

Mobile Dentistry

Entrepreneurial Boom Spurs Debates



BY JANYCE HAMILTON

Each new school year brings the hope of new opportunities, and for Massachusetts school children, this was certainly the case as the 2006-2007 school year began. In September 2006, school nurses from across the state began contacting the Massachusetts Department of Public Health because a number of dental programs had contacted the schools offering to provide sealants to

Medicaid-eligible students. The school nurses were wary of the offers. Were these programs legitimate? Did they provide good service?

While the Massachusetts Department of Public Health was receiving this influx of inquiries from school nurses, Massachusetts' Medicaid reimbursement rates for children's preventive services were increasing; the fee hike was phased in on two separate dates in February and July 2006. While the increase in Medicaid reimbursement was overdue for pro-

viders who had been servicing low-income children, it turned out to be a lure for other providers—particularly those who had less experience bringing services to alternative settings.

In response to the nurses' inquiries, Lynn A. Bethel, RDH, BSDH, MPH, the interim director of the Office of Oral Health, and her colleague, the director of School Health at the Massachusetts Department of Health, began to research the issue. Although the mobile/portable dentistry programs offered dental care to needy children



who might not have received care by any other means, Bethel thought this sudden bumper crop in new mobile/portable program providers painted a suspiciously rosy picture. For Bethel, the promise of "A free toothbrush for each child!" rang hollow if those children did not receive access to dental treatment for pain or infections.

Providing dental care in a school-based setting is very different from providing that same care within a private practice. Certain factors—like offering referrals and providing follow-

up care—need to be considered. The school nurses met with the new program contacts, posed some hard questions, and reported that the dental entrepreneurs who ran the mobile dental clinics in question avoided their requests for data. The nurses were told that precise statistics were not available for the clinics' sealant retention rates, because retention "depends on the dental provider and other factors."

Bethel had been developing school-based sealant programs for the past six years and knew that existing mobile/portable programs with proven track records made a point of following up with patients during subsequent site visits to treat higher grades. The programs *could* track which sealants were lost over time and could provide retention rates. She was, understandably, concerned by the dental providers' response.

Bethel remembered reading a handful of reports and hearing from other state dental directors about mobile/portable prevention program entrepreneurs who appeared—seemingly overnight—when the states' Medicaid rates were boosted. Such increases are a cause for concern, according to some private practitioners and public health dental officers. (Note: Even without a boost, research conducted for this article has revealed that most states are reporting increased mobile/portable program activity.)

In July 2007, all U.S. state boards of dentistry, state and territorial dental directors, and state Medicaid fraud unit investigators were asked to contribute policy and incident accounts for this report. The result was nationwide examples of the beneficial kinds of operations that mobile/portable dental

programs utilize versus those that leave the patient stuck with untreated decay, unprotected molars, too much radiation exposure, and pain—and leave them without a contact for follow-up or emergency care. Recent developments concerning the ways in which states have begun addressing the problem—through legislation, state dental licensing, and board rules and regulations, and a push for registration of mobile/portable providers at health departments—are reported in this article. Nationwide, the 2007-2008 school year began with less confusion for school nurses than the previous year, at least for those states that have enacted policies for mobile/portable dental units.

