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Where oral health lives

Mobile and Portable Dental Services in Preschool and School Settings: Complex Issues.

Purpose and Definitions

Dental disease among children in the U.S. remains a major public and personal health problem confounded by disparities in use of preventive measures and access to preventive and restorative dental services. Increasingly preschools and K-12 schools are being asked to allow provision of oral health services onsite.

> This issue brief will provide an overview of the complex issues that confront communities and states around mobile and portable dental care provided in educational settings such as preschools, Head Starts and K-12 schools. This document will:
> • Explore underlying issues for using mobile or portable dental care systems
> • Provide some examples from communities and states
> • Suggest questions to ask for making decisions about starting such programs
> • List resources for those looking to start or expand such programs
> • Suggest recommendations for action or further research that would clarify or resolve some of the issues.

This issue brief is not a comprehensive review of all models of school-based or school-linked oral health programs. The issue brief does not cover the basics of setting up or financing programs, which are covered in an online Mobile-Portable Dental Manual.[1] The document does not provide legal opinions or endorsements of individual approaches or programs. It also does not cover settings such as long-term care facilities or emergency response situations or any other community-based or school-based or school-linked programs except mobile and portable programs in preschool and K-12 educational settings.

Under the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, a School-Based Health Clinic is a health clinic that meets one of the following criteria:

• is located in or near a school facility of a school district or board or of an Indian tribe or tribal organization;
• is organized through school, community, and health provider relationships;
• is administered by a sponsoring facility;
• provides through health professionals primary health services to children in accordance with State and local law, including laws relating to licensure and certification; and
• satisfies such other requirements as a State may establish for the operation of such a clinic.[2]

The U.S. Task Force on Community Preventive Services uses the following definition for school-based/linked programs:

School-based programs are conducted entirely in the school setting, and school-linked programs are conducted in both schools and clinic settings outside schools.[3]

> For purposes of this paper, mobile programs refer to a mobile self-contained motorized van or a non-motorized mobile trailer, whereas portable programs refer to services provided using portable dental equipment. Hybrid programs combine elements from both systems.

Background: Oral Health Services in Preschools and Schools and Mobile-Portable Dental Programs in Educational Settings

School-Based or School-Linked Dental Services

Dr. Alfred Fones began the first school dental health program in the U.S. in 1914 in Bridgeport, CT in grades one through five.[4] This program was the genesis of the profession of dental hygiene, with the intent to expand the school dental health program across the country and employ the newly graduated dental hygienists. In the schools, dentists used portable equipment to begin a basic restorative program, but the emphasis was on preventive approaches conducted by women who became the first dental hygienists. After five years of services, the incidence of dental caries in permanent teeth of the participating children was reduced by 33.9% compared to a control group of fifth graders.[4]

School dental services have continued in various forms. Some programs provide services in school clinics with stationary equipment, in a room in the school building using portable equipment, or in mobile vans that park at the schools. Four common school dental service models include:

1. School-based dental screening programs (at school entry or at any grade level) linked to community dentists for care

2. School-based or school-linked dental sealant programs at selected grades to reach children for application on 1st and 2nd molars

3. School-based or school-linked dental preventive services, including prophy, fluoride treatment, or sealants, at any grade

4. School-based or school-linked basic preventive and restorative dental services at any grade.

School dental services can be integrated into existing school health centers, operated as stand-alone dental services, or provided by dental professionals in community practices or health centers, with services coordinated by or linked to a school or district. Programs are financed in various ways through federal, state and local funding; foundation grants; in-kind contributions; volunteerism; and reimbursements from Medicaid or CHIP. Federally Qualified Health Centers, State Oral Health Programs, hospitals, non-profit groups and universities with dental and dental hygiene programs have also established mobile or portable dental services to increase their outreach to communities and schools. Examples include:

■ Mission Hospital Children's Dental Program in North Carolina provides 1,500 preventive and restorative dental visits/year from two mobile dental clinics to 600 children aged 7-12, attending 46 elementary schools in 10 counties.[5]

■ The PRASAD Project is a not-for-profit organization committed to improving the quality of life of economically disadvantaged people around the world. PRASAD Children's Dental Health Program is a certified New York State Department of Health Article 28 clinic and school based health center, approved to operate in New York State schools using mobile vans and portable dental equipment. Since 1996 it has served more than 62,380 children and provided more than 170,670 procedures.[6]

■ University of Southern California (USC) Mobile Clinic has served more than 80,000 children via five vehicles, including a sterilization van and modern portable dental equipment. Each year the program holds more than a dozen week-long clinics in rural and urban areas in Southern and Central California. Since 1994 the Mobile Clinic has been a required clinical rotation for all doctoral dental students.[7]

■ Since 1987, the Ohio Department of Health (ODH) has provided grants to support school-based sealant programs (S-BSPs) focusing on highly urbanized and very rural areas. Grantees are local agencies and organizations. During 2009 there were 19 S-BSPs using portable equipment serving 42 of Ohio's 88 counties. Fifteen programs received ODH grant funds, and four were locally funded.[8]

