ORAL HEALTH PRACTITIONER WORKGROUP
ISSUES AND RECOMMENDATIONS

Sec. 26. **[150A.061] ORAL HEALTH PRACTITIONER.**

Subdivision 1. **Oral health practitioner requirements.** The board shall authorize a person to practice as an oral health practitioner if that person is qualified under this section, works under the supervision of a Minnesota-licensed dentist pursuant to a written collaborative management agreement, is licensed by the board, and practices in compliance with this section and rules adopted by the board. No oral health practitioner shall be authorized to practice prior to January 1, 2011. To be qualified to practice under this section, the person must:

(1) be a graduate of an oral health practitioner education program that is accredited by a national accreditation organization to the extent required under subdivision 2 and approved by the board;

(2) pass a comprehensive, competency-based clinical examination that is approved by the board and administered independently of an institution providing oral health practitioner education; and

(3) satisfy the requirements established in this section and by the board.

Subd. 2. **Education program approval.** If a national accreditation program for midlevel practitioners is established by the Commission on Dental Accreditation or another national accreditation organization, the board shall require that an oral health practitioner be a graduate of an accredited education program.

Subd. 3. **Requirement to practice in underserved areas.** As a condition of being granted authority to practice as an oral health practitioner under this section, the practitioner must agree to practice in settings serving low-income, uninsured, and underserved patients or in a dental health professional shortage area as determined by the commissioner of health.

Subd. 4. **Application of other laws.** An oral health practitioner authorized to practice under this section is not in violation of section 150A.05 relating to the unauthorized practice of dentistry and chapter 151 relating to authority to prescribe, dispense, or administer drugs.

Subd. 5. **Rulemaking.** The Board of Dentistry may adopt rules to implement this section.

The work group shall complete its recommendations by December 15, 2008, and the commissioner and Board of Dentistry shall submit a report containing the work group's recommendations and draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education issues by January 15, 2009.

Oral Health Practitioner Workgroup Responsibilities:
Develop recommendations and proposed legislation for the education and regulation of oral health practitioners, including an implementation schedule that allows for enrollment of students in oral health practitioner educational programs by the fall of 2009. The Oral Health Practitioner (OHP) workgroup shall provide recommendations and proposed legislation on the following issues included in the work plan (Attachment A).

Issue 1: The workgroup shall recommend and propose legislation that states the necessary education and competencies, including clinical training, faculty expertise, and facilities.

A. Background:
Oral Health Practitioners must be graduates of an accredited education program that provides didactic and clinical training to meet minimal competencies as defined by the OHP scope of practice. Appendices F and G provide an overview of the training programs being developed at Metropolitan State University of the Minnesota State Colleges and Universities (MnSCU) and the University of Minnesota Dental School.

Metropolitan State University of the Minnesota State Colleges and Universities system, in a 26-month Masters of Science in oral health care, will educate 12-15 Advanced Dental Hygiene Practitioners per year. Admissions requirements include a Bachelors degree, an active dental hygiene license, restorative functions certification, and 2400 hours of clinical practice. This practitioner will have an expanded role in treating patients by providing diagnostic, preventive, prescriptive, therapeutic and restorative services directly to the public under the general supervision of a dentist. These graduates will emphasize primary prevention and referral of patients whose needs reach beyond the OHP's scope of practice.

The University of Minnesota proposes to train 10 OHPs per year, through either a 33-month Bachelors of Science in Dental Therapy or a 28-month Masters in Dental Therapy. The Bachelors program would be available to high school graduates, while the professional Masters degree would require a Bachelors degree and a pre-professional core curriculum for acceptance.

The vision of both academic institutions is to utilize their curriculum, faculty expertise and facilities to train new members of the dental health care team who are competent and ready to practice by 2011. One significant difference between the programs is the level of dental supervision that is required. MnSCU graduates will operate within a collaborative management agreement and under the general supervision of a dentist. The University of Minnesota program will emphasize that irreversible surgical procedures will be performed only under indirect supervision and that examinations, diagnosis and treatment planning are the purview of the dentist.

B. Recommendations:
Both programs can meet the necessary educational requirements, training to a level of competency to meet the OHP Scope of Practice. The Board of Dentistry has received inquiries from external testing bodies, including indication of intention to develop OHP didactic and clinical competency testing materials.

