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Briefing: Post Pandemic Oral Healthcare Workforce in Missouri

BACKGROUND & PROBLEMS

Like all healthcare sectors, the oral healthcare workforce has diminished, and the COVID-19 pandemic exacerbated the decline. The Missouri Office of Dental Health statewide survey of oral healthcare workers and the most recent re-licensure data provided by the Missouri Dental Board (January 2023) indicated an exit of between 1% and 10% of the oral healthcare workforce: 1% administrative staff, 6% dentists, 8% dental hygienists, and 10% dental assistants. The survey also indicated that 20% of the workforce is considering retirement in the next 5 years due to age or job stress. *A summary page from the Office of Dental Health Workforce Survey Report is attached.*

The result is significantly understaffed clinics that are operating at 60%-80% of their capacity. The workforce shortages have more severely impacted rural clinics and clinics that serve the eligible Medicaid population with wait times for appointments in many Federally Qualified Health Centers of weeks or even months long. The Office of Dental Health used license and permit data to determine where providers are located and where they are needed. *Provider distribution maps by county are attached.* The main take-aways are:

- All but a few metropolitan counties have significant oral healthcare workforce shortages. Rural areas are the most severely impacted.
- There is a shortage of dentists and dental hygienists in rural Missouri: 44% of clinics that had an opening for a dental hygienist were unable to fill that opening.
- In 1995 Missouri developed the Expanded Function Dental Assistants (EFDAs) provider category to increase the productive capacity of dental clinics and address access to care issues. EFDAs (dental assistants with additional approved training) can help dentists with many functions including fillings, crowns, dentures and orthodontics. This program has been very successful, increasing productive capacity of clinics by 15%-25% with no complaints about quality of care. However, there is no EFDA provider category to assist dentists and hygienists with periodontal care.
- Currently the Missouri Dental Board has issued the following number of licenses and permits to oral healthcare providers with Missouri addresses: 2,486 dentist licenses, 3,410 dental hygienist licenses, and 7,084 EFDA permits.
- If you refer to the provider distributions maps you will see that EFDAs are distributed more evenly throughout the state, especially in rural areas where hygienists are scarce.

SOLUTIONS

- Missouri needs an Oral Preventive Assistant (OPA), an EFDA with further training, to assist dentists and hygienists in delivery of periodontal care to improve access to care especially for rural clinics and those that serve Medicaid eligible patients.
    - This new category of OPA-EFDA would have a greater scope than current EFDAs, yet a more limited scope than a hygienist and of course a dentist.
    - The OPA-EFDA would be authorized to treat children and adults who are healthy or just have gingivitis that is reversible with a good cleaning and good home hygiene.
    - The OPA-EFDA would be additionally trained to record gum measurement information so dentists could diagnose and triage patients, and then delegate to the OPA-EFDA to remove above-the-gumline tartar, polish teeth and apply fluoride.
    - The OPA-EFDA would operate under the direct supervision of a dentist or hygienist and would free more highly trained providers to treat more serious problems that might require additional skill.
- Last year, a law was enacted to allow pilot projects to explore new ideas to expand access to oral health care delivery. A 12-month pilot program can be designed to train and use OPA-EFDA in 5 to 10 clinics located in areas of the lowest ratios of hygienists per capita. The provisions of the pilot program statute require evaluation metrics to be used and reported back to the Office of Dental Health and the Dental Board for review.
- Missouri needs to allow communities to invest in OPA-EFDA training. It has proven to be the most cost-effective way to leverage the existing dental workforce and increase productive capacity and access. One EFDA can increase productive capacity of a dentist or hygienist by 15%-25%. It costs $5,000-$10,000 to educate an EFDA, $30,000-$60,000 to educate a hygienist, and $350,000-$500,000 to educate a dentist.
- One of the key reasons the EFDA program has been so successful is that the training programs have been made available regionally and do not require rural students to relocate to metropolitan areas for training and certification.
    - The Office of Dental Health provider maps clearly show that few hygienists who train in St. Louis, Kansas City, Springfield, Joplin or Sedalia return to rural Missouri. Currently EFDA training programs are provided through dental assisting education programs and associations, such as the Missouri Dental Association and Missouri Primary Care Association.
    - OPA-EFDA training programs, would be no different and could be made more accessible, especially to rural Missouri, at a modest cost by making online curriculums available to vo-tech educational centers to convey the didactic portions of the curriculum.
    - FQHCs and regional clinics could be utilized for clinical practicums where students could refine competencies in clinical skills under the direct supervision and mentoring of dentists and hygienists, just as they do in dental assisting and dental hygiene schools, without the need for the student to relocate for training.