With increasing acceptance and use of dental sealants to prevent dental decay, school-based sealant programs have grown exponentially. In the 2010 Synopses of State Dental Public Health Programs, most states (78.4%) reported supporting dental sealant programs targeted to elementary school children.[9] A 60% decrease in tooth decay has been documented in multiple studies when sealants are provided through a school-based or school linked program.[10] Based on strong evidence for dental caries reduction, school-based dental services, especially sealant programs, are recommended as part of the Healthy People

2010 National Objectives,[11] the Healthy People 2020 National Objectives (see Figure 1),[12] by the Task Force on Community Preventive Services,[3] by the Association of State and Territorial Dental Directors (ASTDD) in a 2010 Policy Statement,[13] in ASTDD's Best Practice Approaches: Improving Children's Oral Health through Coordinated School Health Programs,[14] and by a Centers for Disease Control and Prevention (CDC) supported Expert Panel.[15] Both CDC's Division of Oral Health and the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) have provided grants to states for more than a decade for school-based or school-linked sealant programs, including software to monitor service data. However, data on the numbers or types of school-based oral health services have not previously been tracked on a national level.

The 2010 Synopses of State Dental Public Health Programs[9] shows that in at least 48 states more than 25% of enrolled school children participate in the free- or reduced-price lunch program, making schools an ideal place for reaching low-income children with preventive services and restorative dental care. With an interest in reaching children earlier than kindergarten or first grade with preventive dental services, some states have created voluntary or mandatory systems for dental screenings or dental examinations on school entry to facilitate early detection and referral for dental problems as well as ongoing care. Limited evidence, however, is available on the effectiveness of such screening programs in linking children with identified oral health needs to completed care.[16]

Figure 1. Healthy People 2020 Objectives Related to this Issue Brief

- OH-1. Reduce the proportion of children and adolescents who have dental caries experience in their primary or permanent teeth. (Baseline [1988-94] for ages 13- 15: 53.7%; target is 48.3%. Baseline for ages 6-9: 54.4%; target is 49%. Baseline for ages 3-5: 33.3%; target is 30%)

- OH-2. Reduce the proportion of children and adolescents with untreated dental decay. (Baseline [1988-94] for ages13- 15: 17%; target 15.3%. Baseline for ages 6-9: 28.8%; target is 25.9%. Baseline for ages 3-5: 23.8%; target is 21.4%)

- OH-8. Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year. (Baseline 26.7% for ages 2-18 at or below 200% FPL; target is 29.4%)

- OH-9. Increase the proportion of school-based health centers with an oral health component:
  - that includes dental sealants (Baseline: 24.1%; target is 26.5%)
  - that includes dental care (Baseline: 10.1%; target is 11.1%)
  - that includes topical fluoride (Baseline: 29.2%; target is 32.1%)

- OH-12. Increase the proportion of children and adolescents who have received dental sealants on their molar teeth. (Baseline for ages 13- 15: 19.9%; target is 21.9%. Baseline for ages 6-9: 25.5%; target is 28.1%. Baseline for ages 3-5: 1.4%; target is 1.5%)[12]

Oral Health Services in Preschools

Mobile and portable dental care systems have allowed dental professionals to expand the types of services provided to local Head Start centers and preschool programs. Common models include:

- Dental exams by licensed dentists with referrals to general or pediatric dental providers in community clinics, private practices, universities or hospitals
- Fluoride varnish onsite or in a mobile van with referrals to community practitioners
- Basic preventive and restorative services in a mobile van.

Provision of basic restorative care for young children can sometimes be accomplished in a mobile van if treatment is not extensive and if the child is cooperative. This is particularly helpful in areas where there are limited numbers of pediatric dentists or in rural areas where dental clinics or practices are not easily geographically accessible. During the past decade, support by the Administration on Children, Youth and Families (ACYF) Office of Head Start, Indian Health Service and other funding sources has increased onsite provision of preventive services in preschool programs and linkages to dental practitioners in the community.[17] The national Delta Dental Plans Association and the National Head Start Association have formed an alliance to provide Head Start Associations and local programs with additional tools and resources to improve the oral health status of Head Start children. Support may be in the form of direct grants or through contributions of items such as toothbrushes or toothpaste.[18] Analysis of data from 2000-2010 in the annual Synopses of State Dental Public Health Programs shows a dramatic increase, from 13% to 58.8%, in state oral health programs sponsoring fluoride varnish programs for young children, many onsite at preschools or Head Starts.[9,19] Other examples include:

- The Mobile Dental Center is a program of Columbia University College of Dental Medicine. It is fully equipped with two dental operatories and staffed with a dentist, pediatric resident, dental hygienist, dental assistant, and driver/data entry clerk. The van travels to more than 65 local day cares, schools, and Head Start centers throughout northern Manhattan and the Bronx during the school year offering children ages 3-5 years comprehensive dental care.[20]

