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RIDA

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WHAT I LEARNED ON MY SUMMER VACATION

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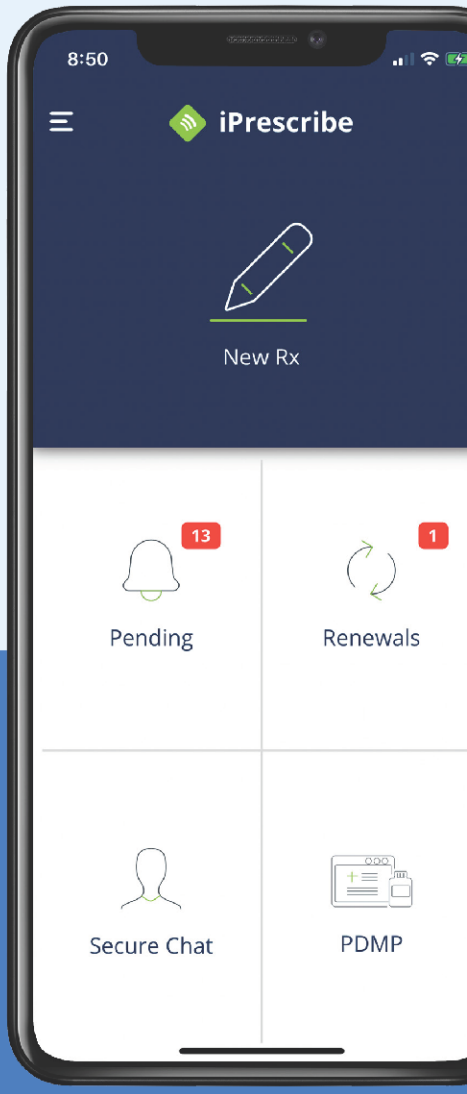

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WHAT I LEARNED ON MY SUMMER VACATION

BY CHRISTY B. DURANT, ESQ.
RIDA EXECUTIVE DIRECTOR

I recently had the opportunity to take a week away from work to spend time with my entire family as we prepared for my younger brother's third deployment to the Middle East. Unfortunately, while COVID-19 has seemed to virtually stop everything in its tracks, it has not impacted the deployment orders of our military. Like most of you, our original vacation plans of a rental house out of state needed to be revised based on the current conditions, so we all settled on a good old fashioned 'staycation' with a beach rental in Narragansett. Granted, the majority of the family lives within 15 minutes of Narragansett, but somehow taking yourself out of your own environment and into a house within steps from the beach gives you an entirely different perspective of Rhode Island you never fully appreciated.

We spent endless days soaking up the sun at the beach, building sandcastles, and teaching the kids how to ride in the best wave while body-surfing. We did an afternoon of clamming 101 for the kids, the bounty of which served as much anticipated dinner (for some haha) later in the week. There was the typical competitive round of mini-golf and an "all cousin" sleepover at the rental house with endless chatter late into the night. We went for early morning walks on the beach and evening strolls for ice cream. Family meals were filled with laughter as we retold stories from when my brothers and I were growing up and some tears were shed as we talked about certain events during the upcoming year and realized my younger brother would not be home to celebrate with us.

Much like every vacation, the time just seemed to slip by. More so than other vacations however, I really didn't want this one to end. As each weekday passed, I think we all began to realize that we were one day closer to my brother leaving, especially my young nephew who grew more and more attached to his dad as the week progressed. I found myself wanting to freeze time and just keep my entire family right where they were in the safe haven of the "beach bubble" we had been living in for the past week. Couldn't we just block out the noise and live in this happy place with no thoughts about my brother deploying and no worries about COVID-19 and what the future would bring? For that moment, I could be sure that everyone in my family was the most safe. When I thought about the tremendously close relationship between my 11-year-old nephew and 9-year-old niece and their dad, I became overwhelmed thinking about how hard this deployment was going to be for them verses the last. As their aunt, I wanted to instantly make everything "better" for them but I simultaneously struggled with my own feelings of sadness and worry, after all, no matter the age, this is still my little brother. What could I do to make it easier for my niece and nephew to get through this year? While playing these dilemmas over and over in my head, I caught myself unknowingly having tears in my eyes. I was literally making myself anxious searching for the perfect answer to a problem I knew I could not fix, but as adults that's often what we do; feel a sense of responsibility to always find a solution for everything despite knowing many things are entirely out of our control. Looking around at my entire family sitting around the patio table on the last night of our vacation laughing and joking, I suddenly realized my failure to live in that moment prevented me from seeing the remedy I was searching for was right in front of me all along. With the love and support of friends and family, particularly their cousins, my niece and nephew are going to be just fine.

You see, at various times throughout the week I witnessed each of the cousins individually and collectively reach out and rally around my niece and nephew to provide comfort when they got sad thinking about their dad leaving. They all came together to lift my niece and nephew's spirits when the needed it the most. They talked about visiting one another more often between Massachusetts and Rhode Island and fun places they could go together during the upcoming year. The cousins offered creative ideas on ways to stay connected with my brother and listened intently as my niece or nephew just needed to talk about what was bothering them. There was even the exchange of countless hugs and several "I love you". I watched in awe as these kids ranging in age from 7-11 years old took it upon themselves to show such compassion, bravery, kindness, and resiliency despite all that has been happening lately in this crazy world. At such young ages, they comprehended the significance of comforting one another through difficult times and the importance of knowing when to talk and when to just listen. Most importantly, each one of these children understood that the simple act of just reaching out to someone to let them know you care, made more of a difference to my niece and nephew than any convoluted, elaborate plan I could come up with to make them forget all about their worries.

When I returned to work the following week, I continued to reflect on how proud I was of the "cousins crew" for stepping up and providing such unprompted support when they saw one of their own upset. No adult had to tell them what to say or how to act and for all I know, they still don't even know I was watching.I immediately recognized the magnitude of my observations among these children and what a profound lesson their simple and innocent gestures could teach all of us. That the support and positive reassurances passed between these children is something that we should all be employing with one another, especially now during these trying times. As I think of all that our membership has been through over these past several months,

categorizing it as unprecedented seems like an understatement. With the sudden onset of this pandemic, the primary focus up to this point has been on the safety and well being of yourselves and your families, as well as the security of your careers, particularly for those of you that own practices, leaving little time to think about colleagues and acquaintances. Rightfully so, your thoughts have been on your own financial hardships, the struggle to obtain adequate PPE, the fear of when you could get back to routine practice, whether or not you would be able to pay your staff, or even whether or not you would have a staff that would want to return to work. There was a point where I am certain many of you felt that the stress and anxiety associated with reopening a dental practice and treating patients amidst the COVID-19 pandemic felt insurmountable. I'm also confident that each and every one of you has had a day, a week, or maybe even a month where you have felt mentally and physically drained, whether since the start of the pandemic or maybe even before it began. In fact, some of you may be dealing with personal or professional stressors entirely unrelated to COVID-19. That doesn't mean those problems are any less important. You are not alone. Regardless of age, race, ethnicity, gender, or socioeconomic status, everyone has likely experienced some level of feeling overwhelmed, stressed, anxious, or depressed, whether situational or more generalized. As we acclimate to the post-pandemic climate, what's important to remember is that although you may all be similarly situated as fellow dentists, you may not have all been impacted in the same way by the pandemic. Some of your colleagues may be experiencing stress at different levels, with some handling it better than others. With almost all practices now reopened and returned to routine care, hopefully some of you are feeling a little less overwhelmed but it would be naive to think that the stressors and burdens of the past several months have simply faded into the background.

I shared the story of my summer vacation not to bore you with the details of the time I spent with my family or to seek attention regarding my brother's deployment. I chose to share this story with you to show that in the process of handling my own situational stresses and that of my niece and nephew, I was reminded of the invaluable lesson from six innocent children that just being there and showing that you care can make all the difference to someone who is struggling. The value of a simple communication to let someone know you were thinking about them is immeasurable. And if you are the one who is struggling, there is no shame in seeking help. If calling a professional is too much right now, consider reaching out to a colleague. Finally, taking time to surround yourself with the love of friends and family does magic for your well being.

With clinical depression and anxiety on the rise since the start of COVID-19, it is imperative that everyone knows they are not alone in this. We all need to continue to find ways to maintain or improve mental health and well being. Being mentally and emotionally healthy is important to every single one of us.

And so, I challenge you. To pass on the lessons learned from the "cousin crew". I challenge each and every one of you in the coming weeks and months to dedicate at least a half an hour every week to reaching out to a fellow colleague to check in and see how they are doing and just say hello. I'm not talking about those colleagues and friends that you talk to several times a week or even once a week, I'm referring to those individuals that you haven't spoken to since the start of this pandemic or perhaps even longer. A fellow classmate from dental school, someone from your referral list, that person you keep saying you have to call but never get around to it, or maybe someone whose office that you drive by on your way to work every day. It's time to pick up the phone and check in with each other to see things are going. Now, I'm not guaranteeing you will always get a receptive response and that's ok. Let them know you just wanted to say hello and if they ever want to talk to give you a call. This one small step may be just what your colleague needed after having a terrible day in the office; or may be the hand that a colleague needed while struggling with reopening post-covid. Who knows. You may build lasting friendships from this challenge; and you may just save someone's life.

I will end with this. The final top 10 things I learned on my summer vacation.

1. Everyone should make time for at least one staycation and explore the true beauties Rhode Island has to offer.
2. Make time for yourself. Be mindful of what you need to refuel and re-energize yourself.
3. Fireworks from Galilee on the 4th of July may be the best place I have ever seen them.
4. There is no limit to how many times you can go our for ice cream if you're on vacation.
5. Body surfing seemed way easier when I was a kid.
6. Kids are amazingly resilient, brave, and kind-hearted little people that can teach us so much. This gives me great hope for our future.
7. Spend time with friends and family.
8. Don't overwhelm yourself with trying to fix things out of your control. Find solutions to manage the stress.
9. Wear R.E.D. on Fridays to show solidarity and support for our deployed heroes to acknowledge the sacrifice they, and their families at home, are making for our country. By celebrating these sacrifices and keeping the deployed ever-present in our minds and hearts, R.E.D. provides real, direct, and meaningful support to deployed heroes and their families by sending a strong message they are never forgotten, and their brave acts of service do not go unappreciated. "Remembering Everyone Deployed" **https://remembereveryonedeployed.today**
10. Don't struggle alone. There is help available and people that care. RIDA is always available to provide additional resources.