C. Outcome measures:
D. Draft legislation:

Issue 2: The workgroup shall recommend and propose legislation that states the appropriate program accreditation.

A. Background:
The Board of Dentistry presented a draft timeline that included the components and timing of licensing and regulatory requirements, including potential licensing fees (Appendix H).

Additional background for consideration includes:

1. Existing dental programs are accredited by the Commission on Dental Accreditation (CODA).
2. The earliest timeframe that new educational programs can achieve accreditation is upon graduation of their first class.
3. The Board of Dentistry has initiated discussions with the Commission on Dental Accreditation regarding examination of OHP applicants.
4. The procedures to be accredited exist in current dentist educational programs.
5. CODA accreditation should be pursued: if not available, or in the interim, the MN Board of Dentistry can perform this function.
6. Multiple OHP program formats will be eligible for accreditation, assuming that the educational content meets criteria for the Oral Health Practitioner scope of practice.

B. Recommendations:
C. Outcome measures:
D. Draft legislation:

Issues 3, 4, 5 and 6:
The Oral Health Practitioner legislation directs the workgroup to recommend and propose legislation that defines the scope of practice, level of supervision, medications that may be prescribed, administered and dispensed, extractions that may be performed, all under the auspices of a collaborative management agreement. Due to their total integration in dental practice, issues 3, 4, 5, and 6 were considered and discussed as a unit in meeting 3 on September 5, 2008 and will be revisited at meetings 4 and 5 in the context of the educational programs and competencies, as well as level of supervision of, and by OHPS in the collaborative management agreement.

Issue 3: OHP scope of practice that reflects the education and training of the OHP and includes the following services:

a. Preventive
b. Primary diagnostic
c. Educational
d. Palliative
e. Therapeutic
f. Restorative

i. Cavity preparation
ii. Restoration of primary and permanent teeth using appropriate dental materials
iii. Temporary placement of crowns and restorations
iv. Placement of preformed crowns
v. Pulpotomies on primary teeth
vi. Direct and indirect pulp capping in primary and permanent teeth
vii. Extractions of primary and permanent teeth
viii. Placing and removing sutures
ix. Providing reparative services to patients with defective prosthetic appliances.

g. Determine services to be provided to children and adults

Issue 4: Level of supervision required by a licensed dentist, including any limitations, restrictions, or dentist supervision requirements the work group recommends that should be applied to any of the services or procedures listed in issue (3).

Issue 5: Medications that may be prescribed, administered and dispensed by an OHP if authorized by the supervising dentist in a collaborative agreement. These may be limited to medications for anti-infective therapies, nonnarcotic pain management, and prevention.

Issue 6: Extractions that may be performed if authorized by the supervising dentist in a collaborative agreement, and are within any limitations, restrictions, and level of supervision requirements recommended by the work group.

A. Background for Issues 3-6:
Levels of dental supervision are defined by Minnesota Rule 3100.0100 Definitions, Subp. 21. (Appendix C).

General supervision means the supervision of tasks or procedures that do not require the presence of the dentist in the office or on the premises at the time the tasks or procedures are being performed but require the tasks to be performed with the prior knowledge and consent of the dentist (Minnesota Administrative Rules 3100.0100, 2008).

Indirect supervision means the dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed by the auxiliary.

B. Recommendations for issues 3-6:
Procedures are listed in the potential OHP scope of practice grid (Attachment B) with notations that they are either non-controviersial or require further discussion, as identified by one or more work group members. OHPs will jointly negotiate a collaborative management agreement with a dentist that assumes a general level of supervision, unless noted otherwise.

Proposed additions to the grid:

1. Space maintainer placement/removal (preventive procedures)
2. Preparation and placement of preformed crowns of any material (restorative procedures)
3. Medications – antifungal and those needed for management of medical emergencies (see Appendix D)
4. Tooth re-implantation stabilization/referral (surgical procedures)
5. Smoking cessation
6. Atraumatic Restorative Technique
7. Sealants (preventive procedures)

Proposed procedures not allowed under general supervision:

1. Dental examination
2. Nitrous oxide
3. Extraction of permanent teeth
4. Placement of sutures

Proposed deletions from the grid – procedures not included in the OHP scope of practice:
Procedures # 7, 8 and 10 are currently dental hygiene procedures. Including them in the OHP scope of practice will depend upon the level of training and whether OHPs also have a dental hygiene license (needs further discussion).