- With funding from Delta Dental Foundation of Kansas, United Methodist Health Ministry Fund and the Kansas Bureau of Oral Health, Kansas Cavity Free Kids has created a network of prenatal and children's oral health services across the state. This Kansas Head Start Association project arranges for community based dental hygienists using portable equipment to provide preventive services and extensive oral health education on site. The dental hygienists also refer children to a dentist's care for diagnosis and treatment.[21]

Mobile and Portable Dental Programs

> *Identifying programs is difficult due to lack of a consistent national definition, multiple funding sources and sponsors, and no current tracking system.*

Comprehensive national and state data on the use of mobile or portable systems to provide oral health services are not currently available. Informal discussions and reports reveal that the number and sophistication of mobile and portable dental care options and programs has grown in the past decade, in part to address access to care issues. Information from the 2006-2010 Synopses of State Dental Public Health Programs indicates support for preventive or restorative services using mobile or portable systems by state oral health programs in at least 29 states. Data also indicate a more cost-effective and appropriate trend to use these systems to provide more than just dental health education; 18 programs in six states in 2006 vs. three programs in three states in 2010 provided education-only programs.[9,22] In 2010, state- supported or state-operated mobile or portable programs provided preventive care in 16 states and restorative care in 25 states. Data are not available for other entities providing or sponsoring these types of services.

Financing for mobile or portable programs is usually through a combination of grants, public and private insurance, agency budgets, state tobacco settlement funds, fees, donations and volunteers. Programs are administered by public and private entities such as Federally Qualified Health Centers (FQHCs), state or local health departments, universities, community-based non-profit and for-profit groups, humanitarian and church groups, individual practitioners or private entrepreneurs.

Services can be provided to children using portable equipment in their school or preschool buildings or on mobile vans. Each type of setting has a unique set of challenges. Services may be targeted to schools with a high proportion of low-income/underserved students or offered to all students in a school district. As noted earlier, services may include dental screenings, preventive care such as dental sealants or topical fluoride, or comprehensive care such as restorations or extractions; complex treatment that requires specialty care is generally not provided. If surgical procedures are performed, arrangement for post-surgical care is needed. Some programs may be part of multidisciplinary health clinics that provide immunizations, vision and hearing screenings, or general health care. Service schedules vary from a few times each week to one day every four to eight weeks, one day every six months, one week during a year, or other intervals. Some mobile van groups have established programs in multiple states.

Dental providers such as dentists, dental hygienists and dental assistants provide services as solo practitioners, employees, contractors, volunteers or students depending upon state practice acts. Additional persons provide other functions such as coordinators, drivers or school liaisons. Licensing and insurance arrangements differ by state. Various regulations, laws, practice acts and policies exist at the federal, state and local levels that govern mobile and portable programs and providers, especially if programs or providers are crossing state lines. Examples of these will be covered in a subsequent section.

An example of the complexity of services just within one state can be illustrated by South Carolina. The SC Department of Health and Environmental Control (DHEC) administers school- based dental preventive services in five programs under the general supervision of dental hygienists, with reimbursement through Medicaid and private insurance. In addition to and not under DHEC, comprehensive dental services are offered:

- On school campuses in fixed clinic sites
- Through a FQHC mobile network, financed through reimbursements by Medicaid and private insurance and by a sliding fee scale
- Through school referrals to FQHCs, using the same reimbursement mechanisms
- By several for-profit mobile dental programs that receive reimbursement through Medicaid and private insurance.[23]

Overview of Key Issues
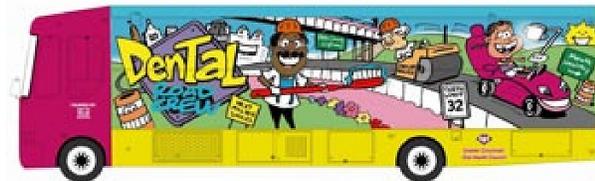
Access to Services

Economic downturns continue to result in budget cuts that diminish or eliminate programs, while families are losing jobs and dental insurance benefits that previously covered their children's dental care. Overburdened state budgets are forcing cuts to entire programs such as the school-based/ school-linked Children's Dental Disease Prevention Program in California that previously provided dental sealants to more than 15,000 children and topical fluoride to 200,000 children.[24] Many local stories exist of school nurses and Head Start health coordinators desperately trying to locate dental care for children, especially for those in pain. Restrictive practice acts in some states do not allow provision of services in community settings by dental hygienists or other allied health care providers unless a dentist is onsite, making mobile and portable service delivery a less viable and more expensive option in those states.[25] Although improved since 2001, available national data show that in 2008 less than 37 percent of children in Medicaid received any dental services; several states reported rates of 30 percent or less.[26]

Involvement of School Personnel

For K-12 programs, the school board or the superintendent usually makes decisions about whether to allow a new program into a school district; the decision may apply to the whole district or be left to the discretion of each school principal in the district. With increased emphasis on educational accountability and severe cuts to education budgets, superintendents or principals may be reluctant to allocate time away from classroom education for health services or to assign additional responsibilities to already overburdened staff. The support of principals and school nurses is crucial for successful programs, as is the commitment of classroom teachers. Depending on the dental service model (e.g., self-contained van vs. portable equipment set up in a room) various school personnel may be asked to coordinate or participate in the program. Responsibilities might include serving as a site coordinator, sending home and collecting consent forms and health histories, determining eligibility for services, scheduling appointments around mandatory school functions, communicating with parents and school administrators, and record keeping. All levels of personnel may be involved, including housekeeping staff, office staff, teachers and aides.

