhode Island, is among the recipients of this year's 10 Under 10 awards, which recognizes new dentist who demonstrate excellence early in their careers. Dr. Benz serves as the director of the Samuels Sinclair Dental Center at Rhode Island Hospital and as program director of the Joseph S. Sinclair General Practice Residency. Dr. Benz also manages a multi-million dollar hospital-based practice specializing in intellectually disabled individuals and medically complex patients. She has procured two grants from Delta Dental of Rhode Island for charitable dental care, equipment and technology upgrades.

Dr. Elizabeth Benz always had an interest in medicine, but was encouraged to explore other career paths by medical professionals who were dissatisfied in their field.

In high school and college, Dr. Benz began shadowing a local orthodontist, and it was there where she fell in love with dentistry. She says it was the hands-on aspect that she enjoyed the most and in 2011, graduated from the Boston University School of Dental Medicine.

However, today, Dr. Benz somehow still finds herself practicing in a hospital setting.

As the director of the Samuels Sinclair Dental Center at Rhode Island Hospital, Dr. Benz works with special needs patients who are intellectually disabled.

"I have patients who have either neglected their dental care or have been unable to be treated at outside practices come and be treated here. And that is probably the most rewarding."

In her almost 10-year dental career, Dr. Benz has done a great deal of work with medical specialists at the hospital in cardiothoracic surgery, hematology/oncology, and radiation oncology.

There, she helps to clear patients for various treatments such as cancer, head and neck radiology, cardiac surgeries, and kidney transplants. She's also a frequent collaborator, doing screenings and health fairs, with Children's Friend, an Early Head Start and Women Infant Children (WIC) program for the state of Rhode Island.

Currently working with 85-90% of Rhode Island's group home patients, Dr. Benz also spends her time
educating staff on how to identify abnormalities in nonverbal patients.

"We have oral hygiene clinics for the group home staff so they know how to take care of these patients", she said.

Making the switch from private practice to working in a hospital came with its adjustments, as Dr. Benz was unaware of all that hospital dentistry entailed.

"When I first went into dentistry, I somewhat knew that there were hospital dentists," she said. "But I really thought it was a just a residency program that trains people and that was the end of their exposure to hospital dentistry. And so, I think since being in this environment, my overall view of dentistry has changed.

"Of all the work that Dr. Benz does, she wants people to know that there is not a single patient that is impossible to treat. She says that whether it's taking multiple visits and having a patient come in every three weeks to desensitize them, or taking a patient to an operating room because they are so medically complex, everyone should be able to receive dental care.

"Being in dentistry has opened my eyes and exposed me to a lot more people than I ever thought," she said. "We meet people from all walks of life, from our referrals from the hospital to our private practice patients that we treat, to the special needs patients and their caregivers and guardians. And I've gained so much just from interacting with them. But overall, just encountering my patients on a day to day basis has really changed me."■

Dr. Elizabeth Benz enjoys a morning in the playground with her children.

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Graduate: University of Connecticut, 2010

Richard Cohen, DDS
New York University, 1979
US Army Dental Clinic Command/Ft Mead, 1991

Mohammad Manaf Alkurdi, DMD
Boston University, 2018

Ana Seith, DMD
Tufts University School of Dental Medicine, 2018

Inesa Tshagharyan, DDS
University of Illinois at Chicago, 2020

Robert Block, DDS
New York University, 2010
VA - Naval Medical Center/Portsmouth, 2015

Robert Block, DDS
New York University, 2010
VA - Naval Medical Center/Portsmouth, 2015

RETIRED MEMBERS

Ronald Sniderman, DMD
32 years of membership

Larry Levin, DMD
42 years of membership

Phillip Barner, DDS
44 years of membership

Peter Wolff, DMD
47 years of membership

Thomas Correia, DDS
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Martin Hanoian, DMD
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Michael Wagner, DDS
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To refer patients for free cessation services, visit mylifemyquit.com and select "resources for healthcare professionals".