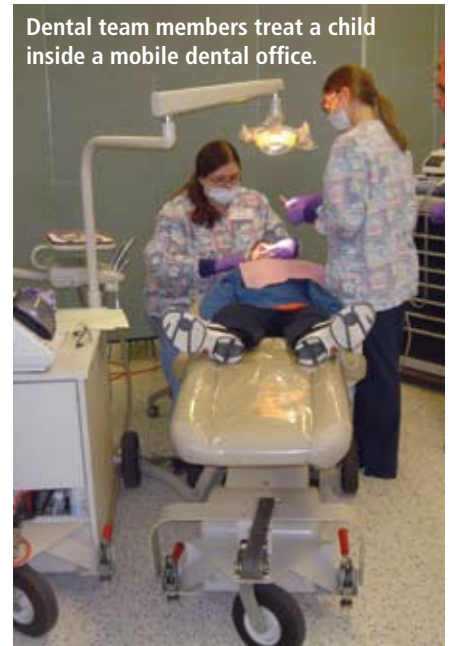
The mobile and portable dental models

Mobile dentists—such as those who provide care in vans and trailers that drive to schools, nursing homes, and community health sites—are an established component of the solution to access-to-care problems concerning hard-to-reach patients. They serve patients who either can't or won't go to a dentist's office on their own. A number of teaching institutions, county health departments, and federally qualified health centers (as well as the Head Start program) fulfill their mission by offering care through mobile/portable facilities. These facilities can be set up on large chassis platforms and driven to the site, or portable dental equipment can be transported (using SUVs and minivans) and set up inside the institutions and schools to treat patients where underserved head counts are high. (Sole proprietors often invest in portable equipment rather than investing in mobile facilities that can have high overhead due to build-out costs and gas prices.)

Since 2000, corporations have been making strategic inroads into the market for transportable dentistry. One model is the for-profit company that has an arm of the business which serves as a not-for-profit with an educational mission. This not-for-profit arm qualifies for grants from foundations to pay employees and for special tax status. Mobile



Dental Access Carolina serves nine school districts in six counties in South Carolina.



Dental team members treat a child inside a mobile dental office.

dental services that operate under such an arrangement can visit public health access and Medicaid meetings, go to school boards to discuss educational campaigns, and attend city council meetings to lobby for municipal promotion. Owners are allowed to meet with nursing homes and institutions for the developmentally disabled and word-pick through state practice acts. They can even contact the presidents of parent-teacher associations to discuss bringing free prevention programs into the school.

These companies always have the same message, says Lawrence Hill, DDS, MPH, dental director for the Cincinnati Department of Health and the Greater Cincinnati Oral Health Council, and president of the American Association for Community Dental Programs. They claim to be "the greatest thing since sliced bread. They send post-cards to dentists [saying], 'If you want an easy day, come and sit in our mobile unit for \$300 to \$400 and do quick exams. Hygienists do the rest.'"

Traditional land-locked dental offices arduously grow patient-by-patient, via the *Yellow Pages*, newspaper advertising, and word-of-mouth. By contrast, once these entrepreneurial mobile units receive approval, they cater to a more captive patient population, which

waits in hallways, gymnasiums, and even storage closets. They target the weary, access-challenged population of patients who have no money, no dental home, and no transportation—in other words, those eligible for Medicaid.

However, mobile dental programs are not all inherently bad, just as private dental practitioners are not all inherently good. Some honest dentists work fervently to deliver care via entrepreneurial mobile/portables. The quality of the dentistry and the dental program is a function of the quality and motivation of the individuals operating the program.

Concern over mobile/portable entrepreneurs

Many mobile/portable dental units are run and operated by dentists who could practically apply for sainthood status; however, the recent focus has been on the few bad apples. Dentists and the public are understandably concerned that greedy mobile office operators may see frank tooth decay, take no radiograph, place a glob of sealant over the tooth, and bill it as a restoration. Is there a systemic flaw that passively and unintentionally compromises the oral health of those who rely on Medicaid dental care? Such ignorance regarding the practices of specific mobile dentists

handicaps the judgment of a downtrodden parent or caregiver who hears that an institution will provide some sort of dental care this year and responds by thinking, "Why pay for it ourselves ahead of time?"

Mobile units are great for simple routine procedures, says Linda Campbell, CPM, executive director of the Oklahoma Board of Dentistry. However, there's concern that, in some states, improperly trained and licensed staff could provide anesthesia or indiscriminately utilize papoose boards, resulting in harm. "Do the mobile units have all of the proper equipment?" asks Campbell. "In the worst-case scenario, a dentist traveling from [his or her] office [may] on one occasion forget to take the pulse oximeter. During the procedure, the patient goes south. Children have died in mobile units."

When it comes to dental mobile units visiting schools, regulators (including Campbell, who also serves as president of the American Association of Dental Administrators) are calling out for that common sense. Campbell points out that there are many questions and few answers. She asks, "Do the parents know [the mobile dentists] are coming? Do the dentists obtain proper authorization? Do they maintain a record for each patient? Do

dentists in the school practice universal precautions from school to school? Does the school have a facility, or does it rely on the dentist bringing the equipment to the school? Does the dentist bring all of the equipment each time treatment is done?"