1. Repair of defective appliances (*Needs further discussion –A narrowed list of procedures is included in the 9/5/08 revised scope of practice grid).
2. Recementing of permanent crowns
3. Behavior management (*Discussion specified restraining pediatric patients/medical immobilization).
4. Extractions–primary/permanent (*The level of training and contents of the collaborative management agreement will determine whether the OHP will do extractions. Primary extractions will probably be done by OHPs. The MN Board of Dentistry suggested that only D7140 and D7110 be allowed).
   D7140: extraction, erupted tooth or exposed root (elevation and /or forceps removal). Includes routine removal of tooth structure, minor smoothing or socket bone, and closure as necessary.
   D7111: extraction, coronal remnants – deciduous tooth. Removal of soft tissue-retained coronal remnants. (American Dental Association [ADA], 2006).
5. Root-tip removal (*D7250: surgical removal of residual tooth roots [cutting procedure]. Includes cutting of soft tissue and bone, removal of tooth structure, and closure [ADA, 2006].) Any cutting would not be in the OHP scope of practice.
6. Incision/drainage of abscesses
7. *Perio-maintenance*
8. *Scaling*
9. Opening of a permanent tooth for pulpal debridement and opening chamber (Endo access opening-emergency)
10. *Full mouth debridement*
11. Rendering a diagnosis

Fluoride treatments and sealants may be provided to both children and adults, as needed. Services restricted to children should be provided to children and services restricted to adults should be provided to adults.

C. Outcome measures:
D. Draft legislation:

Issue 7: The workgroup shall recommend and propose legislation that states the criteria for determining in which practice settings OHP should be authorized to practice in order to improve access to dental care for low-income, uninsured, and underserved population.

Sec. 26. **[150A.061]** Subd. 3. **Requirement to practice in underserved areas.** As a condition of being granted authority to practice as an oral health practitioner under this section, the practitioner must agree to practice in settings serving low-income, uninsured, and underserved patients or in a dental health professional shortage area as determined by the commissioner of health.

A. Background:

Low income populations -

- The 2008 Federal poverty threshold for a single person is $10,400; a family of four is $21,200. Income limit at 200% of FPL for a family of four is $42,400.
- MN Health Care Programs (MHCP) provide basic health care to roughly 666,000 Minnesotans through three publicly funded health care programs – Medical Assistance (507,000), General Assistance Medical Care (33,000) and Minnesota Care (126,000).
- MHCP income eligibility uses the federal poverty limit (FPL), ranging from less than 75% of FPL to 275% of FPL.
- All MHCP enrollees have some dental benefits, but only 42.2 % of all MHCP enrollees visited a dentist in 2006; including 43.6 % of MA enrollees, 36.5 % of GAMC enrollees, and 51 % of MinnesotaCare enrollees (MN Department of Human Services, 2008).
- In FY 2008, 1498 children and 15,884 adults were seen at hospital emergency rooms for treatment of dental pain (Reisdorf, 2008).
- The number of Minnesotan's at 100, 200, and 275% of poverty are as follows:
  Minnesotans below 100% FPL = 8.6% of the total population, (448,035)
  Minnesotans below 200% FPL = 24.2% of the total population, (1,257,824)
  Minnesotans below 275% FPL = 36.8% of the total population, (1,913,764)
  (Minnesota Department of Health, Health Economics Program and University of Minnesota School of Public Health, 2007 Minnesota Health Access Survey).

Uninsured populations -

- The 2007 MN Health Access Survey of parents showed that 33.3% of Minnesotans, age 3 and older do not have dental insurance coverage.
- For each child in the U.S. without medical insurance, there are almost three children without dental insurance (Manski & Brown, 2006).

Underserved populations -

1. Patients with family incomes below 200% of the federal poverty level.
2. Patients with medical disabilities or chronic illness.
3. Patients residing in geographically isolated or medically underserved areas.
4. Patients with limited literacy.
5. Patients confined to residential settings.
   (Pipeline, Profession & Practice, 2006).

