Pathways to Improved Access to Dental Health Services

Even after the adoption of the Affordable Care Act, the existing oral health delivery system leaves enormous levels of unmet need. While multiple strategies will be required to improve oral health, states can and should consider whether legal barriers unnecessarily hamper licensed dentists and allied dental providers from delivering more services to more patients. The Network for Public Health Law has performed a legal analysis of how each state’s laws define — and in many cases limit — the roles of these dental health service providers.

This Fact Sheet describes the state laws governing the respective services provided by members of the dental workforce. The companion Access to Oral Health Care Science and Law Brief more fully explores policy options that public health professionals and community members might consider to expand access to care through allied dental providers. Together the Network intends for these documents to serve as a starting point for developing policies to improve oral health.

There are of course other important means of expanding access to dental health services. For children, programs to encourage oral health screenings by pediatricians and providing wider access to school–based sealant services can provide important benefits. And for many underserved populations, changes in Medicaid reimbursement policies coupled with innovative service delivery models are critical means of delivering needed services. The Network has explored in depth the issue of scope of practice for allied dental providers, as evidenced by this Fact Sheet, and we are prepared to investigate other policy options to improve oral health. If expanding scope of practice is not the focus of your efforts in this area, you are still encouraged to contact your Network Region for legal technical assistance on any oral health issue. There is no cost for this assistance. The Network will monitor requests for assistance in this area and prepare more extensive materials on issues that surface frequently, present promising outcomes or are particularly challenging from a legal perspective.

Oral Health and Scope of Practice of Allied Dental Providers in Minnesota

Poor oral health has severe negative repercussions on overall health, productivity and quality of life. Untreated oral health problems in children can result in attention deficits, trouble in school, and problems sleeping and eating.¹ Employed adults lose more than 164 million hours of work each year due to dental disease and dental visits, and in 2009 over 830,000 emergency room visits were the result of preventable dental conditions.² Poor oral health is also associated with a number of other diseases, including diabetes, stroke and respiratory disease.³ In older adults, poor oral health is significantly associated with disability and reduction in mobility.⁴

The following table highlights indicators of oral and dental health, and shows how Minnesota compares with the nation on these indicators.
Minnesota Compared with the National Average on Oral Health Indicators

<table>
<thead>
<tr>
<th>Adults</th>
<th>U.S.</th>
<th>MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults aged 18+ who have visited a dentist or dental clinic in the past year (2008)</td>
<td>68.5%</td>
<td>74.5%</td>
</tr>
<tr>
<td>Adults aged 18+ who have had their teeth cleaned in the past year (among adults with natural teeth who have ever visited a dentist or dental clinic) (2008)</td>
<td>69%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Adults aged 65+ who have lost six or more teeth due to tooth decay or gum disease (2008)</td>
<td>43%</td>
<td>36.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with a preventive dental visit in the past year (2011-2012)</td>
<td>77.2%</td>
<td>77%</td>
</tr>
<tr>
<td>Children with oral health problems in the past 12 months (2011)</td>
<td>18.7%</td>
<td>14.9%</td>
</tr>
<tr>
<td>Children with two or more oral health problems in the past six months (2007)</td>
<td>8.4%</td>
<td>4.4%</td>
</tr>
<tr>
<td>3rd Grade students with untreated tooth decay (2006-2007)</td>
<td>25%</td>
<td>18.1%</td>
</tr>
<tr>
<td>3rd Grade students with dental sealants (protective of decay) on at least one permanent molar tooth (2006-2007)</td>
<td>40.8%</td>
<td>64.1%</td>
</tr>
<tr>
<td>Children with decayed teeth or cavities within the past six months (2007)</td>
<td>19.4%</td>
<td>14.5%</td>
</tr>
<tr>
<td>Special needs children with unmet preventive dental care needs (2009-2010)</td>
<td>8.9%</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