Mental Health Resources

RI Physicians Health Program (ad on page 13)
www.rimedicalsociety.org/physician-health-program

Prevent Overdose RI
www.preventoverdoseri.org

ADA Resources
https://success.ada.org/en/wellness

National Alliance on Mental Health - Rhode Island
https://namirhodeisland.org/

State of RI Department of Behavioral Health
https://bhddh.ri.gov/

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FROM YOUR PRESIDENT

BY KARYN WARD, DDS
RIDA PRESIDENT 2020-2021

As I sit here four months into a pandemic that has rocked the world of dentistry as we know it, I am struggling to find how to put into words how proud I am of how far we have gotten. I was prepared to spend my summer attending component meetings, mingling with my colleagues, and enjoying a smooth presidential year, but boy was I wrong about that! I want to take this opportunity to thank my predecessor, Dr. Martin Elson, once again for all his work during his presidency. We haven't been able to appropriately celebrate his dedication and hard work during his presidential year, but I hope we will be able to sooner rather than later. As you all know, in addition to our yearly "changing of the guard" at RIDA, we have also welcomed a new Executive Director, Christy B. Durant. Christy came into this position at an incredibly stressful time but has charged headfirst into her new role with passion and ambition. I have no doubt that we are fortunate to have her and these past few months have certainly proved that.

It has been such a pleasure to watch our whole RIDA team come together and work endlessly to get us through this difficult time. My first month as president was filled with weekly meetings, daily group texts, and constant research. Thanks to the hard work of our RIDA team and a group of very generous and wonderful volunteers, we were able to drive 20 palettes to the RIDA Executive Office, up two flights of stairs, unpack and repack over 1,000 bags of PPE, and distribute two months' worth of necessary personal protective equipment to over 500 Rhode Island dentists. Not an easy task to say the least but we were fortunate to have a group of easy to get along with hard workers at our side and are prepared do it again if we are able to obtain another months' supply.

We're certainly not done yet and have a lot of work left to do. The outbreak of the COVID-19 virus has turned our society on its head, but our RIDA team was unphased and has persevered. This situation has found us all coming together for a better future and for that I am incredibly proud to be your leader during this time.

"Teamwork is the ability to work together toward a common vision. The ability to direct individual accomplishments toward organizational objectives. It is the fuel that allows common people to attain uncommon results"

– Andrew Carnegie

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IN TRIBUTE TO VALERIE CELENTANO
RIDA EXECUTIVE DIRECTOR 1977-2014

Valerie "Val" Celentano passed away Monday, February 17, 2020 at HopeHealth Hulitar Hospice Center surrounded by her loving family. Val was the Executive Director of RIDA for over 40 years and a valued member of the dental community. We certainly would not be where we are today without her dedication. She traveled the world, and everywhere she went, she was the life of the party.

"LIVE, TRAVEL, ADVENTURE, BLESS, AND DON'T BE SORRY" - Jack Kerouac

IN MEMORIUM

Valerie Celentano
Leonard Mark, DMD
Conor McNulty, MDS Executive Director

RHODE ISLAND ORAL HEALTH COMMISSION

2020 RI Oral Health Summit
SAVE THE DATE

Date: Friday November 6, 2020 | Time: 9am - 12pm

2020 RI Oral Health Summit

Advancing Women's Oral Health - Challenges and Opportunities

Session 1: ***A Look at Women, Gender, and Health***
This session will lay the groundwork with some background for our exploration into women's health issues in the U.S. today and how women in Rhode Island fare. Particularly, the challenges and causes of inequities will be highlighted.
Speakers: Abigail Brooks, PhD and Professor Jessica Mulligan, Providence College

Session 2: ***Women's Oral Health - Current Status***
This presentation will highlight key contributors to women's oral health today and will review relevant literature on women's health challenges and its effect on health equity as a whole. Lastly, learn how an integrated model of care can help to address some of the most critical issues impacting women's oral health.
Speaker: Namita Khandelwal, BDS, MS - Oral Health and Diagnostic Sciences | UConn Health

Session 3: ***Emerging Women's Health Research***
This session will tie everything together. Participants will be introduced to some of the cutting-edge research and recent on-going studies in women's health from a sociological perspective.
Speaker: Brenda Heaton, MPH, PhD - Boston University Henry M. Goldman School of Dental Medicine

This Summit Planning Committee has transitioned our May Summit to a virtual event we know you will enjoy. More information coming soon.

MARK YOUR CALENDARS AND JOIN US!

CEU credits pending

COVID-19 RESOURCES FOR SMALL BUSINESSES

CONTRIBUTED BY LANA M. GLOVACH, U.S. SMALL BUSINESS ADMINISTRATION (SBA)
AUTHORED BY DCG COMMUNICATIONS

A rundown of the financial programs and guidance available through the SBA for small businesses recovering from the COVID-19 pandemic

Our nation's small businesses are emerging from an unprecedented economic disruption due to the Coronavirus (COVID-19) outbreak. The U.S. Small Business Administration (SBA) is dedicated to helping small businesses get back on their feet. Below are resources and services to support you during this challenging time.

Financial Resources

The loss of income from COVID-19 has presented significant obstacles to small business owners and their employees. SBA programs that have helped offset the economic impact from COVID-19 include:

- **Paycheck Protection Program (PPP):** Accepting new applications through August 8, the PPP is an SBA-backed forgivable loan that has helped small businesses and non-profits continue to pay their employees during the COVID-19 outbreak. The PPP Flexibility Act, passed last month, has extended the covered period for loan forgiveness to 24 weeks after the loan disbursement and lowered the amount of loan proceeds that must be used for payroll costs from 75% to 60%. Forgiveness is mostly based on the employer maintaining or quickly rehiring employees and maintaining salary levels. Forgiveness will be reduced if full-time headcount declines, or if salaries and wages decrease. The loan forgiveness form and instructions include several measures to reduce compliance burdens and simplify the process for borrowers.
- **Economic Injury Disaster Loans (EIDL):** EIDL helps small businesses overcome the temporary loss of revenue they are experiencing as a result of the COVID-19 pandemic. These loans can be used to pay fixed debts, payroll, accounts payable, and other bills that can't be paid because of the disaster (and that aren't already covered by a PPP loan).
- **SBA Express Bridge Loans:** These loans allow small businesses who already have a business relationship with an SBA Express Lender to quickly access up to $25,000.
- **SBA Debt Relief:** : As part of SBA's relief efforts, the agency will automatically pay the principal, interest, and fees of current 7(a), 504, and microloans for a period of six months. SBA will also automatically pay the principal, interest, and fees of new 7(a), 504, and microloans issued prior to September 27, 2020.
- SBA also works with lending partners to provide SBA-guaranteed export loans. These loans – such as Export Express loans – can help exporting businesses respond to opportunities and challenges associated with trade, including COVID-19.

Educational Resources and Local Assistance

In addition to funding options, there are a variety of educational resources available for business owners seeking guidance on how to stay afloat and safely reopen. Guidance for federal contractors affected by COVID-19 is available here (https://www.sba.gov/document/support-federal-contracting-guidance-small-businesses-impacted-coronavirus-covid-19). Small business owners can refer to CDC guidelines on how to protect your workforce during the outbreak and the CDC's decision tree for businesses preparing to reopen.

For step-by-step help navigating SBA relief and loan programs – and for advice on how to manage other aspects of your business during this time – connect with a local SBA resource partner. The SBA resource partner network (including SCORE, Small Business Development Centers, Women's Business Centers, and Veterans Business Outreach Centers) is offering business consulting, mentoring, and training services remotely via video chat and phone.

Resource partners are also providing webinars, blogs, and other helpful content for small businesses, including:

- Small Business Resilience Hub (SCORE)
- Checklist: Reopening Your Small Business After the Coronavirus Shutdown (SCORE)
- COVID-19 Small Business Resources (SBDCs)
- Federal Resources for US Small Businesses (SBDCs and WBCs)

This is an extraordinary time for all Americans, especially small business owners. SBA is committed to supporting you every step of the way as our country emerges from this pandemic. Ongoing updates regarding COVID-19 resources for small businesses can be found at sba.gov/coronavirus

Let the SBA help your small business plan for success! Assistance is available in languages other than English, including Spanish, and all SBA programs and services are extended to the public on a non-discriminatory basis. To learn more about the SBA's programs and services or to connect with one of our Resource Partners, please contact Lana M. Glovach, SBA Economic Development Specialist, at lana.glovach@sba.gov or 401-528-4575, or visit www.sba.gov/ri.

BEST PRACTICES FOR PAID ADVERTISING DURING THE COVID-19 CRISIS

By: Jay Levine, President of PBHS, the endorsed marketing services company for ADA members.
For more information on PBHS dental website design and marketing, visit PBHS.com

As many people nationwide live under safety measures meant to support citizen health and slow infection rates of COVID-19, the online world is experiencing an unprecedented change in behavior. For instance, overall internet traffic has risen by 31% since late February, making the management of your online presence more critical than ever to ensuring the continued vitality of your dental practice.

In particular, the implementation of a paid advertising campaign can yield significant returns, especially given that on average, cost-per-clicks have decreased by 6% since COVID-19 — so your investment goes further.

