



ORAL HEALTH
Issue Brief

Collaborative Practice as a Strategy for Increasing Access to Oral Health Care in Minnesota

Background

Oral health in the United States has improved substantially in recent decades, but the inequitable burden of preventable oral health disease persists. People from rural and low-income communities, racial minorities, individuals with disabilities, and the elderly suffer disproportionately from tooth decay and gum disease and are less likely to visit a dentist than other Americans.¹ In 2017, nearly 63 million people in the United States lived in Dental Health Professional Shortage Areas (DHPSAs)—designated geographic areas with a shortage of dental care providers.² In Minnesota, over half of counties are considered DHPSAs.³ Adequate access to oral health care is a persistent issue for many Americans.

To address the unequal distribution of oral health care, states have begun to increase oral health care access through innovations in the oral health workforce. Collaborative practice is one strategy to provide care to people who are not currently receiving dental care. It may be used to expand the roles of current providers in the oral health workforce (including dental hygienists and dental assistants) or to support new provider types (such as dental therapists). In Minnesota, dental hygienists who enter into a collaborative practice agreement with a licensed dentist may work in community settings without a dentist present. Since a 2017 change in the law, dental assistants may be included in a collaborative practice agreement between a dentist and dental hygienist. In a growing number of states, including Minnesota, dental therapists may provide restorative and preventive services as set forth in a collaborative management agreement with a licensed dentist.

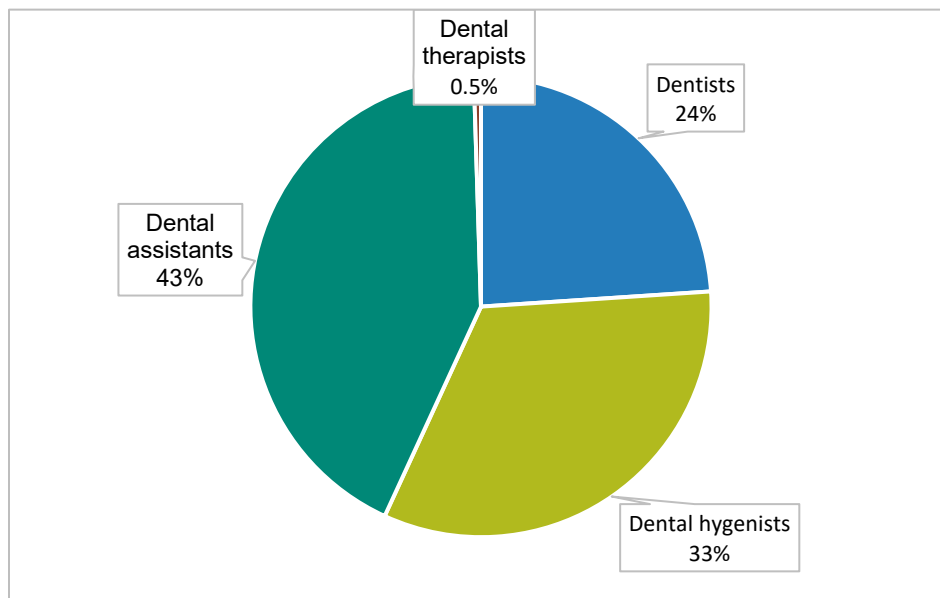
This Issue Brief focuses on collaborative practice models as a strategy to increase access to oral health care for underserved communities in Minnesota. Part I of this Issue Brief outlines new workforce data from the Minnesota Department of Health to help put the oral health workforce landscape in perspective. Part II then describes how collaborative practice models utilizing dental hygienists, dental assistants, and dental therapists can improve access to care for those who need it most. Part II also highlights key legal features of each of these models and addresses barriers which have prevented these approaches from being utilized more widely. Part III discusses Medicaid reimbursement policy and why raising reimbursement rates is critical to improving oral health care access. This Issue Brief focuses on Minnesota but the policies discussed have national relevance. Strategies to expand and maximize the oral health workforce through collaborative practice models are a critical component of a multifaceted approach to improve oral health access among underserved communities.

I. Oral Health Workforce Data and Trends

Looking at overall oral health workforce data and trends helps to put the landscape of the oral health workforce in perspective. The Minnesota Department of Health (MDH) maintains data on the number and distribution of oral health professionals in the state through questionnaires that are administered at the time of license renewal. MDH maintains data on four provider types: (1) dentists, (2) dental therapists, (3) dental hygienists, and (4) dental assistants. Community health workers (CHWs) also play an important role in Minnesota's oral health workforce, however they are not licensed. As a result, CHWs are not included in the MDH workforce survey, which is linked to license renewal.