Health Professional Shortage Area - Dental (HPSA-Dental) -

Area: Must be a rational area to provide service.
Population to dentist FTE ratio of 5000:1 or 4000:1 in high needs area.

Population: Resides in Area; have access barriers; or federally recognized Native American tribes. Includes areas with greater than 30% at 200% poverty, homeless, specific ethnic/race groups.

Facilities: Federal or State correctional, public or non-profit medical facility and insufficient capacity.

(U.S. Health Resources Services Administration, 2008

B. Recommendations:

Recommendation 1 - Oral Health Practitioners will serve:

a. Low-income populations: Residents at or below the upper limit of MinnesotaCare programs, currently 275% of FPL.

b. Uninsured: Individuals with no public, government, or private dental insurance. Further definition was deferred to the discussion of settings. (*Concerns were expressed that this should not include individuals with sufficient means who choose not to purchase dental insurance).*

c. Underserved: Individuals with significant barriers to receiving oral health care.

d. Dental Health Professional Shortage Areas criteria as defined by the U.S. Department of Health and Human Services (Health Resources and Services Administration, 1993).

Recommendation 2 - Oral Health Practitioners will be authorized to practice in the following settings:

a. Critical Access Dental Providers (CADP) - Settings and providers eligible for payments under the criteria for designation. As of FY 2008, a total of 168 dentists have been enrolled in the CADP, with 58 continuously enrolled (MN DHS, 2008).

b. Dental hygiene collaborative practice settings - Settings and providers eligible for collaborative dental hygiene practice arrangements are permitted as listed in statute:

> A "health care facility, program, or nonprofit organization" is limited to a hospital; nursing home; home health agency; group home serving the elderly, disabled, or juveniles; state-operated facility licensed by the commissioner of human services or the commissioner of corrections; and federal, state, or local

public health facility, community clinic, tribal clinic, school authority, Head Start program, or nonprofit organization that serves individuals who are uninsured or who are Minnesota health care public program recipients. (Minnesota Statutes, section 150A.10, Subd. 1a)

Medical facilities and assisted living facilities were added to this list of practice settings.

c. Military and Veterans Administration hospitals, clinics and care settings.
d. Patient home or residence when the patient is home-bound or receiving, or eligible to receive, home care services or home-and-community-based waivered services, regardless of income.

e. Clinics, providers and settings serving low income and underserved populations. Any other clinic or practice setting in which at least *x percent* * of the total patient base for the clinic or practice setting consists of patients who meet the definitions of low-income, ~~uninsured~~ or underserved. This includes mobile dental units. (* *The percentage of practice in this category needs to be defined, as well as who is considered to be uninsured).*

**A clinic or setting that might not otherwise meet these criteria would be able to hire an OHP dedicated to serving a population with access barriers.*

f. Oral health educational institutions.

C. Outcome measures:
D. Draft legislation:

Issue 8: The workgroup shall recommend and propose legislation that states the assessment of the economic impact of OHPs to the provision of dental services and access to these services.

A. Background:
The economic impact of OHPs to the provision of dental services depends on a number of variables and scenarios. Appendix I lists the financial variables that should be included in the economic analysis of OHP impact on provision of dental services. Given the reality that by 2011, 22-25 OHPs will graduate from the University of Minnesota and MnSCU programs, the impact on access to dental services will be determined by the number of practicing OHPs and the number of patients they are able to serve.

B. Recommendations:
B. Outcome measures:
C. Draft legislation:

Issue 9: The workgroup shall recommend and propose legislation that establishes an evaluation process and includes clearly defined outcomes with a process for assessment. The workgroup shall review research on midlevel practitioners, and to the extent possible, base its recommendations on evidence-based strategies that are most likely to:

1. Improve access to needed oral health services for low-income, uninsured, and underserved patients;
2. Control the costs of education and dental services;
3. Preserve quality of care; and
4. Protect patients from harm.

A. Background:
Starting in 2011, approximately, 22-25 OHPS will graduate per year. In 10 years (2021), approximately 220–250 OHPs will be serving clients throughout Minnesota. Given this small cohort, a large–scale evaluation focusing on population measures may not be feasible.