A successful pay-per-click advertising strategy will allow you to boost your authority, find new patients and win the conversation. Follow these recommendations to ensure the success of your marketing initiatives:

- **Target** your audience with search and call-only campaigns focusing on virtual consultations as well as emergency dental care. With limited access to critical dental services, patients will be looking for you online.
- **Enhance** direct engagement and prioritize calls to your office with click-to-call ad extensions and callout ad extensions. Don't forget to route incoming office calls to your remote personnel.
- **Instill Trust** and confidence in your services by bolstering your online reputation through management of your Google My Business page and clearly notifying patients of your additional safety measures and universal precautions.
- **Evaluate** your process over time and adjust to changing audience behavior with insights from A/B testing. A/B testing refers to testing multiple versions of an ad, maybe with slightly different copy or visuals, at the same time to see which gets the best results.
- **Refresh** your negative keyword lists at both the account and campaign levels using trending search queries. Negative keywords let you exclude search terms from your campaigns and help you focus on only the keywords that matter to your patients.Communicate what might be different when your office reopens. Have you changed check-in procedures, waiting room layout, availability of hand sanitization stations for patients, or other things that might be different for your patients? Setting expectations can help with a smooth transition back into practice.

While foot traffic is down, connecting with prospective patients through pay-per-click advertising is a powerful way to ensure you provide critical access to your communities and prepare for the return of patients as the crisis resolves.

THE NEW RETIREMENT RULES: 8 MAJOR CHANGES DENTISTS NEED TO KNOW

BY JOHN K. MCGILL, JD, MBA, CPA

REPRINTED WITH PERMISSION FROM DENTAL ECONOMICS

Some of the biggest retirement plan and IRA changes in more than a decade went into effect on January 1, 2020. Most of these changes are designed to increase retirement savings, but if you're not prudent, some may lead to higher taxes and/or costly lawsuits.

President Donald Trump signed a $1.4 trillion spending bill into law on December 20, 2019, that involves massive changes to retirement plan and IRA rules, some of which became effective January 1, 2020. The retirement portion of the bill (SECURE Act) contains 29 new provisions or major changes in its 124 pages. Here are eight provisions that will affect most doctors.

Has more part-time employee coverage for 401(k) plans—Previously, your retirement plan could exclude part-timers who work fewer than 1,000 hours per year, which is roughly 20 hours a week. Under the new law, your plan must now cover employees if they either complete one year of service by working at least 1,000 hours during the plan year or have three consecutive years during which they work at least 500 hours. Therefore, a two-day-a-week hygienist (16 hours a week) who has worked for at least three consecutive years was not eligible under the old rules but must now be covered effective January 1, 2021. Twelve-month periods beginning before January 1, 2021, will not be taken into account.

Increases maximum age to 72 for taking required minimum distributions (RMDs) from retirement plans and IRAs—If you're not yet age 70½ as of December 31, 2019, you can now defer taking RMDs from IRAs and retirement plans until age 72. If you have sufficient funds elsewhere to cover personal living expenses, this offers a huge tax saving opportunity to defer distributions and convert additional amounts from your regular IRA into your Roth IRA for up to two more years, while you're in a lower tax bracket.

Allows contributions to traditional IRAs after age 70½—If you work later in life, (a current trend since the average retirement age has risen to 69), you can now continue making contributions up to $7,000 per spouse annually to a traditional or Roth IRA if you or your spouse has at least that much earned income.

Changes rules related to 529 plans—The new law allows lifetime aggregate penalty-free distributions of up to $10,000 per child from Section 529 college savings plans to repay student loans.

Allows penalty-free withdrawals of up to $5,000 from retirement plans or IRAs to cover the cost of birth or adoption of a child— Distributions before age 59½ are normally subject to a 10% penalty, but in this case the penalty is waived. However, the withdrawal is still subject to federal and state income taxes.

Expands retirement plan tax credits — Are you setting up a new retirement plan? If so, the new law provides tax credits of up to $5,000 (or $250 per non-highly compensated employee if less) a year for three years, or $15,000 total, to offset the costs incurred to set up, administer, and educate employees about the new retirement plan, using IRS Form 8881. In addition, the new law creates a tax credit of up to $500 a year for three years, or $1,500 total, if you add an automatic enrollment feature to your 401(k) plan.

Promotes annuities as a retirement plan investment option—Bowing to intense insurance industry lobbying, Congress eased the rules for adding annuities as acceptable investments in retirement plans. In their simplest form, annuities are an insurance product that allows participants to convert their account balances into a guaranteed income stream in retirement.

The new law reduces the fiduciary requirement to vet the insurance companies and products before their issue. However, I recommend not investing retirement plan funds in annuities due to the potential for being sued because of their high expenses, surrender fees if the policy is cancelled within the first seven to 10 years, low returns, and potential for default.

According to Morningstar, the average variable annuity costs between 2.18%-3.63% annually, depending on the product type and features selected, but costs are about 10 times the average fees on other 401(k) plan investments. So, stay away from offering annuities inside your retirement plan or IRAs. Rather, another mix of stock and bond investments can provide the steady stream of income you need in retirement without these drawbacks.

Eliminates "stretch" options by requiring most inherited IRA distributions to be paid out in 10 years or less—Under current law, if your children inherit your IRA they can stretch the distributions (and related income taxes) over their lifetimes, which provides longer tax-deferred growth to build family wealth. The resulting distributions are normally smaller, which keeps your children from vaulting into a higher tax bracket during their peak earning years.

The new law requires all inherited IRAs to be distributed, and related income taxes paid, within 10 years of the account owner's death. Fortunately, there's an exception for those inherited by surviving spouses, minors, the disabled, and those who are fewer than 10 years younger than the account owner. This provision is expected to raise taxes by $15 billion over the next 10 years. ■

John K. McGill, JD, MBA, CPA, provides tax and business planning for dentists and specialists and publishes The McGill Advisory newsletter through John K. McGill & Company Inc., a member of the McGill & Hill Group LLC, your one-stop resources for tax and business planning, practice transition, legal, retirement plan administration, CPA, and investment advisory services. Visit mcgillhillgroup.com

"Over your career, you have developed preferences and habits that suit your personality and motivate you to do your best work. Now is the time to think about these preferences and use them to choose your next colleague."

4 Options for Expanding Your Practice

Dr. Suzanne Ebert, ADA Advisor

ADA PracticeTransitions™

Your practice is growing. Maybe you want to work fewer hours or maybe you are thinking about retirement. No matter your reasons, you have decided it is time to bring in another dentist.

Before you start interviewing associates or potential buyers, consider what type of dentist – and arrangement – might be right for your practice, your patients, and your own goals.

Which option fits your needs?
Patients, on-call coverage, liability, costs, decisions, expertise - practice owners can share many things. Your risk tolerance can drive your ideal practice scenario.

Associateship: If you bring in an associate, you remain in charge of the practice. You are responsible for everything including the associate's salary, schedule, and treatment decisions.

Independent contractor: An independent contractor can function as an associate, but they act as the owner of their own business and make their own treatment decisions, without your guidance. They are responsible for their own salary, benefits, schedule, supply costs, and risk – but you, as the owner, assign their patients. An independent contractor can help you use your full office space without incurring any additional liability. The ADA Center for Professional Success details the differences between employees and contractors (next page).

Solo group: Two practices operate independently in the same space in a solo group scenario. That means that you share the facility and common expenses, but not the risk or liability. You may opt to share new patients who come without a referral and you can potentially consult with each other. A solo group practice is ideal for someone who wants to remain in charge of their practice but share some costs.

Partnership: A partner shares ownership of both the practice and patients. The ownership ratio can vary, and it may change over time if you enter into a buy-out agreement. Partners make decisions jointly and share patients and hours, which can give you flexibility. However, partners also share liability - if a claim is made against the practice, both doctors can be held liable.

What does your ideal work environment look like?
Do you prefer an independent or collaborative approach? Do you like a bustling office or a quieter practice? If you want someone to consult with, make sure you bring in a dentist who is also interested in this approach. However, if you prefer to practice relatively independently, you might want to bring in a dentist who will work days/times when you are out of the office. Make these preferences clear to incoming dentists as you are interviewing them so there are no surprises.

In the course of your work, do you tend to refer out certain procedures that you would prefer to bring in house? Hiring a dentist with a certain skill set can also provide the opportunity to expand your practice's offerings. Consider which procedures you typically refer out. Ask staff if patients (or potential patients) are asking for certain treatments. Knowing what you want will guide your search for the best fit for your practice. ADA Practice Transitions can help you navigate your entire transition. If you are unsure what you want, we can help you fully explore your options to identify the best path forward – and then we can match you with someone who shares your goals. Find out how ADA Practice Transitions can help make your entire transition more successful. ■

Dr. Ebert built a successful dental practice from scratch. After selling her practice, she became the Dental Director of a Federally Qualified Health Center where she provided high quality care to underserved populations. She joined the ADAPT team as the ADA Advisor to provide real and tangible benefits to dentists as well as helping to address access to care issues across the country.

ADA Practice Transitions

The purpose of ADA Practice Transitions is to match dentists who are looking to join a practice with owners who are seeking a partner, associate, or someone to purchase their practice.

The program was developed after field research uncovered a need in the marketplace for dentists who want to connect for both employment opportunities and to facilitate the transition of a practice from one owner to another but have had difficulty doing so. Research also found additional needs around learning skills related to basic business management, ownership, patient acquisition, purchasing, and staff relationships.

Visit ADA.org/PracticeTransitions for more information.

AM I AN EMPLOYEE OR AN INDEPENDENT CONTRACTOR?

Knowing your status as either an employee or an independent contractor is vital. It impacts tax liability for you and the owner dentist, as well as other liability issues.

Generally an associate in an office is considered an employee when the employer has the "right to control" how duties are performed. Employees are typically subject to the employer's instruction, such as when and where to work, what supplies must be used, how work is to be completed and other procedures. Employees may not be required to invest in their own materials and may be eligible for benefits. For an employee, the employer dentist must generally withhold income taxes, withhold and pay social security and Medicare taxes, pay unemployment tax, and afford workers' compensation benefits. In making a determination whether an individual is an employee or an independent contractor, governmental agencies will look at factors such as:

1. How extensive the control is over behavior
2. Financial control and
3. The relationship of the parties

Be careful though, as being an employee does not mean that the employee dentist can defer ethical responsibility for care. That always rests with the individual professional. "The boss made me do it" is never a good defense!

Independent contractors have more control and are often paid a flat fee for their work. They are not as likely to be reimbursed for expenses, nor to receive benefits and the relationship is usually just centered around the end results of the work, not the time at or means by which those results are accomplished. There is generally no requirement to withhold or pay taxes for independent contractors — the burden is on the independent contractor. Keep in mind that the final test comes from what actually goes on in the relationship. The label on a piece of paper doesn't matter as much as the day-to-day workings of the practice.