Of course, not all mobile dental care is provided to schoolchildren. Mobile units also visit nursing homes and facilities to treat senior patients and the homeless, who often are medically vulnerable. "Reputable dentists are adamant about the type of care that should be provided to those fragile human beings who are medically compromised," Campbell notes. "Aggressive restorative work on a patient might do more harm." The dentists providing care in these situations must be trained so that they are capable of treating severely medically compromised or developmentally disabled patients.

Merely cleaning the teeth of kids with oral infections and rampant caries is akin to giving a haircut to treat head lice. Dental schools teach dentists to stabilize patients first. A fluoride treatment should never be given to a child with high bacterial load and untreated decay. In that scenario, the child still goes to bed in pain.

As the dental director for the Cincinnati Department of Health, Dr. Hill is the go-to person regarding the creation of a movable dental care unit; he also is one of the lead authors of *The Mobile-Portable Dental Manual* (www.mobile-portabledentalmanual.com/), a collaborative online textbook published recently by the Association of State and Territorial Dental Directors and the National Oral Health Resource Center of the Maternal and Child Health Bureau, Health Resources and Services Administration.

Dr. Hill's experiences with Ohio mobile dental facilities have been similar to those of Bethel's in Massachusetts. For years, Cincinnati's elementary school nurses were reportedly frustrated because they couldn't resolve the students' dental problems. There were no good answers for children who suffered from toothaches, oral and facial swelling, or untreated

caries. The city health department clinics already were filled to capacity, with thousands on waiting lists. Although parents were notified of the problem, the kids were not getting treatment for a variety of reasons. In Dr. Hill's case, he became the ultimate hands-on den-

The dentists providing care in these situations must be trained so that they are capable of treating severely medically compromised or developmentally disabled patients.

tist, raising the funds to build a mobile dental unit for the Oral Health Council.

New doctors, some with substantial educational debt, may be hired for mobile entrepreneurs and work on salaries. However, things gets dicey when the salary is boosted by bonus incentives that tie-in with head counts. One such operation focused on Head Start kids from Indian reservations with a 5 or 8 percent bonus payment "based on their total production for the year." That particular mobile outfit had dentists traveling to New Mexico and Arizona, until an Arizona Health Care Cost Containment System fraud investigator noticed that the practice consistently billed more and with greater frequency than other dentists. One dentist billed for 149 examinations in a single day (which breaks down to approximately 2.5 minutes per child). This and other egregious practices led to a license suspension.

The fact remains that an individual dentist working alone can't handle an entire grade school easily or quickly. Knowing that, it is clear how mobile entrepreneurs get their foot in the door. According to Mike Reza, president of Tooth Mobile in Santa Clara, Calif.,

an operation that does comprehensive care in a 40-ft. rolling office, these mobile operations aggressively advertise to hire local hygienists for their expansion. This aggressive marketing might not sit well with some dentists, Reza admitted.

Mobile dentistry done right

In 1988, a regulation was passed to allow preventive treatment on patients in South Carolina schools and nursing homes without the direct supervision of a dentist, but it was unused until Medicaid rates were increased in 2000, due to the efforts of organized dentistry. Non-dentist providers claimed that some care was better than no care at all, especially if the dentists were not willing to provide it, but members of the dental community were understandably concerned. At a meeting in January 2001 that was attended by a large group of dentists, much of the discussion was centered on these portable, school-based services.

John Reese, DMD, of York County, S.C., called leaders of the South Carolina State Board of Dentistry, the Department of Social Services, the South Carolina Dental Association, and other agencies to find out the best way to provide the services that were desperately needed by so many children. He acquired a used RV and retrofitted it as a mobile dental clinic, obtained approval from the South Carolina State Board of Dentistry, and entered into a contract with one school district to provide complete dental care to Medicaid-eligible children in one school as a pilot program—all in less than 60 days—while continuing to operate a totally insurance-free complex comprehensive restorative and cosmetic brick-and-mortar practice.

"The pilot program was immediately successful and the school district officials asked us to expand our services to more schools. The word also got out to neighboring districts and we received more requests for our services," says Dr. Reese. He sold his practice in 2001 to practice mobile dentistry full-time and has "never looked back." Since then he has designed a custom-built, state-of-the-art mobile dental clinic. His

operation now serves nine school districts in six counties in South Carolina and employs four full-time dentists, one of whom is a pediatric dentist with 25 years of experience.