B. Recommendations:
The workgroup recommends that the evaluation focus on the cohort of OHPs, their activities and selected patient/practice outcomes, including patient safety.

C. Proposed outcome measures:
1. Number of new patients served (per member/per month)
2. Type of services provided by OHPs
3. Reduced waiting times
4. Decreased travel time for patients
5. Impact on ER use (prescriptions for antibiotics)
6. Increase diversity of OHPs to reflect population served.
7. Number/distribution of OHPs throughout Minnesota
8. Setting/type of OHP practice
9. Number of dentists involved in collaborative management agreements
10. Cost to system

D. Draft legislation:

Issue 10: The workgroup shall recommend and propose legislation that states the licensure and regulatory requirements, including license fees.

A. Background:
Based upon review of current licensure fees, the Board of Dentistry proposed that the OHP licensing fee be an amount between that of a dentist and a hygienist.

B. Recommendations:
1. The Board of Dentistry shall charge a fee of $240/ two years
2. The process of licensing foreign trained dental therapists needs clarification.

C. Outcome measures:
D. Draft legislation:

Definitions:

Oral Health Practitioner (OHP):
Accreditation
Collaborative Management Agreement:
Licensed:
Compliance:

Lessons learned from other midlevel practitioner programs:

Alaska –
New Zealand –
Canada -

Appendices:

Appendix A - Work plan

Appendix B – OHP scope of practice grid

Appendix C – Dental board definitions of supervision

Appendix D – Pharmacy board definitions of drug, practitioner, and dispensation

Appendix E – Bibliography

Appendix F - Overview of Metropolitan State University's Master of Science Program (Advanced Dental Hygiene Practitioner)

Appendix G – Overview of the University of Minnesota's Dental Therapy Program (Bachelors of Science and Masters in Dental Therapy)

Appendix H – OHP Regulatory, Licensing and Accreditation Timeline

Appendix I – Financial variables to include in the economic analysis of OHP impact on provision of dental services

Attachment A - Oral Health Practitioner Work Group Meeting Schedule and Work Plan *

Meeting 1 (August 8, 2008) 1- 4pm, Mosquito Control Board
- Welcome/Introductions
- Agreement on guiding principles and goals
- Ground rules and decision-making process
- Adoption of work plan and deliverables
- Election of chair
- Lessons learned from New Zealand and Canada

Meeting 2 (Friday, August 29, 2008) 1- 4pm, Wilder Foundation (Rooms B/C)
- Populations to be served: public programs, private pay and uninsured children and adults, special needs populations, i.e. - nursing and group home residents, prison/jail inmates
- Definition of low-income, uninsured, and underserved populations
- Criteria for determining in which practice settings oral health practitioners should be authorized to practice

Meeting 3 (Friday, September 5, 2008) 1- 4pm, Centennial Office Building (Lady Slipper Room)
- Level of supervision required by a licensed dentist, including any limitations or restrictions
- Scope of practice: array of services included in the legislation; medications that may be prescribed, administered and dispensed

Meeting 4 *CHANGED TO Friday September 26th, 1- 4pm, Mosquito Control Board*
- Overview of education programs; competencies, clinical training requirements, faculty expertise, and facilities proposed by the U of M and MnSCU programs
- Program accreditation, licensure and regulatory requirements, including licensing fees

Meeting 5 *CHANGED TO Wednesday, October 8th, 12 - 3pm, Wilder Foundation (Rooms A/B)*
- Assessment of the economic impact of oral health practitioners to the provision of dental services and access to these services
- Draft collaborative management agreement

Meeting 6 (Friday, October 31, 2008) 1- 4pm, Mosquito Control Board
- Evaluation process that includes clearly defined outcomes and a process for assessing whether these outcomes were successfully met

Meeting 7 (Friday, November 14, 2008) 1-4 pm, Mosquito Control Board
- Review draft legislation and report

Meeting 8 (Friday, December 5, 2008) 1- 4 pm, Mosquito Control Board
- Finalize legislation and report; next steps

Meeting 9 (Friday, December 12, 2008 - if needed) 1 – 4pm, Mosquito Control Board

Work Group meeting flow is intentionally set up to address the array of discussion topics in the following order: Who, What, Where and How. Each meeting will include presentation of background materials about each discussion topic, followed by deliberation, consensus on draft recommendations and proposed legislation. Materials will be sent to members/interested parties in advance of each meeting. Written input from interested parties will be invited/incorporated into meeting agenda/materials via chair.