Talk with your own legal counsel to make sure your professional relationship is properly classified from an IRS perspective. Do this before you establish a working relationship to make sure you start out on the right path. ■

ADA Center for Professional Success™

MY NEW DENTIST LIFE:
STARTING A CAREER DURING THE COVID-19 PANDEMIC

BY DR. JUSTIN GOFF

THIS ARTICLE ORIGINALLY APPEARED ON JUNE 17, 2020 IN THE ADA NEW DENTIST NOW, NEWDENTISTBLOG.ADA.ORG

Hello Everyone,

My name is Justin Goff, and I am a recent dental graduate from Touro College of Dental Medicine at New York Medical College. I am excited to take you on an adventure over the next year. I will tell you about my experience as a dental student and each month keep you updated on my life as a new dentist.

Wow, what a crazy last few months let alone the last four years? Dental school has been a whirlwind and finishing my last months of dental school during the COVID-19 pandemic has been an unforgettable experience to say the least.

Having never been to New York, my experience to interview at TCDM was exciting and overwhelming at the same time. During my interview in 2016 TCDM was still under construction as TCDM's class of 2020 is the first graduating class at this new school. Without a preclinic or clinic, it was difficult then to see what this school would become.

After my interview I told my wife that all the other interviewees were much smarter and surely had a much better application than I did. I assumed that was my first and last trip to New York…

However, weeks later I received an acceptance letter and had less than one month to find an apartment and get to New York. Within the first two weeks of school life got even crazier as we found out that my wife was pregnant. With school and a new baby there were many sleepless nights, but life was fun and exciting to think about the future for our small family. Fast forward to my senior year with board exams, licensing exams, trying to finish competencies to

continued on page 13

continued from page 12

graduate and looking for a job. I had just finished the Commission on Dental Competency Assessments [CDCA] licensing exam when a few weeks later, life in New York and around the world seemed to stop. COVID-19 disrupted everyone's lives, making some people stay home and others work more tirelessly treating those affected. The last few months of dental school were a waiting game to see when we as students would return to clinic, or if we were to return at all. Our school, like many others, finished the year online and celebrated with a virtual commencement.

So, looking back on the last four years, do I feel ready to get to work?

I feel that I have been well prepared and my preclinical and clinical experience were amazing at TCDM. However, dentistry is a career of lifelong learning and I am sure the next few years will present challenges that only years of clinical judgement will provide the answer.

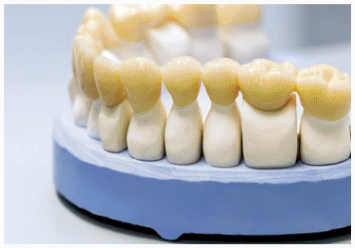
The next phase of my life will begin in Montgomery, Texas, just about one hour north of Houston. I will be joining a practice as a general dentist. However, I will start work in mid-June assisting the doctors until my dental license can be issued. As for now when people ask, "What do you do for a living?" I can't say I am a full-time student, and I can't quite say I am a licensed dentist. BUT, whatever the future holds I know it will be eventful, a continuous learning curve and not at all what I would expect. ■

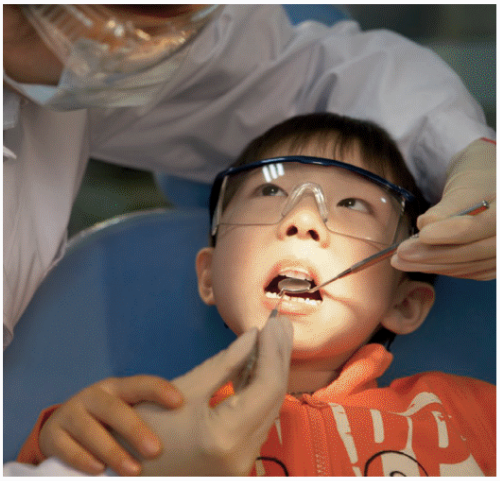
Dr. Justin Goff is a recent dental graduate from Touro College of Dental Medicine at New York Medical College located in Hawthorne, N.Y. He was raised in Wyoming and is a graduate of Utah State University (Class of '16). Dr. Goff is a first-generation dentist. He is married with a 3-year-old daughter. Dr. Goff will be working as an associate general dentist in Montgomery, Texas. Outside of the dental office, he enjoys time outdoors and is an avid fisherman.

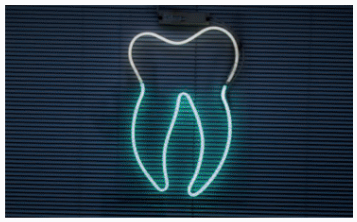
When taking care of smiles, **make each moment matter.**

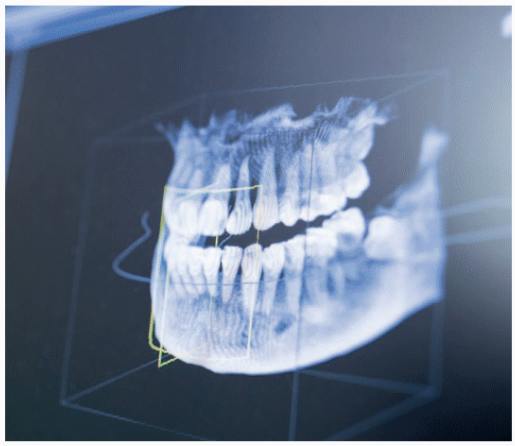
—

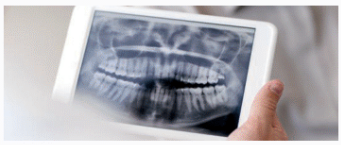
PNC can help.











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VOLUNTEERING OPPORTUNITIES

BELIZE MISSION PROJECT

The Belize Mission Project has been in existence for almost thirty years. This mission was first organized by Dr Frank Whipps, an orthodontist from Centralia, Illinois. His goals for the mission were very clearly defined: to provide a variety of healthcare for the people of Belize in a Christian manner, to encourage people to become involved in mission projects, and to allow participants to have an introspective look into their own lives. The longevity of this mission is a testament to the success of having achieved those goals.

It is difficult to describe my twelve-year experience with the Belize Mission Project. It has been noted by others that it is similar to being "in the zone" for athletes. There is a keen vision of what needs to be done, despite the challenges and the lack of resources. There is an intense focus where one loses track of time and worries about self. "Reality" itself seems to change and failure is not an option. Despite the challenges, and there are many, the experience is rewarding. Now that my days as a clinician are over, I can truly say that my participation with the BMP was the best thing as a dentist that I ever did for others, as well as for myself, with lasting memories and friendships.

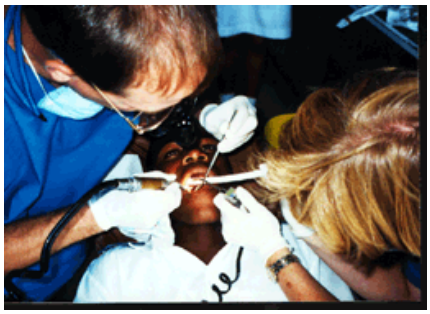
There are usually two trips offered in the fall, each a week in duration with four days of patient contact. Different venues in Belize are served and assignments vary. This is a well-organized trip with travel, lodging and many meals preplanned. The current pandemic has affected many plans and currently this year's mission trip is uncertain.

Although it has been touted as a Christian-based trip, people of all faiths and backgrounds have attended and are encouraged to participate. Tolerance, respect and a good example impact more than preaching. For dentists, this is primarily a restorative trip, although some teeth are extracted. Volunteer lab techs help with delivering partial dentures. Other healthcare providers are welcome and there are usually physicians, audiologists, and optometrists on board. Over the years volunteers from Rhode Island have included Dr Joel Picard, MaryAnne Barry RDH, Lisa McLoughlin RDH, and Danae Calise CDA.

Dr Marc and Sara Orjansen are now running the BMP. Further information on upcoming trips can be obtained by contacting sara.belizemissionproject@gmail.com.

- Allen E. Schenck, DDS

To the world, you may be one person, but to one person you may be the world."



DENTAL LIFELINE NETWORK

In 1989, the Rhode Island Dental Association partnered with Dental Lifeline Network • Rhode Island in developing a Donated Dental Services (DDS) program to help people with disabilities or who are elderly or medically fragile and had no other access to dental care. Dental Lifeline Network operates through a volunteer network of 15,000 dentists and 3,500 dental labs across the United States. Since its inception in 1985, the DDS program has surpassed $378 million in donated dental therapies, transforming the lives of 120,550 people.

The DDS program provides free, comprehensive dental treatment to our country's most vulnerable people with disabilities or who are elderly or medically fragile. These are people who cannot afford necessary treatment and cannot get public aid. We also treat many VETERANS who are eligible for the program.

Rhode Island DDS Program has surpassed the $7.2 million milestone for 3,100 elderly, disabled, and medically fragile Rhode Islanders!

The Donated Dental Services program gives eligible people people the opportunity to have free dental treatment in private dental offices, just like other patients. No clinic, no wait, no shame. All of the dental work performed by a general dentist, dental specialist, dental hygienist and dental laboratory expenses are no charge for the patient.

Now is the time to join with 207 of your RI Colleagues!

• The Clinic: Is your own office
• The Treatment: Is of your own choice. No paperwork.
• Lab Work and Specialists: Handled by the coordinator.

"Without this service I couldn't move forward with another transplant. Now I am presently on the list for another transplant thanks to you for moving as fast as possible. I am indebted to you and your organization for life." - Michael, a 60-year-old Army veteran and DDS patient, after having five teeth extracted, five others restored and receiving a full upper denture and partial lower denture making him eligible for his second kidney transplant.