The burden of oral disease is unequally distributed, with minorities and low-income people significantly more likely to report oral health problems. Many of these disparities are exacerbated by lack of access to dental providers, including non-dentist medical professionals. Allied dental providers, such as dental hygienists and dental therapists, are educated and trained to teach patients proper oral hygiene practices and provide a host of preventive dental services and assessments, typically at lower cost. Lack of access to allied dental providers is a key predictor of poor dental health. These dental professionals play a critical role in improving access to dental services, particularly for underserved or vulnerable populations. There is reason to believe that increased utilization of allied dental providers can help improve access to care, particularly among underserved populations. Regulation of allied dental providers varies across states. Although some states permit hygienists or therapists to practice only in the same physical location as dentists, many have taken steps to improve access to care for low-income people by relaxing this restrictive rule.

Allied Dental Providers in Minnesota

Dental Hygienists

What does the practice of dental hygiene include?
Performance of educational, preventive and therapeutic services including:

**Duties under General Supervision:**
- All services permitted for unlicensed and licensed dental assistants;
- Complete prophylaxis: scaling, root planing, and polishing of restorations;
- Preliminary charting of the oral cavity and surrounding structures: case histories, initial and periodic examinations and assessments to determine periodontal status, and formulating a dental hygiene treatment plan in coordination with a dentist’s treatment plan;
- Dietary analysis, salivary analysis, and preparation of smears for dental health purposes;
- Etch appropriate enamel surfaces, application and adjustment of pit and fissure sealants.
- Removal of excess bond material from orthodontic appliances;
- Replacement, cementation, and adjustment of intact temporary restorations extraorally or intraorally;
- Removal of marginal overhangs;
- Make referrals to dentists, physicians, and other practitioners in consultation with a dentist;
- Administer local anesthesia, after completion of training program; and
- Administer nitrous oxide inhalation analgesia.

**Duties under Indirect Supervision:**
- Restorative procedures:
  - Place, contour, and adjust amalgam restorations;
  - Place, contour, and adjust glass ionomer;
  - Adapt, and cement stainless steel crowns;
  - Place, contour, and adjust class I and class V supragingival composite restorations where the margins are entirely within the enamel.
  - Maintain and remove intravenous lines;
  - Monitor a patient during preoperative, intraoperative, and postoperative phases of general anesthesia or moderate sedation using noninvasive instrumentation such as pulse oximeters, electrocardiograms, blood pressure monitors, and capnography.

**Duties under Direct Supervision:**
- Etch appropriate enamel surfaces before bonding of orthodontic appliances by a dentist;
- Remove temporary crowns with hand instruments only;
- Fabricate, cement, and adjust temporary restorations;
- Place and remove matrix bands;
- Remove bond material from teeth with rotary instruments after removal of orthodontic appliances;
- Attach prefit and preadjusted orthodontic appliances;
- Remove fixed orthodontic bands and brackets;
- Initiate and place an intravenous infusion line in preparation for intravenous medications and sedation.

**Duties under Personal Supervision:**
- Concurrently perform supportive services if the dentist holds a valid general anesthesia or moderate sedation certificate and is personally treating a patient and authorizes the dental hygienist to aid in treatment including the administration of medication into an existing intravenous line, an enteral agent, or emergency medications in an emergent situation.

**Administering Anesthetics:**
- Administer Local Anesthetics, under any level of supervision
- Administer Nitrous Oxide, under any level of supervision
- Perform Supportive services under personal supervision, for a dentist who holds a valid general anesthesia or moderate sedation certificate.

<table>
<thead>
<tr>
<th>Level of Required Dentist Supervision</th>
<th>Hygienist Activities Within a Dental Office</th>
<th>Collaborative Practice Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal/ Direct</td>
<td>Full Scope of Practice</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>✓ Local Anesthesia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Nitrous Oxide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ All practices allowed under indirect and general supervision</td>
<td></td>
</tr>
<tr>
<td>Indirect</td>
<td>Limited Scope of Practice</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>✓ Local Anesthesia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ Nitrous Oxide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>✓ All practices allowed under general supervision</td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>Limited Scope of Practice</td>
<td>n/a</td>
</tr>
<tr>
<td></td>
<td>✓ Local Anesthesia</td>
<td></td>
</tr>
<tr>
<td>Under Collaborative Agreement</td>
<td>Nitrous Oxide</td>
<td>Limited Scope of Practice</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td></td>
<td>n/a</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>✓ Nitrous Oxide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✓ Other practices authorized under agreement, and as allowed by law</td>
</tr>
</tbody>
</table>