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Appendix C - MR3100.0100 [DENTAL BOARD] DEFINITIONS

Subp. 21. **Supervision**. "Supervision" means one of the following levels of supervision, in descending order of restriction:

A. **"Personal supervision"** means the dentist is personally operating on a patient and authorizes the auxiliary to aid in treatment by concurrently performing supportive procedures.

B. **"Direct supervision"** means the dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before dismissal of the patient, evaluates the performance of the auxiliary.

C. **"Indirect supervision"** means the dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed by the auxiliary.

D. **"General supervision"** means the supervision of tasks or procedures that do not require the presence of the dentist in the office or on the premises at the time the tasks or procedures are being performed but require the tasks be performed with the prior knowledge and consent of the dentist.

Appendix D - 151.01 [PHARMACY BOARD] DEFINITIONS

Subd. 5. **Drug.** The term "drug" means all medicinal substances and preparations recognized by the United States Pharmacopoeia and National Formulary, or any revision thereof, and all substances and preparations intended for external and internal use in the diagnosis, cure, mitigation, treatment, or prevention of disease in humans or other animals, and all substances and preparations, other than food, intended to affect the structure or any function of the bodies of humans or other animals.

Subd. 6. **Medicine.** The term "medicine" means any remedial agent that has the property of curing, preventing, treating, or mitigating diseases, or that is used for that purpose.

Subd. 16. **Prescription.** The term "prescription" means a signed written order, or an oral order reduced to writing, given by a practitioner licensed to prescribe drugs for patients in the course of the practitioner's practice, issued for an individual patient and containing the following: the date of issue, name and address of the patient, name and quantity of the drug prescribed, directions for use, and the name and address of the prescriber.

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathy duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, or licensed veterinarian. For purposes of sections 151.15, subdivision 4, 151.37, subdivision 2, paragraph (b), and 151.461, "practitioner" also means a physician assistant authorized to prescribe, dispense, and administer under chapter 147A, or an advanced practice nurse authorized to prescribe, dispense, and administer under section 148.235.

Subd. 30. **Dispense.** "Dispense or dispensing" means the preparation or delivery of a drug pursuant to a lawful order of a practitioner in a suitable container appropriately labeled for subsequent administration to or use by a patient or other individual entitled to receive the drug.

MR 6800.7100, Subp 2: Drug administration.
"Drug administration" means to deliver by or pursuant to the lawful order of a licensed practitioner a single dose of a drug to a patient by injection, inhalation, ingestion, or by any other immediate means and shall include:

A. preparing the individual dose from a previously dispensed, properly labeled container;
B. verifying the dose as prescribed;
C. giving the individual dose by the proper route to the correct patient at the proper time;
D. assuring that the dose is taken; and
E. promptly recording the time and dose given.

Appendix E – Bibliography

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Appendix I - Financial Variables To Include in Economic Analysis of OHP Impact On Provision of Dental Services

Patient Variables
Individual-based: Number of visits and type of procedures
Demographic:
Demand - unmet needs
Population growth and age trends
Initial oral health status
Income and insurance Status

OHP variables
OHP Scope of Practice
Salary
Productivity (number of encounters)
Hours worked
Revenue/fees
Overhead (includes licensure, insurance)
Equipment (personal tools)

Practice variables
Productivity
Payor mix (cost shift)
Bricks and mortar
Cost of procedures
Operational efficiency
Demand
Supervision
DDS supervision cost
DDS new earnings potential
Capital investments
Equipment
Practice size and composition
Practice setting/structure - profit, nonprofit, government
General overhead
Care delivery design/redesign

Industry variables
Provider supply/demand balance
Changes in technology

Education variables
Bricks and mortar
Tuition
Training costs

State Government Variables
Reimbursement rates
Non-reimbursement subsidy
Number of MHCP Encounters
Payout per encounter
Total MHCP payouts
Percent MHCP patients seen
ER payouts
Other related medical payouts, short term and long term (heart disease)