Head Start programs and centers are administered in several ways. Some fall under school districts. The local model used will determine who makes decisions about health programs. Health is a high priority for the federally funded Head Start program. Local Head Starts must meet federal requirements and performance measures related to health, including dental assessment and care, and have a health advisory committee. Staff, therefore, are already committed to assuring that students receive the mandated oral health assessments, and they help arrange for/coordinate dental care with local dental professionals. Health coordinators, family service coordinators, program directors, teachers aides and some parents may be involved in all aspects of the child's oral health, as well as helping families to understand and seek preventive oral health care.

Equipment and Location of Services

Earlier versions of portable equipment and poor mobile van design previously limited the scope of care that could realistically be provided. Improvements in design and technology have solved most of these earlier problems, and more equipment and van options are available. Some dental professionals, however, are still uncomfortable providing services in other than a fixed clinic setting with full dental operatories and support staff. Finding areas to locate portable equipment within schools to avoid disruptions to classroom activities and to guarantee provider/pupil safety and compliance with federal infection control guidelines create additional challenges. Equipment malfunctions or van breakdowns can be costly and cause interruptions in schedules.
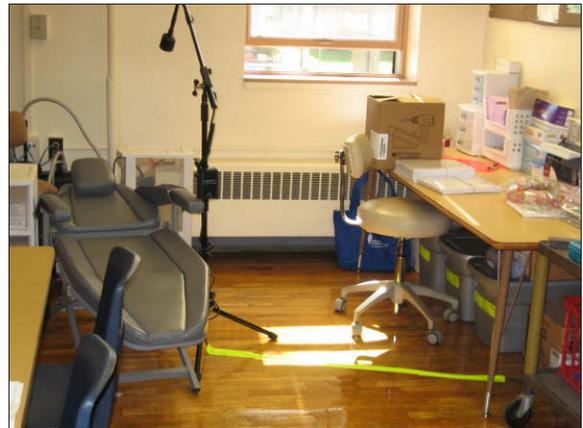
Liability and Insurance

A variety of personal, professional and programmatic liability concerns must be addressed. If guidelines or regulations are not in place or are in need of updating, additional preparation must take place before programs can be implemented. Malpractice insurance and other liability issues present barriers to "out of office" provision of care using mobile vans and portable equipment. Questions about liability for service delivery by the individual provider or the program owner/administrator should be clarified, as well as liability for the school where services are delivered. Training and supervision of multiple volunteers as well as standardization of procedures, processes, protocols, documentation of services, and regulatory compliance must be planned and managed.

Financing and Reimbursement

Many programs are created from initial or "seed" grant funds that end after one or more years. Short-term availability of grant funds, free equipment donations and other resources often pressure or motivate programs to consider or to implement mobile and portable options without doing the necessary needs assessment or planning. Mobile vans and portable equipment incur additional overhead expenses related to transportation, equipment set up or clinical preparation, handling of hazardous wastes, travel time to sites, and overnight accommodations if traveling among towns in rural areas. Medicaid and private insurance programs do not compensate for these additional expenses.

States regulate health care in various ways, but three functions apply to mobile and portable care: 1) licensing, 2) certification for who can receive payment, and 3) payment policies, structures and rates. Provision of dental services in preschools and schools, whether using stationary equipment, portable equipment or mobile vans, is greatly affected by all of these. Reimbursement issues include low Medicaid reimbursement rates in many states, coverage in "out of office" settings, differing state policies on direct reimbursement to dental hygienists, duplicate billing by multiple providers for diagnostic and preventive services, and lack of reimbursement or confusing reimbursement policies for administrative and outreach services.

Continuity of Care

Difficulties establishing a "dental home," becoming "patients of record" and the availability of emergency or follow-up care are common problems. Schools and preschools must consider coordination of dental services with other medical and social services to avoid duplication, gaps in continuity of care and unnecessary time and cost burdens on families. The majority of programs are well-managed, but a few offer limited care or operate as "one-visit only" programs across multiple states, while aggressively marketing their services and competing with local programs or practitioners. Such programs see a high volume of children in one day but do not provide follow-up care. This leaves families to pay out-of-pocket costs for additional diagnoses or for the rest of their care, thus creating additional burdens on parents and the local systems of care.[27]

Specific Strategies to Address Issues

This section will discuss a variety of examples and suggestions to address concerns about mobile and portable dental care and to support effective models of care. Strategies fall under the core public health functions of assessment, policy development and assurance in the following categories:

• Needs Assessment, Planning, Communication, Coordination and Case Management

• State Laws, Rules and Regulations

• Program Information, Policies and Procedures

• Financing, Reimbursement and Sustainability

• Tracking, Monitoring and Evaluation

Needs Assessment, Planning, Communication, Coordination and Case Management
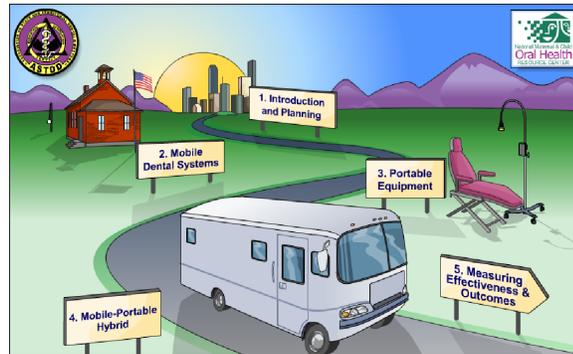
Chapter 1 of the ASTDD Mobile-Portable Dental Manual[1] presents information on assessment and planning, including the importance of community partnerships. Many links to examples of mobile and portable programs are included so those issues are not covered in depth in this issue brief.

State oral health programs have administered, coordinated and funded education and service programs in schools and Head Start programs for many years, and remain a key player. True collaborative efforts create more sustained support and facilitate marketing and program replication in other sites. The success and sustainability of any program depends upon stakeholder buy in, commitment and ownership. This is particularly true for school-based and school-linked health programs. The involvement of parents, community groups and local dental care providers is extremely important to avoid misperceptions of competition and to assure that quality of care is addressed.

> *Working with schools, parent groups, dental societies and health departments at the outset to assess community needs and develop programs to meet the needs is key to having successful programs.*

One key aspect of planning is the need to interface with other supportive services; procedures for enrollment of families in Medicaid, state Children's Health Insurance Programs or Women, Infants and Children programs (WIC); Family Resource Centers for Children and Youth with Special Health Care Needs (CYSHCN); and case management with local providers to ensure availability of follow-up care. New Mexico's state oral health program employs two case managers who help children and families find a dental home, negotiate with providers, secure funding and ensure that appointments are kept and that treatment plans are completed.[28] Communication with parents orally and in writing in their primary language is crucial.

Some schools have a long history of integrating oral health into their classroom curriculum and have expanded into clinical services. States such as South Carolina and Ohio have manuals that describe their school-based programs.[29,30] Other schools may be hesitant to include onsite delivery of preventive services or comprehensive care. Dental professionals can work with school health clinic advocates to partner in developing effective and proven strategies for program implementation.

> *Devoting sufficient time to collaborative needs assessment and planning and asking the right questions may prevent hasty and costly decisions. Creating sound policies as part of program development will help guide decisions to address potential problems and avoid misunderstandings.*

School personnel may not have enough knowledge about oral health services or service delivery systems to make informed decisions. The questions in Figure 2 provide guidance for school decision makers who are considering school-based oral health services or who are approached by companies marketing such services. State oral health programs and community-based dental professionals, especially those with public health experience, can help school personnel analyze responses and make decisions.

Schools enter into a variety of informal and formal agreements such as contracts and Memoranda of Understanding (MOU). A group of California education and dental professionals recently developed a sample MOU for schools to use with mobile or portable contractors.[31] Informal discussions among school personnel reveal that formalized agreements work well in many programs, while other schools complain they have established MOUs with companies that have not honored all of the stipulations before leaving the school site.

Figure 2. Questions for Preschools and Schools Considering or Contacted for Onsite Mobile or Portable Dental Services

1. Who owns the program and how is it funded?
2. Who can they provide as references?
3. How and where are services provided, e.g., in a mobile van in the parking lot, inside the school using portable equipment? What are the space, water and other needs?
4. How often and for how long will they be at the site, e.g., once per year, once per week, until a school or grade is finished, or some other arrangement?
5. What are the daily hours of operation and how do they work around the school schedule or required activities?
6. Who supervises the program onsite?
7. Is there a coordinator or liaison to work with the school? What do they do?
8. What are the school's responsibilities and how much time is involved?
9. Does the program establish any type of contract or an MOU?
10. How are appointments scheduled, e.g., by individual, by class, and who works out the schedule?
11. Who provides the care and what is their status, e.g., employee, contractor, student, volunteer?
12. Have practitioners been trained/oriented to provide mobile/portable care?
13. What is the liability coverage for the providers and what liability would the school have?
14. What scope of services do they provide? Just screenings or diagnostics? Preventive services such as sealants and fluorides? Restorative care? Any types of specialty care? Is there follow-up for surgical care? Do they provide 24-hour emergency care arrangements?
15. What referral mechanisms have been established with local providers or clinics?
16. Do they provide any case management services?
17. How is eligibility for their services determined?
18. What type of informed consent process do they use and what is covered?
19. Does a parent need to be present when the child is seen?
20. Are treatment plans developed and how are they completed in the timeframe?
21. How do they determine if a child has a regular provider?
22. How are services financed? Are insurers billed and who collects that information from the family? How are costs of services documented? Are there costs to the families? Are there costs to the school, and if so, for what?
23. How are records maintained and stored? How do they comply with HIPAA or other privacy requirements?
24. What data are collected on oral health status and services?
25. What information is shared with school staff and how? With parents? Is information translated into multiple languages?
26. Are there provisions for language translation during care?
27. Are any medications dispensed and how?
28. How will a child who has received dental anesthetic for fillings or extractions be supervised until it wears off?
29. How do they comply with federal and state infection control guidelines?
30. How is quality of care determined, e.g., sealant retention, follow up on extractions?
31. What are their policies on photography and use of information for marketing or with the media?