Dental assistants make up the largest segment of the workforce, followed by dental hygienists, then dentists. Among these three provider types, those with the broadest scope of practice (dentists) are the least numerous. Dental therapists, an emerging type of mid-level provider often analogized to nurse practitioners and physician assistants, are found in small but growing numbers and are an exception to the observed inverse relationship between broader scope of practice and number of that type of provider. Figure 1 shows the overall distribution of the oral health workforce in Minnesota. Collaborative practice provides one means to take greater advantage of the greater number of dental hygienists and dental assistants, as well as their focus on prevention, while still taking advantage of the leadership and support provided by dentists.⁴

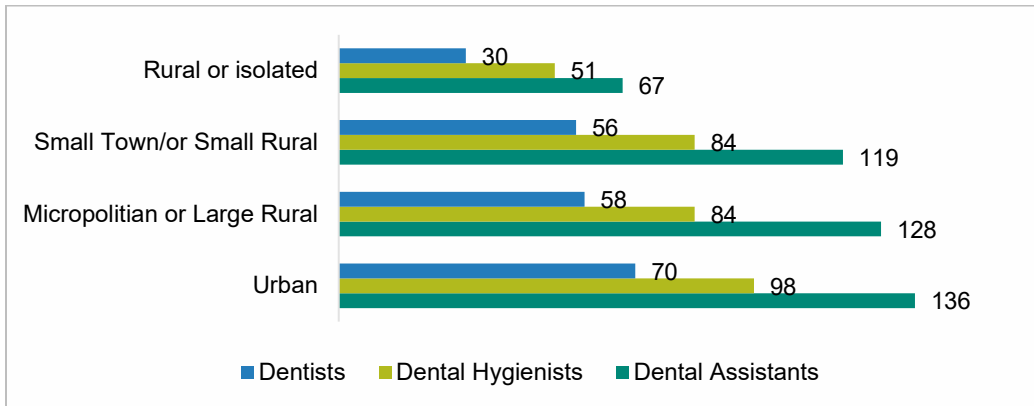
Figure 1: Distribution of Minnesota's Oral Health Workforce 2018



Source: Minnesota Board of Dentistry (2018) Analysis completed by Minnesota Department of Health.

One way to look at the distribution of the workforce is through provider to population ratios. Minnesota's overall rate of dentists per 100,000 population is 63.5, compared to 61.0 nationally. While the overall rate of dentists in Minnesota is slightly above the national average, looking at regional information demonstrates that there are communities with lower ratios, especially in rural or isolated areas of the state. The oral health workforce is concentrated in the Minneapolis-St. Paul metro area. Fifty percent of the state population is located in the Minneapolis-St. Paul area, while between 58 to 63 percent of the oral health workforce is in the same region.

Figure 2: Rate of Dental Professionals Per 100,000 Population in Minnesota



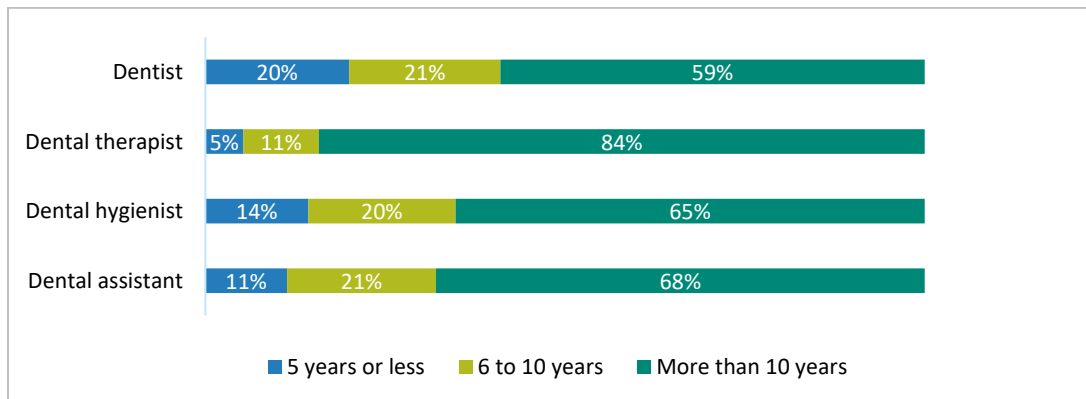
Source: Minnesota Department of Health Workforce Questionnaire (2016-2017).