Rhode Island Dentist Testimonials

• Genuine thanks and gratitude from these patients, more than the token thank you from every day patients!
• Most of the patients I have treated have remained my patients for years.
• Wonderful experience for our office because of the appreciation these patients express as well as gratitude. Very humbling for us all
• The patients that we get are very kind and happy, and never miss appointments.
• Patients have all been nice, and appreciative of our efforts. It is personally gratifying to me and my staff to give back to those less fortunate.

Things we all take for granted, like the ability to eat without pain, speak, smile, and have self-esteem, these people do not have.
ONLY VOLUNTEER DENTISTS CAN HELP THESE UNFORTUNATE PEOPLE.

PLEASE JOIN US AND TRY ONE PATIENT

PROJECT SMILEWELL

Locally, nationally, and internationally, Project SmileWell is determined to help people smile well. They travel to every corner of the globe to help children and families in need. Project SmileWell is on a mission to reach out and help the world smile. *"It takes so little for us to help , "Why not? I ask". With a little effort from a few, we can deliver some smiles to many."*

Rhode Island Dentist, Dr. David Ward: My Mission Journal took me to the other side of the world in Zambia, Africa. One of my dental school classmates, Dr. Bill Papadopoulos, started a 501c named Project SmileWell. We would travel to two locations in Zambia. The first was an orphanage with nearly 700 children who's parents had died from AIDS or were unable to care for them due to drug or alcohol addiction. The second stop was more rural at a banana farm hosted by the Seventh Day Adventists church. We would travel to a school where we would treat the local adults who needed care. Many of them would have to walk 2 or more hours to get there. The services were provided in a two operatory truck with most of the patients needing extractions. I have made the journal twice and it has now become a family affair as Dr. Bill and I brought our two daughters who are now finishing their first year of dental school at Tufts in Boston.

Please contact Dr. Bill Papadopoulos at drbill@projectsmilewell.org or visit www.projectsmilewell.org for more information.




"A smile is the first step to hope"

MOVING HEALTHCARE FORWARD: CONSIDERATIONS AS PRACTICES REOPEN

BY **CRAIG B. EVANS**, RELATIONSHIP MANAGER, HEALTHCARE SPECIALTY GROUP, CITI COMMERCIAL BANK AND **JAMIE MANTLE**, RELATIONSHIP MANAGER, HEALTHCARE SPECIALTY GROUP, CITI COMMERCIAL BANK
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For most healthcare providers, 2020 began on an optimistic note. With a strong economy, many practices were humming along - with full patient schedules and a booked out calendar - the industry was positioned for another year of growth. Then COVID-19 hit. The world as we knew it changed, possibly forever. Healthcare providers were mandated to cease elective procedures and, in many cases, close down offices altogether.

Even as states lift shelter-in-place restrictions and healthcare providers are given the greenlight to start seeing patients again, healthcare practices face unprecedented headwinds. Chief among these are the financial uncertainties that lie ahead. So, what should providers be thinking about as they reopen? And how can they partner with their bank to align for success in such an uncertain environment?

Once offices reopen, how can I get patient and cash flow back to normal levels?

The first priority should be to assess business operations and focus on getting back to profitability. Many providers have reported busy schedules in the initial weeks of reopening due to pent up demand during the shutdown. Effectively managing patient scheduling and ensuring you have adequate staff and supplies to safely meet patient needs will be critical in these initial stages. There will be enhanced procedures and safety requirements to adhere to, which may increase costs.

Patient engagement will also be vital. Providers that have embraced technology to stay in touch with patients while practices were closed are well positioned for growth. Companies that are only now contacting patients should assess whether any initial surge in volume can be sustained. Expect cash flow to remain tight in the early weeks as the revenue cycle catches up with patient flow. Forecasting key metrics and expenses will help to identify your cash needs. Such insights will be invaluable to understanding the pace of business recovery. As most healthcare providers are reimbursed through commercial insurers or the Center for Medicare and Medicaid, there is likely to be a 30-45 day lag between patient treatment and cash collection. It is therefore more important than ever to keep a heightened focus on revenue cycle management, compliance and process integrity to ensure that cash flow increases in lockstep with patient volume.

What does it mean to my company if my loan covenants are violated?

With companies required to cease operations for several weeks, there have been material changes to bottom-line performance. Covenant violations will be a likely side effect. Consequently, communication with your banking partner should be a priority to ensure all parties work through these events together. Your banking partner wants to hear from you in both good times and bad; it is important to share information even if the outlook is challenging or uncertain. You will need to be able to demonstrate you understand the operational challenges you face and articulate a strategy to return your business back to plan.

Review the terms in your loan agreement, understand how the covenants are calculated and the recourse if violations occur. Consult with a trusted advisor such as your attorney, CPA or your lender. You may be asked to provide additional financial reporting and a 13-week cash flow forecast. Use this as an opportunity to assess your operations and reinforce your credibility with your banker. If you do so, when you are ready to shift focus back to growing your business, you will be well positioned to take on additional capital. Banks have generally shown a willingness to support covenant waivers and if needed, payment deferments. Be patient with the process and know that your banker will want to see your company return to normal and recover successfully as much as you do.

Should I be making acquisitions now? Is this going to impact multiples?

The decision to expand your practice is now more complex as a result of COVID-19. The severity of COVID-19 in the states where you operate will likely determine the impact on your office's finances. This financial impact could dictate whether you can entertain new acquisitions. While public market transaction valuations are down roughly 20% since the COVID-19 restrictions began, healthcare providers appear to have retained their value so far, with minimal changes to transaction multiples. Some structural enhancements should be considered for near-term acquisitions such as earn-outs or deferred payment compensation to ensure interests are aligned and these companies are able to resume normalized operations. If you were evaluating acquisitions prior to COVID-19 and are experiencing a meaningful reduction in cash flow and/or repayment capacity, aim to demonstrate sustainability of stabilized operations for a period of one or two quarters before taking on additional indebtedness for transactions. Communication with your banker will be important to reestablish access to capital.

When will banks be willing to lend again? How much liquidity will be available during the remainder of 2020?

While the 2008 recession was caused by a structural disruption in the financial markets, the recent downturn was started by a public health crisis; this is not a financial crisis. As such, banks remain well capitalized and are financially stronger than in the last recession.

Banks have sufficient liquidity to lend but they want to ensure they are lending to practices best positioned to succeed in the aftermath of several weeks of distribution or outright closure. Although healthcare is a resilient industry, providers that have struggled with patient and staff engagement and do not have appropriate operational control may experience a protracted recovery relative to those that have embraced the recent challenges. You should be prepared to discuss these issues with your banking partner.

The healthcare industry has been significantly impacted by COVID-19 and will take time to recover. Moreover, the road to recovery will vary, depending on your specialty and location. However, no healthcare provider has to navigate the post-shutdown world alone. You need to work with your closest advisors and gain the benefit of their insight, guidance, and counsel. Your accountant, attorney, banker, and industry cohorts can act as a sounding board when you are developing and executing on your plan. With most shelter-in-place orders being lifted and healthcare practices re-opening, these relationships will help position your company to weather the storm and succeed amidst the COVID-19 landscape. ■

UPDATE ON EMERGENCY DEPARTMENT VISITS IN RHODE ISLAND FOR NON-TRAUMATIC DENTAL CONDITIONS, 2014-2018

BY YARA HALASA-RAPPEL, PHD, DMD AND SAMUEL ZWETCHKENBAUM, DDS, MPH

Key Findings

- The number of visits to Emergency Departments (ED) in Rhode Island for non-traumatic dental conditions decreased by 37% from 2014 to 2018.
- Highest ED use is among people age 27-32.
- People with Medicaid have disproportionately high rates of ED use.
- People from communities with low median income have disproportionately high rates of ED use.
- There is disproportionate ED use by Rhode Islanders of Black and Hispanic ethnicity.

Introduction

Use of the ED for dental complaints is not only costly, but it is also inefficient as it is not likely to result in treatment that addresses the dental problem.[1][2][3] Some ED use for dental care due to oral trauma can be expected, particularly for oral trauma occurring after hours and on the weekend. However, a large proportion of oral problems presenting at EDs are not a result of trauma. They tend to be dental infection and pain likely related to dental caries or periodontal disease and are often referred to as non-traumatic dental conditions (NTDCs). NTDCs can be treated more effectively, or prevented altogether, through regular dental care in a primary dental care setting. Those who seek care in the ED often do so due to failures of the healthcare system. In many cases, they did not receive adequate primary preventive services to prevent disease or did not receive secondary preventive services that could treat the disease before it became an emergency. Those seeking ED services may face barriers to care, including limited financial means; limited access to providers who accept Medicaid; and lack of transportation, regular provider availability, and/or accommodations for physical impairments.

ED use has been analyzed through a number of resources, but most notably, through claims data and discharge data. While claims data have the advantage of showing real dollars paid for the visits, it does not include self-pay patients, unreimbursed services, and insurers that do not report to the All Payer Claims Database (APCD). Hospital discharge data provide the actual charges and capture the economic cost associated with NTDC care at the ED. (The dollar amounts in hospital discharge data do not reflect what is ultimately paid by insurers.) In addition, hospital discharge data collect significant

continued on page 19

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information, including additional diagnoses and any uncompensated care. Analyses have been performed in individual states and nationally; however, there is slight variation in methodology such as which ICD-9 or ICD-10 codes to search for and in cases where multiple columns of diagnoses are listed for an individual, how many columns to analyze.

The most recent evaluation of ED use in Rhode Island for dental complaints was done in 2016. That analysis examined data from 2010-2014 and focused on first diagnosis only. The results showed 6,510 ED visits in 2014 for dental complaints among adults age 21-64 and accounted for 2.6% of ED visits for all diagnoses[4]. Much has improved in Rhode Island since the 2016 report, yet there is still room for considerable improvement. There is more capacity for dental care in the federally qualified health centers (FQHCs) and hospitals; however, Medicaid reimbursement rates have not increased so dentists are not incentivized to provide care to lower-income patients. The number of patients seen for primary dental care services at health centers increased by 16% from 2013-16, and by 43% at hospital-based dental clinics. The significant increase in utilization of hospital-based dental clinics can be attributed to the start of residencies in pediatric dentistry and advanced education in general dentistry at St. Joseph Health Center. Clinical staffing at health centers increased by 37% to more than 150 full-time equivalent (FTE) clinical dental staff, and the total number of operatories where care is provided increased from 138 to 167.[5] While increases in staffing and operatories improve access for preventive services and treatment, significant gaps and low utilization rates remain. We could see continued improvements with additional access points and a more even distribution of those access points through the private practice sector.