State Laws, Rules and Regulations

Licensure, Certification and Staffing
of Mobile or Portable Dental Programs

A number of states have adopted laws and regulations governing licensure requirements, certification, and/or staffing for mobile or portable dental programs. Examples of states that have Board of Dentistry or Medicaid Mobile/Portable program requirements include California, Florida, Indiana, Kansas, Louisiana, Maryland, Mississippi, Missouri, New York, South Carolina, Tennessee, Texas and Virginia.[1,26] Links to some of these documents are included in the ASTDD Mobile-Portable Dental Manual.[1] Other states are also in the process of considering regulations.

Requirements for (biannual) registration of a mobile dental facility are found in Indiana's Administrative Code. Topics addressed include physical requirements, names of licensed personnel, proof of radiographic inspection, written procedure (and letters of support) for emergency follow-up care, and copies of valid driver's license, consent form, and patient information sheet and proof of a communication process with the facility.[33] Kansas has a similar biannual registration requirement, and the Board adopts rules and regulations relating to aspects such as maintenance of dental records, procedures for emergency follow-up care and communicating with facilities.[34]

In Florida, mobile dental units are addressed under statutory provisions for optional Medicaid services, that authorize payment for "diagnostics, preventive, or correctives procedures . . . to a recipient under age 21," but, "Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for one:

(a) Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

(b) Owned by, operated, or having contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

(c) Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

(d) Owned by, operated by, or having contractual agreement with a state-approved dental educational institution."[35]

Rules and regulations for mobile or portable dental care are under active consideration by several states. Regulations for mobile and portable dentistry in Massachusetts include requirements for a permit and for operation, as well as related practice requirements.[36]

Tennessee and Maryland have developed policies and procedures for administrative review for the state's Medicaid dental third party administrator for credentialing providers using mobile and portable dental units.[37,38]

The Federal Trade Commission (FTC) (charged by law with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce),[39] has advocated in a number of states with respect to actions by legislatures and/or professional boards on health care delivery and scope of practice, including dental. For example, in Louisiana in 2009, legislative consideration of a bill to restrict who can provide or administer mobile dentistry services in school settings prompted the FTC to write a letter arguing that the bill "will restrict competition among dentists and does not appear to provide any countervailing benefits to consumers."[40] As a result of advocacy and support of mobile oral health services in Louisiana, the bill was reframed to require the adoption of state board rules to regulate the operation of mobile dental services to comply with administrative, clinical practice, and infection control provisions. These rules and issues have not been finalized.[41]

Charitable Immunity Legislation for Volunteers

Before offering to be a volunteer for a mobile-portable dental program, a dental professional is likely to want information on potential liability exposure and other legal (e.g., Health Insurance Portability and Accountability Act [HIPAA]) and/or tax implications. At the same time, the sponsoring programs will likely require volunteers to hold a current license and produce evidence of professional liability insurance. In some states, all or certain (e.g., retired) volunteer dental providers who do not have professional liability insurance coverage may benefit from state funding to provide commercial insurance. In some states, volunteer dental professionals are covered by the "Good Samaritan Act" and additional liability is not required.

> *Overall, organizations that operate mobile or portable programs are routinely advised to seek legal and insurance advice on issues concerning program volunteers.*

States have responded individually to the issue of charitable immunity, and the approach for protection varies considerably. For state policymakers, constituents include both those who provide services and those who receive services. In 2003, 21 states had adopted charitable immunity laws that make a specific reference to dentists or dental care (reference includes a state-by state table that has not been updated).[42] In addressing charitable immunity, states typically either change the negligence standard (for all volunteers or for specific volunteers in specific settings) or extend state employee protections to volunteers (i.e., indemnify volunteer providers). Arizona's negligence standard illustrates the nature of volunteer "protection".[43] Wisconsin is an example of a state that offers indemnity for volunteer clinicians.[44] As noted, some states have framed legislation to purchase (or enable the purchase of) malpractice insurance to assist in extending immunity. Washington is permitted to provide insurance for retired dentists who volunteer for a non-profit agency.[45]

A federal law, the Volunteer Protection Act (VPA), offers certain protections from liability for properly licensed volunteer clinicians working with nonprofit or governmental organizations (the VPA preempts state laws that are less restrictive, and states can adopt additional provisions).[46] Another federal law, HIPAA, expands Federal Tort Claims Act protection against malpractice lawsuits in free clinic settings by "deeming" the volunteer a federal employee, although, as of 2006, it was suggested that implementation proved to be burdensome to clinics.[47]

The issue of malpractice insurance for volunteers may be a significant concern for both providers and volunteers. Still, one review of health care programs indicated that "over half of the programs [free clinics] we visited did not identify malpractice coverage as a major issue at this time." [47]