In rural or isolated areas, the rate of dentists is approximately only 30 dentists per 100,000 population. In comparison, there are 70 dentists per 100,000 population in urban areas. As the available pool of licensed dentists is aging with many retirements projected, access challenges due to lack of dentists are expected to continue, especially in non-urban areas.⁵

More dentists are projected to move out of the workforce and into retirement between 2015 and 2030 than in the last six decades combined.⁶ As of fall 2017, 41 percent of dentists are planning to work in the profession 10 years or less, with 20 percent planning to work five years or less. Dental therapists have the most expected longevity in the field, with the majority of them planning to work in the profession for more than 10 years. Dental assistants and hygienists plan to remain in their occupations a similar time; about one out of three plan to leave their professions in 10 years or less.

Figure 3: Minnesota Oral Health Workforce Projected Retirements

“About how many more years do you plan to work in this profession?”



Source: Minnesota Department of Health Workforce Questionnaire (2016-2017 dentists, dental hygienists, and dental assistants, 2018 dental therapists).

The recent workforce data highlights the shortage of oral health professionals in rural areas of the state. With many dentists aging out of the workforce as well, planning to use the full oral health workforce is especially important. Laws and policies that support oral health professionals working in expanded roles can help bring needed care and services to these underserved areas.

Expanding the use of dental hygienists and dental therapists in community settings through collaborative practice may help to ameliorate the impact of dentist shortages in non-urban and underserved areas of the state. The workforce data also suggests that collaborative practice dental hygiene may present an important opportunity to bring dental hygiene services to underserved populations as well as an opportunity for dental hygienists to grow professionally.

II. Increasing Oral Health Care Access through Collaborative Practice

Policy approaches that expand the role of allied dental professionals—including dental therapists, dental hygienists, and dental assistants—through collaborative practice models can help to increase access to care for underserved communities and address deepening gaps in the oral health workforce described above.⁷ These innovative workforce approaches have already begun to improve access to oral health care in Minnesota and across the nation. Despite their great potential, however, these approaches are underutilized.

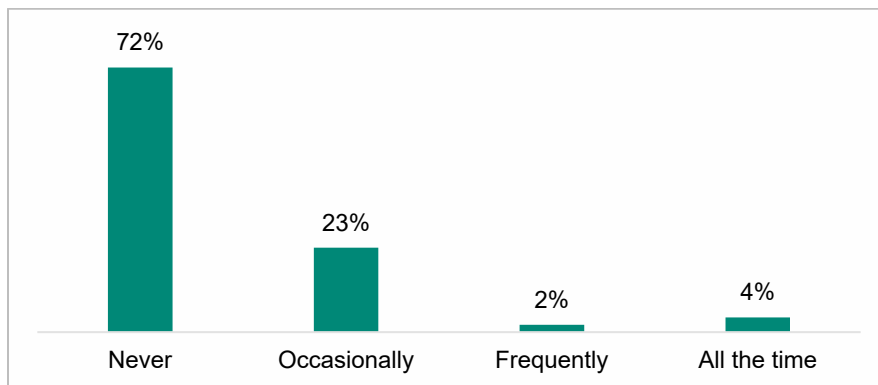
A. Dental Hygienists

A number of states have adopted innovative approaches with respect to scope of practice and supervision requirements of dental hygienists to expand access to care. For example, Minnesota has authorized dental hygienists with a collaborative practice agreement to provide expanded services under the terms agreed upon with their collaborative dentist. In Minnesota, a “collaborative practice agreement” is defined as a “written agreement with a licensed dentist who authorizes and accepts responsibility for the services performed by the dental hygienist.”⁸ Other states with innovative approaches, including related models such as extended function, direct access, and independent dental hygienists include California, Colorado, Iowa, Kansas, Maine, and New Mexico.⁹


Since passage of Minnesota’s collaborative practice legislation in 2001, dental hygienists with a collaborative practice agreement can provide preventive and therapeutic services under the terms agreed upon by their collaborative dentist. The law has been amended several times since its initial passage, with the most recent change in 2017.

While collaborative practice dental hygienists have been authorized under Minnesota law for many years, recent statistics show that they continue to be underutilized. As of fall of 2017, only 11 percent of dental hygienists in the state report that they have a collaborative agreement with a dentist.¹⁰ Few who have these agreements report actually using them; 72 percent report they never use it, followed by 23 percent who occasionally use the agreement. Two percent indicate that they use their collaborative practice agreement frequently, and only four percent indicate that they use it all the time. These low numbers indicate that there is room to expand the use of collaborative practice agreements among dental hygienists.

