Workforce Shortages, Part 2: Leaders Plan Solutions

SEE RELATED WHO/WHAT/WHEN SUMMARY PAGE 21

by GUY DEYTON, DDS

There is an old saying: "The best way to predict the future is to create it!" This article moves from explaining the problem of severe oral healthcare workforce shortages (which I covered last issue) to discussing possible solutions.

This spring, the Office of Dental Health (ODH) was asked by Governor Parson to report on the state of the oral healthcare workforce and recommend solutions. To that end, ODH sent out and analyzed a workforce survey and co-facilitated an ad hoc committee of dental leaders to understand and recommend solutions for workforce shortages.

In my previous article (refer to QR code next page), I discussed why many oral healthcare facilities in Missouri, including all practice models (private, corporate and clinics) have had great difficulty filling staff openings. In this article, we will briefly review the reasons for oral healthcare workforce shortages. We'll also review the major takeaways from the Oral Healthcare Workforce Surveys distributed and report on initial outcomes of a Workforce Ad Hoc Committee. Lastly, we will outline possible actions to begin addressing oral healthcare workforce shortages so facilities can be adequately staffed and patients have reasonable access to care.

WHY CAN'T YOU FIND STAFF?

As a review, these are some reasons there are too few oral healthcare providers in Missouri and facilities are often understaffed:

Preceding the COVID-19 pandemic there was a significant shortage of dentists in Missouri. Missouri had 327 fewer dentists in 2020 caring for Missourians than we had in 1990. See my last article for full explanation.

The average workload per dentist increased by 35 percent from 1990 to 2020. This workload increase was due to the decrease in dentists and a state population increase of more than 1 million people.

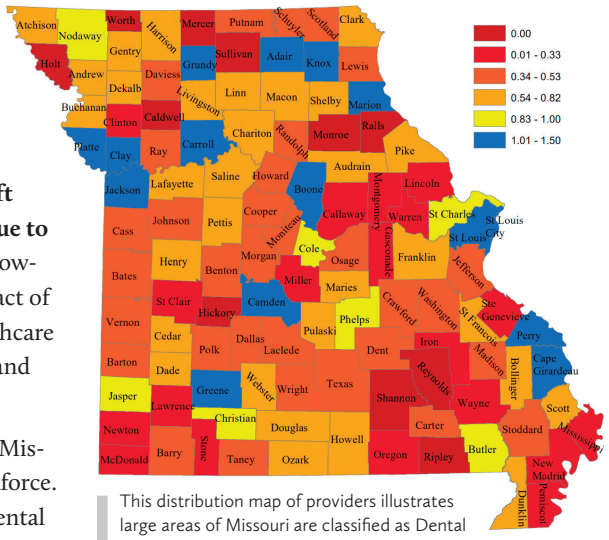
A significant number of people left the Oral Healthcare Workforce due to the COVID-19 pandemic. The following are ODH estimates of the impact of COVID-19 on Missouri's oral healthcare workforce between January 2020 and March 2022:

- Approximately 1-3 percent of Missouri dentists exited the workforce.
- Approximately 8 percent of dental hygienists left the oral healthcare workforce.
- Between 5-10 percent of dental assistants left the oral healthcare workforce.
- Approximately 3 percent of administrative staff left the oral healthcare workforce.

The workforce shortage cuts across all roles in Missouri oral healthcare facilities:

- *Dentists:* 57 percent of surveyed facilities were unable to fill openings for dentists.
- *Hygienists:* 44 percent of surveyed facilities were unable to fill openings for RDH.
- *Dental Assistants:* 45 percent of surveyed facilities took longer than three months or were unable to fill openings for dental assistants. Many hired untrained applicants and trained OTJ.
- *EFDAs:* 60 percent of surveyed facilities were unable to fill openings for EFDAs.

ODH estimates the oral healthcare workforce lost approximately 1,000 oral healthcare workers statewide due to the COVID-19 pandemic. The most acute shortages are hygienists and EFDAs. Anecdotal evidence indicates that rural areas were more severely impacted.



This distribution map of providers illustrates large areas of Missouri are classified as Dental Healthcare Professional Shortage Areas. All areas NOT colored blue are designated as such. Providing care to the state, considering this data, is just one of the statement of problems identified by the Workforce Ad Hoc Committee. (2,100 population-per-dentist based on https://pubmed.ncbi.nlm.nih.gov/28765446. Population data 2020 MICA Dentist https://pr.mo.gov/listings-den.asp.)