Dr. Reese says that when other states were being investigated for unscrupulous and fraudulent mobile and portable dental units, South Carolina began the process of passing regulations requiring the registration of Mobile and Portable Dental Operations. Because of his unit's reputation for providing quality dental care in the mobile environment, the leadership of the South Carolina Dental Association and State Board of Dentistry asked Dr. Reese to help write the law, which passed in 2006.

Boards discuss legislation

The Oklahoma Board of Dentistry suffered through something of a public cat fight in 2007 when concerned officials wrote a new policy for the operation of mobile/portable units. Board members were surprised when public arguments erupted regarding whether new mobile/portable dentistry rules should be added to the books or not.

Terry Grubbs, DDS, former chairman of the Oklahoma Board's rules committee, recalls, "I hung up my spurs [and resigned] from the committee after they wouldn't pass any rules to make mobile outfits adhere to the same rules as fixed dental facilities." Dr. Grubbs recalled that people were angered during a public hearing in early 2007 because of the perception that the board was trying to restrict nursing home care. The public did not understand that rather than restrict care, the board was attempting to protect those vulnerable patients and ensure that they received quality care. Dr. Grubbs worried that mobile outfits would prey on bed-ridden nursing home residents, when those patients should receive treatment in a hospital setting. He cited an example of an Alzheimer's patient in a nursing home who had a feeding tube and two IVs. "Her jaw was clamped shut, so the dentist couldn't get partials in," says Dr. Grubbs. He maintains that the mobile dentist should never have billed Medicaid for this patient to receive a partial denture in the first place: "You'd

have to break her jaw open to get in partials."

The next legislative session for Oklahoma is slated for February 2008. The board is gathering as much supplementary information about mobile dentistry as it can in preparation for battle.

Meanwhile, in Colorado, the State Board of Dental Examiners issued a cease and desist order in February 2007 for the mobile operation of a dentist who received an unannounced inspection of his mobile practice while operating at a grade school. The dentist, who wasn't washing his hands between patients, said he "did so at the beginning of each day." The surprise inspection also discovered that neither he nor his dental staff members wore gloves, and that the practice had submitted inaccurate Medicaid billing records, including submitted claims for panoramic X-rays that had not been taken and a sealant on a tooth that had yet to erupt.

Michigan dentists and policy makers are concerned also. Christine Farrell, RDH, MPA, a Medicaid policy specialist for the Medical Services Administration of the Michigan Department of Community Health and a Medicaid Audit and Investigation representative, observed 25-minute cleaning and prevention treatments performed on children in an elementary school. She says, "Unless something changed when we weren't there—[such as] shortcuts to procedures or quick exams—we couldn't find any fault."

On the Las Vegas strip, mobile dental vans have been known to provide "parking lot dentistry." Although the phrase doesn't sound good, these vans provide a true service for low-income patients who work more than one job and cannot take time off work to visit a dentist but can visit the mobile dental van during their lunch break.

The dental profession's public, corporate, manufacturing, and association leaders remain at odds over whether the entrepreneurial mobile/portable model does more overall good than harm. For every profit-driven program, Dr. Hill estimated there are three or four more

wonderful, child-centered mobile/portable programs: "The problem is with the individuals, not the settings."

Impact on private practitioners

The mobile dentists who don't provide follow-up aren't just a liability for their patients; they also create problems for private practitioners who accept Medicaid. The dentists interviewed for this story believe that during the last few years there has been an increase among 5- to 11-year-old children who seek treatment from private offices within six months of an examination by a mobile dentist. These patients often don't bring in any documents detailing findings of their screening/exam and rarely have a copy of X-rays. Although the dental office may get contact information for the mobile dentist from the school, the school secretary or nurse may not have that information if an organization outside of the school arranged the visit. If a dentist does reach the mobile dentist, there still is no guarantee that the records will be provided.

Dentists may not be able to complete the treatment plan he or she had prescribed for patients who have received services in the mobile dental office. The benefits for the exam can be denied if the patient has already received these services in a mobile unit.