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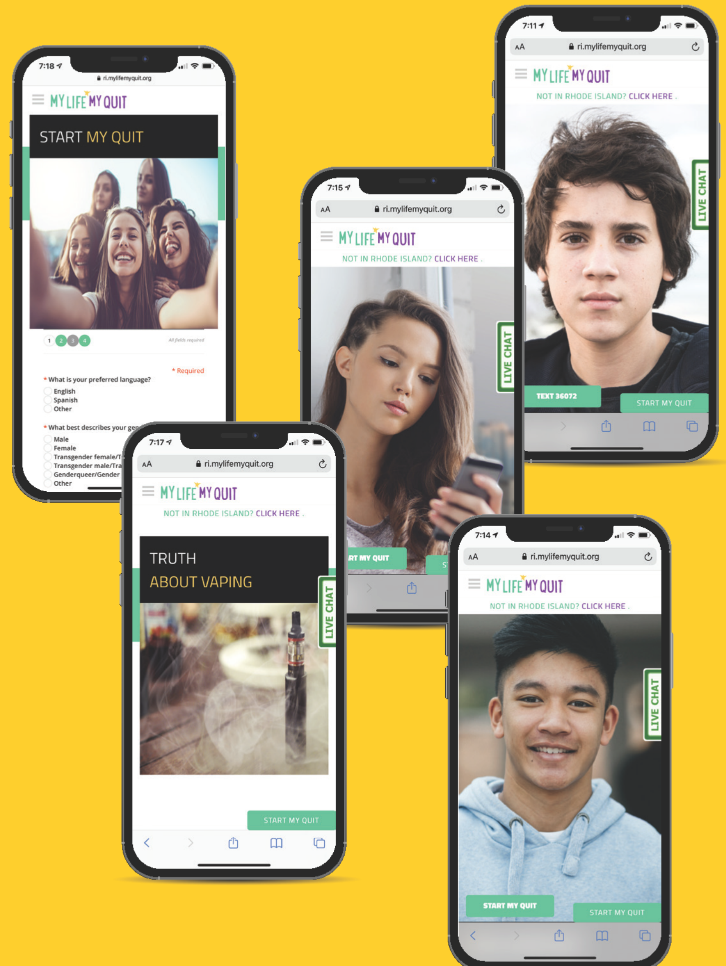

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Dental Office for Lease: This is a great opportunity for a dentist to lease an 1800 sq. ft. suite with an adjoining 600 sq. ft. for expansion. Private toilet and break room, parking and building wheelchair accessible. Located in Woonsocket, the gateway to Rhode Island, population 41,603 (2019). The city is the home of the Historic Stadium Theatre Performing Arts Centre & Conservatory, the corporate headquarters of CVS Health, the home of Landmark Medical Center, the Museum of Work and Culture and in close proximity to several schools and after school programs. Questions: call (401) 265-8316

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Providence Community Health Centers, Inc., (PCHC) in Providence, Rhode Island is seeking experienced Dentists to provide preventive and restorative services in dentistry, promoting optimum oral health for children age 1-19 and obstetric patients in our Prairie Avenue clinic; and adults in our Crossroads clinic. To apply, please send your CV to Anny Naya, Director of Provider Recruitment, anaya@providencechc.org. Visit www.ridental.org/news-classifieds/classifieds for more information.

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President of Dental Education Non-Profit Seeks Assistant
The president of the Center for Research and Education in Technology (CRET, Inc) is seeking an assistant in coordinating ongoing dental educational programs. CRET is a not- for- profit philanthropic organization that awards grants to dental schools to acquire advanced digital technology from corporate sponsors (see cretdental.org). Applicants must have an interest in dental students and dental education and have knowledge of clinical dentistry including a familiarity with dental terminology and a working knowledge of dental procedures. Motivation, organizational skills with leaders from corporate dentistry and dental education required.

Responsibilities include coordinating ongoing dental educational programs, organization of virtual meetings, management, and oversight of three CRET Innovation Centers and developing and implementing new programs. Almost all activities (emails, virtual meetings) can be performed electronically from home and at times convenient for applicant. Travel to US dental schools for meetings is optional.

This is a part- time, hourly position, with a minimum of 12 hours/wk. The salary is negotiable depending on experience. The position reports directly to the president. For more information, please send resume to cretdental4@gmail.com Edward Rossomando DDS, PhD Professor emeritus UConn School of Dental Medicine President CRET

RHODE ISLAND DENTAL ASSOCIATION
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ADDRESS SERVICE REQUESTED

Rhode Island Medical Society

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We invite you to look at our website: www.rimedicalsociety.org/physician-health-program.html for more information or feel free to shoot us an e mail:

Jason Conforti, the Physician Health Committee's representing dentist, jdconfor@gmail.com
Or Kathleen Boyd, RIPHP Director
Kboyd@rimed.org

You've got a confidential place to turn to if you need assistance.