PART TWO

Do well while doing good

You can do a good service for people and make a living while doing it

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LAST MONTH, we highlighted the myths surrounding mobile dentistry as well as those that say providing care to low-income patients is not economically viable. We also discussed how the access-to-care issue in dentistry can be positively impacted by properly employing the use of mobile clinics. Now we will tell you how we were successful in doing just that.

One key to the success of Dental Access Carolina (DAC) has been building and maintaining excellent relationships with the nursing staff at the places we serve. We have developed a reputation for providing high-quality, compassionate treatment to our patients, many of whom would receive little or no dental care were it not for us. The school staff members are very appreciative of our services.

We visit schools on a regular basis, depending on the number of eligible participants. Instead of camping at a location until all patients are done, our visit frequency ranges from twice a month to twice a year, with the goal of seeing each eligible child at least once during the school year. Often we are able to perform two cleanings and complete all necessary treatment on a child during a school year. If treatment is not completed, we can continue the next school year because of our ongoing relationships with the schools.

By visiting more often than semiannually, we are able to identify and address potentially more urgent needs that may be left untreated in the alternative approach, especially if that alternative is preventive (sealants only). As an added safety net, the school staff knows if a child has an urgent need between scheduled visits, we can see that child at a different location as long as we are aware he or she is coming and we have consent to treat the child.

Having a place to send patients in need is a huge benefit to the nurses. Dental issues are the number one reason children visit the school nurse, yet fewer than 5% of patients referred by nurses to the dentist actually seek treatment. DAC has an excellent record of following children all the way from pre-K through high school graduation. Sadly, due to the transient nature of many of our patients, some will disappear from our roster only to reappear years later at a different location, having had no treatment in the interim and with severe treatment needs once they reappear. Thankfully we have their previous records and can resume treatment, hopefully to completion on the second go-round.

After we overcame the skepticism and turf protection issues from some in the dental community, the biggest challenge during the life of our mobile practice has been staffing. We have been very successful in attracting high-quality and loyal support staff members who appreciate and understand our philosophy of treatment and have had very little turnover. However, attracting high-quality, committed doctors is another story.

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We have had a number of doctors who were very good fits for our practice but who have moved on to other phases of their lives. We have also had several who were either not qualified clinically or ethically for our practice and were asked to leave.

In either case, the difficulty of finding suitable replacement doctors has been very challenging. Many of the causes are a lack of knowledge, misconceptions, and misinformation about mobile dentistry. Add fears about working on kids under Medicaid and the mountain grows to Everest proportions before doctors even consider student loans and compensation.

As so aptly described by James Hicks, DMD, these beliefs are untrue in our practice. Dr. Hicks is a new dentist, but he is not a young dentist. He worked in management for a large leasing corporation before making a career change in his mid-30s. He then worked in several corporate practices before coming to work for us. He appreciates the atmosphere and opportunity provided by our practice compared to his previous experience.

On the other end of the spectrum is our youngest dentist, Nathan Becker, DDS, who graduated from dental school in 2015. He had very little professional experience to compare to working with us, but he understands the opportunity he has been given. "[This is a] unique opportunity to help the most underserved patient population: low-income children," he says. "It is extremely satisfying to know that you are the only outlet of dental care for some children.

"Because there are no missed appointments from lack of booking or no-shows (both of which plague brick-and-mortar practices), Dental Access provides a maximally efficient way to practice hand skills from the moment the workday begins until it ends. Speed, accuracy, and quality of hand skills develop rapidly. The development of chairside manner with an unsedated child creates a patient, calm, and compassionate provider. This set of interpersonal skills is not only useful for dentistry done on patients of all ages, but it is also character building for daily life.

"The compensation structure is generous and reliable and promotes teamwork with the entire staff," he says, contradicting the financial myths surrounding compensation in the Medicaid realm. In the right circumstances, a tax-free federal student loan repayment of up to $25,000 per year is also available for providing care to low-income patients, further enhancing compensation. Additionally, Dr. Becker likes the fact that mentoring is available for new dentists. "[That helps] to smooth the sometimes surprising disconnect between what's taught in dental school and what's done in private practice," he says.

We are a for-profit practice, as are 99% of all dental practices, but we are not profit-driven. We employ sound business principles and systems in all phases of our operation—from verification of patient eligibility to our repeatable and consistent clinical functions and the design of the mobile clinics. There are many moving parts (no pun intended) to our operation. To the untrained eye, what we do looks very easy, but our success is based on more than a decade and a half of experience, most of which was trial and error!

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We are very specific, almost to the point of being dogmatic, in almost every phase of our practice because we have learned from making almost every conceivable mistake. We have arrived on-site to perform composite restorations, forgetting the curing light. We have had to abort treatment because the generator ran out of gas before we finished. There has been a host of other similar problems. As a result, we have developed a treasure trove of sound systems and procedures that are easy to duplicate and easy to teach.

While we are always open to improving our efficiency, it is sometimes hard to convince doctors that we do things for a reason and that deviating from the standard protocol in one area results in a breakdown in another, no matter how simple it may seem. Some new ideas are discounted to the dismay of the presenter because we want the playing field to be level for everyone every day. It has been best said by Michael Schuster, DDS, from Scottsdale, Arizona: "Systems run the practice and people run the systems." By having consistent, repeatable systems in place, ideally we can plug any person into the system at any location and the practice runs seamlessly. This concept is what afforded McDonald's the opportunity to sell "billions and billions" of hamburgers with mostly high school students as employees.

Hopefully, these two articles have dispelled the myth that says providing ethical, high-quality treatment to the economically disadvantaged population via mobile dentistry is not economically viable. Hopefully, it has also sparked more interest in this very valid way of delivering dental care in the 21st century.

Many groups offer consulting to dental practices regarding their operations. Some "specialize" in mobile dental operations, but very few have actually made a living doing what they are teaching—especially in the mobile environment. I always use this example: Would you rather learn to swim from an Olympic swimmer or from someone who took a swimming class at the YMCA and watched all of the Olympic swimming events on TV? You be the judge, but remember, your economic and professional outcomes depend on your choice.

Remember also that success leaves clues. Instead of listening to the naysayers or those who have failed, find those who have succeeded and learn how they became successful. Hopefully, you will use this information and the information gained from your own research to jump onto the wave of delivering dental care directly to the patients and truly solve the access-to-care issue in our lifetime! **DE**

JOHN E. REESE III, DMD, graduated from the Medical University of South Carolina in 1988. In January 2001, he founded Dental Access Carolina LLC, a mobile dental practice. When its success was proven, he designed his own mobile clinic and now markets the clinics internationally. To learn more, visit dentalaccess.com.

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