**What services may a dental hygienist not perform?**

*A licensed dental hygienist may not:*

- Establish a final diagnosis or treatment plan for a dental patient.\(^{37}\)
- Perform any dental treatment or procedure on patients not authorized under the appropriate Minnesota rules.\(^{38}\)

**What are the supervision requirements for the practice of dental hygiene?**

Dental hygienists may practice under the following types of supervision, based on the service to be performed.

**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.\(^{39}\)

**Indirect Supervision:** means the dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed.\(^{40}\)

**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 dental hygienist.\(^{41}\)

**Personal Supervision:** means the dentist is personally operating on a patient and authorizes the allied dental personnel to aid in treatment by concurrently performing supportive procedures.\(^{42}\)

**What are the supervision requirements for dental hygiene collaborative practice settings?**

Notwithstanding the requirements above, a dental hygienist may be employed by a health care facility, program, or nonprofit organization to perform some dental hygiene services without the patient first being examined by a dentist or a dentist being present.\(^{43}\) The dental hygienist must enter into a collaborative agreement with a dentist that designates authorization for services provided by the dental hygienist. **What body is responsible for professional oversight of licensed dental hygienists?**

The Board of Dentistry is responsible for carrying out and enforcing the licensure of dental hygienists.\(^{44}\) The board may promulgate rules necessary to carry out its authority.\(^{45}\)

**Dental Therapists and Advanced Dental Therapists**

In 2009, Minnesota became the first state to license dental therapists and advanced dental therapists.\(^{46}\) The Alaska Native Tribal Health Consortium had previously begun to license dental health aide therapists.\(^{47}\)

**What does the practice of dental therapy include?**

**Dental Therapists:**

**Duties under General Supervision.**

Unless restricted by the collaborative management agreement, a dental therapist may perform the following under general supervision:\(^{48}\)

- Oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;
- Preliminary charting, making radiographs, mechanical polishing;
- Application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
- Pulp vitality testing, application of desensitizing medication or resin;
- Fabrication of athletic mouthguards and soft occlusal guards;
- Placement of temporary restorations;
- Tissue conditioning and soft reline;
- Atraumatic restorative therapy;
- Dressing changes;
- Tooth reimplantation;
- Administration of local anesthetic;
- Administration of nitrous oxide.

**Duties under Indirect Supervision.**
Unless restricted by the collaborative management agreement, a dental therapist may also perform the following under indirect supervision:  
- Emergency palliative treatment of dental pain;
- Placement and removal of space maintainers;
- Cavity preparation;
- Restoration of primary and permanent teeth;
- Placement of temporary crowns;
- Preparation and placement of preformed crowns;
- Pulpotomies on primary teeth;
- Indirect and direct pulp capping on primary and permanent teeth
- Stabilization of reimplanted teeth;
- Extractions of primary teeth;
- Suture removal;
- Brush biopsies;
- Repair of defective prosthetic devices; and
- Recementing permanent crowns.

**Dispensing Authority**
Unless restricted by the collaborative management agreement, a dental therapist may also administer analgesics, anti-inflammatories, and antibiotics, including samples, but may not administer narcotics.

**Obtaining Services from Dental Assistants and Hygienists.**
Unless restricted by his or her collaborative management agreement, a dental therapist may obtain services from a licensed dental hygienist, or a dental assistant, but may not supervise more than four licensed dental assistants or nonlicensed dental assistants at any one practice setting.

**Advanced Dental Therapists**

**Duties under General Supervision.**
Unless restricted by the collaborative management agreement, an advanced dental therapist may perform the following under general supervision:
- An oral evaluation and assessment of dental disease;
- Formulation of an individualized treatment plan authorized by the collaborating dentist;
- The services and procedures within a dental therapist’s scope of practice;
- Nonsurgical tooth extractions of diseased permanent teeth in specified circumstances.