The objective of this report is to assess the status of ED use for NTDC and determine if disparities exist based on race/ethnicity, insurance coverage, and ZIP code and to help create recommendations for targeted interventions.

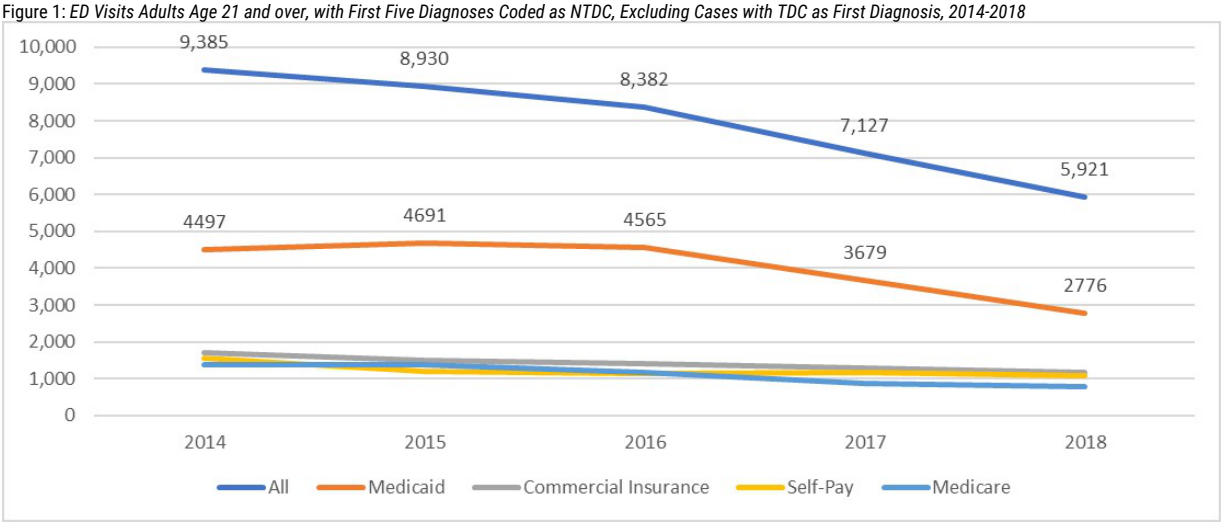
Methods

We used Rhode Island hospital discharge data from the Rhode Island Department of Health (RIDOH) for 2014 through 2018 to study trends in ED visits for NTDC. Data provided include information on patient demographics, all diagnoses provided, all procedures performed during the hospital visit, and total charges for all ED visits. Information on amounts actually paid are not available. We defined an NTDC as any ED visit in which the first five diagnoses were coded as NTDC but excluded these cases if the first diagnosis was for a traumatic dental condition (TDC). An identified set of ICD-9 and ICD-10 codes were used which represent dental conditions and maxillofacial infection. We estimated the total visits and aggregate cost and reported these parameters as a trend for 2014 through 2018, after adjusting the aggregate cost to 2018 dollars. We used the medical record number generated by the ED to identify individuals using ED for NTDC and the average number of NTDC ED visits per person. We stratified the results by insurance coverage, age, race/ethnicity, and ZIP code. We estimated the rate of individuals with a NTDC-ED visit by dividing the number of individuals using the ED for NTDC in a defined category by the number of populations in that category. The methodology used was adapted from the Association of State and Territorial Dental Directors' (ASTDD) *Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments*, published in September 2017.[6] The methodology differs from that used in the previous report so it will be

Table 1: *NTDC ED Visits and Hospital Charges, Adults Age 21 and Over, 2014-2018*

	2014		2015		2016		2017		2018	
	Visits	Charges	Visits	Charges	Visits	Charges	Visits	Charges	Visits	Charges
Medicaid	4497	$9,672,261	4691	$9,956,834	4565	$9,132,834	3679	$9,142,549	2776	$8,707,788
Commercial Ins.	1700	$5,875,937	1486	$4,670,833	1395	$4,633,297	1296	$4,539,847	1161	$5,095,266
Self-Pay	1564	$2,634,100	1189	$2,530,679	1146	$2,096,479	1168	$3,375,724	1075	$2,733,163
Medicare	1387	$5,630,187	1382	$5,958,538	1181	$5,609,328	884	$4,399,210	776	$5,082,852
Other	237	$1,379,241	182	$1,566,417	95	$785,202	100	$902,607	133	$1,408,634
Total	9,385	$25,191,726	8,930	$24,683,300	8,382	$22,257,296	7,127	$22,359,938	5,921	$23,027,704

Figure 1: *ED Visits Adults Age 21 and over, with First Five Diagnoses Coded as NTDC, Excluding Cases with TDC as First Diagnosis, 2014-2018*



more accurate to compare years within each report than between different reports.

Results

The total number of visits to an ED in Rhode Island with dental diagnosis dropped by 37% - from 10,191 in 2014 to 6,449 in 2018 (Table 1). This decrease was observed in all payer groups (Figure 1). All dental-related visits accounted for 1.6% of 401,260 ED visits in 2018 for those age 21 and over. Additionally, total charges have decreased by almost $2 million (Figure 2), and the greatest drop was seen among those with Medicaid and those with private insurance coverage.

Despite a significant reduction in the number of individuals using the ED for dental complaints, a more nuanced examination reveals that disparities persist. With a goal of optimum oral health for all, we looked at use of services based on age, race/ethnicity, geography, and insurance coverage.

In calendar year 2018, people age 20-44 had the highest utilization expenditures, and this holds true in all payer groups, with the exception of Medicare (Figure 3).

The breakdown of the percent of ED visits due to NTDC by age shows a peak in the 27-32-year-old age group (Figure 4).

There was a disproportionately high use of the ED for NTDC by Hispanics and Non-Hispanic Blacks in 2018. These two groups combined account for 17% of the State's population; however, they accounted for 34% of people who used the ED for NTDC (Table 2). Non-Hispanic Blacks were three times more likely to use the ED for NTDCs than Whites, and Hispanics were twice as likely to use the ED for NTDC as Whites (Figure 5).

Significant disparities also were seen based on community as assessed by ZIP code (Table 3 and Figure 6). Communities with low income, such as Central Falls, Woonsocket, and the Olneyville section of Providence have rates of use of the ED for dental complaints that are five to 10 times higher than wealthier municipalities such as Barrington, Cumberland, and East Greenwich.

The most common insurance among those using the ED for dental complaints continues to be Medicaid, representing 48% of visits. Individuals covered by Medicaid are disproportionately represented among those using the ED (Table 4).

Figure 2: *Charges of ED Visits, Total and by Insurance Type with First Five Diagnoses Coded as NTDC, Excluding Cases with TDC as First Diagnosis, 2014-2018, 2018 Dollars, Adults Age 21 and over, M=Millions of Dollars*

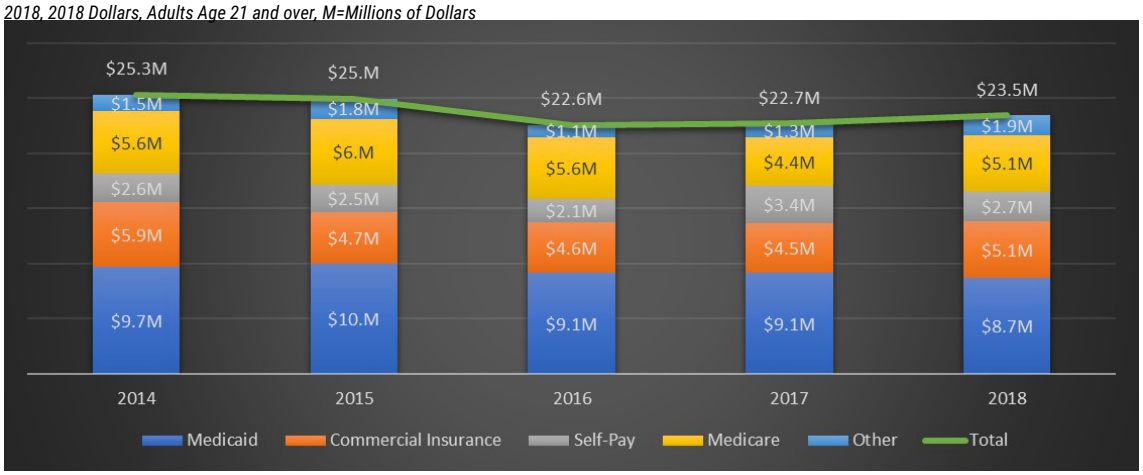
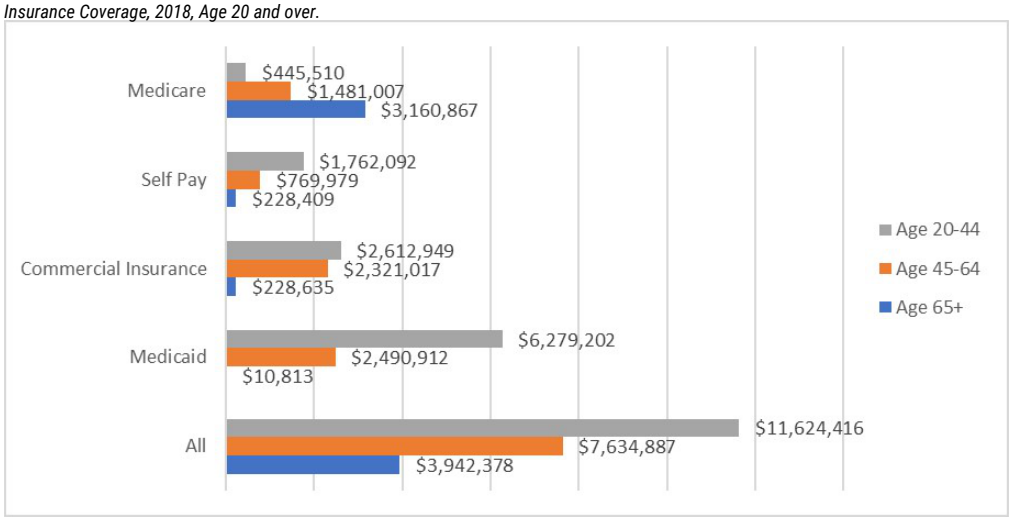


Figure 3: *ED Expenditures for Visits with First Five Diagnoses Coded as NTDC, Excluding Cases with TDC as First Diagnosis, by Age and Insurance Coverage, 2018, Age 20 and over.*



The most frequent site of presentation for individuals with dental complaints in both 2014 and 2018 was Rhode Island Hospital's (RIH) ED. This is not surprising, as RIH is the State's largest provider of hospital-based emergency care. While overall numbers decreased at all hospitals, the proportion among those seeking care going to RIH increased, from 27.6% in 2014 to 32.5% in 2018. This could be related to the closure of Memorial Hospital at the beginning of 2018. Westerly and Landmark Hospitals also saw large decreases proportionally, at 47% and 43% respectively, and Roger Williams, Newport, and Rhode Island Hospitals saw smaller decreases.