In some states, dentists cannot turn away a "patient of record"—even if it's the patient's first time in their chair—regardless of the ability to pay; doing so could be construed as abandonment. Instead, the private dentist must eat the cost of repairing a sealant, doing a full exam, and—if decay is rampant and the teeth haven't been brushed in months—administering prophylaxis and fluoride varnish. Aside from the financial issues, dentists also face ethical issues. Many dentists are uncomfortable prescribing additional X-rays because of the additional radiation exposure; however, if pain necessitates doing so, these new X-rays will be paid for out of the dentist's own wallet.

One practitioner estimates that the bill for one patient with intact Medicaid benefits is equal to that from three patients who recently had been

PENDING REGULATIONS

Are Dental Policy Makers on the Verge of Restricting Mobile Dental Providers?

Dental policy makers are unsure whether adding regulations for mobile/portable oral care will create positive change. These new rules could change little and decrease access further, or they could influence current providers to operate more mindfully to secure post-visit follow-up. However, some states have clarified their rules to serve as pilot programs for addressing these questions (see Table 1).

On a national basis, however, nothing has caused the federal Medicaid program to institute policy revisions, although Conan Davis, DMD, MPH, the chief dental officer at the Center for Medicaid Services in Baltimore, has vowed to “keep an ear to the ground for rumblings” from Maryland and other state Medicaid programs.

A report of state public health legislation through Dec. 31, 2006, found a few items of note:

- 10 states have increased Medicaid reimbursement for dental services.
- Nearly half of the states (23) introduced bills to expand dental access for those needing it most.
- Eight states increased “scope of practice,” allowing hygienists to provide more services to low-income citizens, including administering anesthetic injections (under direct dentist supervision) after completing coursework and passing a board exam.

- After losing a court case concerning the ability of dental “aides” to perform dental procedures (commonly via mobile and portable programs) in rural Alaska, the American Dental Association (ADA) and Alaskan Dental Association announced plans to contribute more than \$500,000 to ensure dentists help program managers bring care to those in need.

One health department source admitted that, unscientific as it might be, the best tool for weeding out the good entrepreneurial mobile/portable outfits from the bad remains by word-of-mouth. That process can include reviewing lists from the board of dental examiners to determine if the state has ever licensed or reprimanded the outfit in question.

According to Millard Howard, DDS, a dental coordinator with the Florida Department of Health and a former Florida Medicaid staffer, most mobile dental entrepreneurs (who had been performing activities like going to low-income areas to solicit patients) responded to Florida’s banning of such activities by leaving the state and fleeing for neighboring states like Alabama, Georgia, and even Ohio. “My counterparts were joking that they were going to try to cut them off at the border,” he says.

seen by a dental program that billed their Medicaid benefits. All this adds up to economic practices which may not be illegal but arguably are on shaky ethical ground.

Beverly Largent, DMD, a pediatric dentist in Paducah, Ky., is president-elect of the American Academy of Pediatric Dentistry; she also has served on the ADA’s Council of Ethics, Bylaws and Judicial Review and is a past president of the Kentucky Dental

Association. Forty percent of her patients are with Medicaid; some drive more than an hour to reach her practice.

Dr. Largent has treated patients who have seen mobile dentists and she has conflicting feelings about the service. “One [mobile dentist] blew into town and went to an underprivileged neighborhood,” she says. “Soon I got a couple of the patients who were in pain from their inappropriate restorations.” When the patients’ Medicaid codes

were entered, benefits were denied. Dr. Largent treated these patients *pro bono* because “the kids were in dire need.”

Sensing that Medicaid dentists were fed up with mobile dentists cutting into the reimbursements they can receive, Washington state policy makers got creative and added a whole new category of care. Hygienists in the state can now provide “screening assessments.” The CDT code D9999 is used for hygienist screenings. This distinction between

Table 1: National Examples (By State) Regarding Board of Dentistry or Medicaid Mobile/Portable Program Requirements and Those Contemplating Adding/Changing Rules.*

Are Regulations, Laws, or Registration Required for Mobile/Portable Units?