Program Information, Policies and Procedures

Based on informal review of several websites of mobile and portable programs, program descriptions vary widely. Some sites provide a vague description of their program, funding and eligibility, primarily highlighting the number of children receiving services (types of services are not described). Readers can only gain specifics by contacting the program. Those programs that target a specific geographic area or age group and are supported by grants or community funding tend to provide more specifics, including eligibility and testimonials. Some programs, such as St. David's Foundation in Texas, Columbia University Community DentCare Network, or Tooth Mobile in Santa Clara County, CA provide extensive information including the history of the program, articles and final reports, who provides the care, the forms that are used, schedules, as well as specific information for schools, agencies and parents.[20,48,49]

Long-standing school-based programs that are coordinated and supported by state or federal funds have manuals on many aspects of school-based services, but comprehensive program or policy manuals for the school and for providers are not generally available or are state specific. At least two online resources are available to assist programs in developing and sustaining school-based dental sealant programs.[50,51] One issue that may not be readily apparent as a concern to non-dental school personnel is whether programs have procedures and policies in place to comply with federal infection control guidelines, including

management of sharps injuries. New materials, including a site assessment and infection control checklist for mobile and portable systems from the Organization for Safety and Asepsis Prevention (OSAP), will help programs assess potential delivery sites as well as their policies and procedures to determine risks and develop acceptable practices.[52,53] Well-planned programs can be extremely productive with the right mix of equipment in a large enough space that can accommodate equipment, dental personnel and students.

The California School Boards Association has published a guidebook, Integrating Oral Health into School Health Programs and Policies, to help school districts and school boards develop relevant policies for school oral health programs.[54] Another California group recently developed School-based Dental Services Guidelines that outline school responsibilities and mobile/portable provider responsibilities. A section is included on what school districts can do to prevent liability claims and to ensure that the Guidelines are followed, as well as a section on background checks and fingerprinting.[31] Whether utilizing immunity laws for practice protection or other insurance, programs should have established policies and procedures to perform basic background checks on volunteers, including licensure status, to ensure protection of the populations being served.

Financing, Reimbursement and Sustainability

Several resources have been created to help programs with the important steps involved in needs assessment and planning for financial sustainability.[1,55,56] Depending on the target population and the economic environment, funding feasibility and opportunities may vary. Many providers report that it is not economically feasible to use a mobile van for treatment of Head Start children when many of the students have advanced dental decay and need specialty care. One helpful option in making treatment and referral decisions is teledentistry, which allows electronic transmittal of crucial diagnostic data to dental consultants who can be located offsite.[57,58] Using portable equipment for providing preventive care may be more cost-effective than using mobile vans as transportation and maintenance costs for vans is expensive and weather/road conditions affect van travel. A dental van often eliminates the need to transport children to a fixed site and the time required to set up and remove portable equipment and supplies. Schools often find it difficult to commit room(s) for dental program use. A dental van uses the same equipment that practitioners are comfortable using in fixed clinics, which may increase productivity. Other programs use both portable equipment and dental vans, depending on the services to be provided. A recent study looks at a dollar cost analysis of financing a mobile van, including a comparison of leasing and purchasing options.[59]

> *Successful programs have sought ongoing commitments from multiple funding sources early on in addition to seeking reimbursement for services from insurers.*

Although most funders expect programs to find additional funding sources for sustainability, this expectation often is overlooked, with programs relying on a sole funding source. Most preventive and restorative services provided in mobile/portable settings are reimbursable by state Medicaid or CHIP programs. Some may also reimburse for costs for administration, training, outreach, care coordination, arrangement of transportation and/or translation services. The Centers for Medicare and Medicaid Services (CMS) has created a Medicaid School-Based Administrative Claim Guide.[60] Care coordinators can help eligible pupils sign up for dental coverage or arrange follow-up care with dental providers in the community.

Programs such as Apple Tree Dental, which has mobile and clinical programs in MN, with replication sites in NC and LA, provide care primarily to children enrolled in Medicaid or other public insurance programs. The remainder of their funding is a combination of fundraising efforts.[61] CincySmiles Foundation uses a variety of funding sources to operate multiple programs:1) school-based dental sealant program in Hamilton, Butler, Warren, Adams, Brown, Clermont and Highland counties in Ohio, place

more than 20,000 sealants in 6,000 children annually, 2) the Dental Road Crew two-chair state-of-the-art dental office on wheels visits Cincinnati public schools and area Head Start programs to provide comprehensive dental care to more than 2,000 children and adolescents in need, and 3) they partner with Head Start programs in Clermont, Butler and Hamilton counties to assist their 5,000 enrolled children with access to dental exams and treatment.[62]

