As a member of the current Workforce Committee formed by ODH and as the MDA Legislative and Regulatory Committee chair, I often ponder, "what do we do with all the issues we see with workforce shortages and how can we guide our profession?"

As profession, we must work on this because there is no denying it's a problem not subsiding. I would venture to say at some point over the past couple of years, every provider has experienced staffing shortages. I feel until we address workforce changes needed at the core of our profession, we won't have adequate providers to serve the populations in our state: dentists, hygienists or assistants. I believe it is time for MDA to start finding solutions, or they will be found for us. People in the state are asking and will make plans without us; however, if we work together with other oral health stakeholders, we can come out as leaders instead of adversaries to change.

This rings true now more than ever, especially when you look at actions in other states and precedence being set. For example, Colorado had such an issue this year. HealthierColorado, a consumer help group, had sponsored language for a dental therapist. This group had success the previous session and, for lack of better terms, steamrolled the Colorado Medical Society with legislation. With this they pushed forward with dental therapist legislation.[1] The bill sponsor became the president of the Senate, which poised the bill to be a train headed down the tracks. The Colorado Dental Association (CDA) had no chance of defeating it and opposition would have led to a furious fight in the Senate and House committees, as well as a battle on both houses floor. This forced a shift in the CDA's effort, from one of fighting the bill to that of shaping it as much as they could.

I believe strongly in this association and will fight for it for many years to come if membership will have me as a leader. And I believe the time is now to think more broadly of the dental health of our state. More and more groups interested in addressing overall healthcare and social issues are taking notice that do not have the same pulse on dentistry. This easily can lead to change beyond our control and liking. We must be mindful and aware of how the pressure of other groups and agencies, offering their solutions, can rapidly occur.

I am grounded in certain philosophies for my practice, as I'm sure each of you are grounded in your own philosophy of care, or delivery model, or practicing in a certain geographic area, etc. This is what makes Missouri dentistry diverse. Yet, I think one thing in our profession we can agree unites us is patient care. I would venture to say for the diversity of our membership, we certainly are not diverse in our thoughts on ways to expand care through proven models. It is this diversity that has the power to make us stronger if we unite and support each other. Without unity and support we will eventually fall.

In November 2020 we asked members about these issues (IRT, anesthesia, scaling, expanded functions) and presented these results[2] at the 2021 House of Delegates. In summary, these findings indicated:

- Majority support for a trained assistant to work under the supervision of a hygienist. This includes chairside suctioning, intraoral pictures, radiographs and coronal polishing.
- Majority disagreement of allowing hygienists to place interim therapeutic restorations under the general supervision of the dentist.
- Regarding local anesthesia under general supervision for hygienists: Majority support for topical and infiltration anesthesia under general supervision; 48 percent of respondents support block anesthesia under general supervision.
- Majority support for the expanded function dental assistant program to include a scaling component curriculum.

If you're not familiar with the levels of supervision in Dental Practice Act,[3] I ask you to review them with the above information as they pertain to each survey answer. You can access those definitions at modental.org/practiceact (under Dentists, Supervision rules) or use the link in the References.

These surveys, as well as calls and emails to the MDA office and more, indicate members want to consider what can be done to assist with patient care, yet archaic policies and resolutions tie our hands. Not only do I see MDA losing membership to this issue if we do not start to make significant change, but we will lose our voice as being a major stakeholder in the dental healthcare delivery system within our state if we do not offer solutions to put our own "house in order." Membership decline and apathy means loss of voice and power at the Capitol.

Challenges can bring opportunities—opportunities that can truly make a difference for oral healthcare needs, and at the same time, continue to be grounded in important policy to protect the profession and the public. I firmly believe the delivery of that care by a team needs to be enhanced and reconsidered. MDA will not give up diagnosis or treatment planning, yet MDA should support trained and educated dental professionals working at the top of their scope.

Let us look at EFDA dental assistants for example. If a provider does not believe in the program, or want to delegate these procedures, they do not have to allow it in their office. By having a rule that allows more to be delegated, it does not force a provider if they are not comfortable. But it does allow the ability for dentists, who are comfortable delegating procedures under direct supervision to trained and permitted assistants, to add this scope to their practice to better manage patients, increase efficiencies and see more people in shortage areas.

I personally can speak to the value of the EFDA program being available in my rural private practice, which also is one of the few Medicaid provides in the area. I am inundated with patients, and to continue to serve my county and surrounding counties, I must be vigilant and utilize efficiencies in which I have trust and faith. I do not allow everything "legal" in the Practice Act to be done in my

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.		