State	Yes	No
Arkansas.....		X
California.....	X	
Colorado.....		X
Florida.....	X	
Idaho.....		X
Indiana.....	X	
Kansas.....	X	
Louisiana.....	X	
Michigan.....		X
Mississippi.....	X	
Missouri.....	X	
New Hampshire.....		X
New York.....	X	
Ohio.....		X
Oregon.....		X
Rhode Island.....		X
South Carolina.....	X	
Tennessee.....	X	
Virginia.....		X
Washington.....		X

Actively Assessing Need to Draft Regulations or Registration for Mobile/Portable Units?

Arkansas.....	X	
Illinois.....		X
Massachusetts.....	X	
Michigan.....	X	
Oregon.....		X
Rhode Island.....	X	

**This is not an inclusive list. Examples are provided based on reports by representatives from state agencies.*



Mobile dental operatory setup

diagnostic and screening allows hygienists to provide sealants, fluoride applications, and assessments without a dentist's supervision.

Concurrently, Washington's Medicaid rates increased for some services in July 2007, according to John Davis, DDS, JD, dental administrator, Division of Healthcare Services, Health and Recovery Services Administration, in Olympia, Wash. Dr. Davis is pleased by the recent combination of benefits for the oral health of low-income citizens, especially since many states haven't seen improvements in Medicaid rates or providers for several years.

It's not only private practitioners

who feel dumped upon when they get patients whose benefits have gone dry. Some health departments and agencies, such as the Indiana Health Service, are silently swearing off their mobile/portable provider allegiances. Sub-par treatment challenges limited budgets when, for example, patients who received such services come in for a fix on new sealants that fell off prematurely. Publicly, the sporadic, intermittent mobile/portable dental visiting programs may not be criticized because alternatives may be lacking. "Should we grant exceptions because some are trying to provide patients care in low income areas? Everyone

has a right to quality care, regardless of income," says Campbell.

What about the patients?

When a patient sees a Medicaid dentist, it may be because a bus token was lent by the Veterans Administration officer. The visit might have cost the patient a day of work, when his or her paycheck already doesn't cover food for the family. When this stressed-out patient hears that his or her benefits are insufficient, or senses an attitude of irritation because the doctor has to start from scratch, he or she may become panicked or confused—and may respond by not coming back for additional treatment.

It is also important to consider other special needs patients covered by Medicaid, such as those who may suffer from mental illness, substance abuse, HIV/AIDS-related opportunistic infections (for example, tuberculosis), or emotional and/or physical abuse. According to the American Dental Association, 24 percent of Medicaid dental patients (compared to 14 percent of privately insured patients) may be no-shows, which may be the deal-breaker for the few dentists who do accept public aid.

Medicaid has received a lot of public scrutiny in the past year. The February 2007 death of 12-year-old Deamonte Driver was a stain on the Medicaid dental system. The Driver family experienced a bout of homelessness, and paperwork was likely lost when mailed to a shelter; as a result, their Medicaid benefit eligibility lapsed. The boy's family pleaded and finally received assistance from the Baltimore-based Public Justice Center to find a dentist who would take them while they were straightening things out. The general dentist made a referral to an oral surgeon. The Driver child was placed on an oral surgeon's waiting list for "an examination," even though his teeth hurt "all the time"—the result of an abscess. Eventually, he received a hospital-based extraction in the emergency room. By then, the infection from the dental abscess had spread to his brain.

Whether mobile dentistry could have helped Deamonte or other chil-

dren like him is uncertain, but it underscores the importance of treating patients who do not have access to care by other means. In 2005, 16 percent of Maryland's children receiving Medicaid benefits used them for restorative care; Medicaid-eligible children are estimated to have twice the decay as non-Medicaid children.

Public outcry

Dental examiners and public health dentists have looked to other states' policies to decide if certain mobile/portable practices should be regulated or outlawed entirely. In addition, the decision of whether or not to regulate these practices has been impacted by public outcry.

Sometimes that outcry comes from the school nurses who want guidelines to assure parents that their children will be receiving quality oral health-care in the schools. Other times, families contact Medicaid agents with misgivings about a program.

Often, the negative attention concerning mobile dental operations is caused by horror-story-like cases of negligence and fraud. For instance, as recently as 2004, a non-dentist operated mobile dental services in Kentucky, Ohio, and Indiana. This mobile office served Medicaid children in public housing, daycare centers, and schools to the tune of \$4 million in reimbursements. Allegedly, this non-dentist hired dentists and hygienists in the three states and instructed the hygienists to do sealants on any primary tooth with a stain.

