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Colorado Dental Association
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Task Force Members;

Research has shown that even if FREE care is available, most individuals that qualify do not take advantage of it. According to The Kaiser Commission on Medicaid and the Uninsured there is a direct correlation between people that have poor physical health also having poor dental health. Parents, their children and adults in states with free dental programs, are not taking advantage of the opportunity to have regular examinations.
(www.nhchc.org/Network/Accesstoaffordabledentalcare.pdf)

If we are looking at ways to enhance the delivery of care for individuals that do not have the financial ability to access care we must remember that the higher the dental IQ the more likely they will find way to access the needed dental care. Education and prevention must be a part of this formula when looking at how best to meet the needs of these individuals.

It should also be noted prior to moving forward with options, that none of the mid-level programs are accredited by the American Dental Association (ADA) and according to the Commission on Dental Accreditation (CODA), they are not planning on accrediting any programs at this time.

When we consider the costs of setting up a mid-level practice, (the supplies, malpractice insurance and dental equipment), the savings for the dentist, the mid-level provider and the patient is not much different than having the patient be treated by a dentist. Yet there is a savings when the practice uses an Expanded Function Dental Auxiliary (EFDA). This is documented in the 2003 Joint Task Force Bravo that provided dental care to the Honduras population. By using EFDA's the military was able to provide over $91,000 in dental care and took the mission from extraction based to a comprehensive based program by using EFDA's.
(www.thefreelibrary.com/maximizing+care+through+dental+assistant+expanded+function)

When developing a mid-level provider program, I would treat it similar to a physician assistant program instead of the mid-level program that has been developed in Minnesota. There are numerous dental assistants that have returned to college and do have their bachelor degree. To require them to be a hygienist first would deter or discourage a number of individuals that would make excellent mid-level providers but have no desire to be a dental hygienist first.

I believe that the program should require at least a bachelor degree in the sciences and at least 750 hours of direct patient care in the dental field prior to even applying to the program. By offering it at the community college level, it would be a two year or 25 months certificate program. However the opportunity to have coursework apply towards a Master's degree at one of the four year institutions could be a possibility. This program could be offered at any one of

the five CODA programs in the state of Colorado, (Front Range Community College, Pikes Peak Community College, Pueblo Community College or Northwestern Junior College.)

The program would need to include: Dental Anatomy and Morphology, Dental Materials, Dental Radiology including interpretation and diagnosis, medical emergencies pain control and all clinical experiences including cavity design and preparation and local anesthesia.

The clinic would have to have a minimum of 20 treatment rooms in a clinic along with a dental laboratory for students to learn skills to the laboratory level prior to treating patients to the clinical level. Faculty would need to be hired that would need to include dentists and others at the Master's level in their area of expertise.

The cost of opening a program at this time in this financial climate may not be possible especially with the state of Colorado being ranked 48th in the nation for funding of higher education. (The cost of starting up such a program in the state could very well be over one million dollars.)

As a side note, at the 2009 House of Delegates Meeting in Vail, the dean of the University Of Colorado School Of Dentistry stated that they would not be willing to teach the mid-level provider. Was this statement made because philosophically they do not believe in the mid-level provider or because of the cost of operating such a program? The School has found that it is more economically sound to have foreign students then either dental hygiene students or start up a mid-level provider program.

This then brings us back to looking at EFDA's. The state could and should register all individuals that perform expanded functions. By having these individuals demonstrate their skills in a board setting with either the Dental Assisting National Board (DANB) or the State Board of Dental Examiners hiring dentists to administer and grade the exam would put qualified and knowledgeable EFDA's all on the same levels when it came to treating patients.

EFDA's do provide many positive services for patients all ready. They include, placing restorations and finishing restorations, adjusting and seating provisional crowns, taking final impressions for both fixed and removable prosthetics and after the initial adjustment they are adjusting removable prosthetics. By registering these individuals, the state can ensure that patients regardless of whether they are receiving free, low cost or normal cost dentistry are receiving optimal treatment.

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As I am looking at the mid-level provider and what it would look like in CO, several questions have come to mind and if anyone can give me some insight into this I would greatly appreciate it.

1. Who will be paying for the mid-level provider's equipment and supplies? If it is the mid-level provider, will it really be saving the patient money? The mid-level provider will be paying the same for the above as a dentist. Or am I over simplifying it?

2. If a dentist is on sight while the mid-level is providing treatment, what is the dentist doing? Treating similar patients, and if they are, why not use an expanded function dental assistant instead of a mid-level provider. It would be less expensive and perhaps that would lower the fees for the patient.

3. Fees will have to take into account for a mid-level provider the fact that they have additional education compared to an expanded function dental assistant.

4. At the CDA Annual Session in 2009, the University Of Colorado School Of Dentistry's dean did state at that time that they would not be providing the education for mid-level providers. If they are not willing to provide this education, who will do it. Do we allow non American Dental Association accredited programs to teach this or only ADA accredited programs?

5. Do lower socioeconomic deserve to be treated with lower quality dental care?

If anyone has insight into the cost comparison for mid-level providers and using expanded function dental assistants I would like to see those figures.

Thanks again for any insight that you might be able to provide me before I finish writing my proposal.

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