For services or populations that don't qualify for Medicaid and/or CHIP funding, other federal resources might be available. The HRSA Maternal and Child Health Services Block Grant (MCHBG) provides funding for school-based oral health services in some states.[63] The Illinois state oral health program administers a dental sealant grant program using MCHBG funds to assist providers of public health services to develop and implement appropriate and feasible programs with clear and measurable objectives to provide dental sealants to Illinois children at high risk for dental caries.[64] A few discretionary grant programs have funded school-based/linked dental services or supported mobile/portable programs.[65,66] In 2011 CDC supports 19 states for State-Based Oral Disease Prevention Programs.[67] Funding supports a .5 FTE dental sealant program coordinator; a needs assessment to identify school-based sealant program capacity and priority populations; and development, coordination, implementation, cost analysis and evaluation of school-based or school-linked sealant programs. Two provisions in the Affordable Care Act authorize funding to 1) provide grants to school-based health centers to include oral health services as part of the qualified services, and 2) require that states receive grants for school-based dental sealant programs; funding for these provisions has not yet been appropriated.[68] As of October 2010, $100 million had been released for capital expenditures, including dental equipment.[69]

Public funding may also be available from county, city or local health departments. School districts or Head Starts may contribute funds or in-kind services to a program's operation. Non-profit agencies, foundations, service groups, and private donors are also consistently identified as sources of funding support. In Texas the St. David's Dental Program is solely supported by financial backing from local groups, agencies and foundations.[48]

Tracking, Monitoring and Evaluation

In response to the lack of national tracking of school-based oral health programs, the National Assembly on School Based Health Care (NASBHC) worked with ASTDD and CDC to develop a new question for the 2007-2008 NASBHC Census that now allows monitoring of trends for key oral health indicators.[70] The new question asks: "Indicate which of the following oral health services are provided onsite: oral health education, dental screenings, dental examination (by a dentist), dental sealants, fluoride mouthrinse, fluoride varnish, fluoride supplements (tablets), dental cleaning, general dental care (fillings, extractions), specialty dental care (orthodontics, root canal)." If not provided onsite, respondents indicate which services are provided offsite by referral, or not provided or referred. The new question will permit trend reporting for Healthy People National Objectives, the *ASTDD State Synopsis* and the National School-Based Health Care Census. This census, however, may not distinguish between services provided using fixed equipment, portable equipment or mobile vans.

The CDC DOH requires its funded states to use Sealant Efficiency Assessment for Locals and States (SEALS) software to evaluate the effectiveness and efficiency of their school dental sealant programs. The Excel-based software automates:

• capture, storage, and analysis of data on the oral health status of participating children,

• types and numbers of services delivered at school events,

• costs and logistics of events, e.g., personnel, equipment, materials, and travel.

Examples of summary and performance measures generated by SEALS are cost per child receiving sealants, sealant retention, averted caries, and number of children sealed per chair-hour.[71]

Head Start (HS) programs are held accountable for performance measures that include oral health measures. The Office of Head Start tracks HS program performance through Program Information Reports (PIR) submitted by HS grantees. Analysis of national PIR data from 2003 to 2007 showed increases in the percentage of children receiving preventive care and treatment over that time period.[72] No current system documents how many of their services are provided onsite using mobile or portable equipment.

Few studies of evaluation of mobile or portable dental programs have been published in peer reviewed journals, although some have been presented as poster presentations at national scientific meetings. For more information on evaluation of mobile and portable programs, see Chapter 5 and the resources tab in the online Mobile-Portable Dental Manual.[1]

Some Recommendations for Action

National

- Clarify definitions of mobile and portable dental care systems and share with states and insurers. Currently it is difficult to compare costs and effectiveness across programs.

- Create a database of state laws, rules and regulations related to mobile or portable dental services and school oral health services.

- Collect examples of best practices or promising models for providing dental services in preschool and school settings using mobile and portable systems.

- Develop measures to evaluate the cost effectiveness and benefits of these programs.

- Create tipsheets for different audiences (schools, communities, dental professionals) who are considering onsite dental services in preschools or schools.

- Research additional ways to maximize reimbursement and other funding or cost-sharing mechanisms in light of health care reform.

- Promote use of existing and new resources on preschool/school-based or school-linked mobile and portable dental service delivery to government and foundation administrators for creating funding priorities and grant programs.

- Create online training courses accompanied by professional mentoring to help dental professionals learn: a) important differences in delivering dental care in mobile or portable systems, and b) developing positive, productive relationships with school personnel, community support groups and parents.

State/Local

- Develop or adapt already existing manuals and templates for schools and preschools to use in making decisions and creating contractual arrangements and policies for onsite mobile and portable dental services.

- Develop statewide tracking systems of mobile and portable dental services provided in or for preschools and schools. State oral health programs would need to work closely with state departments of education and state Medicaid and CHIP dental programs.

- Promote use of preschool and school oral health coordinators and create sample scopes of work.

- Provide information to groups such as school nurses associations, school board associations, parent/teachers associations and school superintendents associations, Head Start grantees and Head Start health advisory boards to assist in decisions on use of mobile and portable services in school settings.

- Create sample policies for schools related to onsite dental services provided using portable or mobile dental systems.

- Consider use of teledentistry in combination with portable programs in schools to improve consultation and electronic records options and the most efficient use of personnel in areas where access to care is difficult.

Acknowledgments

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