WorkForce Task Force

What workforce model would best address oral healthcare needs in Colorado?

I agree with Pasco that we do nothing to bring up a workforce issue or a midlevel provider with anyone in Colorado Government unless they bring it up first. **That should be Plan A.** I also believe that we as a committee need to be united in what we put forward. Any areas we do not agree on should have a compromise found within the group and an agreement to move forward with that compromise by all of us.

I also agree that we create a detailed Colorado white paper. The Georgia paper provides us a nice infrastructure. I agree with Dr Kahl that details on specific solutions and Colorado statistics will be needed and this will require the entire group.

In the AGD article "Is Dentistry Dead" on page 27 they outline other proposals or recommendations other than a midlevel that could work. We should outline in our white paper those areas Colorado is already doing.. I am in agreement with Dr. Scarpella that one of the proposals we suggest as a solution be the ADA's Community Dental Health Coordinator Model. **This should be our Plan B.** This is an economical solution that could have huge impacts in actually improving access in that it will help the underserved find a "dental home." This "Dental Home" initiative should be a much better sell to politicians than a midlevel. To successfully have it be a better sell we need to put statistics in the white paper that show the extreme costs of funding the education of a midlevel and data that shows a midlevel economically is unlikely to provide care to the populations we are targeting. The AGD white paper did a good job at that.

Part of **Plan B** must be to report a systemic connection to the oral cavity, quality of care will be compromised under a midlevel, costs to fund a midlevel will be too high, midlevels will be unlikely to provide care to targeted populations. All of this supported with statistics and alternative solutions other than the "dental social worker" may be needed.

I believet Myra is correct in that a midlevel education will be a compromised one resulting in compromised care. We must report the surgeon generals report on how the body has a systemic connection to the mouth. And under a midlevel model we remove the provider who has the overall knowledge of this and who can refer necessary medical treatment. The AGD white paper states throughout that there is no helath or financial gain in compromising healthcare.

However, we must be careful not to make quality of care our only or our strongest argument. Many Politicians believe "some care is better than no care" so this argument could backfire on us if we do not stress that a midlevel is not economically feasible. The inability to pay for this and the likelihood of it not being utilized by the targeted populations are arguments politicians will understand. State programs have economic costs and Colorado will not be able to afford them. We must show them statistically how the program already in place are working and offer solutions to improve those programs.

A privately funded midlevel education may be brought up so we must be prepared to show how the midlevel is very likely to practice in areas that are not underserved and that there is a cost to running a dental business that will only be successful with a dentist involved. The AGD white paper also does a good job at explaining this. The AGD article states, “The Develpoment of a curriculum which mirrors what is already being done but yields a less qualified product, is a poor fiscal policy and wastes precious dollars and resources.”

I submit we also tackle the idea that the medical model that physician assistants and nurse practitioners practice in is much different from a dental health model. Almost every-time we see a patient we have to provide surgical therapy and not just prescribe meds for symptoms. The body heals many medical ailments but often does not heal dental ailments.

We should also stress that we have a state that basically already has a midlevel, in that our Hygienists can practice apart from dentists and that EDDAs can do so many dental procedures. If it should come to this, I think, we should use independent hygiene and EDDAs to our advantage and have a **Plan C** in working form in case we need it. I would be fine with that **Plan C** allowing hygiene to drill/fill and extract or EDDAs to supragingival scale as long as they are under the direct supervision of a dentist and hygienist. This is definitely the lesser of two evils for all of us should a Midlevel Therapist be allowed to practice scaling, fillings, extractions down the street from us. We must die on the sword fighting a midlevel being in independent practice.

See you at the meeting
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