**What services may a dental therapist not perform?**

*A licensed dental therapist may not:*
- Perform any dental practice not authorized by statute or rule, or outside the parameters of the collaborative management agreement.  

An advanced dental therapist may not:
- Perform any service or procedure except as authorized by the collaborating dentist.

What are the supervision requirements for the practice of dental therapy?

Collaborative Management Agreement: Prior to performing services as a dental therapist, a dental therapist must enter into a written “collaborative management agreement” with a Minnesota-licensed dentist. The agreement must be reviewed, updated, and submitted to the board on an annual basis. No dentist may enter into such an agreement with more than five dental therapists or advanced dental therapists at any one time. The agreement must include:

- Practice settings for the dental therapist’s services and the populations to be served;
- Any limitations on services that may be provided by the dental therapist, including the level of supervision required by the collaborating dentist;
- Age-specific and procedure-specific practice protocols, including case-selection criteria, assessment guidelines, and imaging frequency;
- A procedure for creating and maintaining dental records for patients treated by the dental therapist;
- A plan to manage medical emergencies in each practice setting;
- A quality assurance plan for monitoring care provided by the dental therapist, including patient care review, referral follow-up, and a quality assurance chart review;
- Protocols for administering and dispensing medications;
- Criteria for care of patients with specific medical conditions, or complex medication histories, including requirements for consultation prior to the initiation of care;
- Supervision criteria of dental assistants; and,
- A plan for provision of clinical resources and referrals in situations which are beyond the capabilities of the dental therapist.

The agreement must be reviewed, updated, and submitted to the board on an annual basis.

Collaborative Management Agreement for Advanced Dental Therapists

In addition to the collaborative management agreement requirements for dental therapists, a collaborative agreement between an advanced dental therapist and a dentist must include specific written protocols to govern situations when a patient requires treatment exceeding the scope of practice of the advanced dental therapist.

Limited Practice Settings:
Dental therapists must practice primarily in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area. Such settings include:

- Critical access dental providers.
- Dental hygiene collaborative practice settings.
- Military and Veterans Administration hospitals, clinics, and care settings.
- A patient’s residence or home when the patient is homebound or receiving or eligible to receive home care services, or home and community-based waivered service, regardless of income.
- Oral health educational institutions.
- Other qualifying clinical or practice settings, including mobile dental units.
- Dental Health Profession Shortage Area

What body is responsible for professional oversight of allied dental providers?
The Board of Dentistry is responsible for carrying out and enforcing the licensure of dental hygienists and dental therapists, and for certification of advanced dental therapists. The board may promulgate rules necessary to carry out its authority.
The Network for Public Health Law is a national initiative of the Robert Wood Johnson Foundation with direction and technical assistance by the Public Health Law Center at William Mitchell College of Law.

This document was developed by Neil Pederson, law student at William Mitchell College of Law and reviewed by Jill Krueger, Senior Attorney, at the Network for Public Law—Northern Region, at the Public Health Law Center at William Mitchell College of Law. The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.


2 HHS, Oral Health in America, supra note 1, at 3; PEW CENTER ON THE STATES, A COSTLY DESTINATION: HOSPITAL CARE MEANS STATES PAY DEARLY 1 (2012).


4 IOM, Improving Access, supra note 3, at 52.

5 Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, National Oral Health Surveillance System: Adults Aged 18+ Who Have Visited a Dentist or Dental Clinic in the Past Year, available at http://apps.nccd.cdc.gov/nohss/ListV.asp?qkey=5&DataSet=2. (last visited October 7, 2014).


7 Centers for Disease Control, National Center for Chronic Disease Prevention and Health Promotion, National Oral Health Surveillance System: Adults Aged 65+ Who Have Lost 6 or More Teeth Due to Tooth Decay or Gum Disease, available at http://apps.nccd.cdc.gov/nohss/ListV.asp?qkey=7&DataSet=2. (last visited October 7, 2014).