Another case happened in Little Rock, Ark., where a dentist outfitted a van with a dental chair and pulled into small towns like Blytheville and Forrest City. Priscilla Kilgore, a member of the state's Medicaid fraud unit, recalled that the dentist parked on the street and got the neighborhood kids in for treatments but simply pitted children's teeth by making holes in the enamel large enough to place superficial fillings. He billed Medicaid for stainless steel crowns that weren't provided, which was used as evidence when he faced a fraud conviction.

In Florida, "recruiters" were hired

to pick up children—some as young as age 2—and bring them to a mobile dentist, without consent from a parent or guardian. The recruiters bribed the children with five-dollar bills, promises of McDonald's meals, and Pokémon cards, and were paid \$25 for each child. In a more troubling allegation, a convicted sex offender claimed he was paid to take X-rays for one mobile dental unit.

Because of these allegations, Florida lawmakers created a statute that requires mobile dental providers to have a contract with a teaching institution, county health department, or federally qualified health center. The tooth van can no longer pull up like an ice cream truck to a schoolyard anywhere in Florida, although they come and go legally to nursing homes, providing dentures, partials, and emergency services.

Dr. Hill is skeptical of mobile entrepreneurs, maintaining that a dental examination implies that a treatment plan will be created. "But doesn't billing for a treatment plan with no intent to treat seem like abandonment?" he asked. "Could that border on fraud?"

"I've seen the epitome of poor practice in mobile/portable dental entrepreneurs in Ohio," he continues. "It can be very exploitative. Not every mobile/portable provider in Ohio is a problem, but one in particular—who shall remain unnamed—was shamelessly aggressive, speaking to state dental association members at a dental access meeting and going so far as to insist 'I can teach a newly minted dentist how to treat profoundly disabled patients and special needs pediatric patients in two weeks.'"

Eventually, the Ohio-based dental mobile practice operator was convicted of Medicaid fraud, but there are others who speed through examinations and provide superficial care. When they return for follow-up care, some patients have discovered that the dentist and dental records are nowhere to be found or that the cell phone signal didn't follow the dentist across state lines.

Georgia outlawed new mobile dentistry providers a decade ago. "They were outfitting vans and providing

services any way they wanted—like the Wild West days," explains Margie Preston, the director of Medical Policy for the Georgia Department of Community Health, Medical Assistance Plans. "So, we sent them packing."

Reputable mobile/portable units

Organized dentistry generally supports the use of mobile offices to treat the underserved—when it's done correctly. Phil Latham, executive director of the South Carolina Dental Association (SCDA) commented that "Since the new Medicaid program took effect in 2000, many new and innovative ways to deliver dental care have developed in South Carolina. Several of these methods include dental care delivered by dental vans. The SCDA supports these van units that are operating to deliver dental care to areas of our state that most need care."

When reliable mobile dental offices provide services in a state, school administrators as well as organized dentistry takes note. For instance, Dr. Reese's program has received a lot of support from the communities in which it serves. Many people in the communities it serves offer glowing praise, including Kathy Durbin, PhD, NCSF, the student services director for the Lancaster County South Carolina School District; D.W. Newton, Jr., DDS, former president of the South Carolina Board of Dentistry and current legislative chairman for the South Carolina Dental Association; Susan York, the director of school climate for Rock Hill, S.C. District Three; and Deborah M. Keener, RN, BSN, at Independence Elementary School in Rock Hill, S.C.

According to Dr. Reese, Dental Access Carolina (the company Dr. Reese established to provide mobile dental services) is an all-around team effort. "We utilize the true team concept of dentistry by having a dentist, a hygienist, and an assistant in each mobile clinic. We have provided true comprehensive and continuing care to more than 5,500 children during more than 14,700 patient visits since our program started in 2001," says Dr. Reese. "We do everything from prophylaxis to

endodontics in our facilities—without the use of restraints or sedation.