AD HOC COMMITTEE OUTCOMES

To understand and plan solutions for the workforce shortage, a Workforce Ad Hoc Committee of oral healthcare leaders convened in May and early June. Each of the three major associations (MDA, Missouri Dental Hygienists' Association (MDHA) and Missouri Primary Care Association (MPCA)) nominated three representatives. I along with Brian Barnett, Missouri Dental Board executive director, facilitated the four meetings. The following is a synopsis of discussion items and possible solution paths to pursue:

Statement of Problems

- **Many oral healthcare facilities in Missouri are operating at reduced capacity due to workforce shortages.**
  - There are large populations in Missouri currently not receiving care.
  - There are 65,000+ Missouri nursing home residents. ODH estimates only 6 percent are receiving care.
  - 250,000+ children are categorized as high-risk for decay because they come for a socio-economic strata that seeks

only emergent care. ODH school-based surveillance estimates that 36 percent have observable decay based on visual screenings. Actual decay rate is probably over 50 percent. School based programs could arrest decay and refer for treatment.
  - 170,000+ adults are newly eligible for Medicaid including dental care. Medicaid remuneration has been increased to levels comparable to many insurance plans. The state's expectation is we will take care of these people. *How?*
  - Federally Qualified Health Centers, especially in rural Missouri, have wait times for restorative appointments several months long. Many do not have the excess capacity to care for the newly eligible Medicaid patients.
- **Governor Parson signed a record increase in dental Medicaid remuneration rates because he expects the oral health community will care for this population if they are paid fairly.** *How are we going to fulfill that obligation?*
- **The distribution map (previous page) of providers illustrates large areas of Missouri are classified as Dental HPSAs** (Healthcare Professional Shortage Areas). All areas NOT colored blue are designated as such. *How are we going to provide care?*
- **Within each legislative session there always is the chance a bill will come up that focuses on oral healthcare—from the MDA/oral health stakeholders or another outside group.** If we don't come up with solutions to provide access, someone else just might.

Possible Investigations/Solution Paths Identified by ODH

- **Expand EFDA training and remove bottlenecks to make training more accessible.** Consider converting didactic portions of EFDA training to online access. Consider apprenticeship/mentoring training with supervising dentist with regional testing to make EFDA training and competency testing more accessible, especially for rural dentists. The impact? EFDAs have proven to increase a facility's productive capacity by 15-20 percent.
- **Investigate funding for pilot vo-tech dental assisting programs in select high schools** utilizing online training modules and externships in local clinics.
- **Advocate for expanding and funding the tuition rebatement program for dental professionals who serve in dental HPSAs after graduation** to include five dentists, five hygienists and 10 dental assistants per year. This will help direct care providers to underserved areas.
- **Use the planned ODH pilot project to investigate the use of teledentistry** as a method for dentists to supervise hygienists and assistants extended into nursing homes and other underserved high-risk populations.
- **Support inclusion of telehealth methodologies** in all state supported dental education curriculums to extend the reach of graduating professionals.
- **Support an increase in dental education funding** for state-supported dental education programs to gradually increase the number of care providers in Missouri.
- **Encourage dialog between the MDA and the MDHA on acceptable agreements** for new a EFDA hygiene assistant to assist dentists and hygienists, and relaxing hygiene supervision requirements to enable care to reach underserved populations.

To reinforce the urgency for dentists to proactively address access to care for underserved populations, I only need to cite Colorado. That state recently became the 14th to approve Dental Hygiene Therapists because that was the best solution presented to the Colorado legislature.

If you want to predict the future of dentistry in Missouri, I encourage you to proactively create it now by finding access to care solutions. Your job isn't to keep things the same; it's to make things better.

Contact Dr. Deyton at 573-526-3838 or guy.deyton@health.mo.gov.
Use the QR code to access his previous workforce article from Issue 3, 2022 (May/June).

office, but this is the beauty of having control of our own domain within our own practice walls.

I want to be very clear: I, nor any changes the workforce committee is discussing, support a mid-level or dental therapist type of provider (such as those that have come about in Minnesota, Alaska and Colorado).

Rather, what I am suggesting is the scope discussions we surveyed members about in November 2020 are steps we can take to help dental practices and patient care by allowing trained and educated dental professionals to work at the top of their scope, under supervision, and prevent ideas like mid-level providers or dental therapists from becoming reality in our state. I recognize some of the survey results do not have overwhelming support, but there is meaningful support of the aforementioned survey results.

