Strengths

- Provide care in public school setting to avoid missed time at school/work. Decrease no shows. Youth exposure to oral heath careers. (3 stickers)
- Innovative educators (2 stickers)
- Health Workforce Council Meeting are connecting various organizations together to collaborate. (2 stickers)
- HOSA programs for introductions to the dental field (1 sticker)
- Skills centers with dental programs (1 sticker)
- Rural health clinics who have expanded to offer dental services and receive encounter rate (1 sticker(
- Community support systems within the dental professions in rural areas.
- Look at collaboration with schools (DA, RDH, DT and DDS)
- Increase the number of education programs.
- Data indicating that DAs and RDHs seem to be more evenly distributed in rural and urban areas.

Weaknesses

- Cost of education (4 stickers)
- Skill Centers underutilization for community clinics for program collaborations (2 stickers)
- Are of rural providers. What happens to practice when they retire? Trust built between provider and community serving. (1 sticker)
- Limited practice locations/settings for Dental Therapist. Solution ↓ (I didn't find anything) (1 sticker)
- Under used community training infrastructure. Can we use existing facilities instead of building new clinics to train? (1 sticker)
- DOH credential application wait times are exceptionally long right now (1 sticker)
- Lacking non traditional school/training hub for dental professions (1 sticker)
- Cost of running ed programs and costs for students.
- Ongoing convening is a challenge
- Low numbers of dental training programs.
- Many rural communities lack access to colleges with hygiene programs.
- Parents have to take time off work to take children to appointments (lost wages)
- Hygienists workforce life span only 7 years
- Lots of unknowns
    - Resources available.
    - "like" organizations to collaborate
    - Advocacy efforts.

Opportunity

- Increase awareness to dental positions in the youth space (externships, internships, apprenticeships) (5 stickers)
- Have DA programs at all RDH program sites (3 stickers)
- Medical Dental integration movement momentum (2 stickers)
- New dental school PNWN add hygienist school (2 stickers)
- Strengthening existing and opening additional CTE programs in health sciences. (2 stickers)
- Hybrid training for didactic education component of hygiene and DA training (2 stickers)
- Expand hygienist scope of practice to include the fullest extent and independence as possible could be focuses on certain pop. (1 sticker)

- Expansion of scope, DAs, RDHs, DDS. (1 sticker)
- Opportunity to sponsor "student" or education scholarships in exchange for 3-5 years commitment to address workforce shortages. (1 sticker)
- Open opportunity through apprenticeship and other OJT programs (1 sticker)
- Amplify attention to significant disparities in oral health access between Apple Health and commercial (1 sticker)
- Use current environment to re-imagine Medicaid benefit (1 sticker)
- Capacity, longevity. What is the evidence for frequency of care? Should we pay more for less frequent visits to free access and dollars for higher need care? (1 sticker)
- Opportunity for fundamental changes (1 sticker)
- Can we start a more flexible and innovative dental accrediting body (vs CODA) (1 sticker)
- Collaborate with all training institutions to coordinate students to practice @ community clinics/free oral clinics, under general supervision of dentists. (1 sticker)
- Does the growing trend toward minimally invasive dentistry bring workforce changes? (1 sticker)
- WAC age restrictions/requirement (1 sticker)
- Mobile/remote sites for RDH/DA utilizing virtual didactic and local clinical (1 sticker)
- Dental Hygienist CODA accreditations limits program innovation (lock-step curriculum). Standards revision is an opportunity.
- Hygiene workforce leaving at 7 years
- Collaboration with others here and outside of this group of like mindedness.
- Greater acceptance of new models and proactive types.
- Expand where dental therapist can practice beyond FQHC ideas: RHC, 0/0 of Medicaid (mimesta (sp?) model) schools, ALF/SNF
- Current federal funding opportunity for rural health
- Rural health transformation plan under HR1 – comments to HRA.
- More partnerships between academic programs and community clinics for training in "real" practice environment.
- Provide impact training – the difference they can make in their communities.
- Improved technologies asynchronous telehealth
- Utilize rural nursing education program (RNEP) model for training dental assistants/hygienists – "grow your own" model using remote education.
- Are incentives of any kind possible?
- Grad ÷ Student Loan caps
- Demographic data provided at licensing/registration. Know more about characterizing of providers compared with populations.
- Ensure that those in bona fide DA programs are able to be employes or paid via an externship even if not 18.
- We need to do a cost benefit analyses of each of these models we heard about today. Especially if we could have these programs provide community care – like Sno-Isle program.
- ACH – HUB CBW = Access
- Keep ability for students under 18 to be registered as DA w/state
- Why not advocate for an alternative accreditation for RDH programs.

Threats

- Funding/low reimbursement
- Financial barrier to follow a traditional track of education for underserved. Can we innovate and consider work experience for certain dental roles? (5 stickers)

- Access to housing. (4 stickers)
- Lack of interest working/living in rural areas (3 stickers)
- Grad ÷ Students loan caps (2 stickers)
- Medicaid cuts (2 stickers)
- Age requirement for entry level for DAs. (2 stickers)
- Federal uncertainty on oral health grant (1 sticker)
- Retention RDH ergonomics (1 sticker)
- Ability to hire young people (under 18) for H/C occupations eg Dental assistant
- Age in rural
- Internal industry skirmishes – scope – DA v RDH v DDS
- Growing number of female dentists most DAs and RHD
- Low reimbursement by both Apple Healthcare and other insurers
- CODA accreditation requirements and limitations.
- RDHs – perceived lack of respect, opportunities
- Current reimbursement models ie dental insurance separate from medical
- Apple Health/Medicaid. Threat of Rack Audits, challenging admin
- Costs associated with education
- Federal funding may increase opportunity for international students who might move back home.
- Monitor trend for provider movement from FQHC to private.
- Decrease cuts in federal funding in ALL areas involving public health/community health.
- Increase burden on state capacity and capabilities.
- Decrease funding for student loan repayment.
- Sheer size of the problem. 90% of counties are HPSA