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Discussion

The drop in the total number of visits of people seeking care in EDs for dental care is an achievement that should be celebrated. Resources for care have increased significantly in Rhode Island in the last 10 years, including capacity for dental care at health centers and hospitals, and continued strong participation in programs such as Rhode Island Mission of Mercy and Dental Lifeline Network. It is critical that these key programs continue to be supported by volunteers and funders.

Figure 4: *NTDC Visits to ED, by Age, 2018. Note-does not include those visits which ended up as an inpatient visit.*

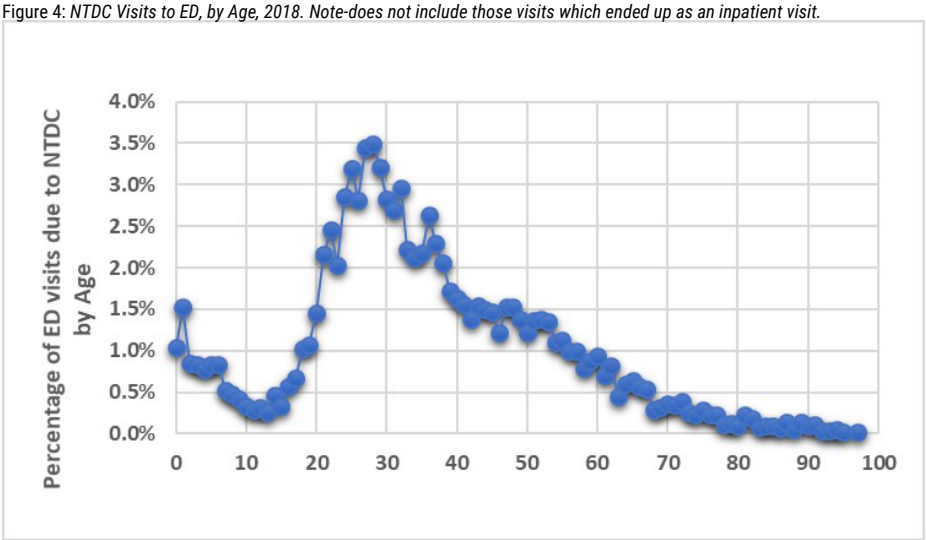


Table 2: *ED Use for NTDC by Race/Ethnicity, All ages*

	ED visits for NTDC	Percentage of visits of ED for NTDC	Rhode Island Population	Percentage of Rhode Island population
Non-Hispanic White	4,235	62%	810,631	77%
Non-Hispanic Black	972	14%	56,797	5%
Hispanic	1,288	19%	130,655	12%
Non-Hispanic Other	386	6%	54,484	5%
Total	6,881	100%	1,052,567	

Table 2: *ED Use for NTDC by Race/Ethnicity, All ages*

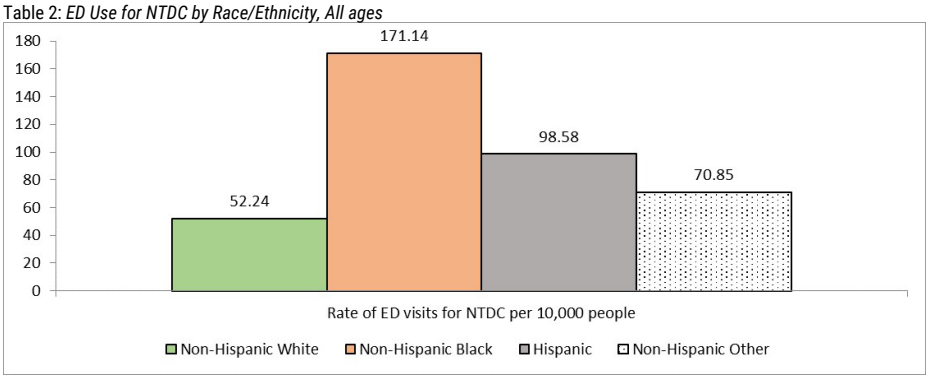


Table 3: *Use of ED Services by selected ZIP Code, Relation to Income*

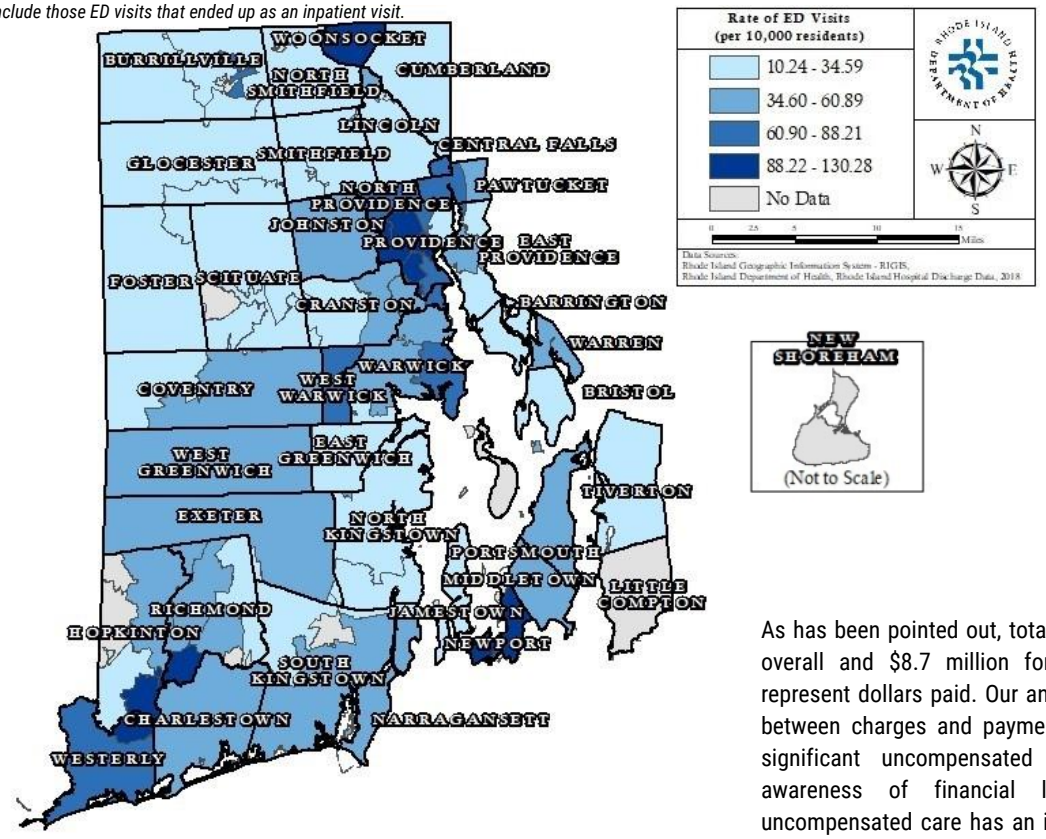
Community	ZIP Code	Median Household Income	Percent Population below Federal Poverty Level	Rate of visits per 10,000 residents
Barrington	02806	$117,408	2.8	12.88
Central Falls	02863	$30,794	30.7	88.21
Cumberland	02864	$81,810	7.3	23.66
East Greenwich	02818	$97,800	4.2	20.46
Providence (Olneyville section)	02909	$33,661	36.9	105.42
Woonsocket	02895	$38,340	24.4	114.6

Data from the ADA's Health Policy Institute (HPI) also saw a drop in ED use on the national level from 2010-2017, with the greatest drop seen in the 18-25-year-old age group.[7] It is possible that the increased emphasis on dental care for children in the last 15 years, including placement of dental sealants, has resulted in a cohort of young adults with improved oral health and fewer dental emergencies. Keeping youth, up to age 26, on parents' insurance through the Affordable Care Act has also increased access to dental insurance for young adults.[8] It is critical that these investments and supports for childhood prevention continue. This age group is most likely to have a health plan that does not include dental insurance and least likely to obtain routine dental care, according to ADA HPI data.

Other factors which may contribute to reduced use of ED is the reduced availability of opioids as a management strategy. Preliminary RIDOH data from the Prescription Data Monitoring Program show a reduction in prescribing of opioids in multiple locations. Individuals expecting opioids may no longer go to the ED as they are more likely to receive long-acting injected local anesthetic to provide pain relief for dental care. It is also unlikely that individuals presenting to an ED with NTDC will receive definitive care, or care that addresses the problem and its cause. While some academic medical centers have residency programs which provide dental care, these programs are not intended to provide care at night or during the weekend. EDs which do wish to address dental issues may wish to consider placing a dental chair in the ED and hiring dental staff to properly address patient needs.