The mission statement of the MDA is helping all members succeed. Are we really supporting our members when we have 50 percent or more supporting certain concepts, yet we have position statements against?

While some of these ideas and potential changes do not sit well some members, we need to have healthy discussion of how we are going to move forward. The old way has worked, but the dam is cracking. This article is not put forth to instill fear of change, but rather as a reality of what is happening around us. Digging in our heels is not going to produce a healthy outcome. We are still captains of our ships; let's open our thoughts so we can continue to run our vessels.

Opinions expressed in My View are that of the author's and do not represent an official position by the MDA. Contact Dr. Wilkerson rwilker82@gmail.com or 573-265-8402.

REFERENCES

1. https://leg.colorado.gov/sites/default/files/2022a_219_signed.pdf
2. MDA Dental Team Scope of Practice, Results from a Survey Conducted by ADA Health Policy Institute on behalf of the MDA, November 2020
3. https://www.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c2110-2.pdf#page=3

Who / What / When

The following chart relates to Dr. Deyton's article about groups discussing dental workforce issues and outcomes.

WHO ARE THE GROUPS HAVING DISCUSSIONS?		
DHSS Workforce Group	***Workforce Ad Hoc***	***Outside Entities***
The Missouri Dept of Health and Senior Services (DHSS) convened a healthcare workforce committee for all healthcare disciplines. It's purpose is to develop recommendations for Governor Parson to address healthcare workforce shortages in Missouri. The MDA and Office of Dental Health (ODH) have given input for consideration along with other recommendations that may be presented to the Governor.	A Workforce Ad Hoc Committee consisting of representatives from each of the three major Missouri oral health stakeholders (MDA, MO Dental Hygienists' Association and MO Primary Care Association). The Committee was tasked with understanding the oral healthcare workforce shortages and recommending solutions. Dr. Guy Deyton, ODH and Brian Barnett, Dental Board executive director, facilitated four meetings in May and June.	The history of oral healthcare workforce revisions in other states often involves advocacy from interest groups outside the state, like the PEW and Kellogg foundations. These outside groups fund advocacy when they perceive there is political feasibility to change the care delivery systems to improve access to care. Recently in Colorado, a consumer advocacy group aligned with the Colorado Medical Society to support and pass a Dental Therapist bill.
WHAT COULD THE NEXT STEPS BE FOR THE GROUPS?		
DHSS Workforce Group	***Workforce Ad Hoc***	***Outside Entities***
This group called for all recommendations to be submitted by June 17, which will be reviewed with the decision made by August 1 as to what to pass on to Governor Parson. The Governor will review the recommendations and decide what will be included in his legislative agenda for 2023.	This committee established a list of topics that will be taken to the respective associations' governing boards and annual meetings for discussion and possible action. If agreement on workforce initiatives can be reached by the associations, they will collaborate on legislative proposals to be considered in the 2023 legislative session.	The effort to convene representatives from each of the major oral healthcare associations to recommend workforce and access to care recommendations is an effort to have Missouri dental healthcare providers find solutions for Missouri dental healthcare issues without undue influence from outside entities.
WHEN WILL PROCESSES INVOLVED WITH POSSIBLE NEXT STEPS HAPPEN?		
DHSS Workforce Group | Any workforce solutions that require state appropriation or statutory change must be presented to the legislature. Governor Parson will decide what he wishes to include in his 2023 agenda.		
Workforce Ad Hoc | Any workforce initiative that proposes the state underwrite all or a portion of the cost requires a legislative proposal to be considered and passed. ***Some workforce changes discussed by the committee could be accomplished by rule changes at the Dental Board level.*** A good example might be streamlining the EFDA training process to make it more accessible. If there is agreement at the Dental Board level, a rule change can be affected in 6-8 months. ***Some workforce changes discussed by the committee would require a change in statutes.*** Examples might be creation of a new EFDA Hygiene Assistant and changes that may allow hygienists and assistants to be extended to nursing homes supervised by dentists using teledentistry. As a general rule, statutes can be passed if there is agreement and support by the major stakeholders and the fiscal note is palatable. Statutes passed take effect August 28, after the close of the legislative session. If rules are necessary subsequent to a statute, then the normal Dental Board rule making process would follow.		
Outside Entities | Uncertain, but other states have models of mid-level provider and dental therapist legislation, that, if are the only solution or perceived best solution, could be considered by state entities/legislatures.		