18 See generally David Nash, Adding Dental Therapists to the Health Care Team to Improve Access to Oral Health Care for Children, 9 ACAD. PEDIATRICS 446 (2009).

19 See Ann Battrell et al., A Qualitative Study of Limited Access Permit Dental Hygienists in Oregon, 72 J. DENTAL EDUC. 329, 340 (2008).


21 See Id., IOM, Improving access at 3-29.

22 MINN. STAT. § 150A.05, subd. 1a (2014). Certain exemptions and exceptions apply, including for the practice of dental hygiene in the U.S. Public Health Service. MINN. STAT. § 150A.05, subd. 2.

23 MINN. R. 3100.8700, subp. 1.

24 See id. 3100.8400 (unlicensed dental assistants); id. 3100.8500 (licensed dental assistants).

25 “Before administering local anesthesia, a dental hygienist must have successfully completed a didactic and clinical program sponsored by a dental or dental hygiene school accredited by the commission on accreditation, resulting in the dental hygienist becoming clinically competent in the administration of local anesthesia.” Id. 3100.8700 subpart 1(J).

26 According to part 3100.3600, subparts 4(C)-(F) and 5(D) (requiring appropriate training and supervision).

27 Id. 3100.8700, subp. 2.

28 Restorative procedures are listed in Minnesota Statutes, section 150A.10, subdivision 4(a)(1)-(4) and specifies training requirements for administering them in (b) and (c).

29 MINN. R. 3100.8700, subp. 2a.

30 Upon completion of course. Id. 3100.8700, subp. 2a(E).

31 Upon completion of course. Id. 3100.8700, subp. 2a(H).

32 Id. 3100.8700, subp. 2b.

33 Upon completion of courses. Id.

34 See supra general supervision section.

35 See supra general supervision section.

36 See supra personal supervision section.

37 MINN. STAT. § 150A.10, subd. 1; MINN. R. 3100.8700, subp. 3.

38 MINN. R. 3100.8700, subp. 3.

39 Id. 3100.0100, subp. 21(D).

40 Id. 3100.0100, subp. 21(C).

41 Id. 3100.0100, subp. 21(B).

42 Id. 3100.0100, subp. 21(A).

43 MINN. STAT. § 150A.10, subd. 1a.

44 MINN. STAT. § 150A.02, subd. 1.

45 Id. § 150A.04, subd. 5.

46 For information on the development of Minnesota’s law, see Pew Center on the States, The Minnesota Story: How Advocates Secured the First State Law of Its Kind Expanding Children’s Access to Dental Care (2010), available at


47  MINN. STAT. § 150A.105, subd. 4(c).
48  Id. §150A.105, subd. 4(d).
49  Id. §150A.105, subd. 5.
50  Id. § 150A.10, subd. 1.
51  Id. § 150A.10, subd. 2.
52  Id. § 150A.105, subd. 7(b).
53  Id. § 150A.106, subd. 2.
54  Id. § 150A.106, subd. 2(a)(3), subd. 3(b).
55  Id. § 150A.106, subd. 6.
56  Id. § 150A.106, subd. 3(a).
57  Id. § 150A.105, subd. 3.
58  Id.
59  Id.
60  Id. § 150A.105, subd. 3(c).
61  Id. § 150A.106, subd. 3(e).
62  Id. § 150A.105, subd. 2.
63  Id. § 150A.105, subd. 8.
64  Id. § 256B.76, subd. 4(b); see also id. § 150A.105, subd. 8(b)(1).
65  Id. § 150A.10, subd. 1a; see also id. § 150A.105, subd. 8(b)(2).
66  Id. § 150A.105, subd. 8(b)(3).
67  Id. § 150A.105, subd. 8(b)(4).
68  Id. § 150A.105, subd. 8(b)(5).
69  Id. § 150A.105, subd. 8(b)(6).
70  Id. § 150A.105, subd. 8(c).
71  Id. § 150A.02, subd. 1; Id. § 150A.106, subd. 1.
72  Id. § 150A.04, subd. 5.