The largest source of insurance among those using the ED for dental complaints continues to be Medicaid. This is likely multifactorial but represents issues of access. This calls for targeted initiatives to inform individuals of the services available to them and encourage them to use the services for which they are eligible. Yet the burden for seeking care should not lie with patients alone. Policy makers and practitioners must work to increase access. The number of providers in private practice who also participate in Medicaid has decreased significantly in the last

Figure 6: *Rate Per 10,000 residents of ED Visits to Rhode Island Hospitals Due to a Dental Diagnosis, by ZIP Code of Residence, 2018. Does not include those ED visits that ended up as an inpatient visit.*



10 years, largely attributed to the low reimbursement rates, and federally qualified health centers (FQHCs) are left to fill the gap. Rhode Island has a lower dentist to population ratio compared to neighboring states, resulting in high volume levels. Dentists do not seek to participate as Medicaid providers when reimbursement rates are insufficient to meet costs of providing care. While health centers have made a great difference over the years, they are not fully able to manage all of their patients' complex problems, based both on capacity and location.

As has been pointed out, total dollars indicated for 2018, ($23 million overall and $8.7 million for Medicaid), are charges and do not represent dollars paid. Our analysis is unable to obtain the difference between charges and payments, but it is likely that this represents significant uncompensated care for hospitals. With continued awareness of financial loss at local hospitals, additional uncompensated care has an impact on resources of the hospital and its ability to serve the community.[9]

Table 4: Use of ED for NTDC, by Insurance Type, All ages, excluding admitted patients

Coverage Type	Number of ED visits for NTDC	Percentage of visits of ED for NTDC	Percentage of Rhode Island population
Commercial	1,372	20%	52%
Medicaid	3,396	49%	24%
Medicare	777	11%	18%
Uninsured/Self-pay	1,152	17%	4%
Other/Military	184	3%	3%
Total	6,881	100%	100%

As has been pointed out, total dollars indicated for 2018, ($23 million overall and $8.7 million for Medicaid), are charges and do not represent dollars paid. Our analysis is unable to obtain the difference between charges and payments, but it is likely that this represents significant uncompensated care for hospitals. With continued awareness of financial loss at local hospitals, additional uncompensated care has an impact on resources of the hospital and its ability to serve the community.[9]

Finally, we do not fully understand the reasons why some patients consistently pursue care for dental complaints in the ED. Identifying these factors, and perhaps even socioeconomic or regional differences in these reasons, will help to design targeted interventions to help individuals seek appropriate and cost-effective care. Further analysis of medical and behavioral health issues should help focus efforts. Research has looked at incidence of behavioral disorders among those seeking service in the ED. A high degree of fear may be a motivator to go to the ED, knowing that care will not be attempted. Fear of dentists may be greater among those who had more dental disease and poor access to care as a child. Behavioral health strategies have been effective in reducing dental fear. In order to reduce disparities, efforts to address dental fear through behavioral therapy should be more widely available by placing these services in health centers and by covering the services through insurance. A good example is a partnership with a behavioral health specialist who provides stress reduction strategies to reduce patients' fear at WellOne Primary Medical and Dental Care.[10]

Limitations

The strategy used to determine how deep into the list of diagnoses to look for a dental diagnosis was based on concern that coders could list medical diagnoses first, therefore missing the case as a dental case. The reality is, the more diagnoses allow, i.e. looking deeper into the list, the greater likelihood of false positives. However, if only looked at first diagnosis, we may miss many dental cases. Number of users was based on medical record number (MRN). While the same MRN is used for each user across hospital systems, if a user goes to a different hospital system, another MRN could be used, increasing the number of users and decreasing the identification of repeat visits. Additionally, ICD coding transitioned from ICD-9-CM to ICD-10-CM prior to the fourth quarter of 2015, and some of the differences in number of cases observed from 2014 to 2018 may be attributed to this changing case

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*Memorial Hospital closed in 2018

Hospitals (NTDC visits, all ages)	Number with dental diagnosis 2014	Proportion of all ED visits, 2014	Number with dental diagnosis 2018	Proportion of all ED visits, 2018	Actual change	Percent change
RI Hospital	2,952	27.6%	2,232	32.5%	-720	-24.4%
Kent	1,546	14.5%	931	13.5%	-615	-39.8%
Miriam	1,282	12.0%	830	12.1%	-452	-35.3%
Landmark	1,070	10.0%	608	8.8%	-462	-43.2%
Newport	746	7.0%	578	8.4%	-168	-22.5%
Fatima/St. Joseph	688	6.4%	514	7.5%	-174	-25.3%
Memorial*	675	6.3%	0	0.0%	-675	-100.0%
Westerly	631	5.9%	337	4.9%	-294	-46.6%
Roger Williams	592	5.5%	526	7.7%	-66	-11.1%
South County	424	4.0%	286	4.2%	-138	-32.5%
Women & Infants	78	0.7%	29	4.0%	-49	-62.8%
Total	10,684		6,871		-3,813	-35.7%

definition. While this may affect total number of cases and change from 2014 to 2018, it likely wouldn't have influenced the disparities in demographics observed in 2018. This study did not look at charges of those who were admitted as inpatients. While this applies to a small proportion of visits, it adds significant cost. This will be left for a future report.

Conclusions

While there is reason to celebrate the reduced number of people using EDs for dental complaints, it is clear that age, socioeconomic, and race disparities persist. With the goals of eliminating disparities, we must identify causes and address them. Further review of the data may help identify concurrent medical or behavioral health concerns that could serve as barriers which may point to potential solutions. Strategies aimed at increasing the number of dentists who participate in the Medicaid program will also make a big difference. ■

Key Findings

- The number of visits to EDs in Rhode Island for NTDCs decreased by 37% from 2014 to 2018.
- The highest ED use is among those age 27-32.
- People with Medicaid have disproportionately high rates of ED use, representing more than $5 million in annual charges.
- People from communities with low median income have disproportionately high rates of ED use.
- There is disproportionate ED use by Rhode Islanders of Black and Hispanic ethnicity.

Recommendations

- Improve Medicaid reimbursement rates for potential increase in use of preventive dental services which can lead to savings in ED use.
- Continue to look at Rhode Island's dental workforce to assure that accessible and affordable care is available in all neighborhoods at times of day that are convenient to the local community. Work to assure that the diversity of the dental workforce mirrors the diversity of the State.
- Institute a referral system from EDs to health centers and private practices participating in the Medicaid program.
- Increase medical-dental integration to increase likelihood of referral in cases of dental complications related to medical conditions or treatment.

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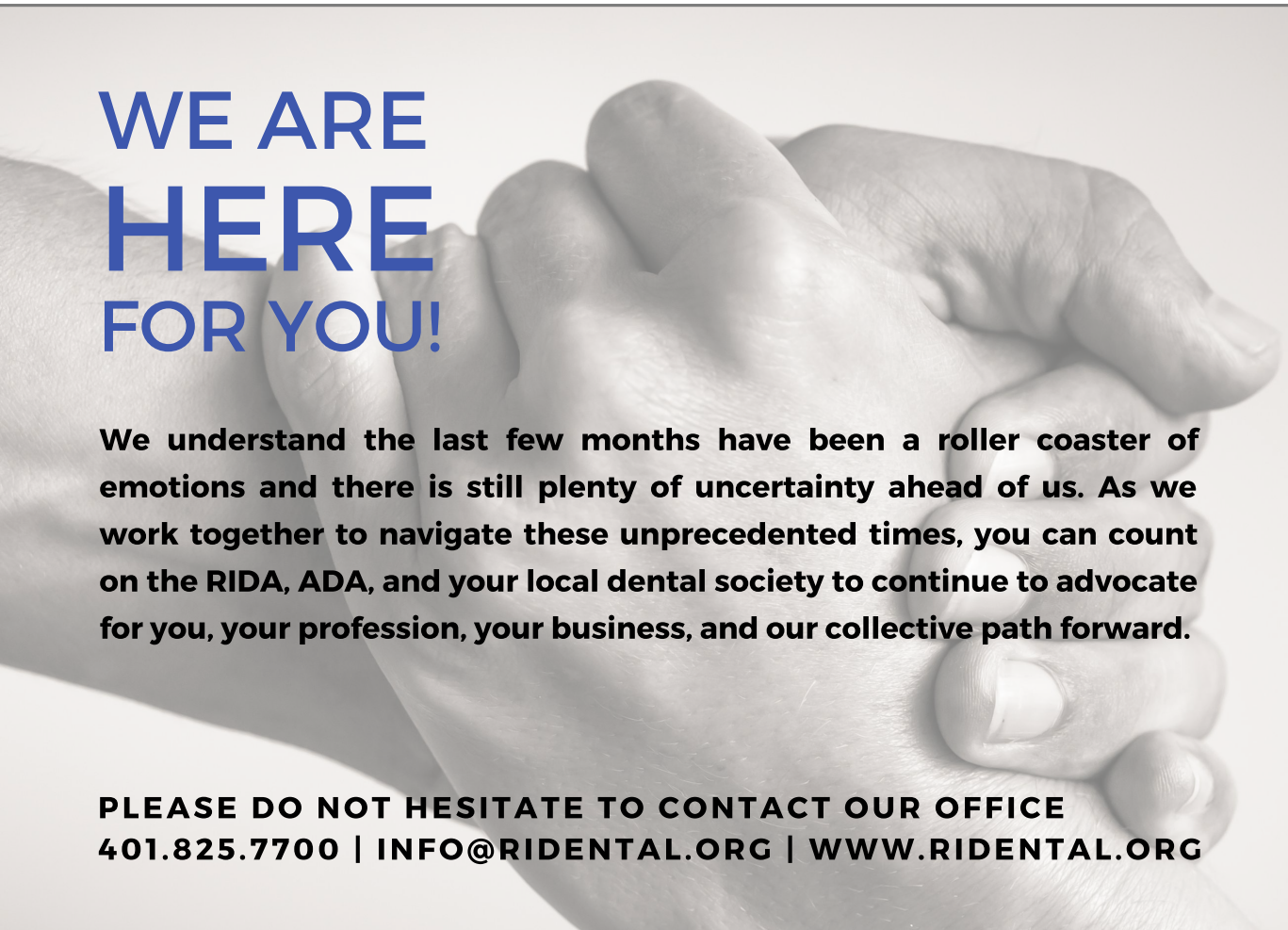

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