"Increasing access to care has been the catchphrase of organized dentistry for the last few years, especially since the Surgeon General gave a failing report because of the level of dental disease in this country and reported that the number one reason children visit the school nurse is for dental-related pain. The ADA and the AGD talk about access to care. But access to care can't just be a mantra, we must really believe in the concept. Our program is providing access to care. One of the first things I said when addressing the South Carolina House of Delegates was that preventive care is great—but you can't correct a toothache by polishing teeth or prevent a cavity that already exists by placing a sealant. I've been diligent in making sure correct treatments are performed on outpatients. I also make sure that my office's recordkeeping is impeccable. I have records on patients dating back to 2001."

Dr. Reese's mobile office only treats patients who have signed consent forms from their legal guardians. The team maintains records for every patient and they keep them in a central office location. They send written information home with each patient and provide access to patients in the event of emergencies. Dr. Reese says, "Our goal is to provide compassionate, comprehensive care to children at their schools or other central locations in an environment that fosters a true winning relationship for all who are involved: the schools, the parents, the dental team, and most importantly, the children."

Many other mobile dentists also live up to their claims. Apple Tree Dental, a Minneapolis-headquartered, full-service mobile/portable operation, benefits from Medicaid coverage of a hygienist's "basic screening survey." An Apple Tree Dental representative explained that representatives act as dental directors on a site, designating patient coordinators and appointing a dental liaison. Reputable, full-service mobile/portable providers provide restorations and refer patients to their own dentists (provided the patient has

one) for care. Representatives from Apple Tree also contributed to Dr. Hill's mobile-portable manual.

For 23 years, the Ohio Health Department has operated a school-based dental program in Cincinnati. This special \$325,000 sealant prevention program vehicle was funded by tobacco settlement money from the Ohio Department of Health and the support of a local foundation. That cost doesn't include dental equipment and related expenses, which brought the total cost closer to \$485,000. Nonetheless, it appears to pay dividends of a different sort—in 2005 and 2006, this unit provided care to 2,000 children.

Another Cincinnati program utilizes a shuttle bus to move children to and from their school and a publicly funded neighborhood dental clinic. Says Dr. Hill, "This program focuses on those children who were identified with treatment needs after a dental screening performed by a school nurse and/or an examination by a dentist in the Cincinnati Health Department's school-based dental sealant program." The program provides comprehensive treatment to approximately 1,000 children every year; however, unlike the mobile program, it requires intense coordination between the dental program coordinator and the school nurse to assure that consents are received and that children are scheduled properly for the shuttle and with the care provider.

It is understandable when only a handful of state health agents are brave enough to take certain practices of mobile dental vans to task because they don't want to offend the few dentists who are now providing services for modest Medicaid reimbursements. Some public health officials may keep quiet out of fear of adding insult to economic injury by lumping good dentists with bad ones.

The problem requires the collective, collaborative efforts of the state dental boards, state Medicaid officials, state health departments, and the dental profession. Fair, rational, and objective regulations should not offend anyone; in fact, they should protect the legiti-

mate mobile practices from the less legitimate.

Picking out the bad apples

Every profession has its "bad apples" and dentistry is no exception. Many screening- and prevention-only school dental programs can and do at least remind parents that their child needs dental care. However, concerns about mobile/portable entrepreneurial dental practices will not go away until rules are established that require coordinated, solid treatment referrals. Until these entrepreneurs are forced to provide patients or the school with a paper copy of an individual's screening assessment/exams, Medicaid and state dental directors are largely impotent.

Massachusetts' pending registration requirement for all mobile and portable oral health programs will patch the gap in coordinated care for low-income residents who will have the means to receive treatment from a dentist or dental program for comprehensive restorative services. Their registration requirement will be enacted in the 2007-08 or 2008-09 school year and will gather vital information about the programs—including the name of the owner and the professional who is providing the dental services, as well as the collaborating partners who will provide restorative treatment and follow-up for emergency coverage. According to Bethel, the registration program "just makes sense. It's a solid, practical means for all individuals treated in mobile and portable programs to receive continuity of care. Hopefully, the Massachusetts experience and solution will serve as a model for other states."

Other states' dental directors are watching these developments across the country and have started filing away the wording in statute and regulations on mobile/portable dentistry from other states. If their phones begin ringing from parents or nurses who are questioning the new mobile/portable outfits in town, they are expected to follow suit. ♦

To comment on this article, send an e-mail to impact@agd.org.