Figure 4: How Often Collaborative Agreement is Used



Source: Minnesota Department of Health Workforce Questionnaire (2016-2017).



In May 2017, Minnesota’s collaborative practice statute was amended to more clearly describe collaborative practice and to remove barriers to those seeking to work under collaborative practice. The amendments took effect on August 1, 2017.¹¹ A summary of the amendments is set forth below, and a detailed description of the changes is included in the Appendix.

The amended law provides that a licensed dental hygienist may be employed or retained by a health care facility, program, or nonprofit organization to perform all duties that fall under the general supervision category without the patient first being examined by a dentist if the dental hygienist: (1) has entered into a collaborative practice agreement with a licensed dentist that designates authorization for the services provided by the dental hygienist, and (2) has documented completion of a course on medical emergencies within each continuing education cycle.¹² The new legislation makes it easier for dental hygienists to participate in this delivery model by removing the prior requirement that dental hygienists have at least 2,400 post-licensure clinical hours before being eligible to participate in collaborative practice.


Previously, the statute specified that the collaborative practice dental hygienists were limited to a list of specific procedures, but the new law provides that they may perform all duties that fall under the general supervision category set forth in Minnesota Rules.

The amended law also clarifies the eligible setting types. A “health care facility, program, or nonprofit organization” is defined to include the following setting types: 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.¹³ The expansive description of settings opens the door to a variety of setting types for dental hygienists to better reach Minnesotans in need of better access to oral health services, especially underserved populations.

The 2017 revision to the law further clarifies that the referred patient does not become a new patient of record of the dentist to whom the patient was referred until the dentist accepts the patient for follow-up services after referral from the dental hygienist. This change could alleviate the concerns of collaborating dentists who are hesitant to take new patients through collaborative practice, but does not fully resolve the challenge of finding referrals for patients requiring follow-up treatment.

The statute provides that a collaborating dentist “authorizes and accepts responsibility” for the services performed by the dental hygienist, but does not further clarify the role of the collaborating dentist in terms of risk management.¹⁴ The phrase “accepts responsibility” is somewhat imprecise statutory language, and research for this issue brief did not uncover any cases interpreting this language. Although risk is part of any contractual relationship, there are strategies to minimize risk related to liability and malpractice. Dentists, dental hygienists, dental assistants, and dental therapists may each wish to discuss with their insurance provider or their employer the nature and extent of insurance coverage available or provided to them. Dental providers contemplating entering into collaborative practice agreements may wish to include provisions setting forth details regarding liability insurance policies carried by each of the parties to the agreement.¹⁵ According to research conducted by the Minnesota Department of Health and Minnesota Board of Dentistry, liability insurers in Minnesota report that there is no higher cost for professional liability coverage for an employee who is a dental therapist as compared to an employee who is a dental assistant or hygienist.¹⁶

Soon after the changes in the law took effect, in fall 2017, the Minnesota Department of Health (MDH) conducted a study of the facilitators and barriers of those currently engaged in collaborative practice dental hygiene. MDH conducted interviews with a total of 22 dental hygienists, dentists, program managers, and other key staff. The full results of this survey will be available in a forthcoming MDH report. One of the main challenges identified in the study was a lack of awareness and education about collaborative practice among the oral health community.¹⁷ The MDH study also revealed that it can be hard for dental hygienists to find a dentist who will enter into a collaborative practice agreement. One of the main reasons for hesitation is misinformation or lack of understanding about collaborative practice agreement requirements, especially related to liability and malpractice issues. Another barrier identified is that collaborative practice dental hygienists sometimes have difficulty identifying a dentist who will take the referral or do follow-up care. This Issue



Brief is one part of an overall strategy to increase awareness and understanding of collaborative practice arrangements in Minnesota.

One perennial challenge in Minnesota has been the difficulty in collecting data related to oral health workforce innovations, including collaborative practice. Data collection is an essential precursor to assessment and evaluation, including assessment of the effectiveness of laws and policies. The Minnesota Board of Dentistry encourages, but does not require, dental hygienists to register their collaborative practice agreements with the Board through the Board's online tracking system.¹⁸ In contrast, collaborative management agreements between a dentist and a dental therapist must be reviewed, updated, and submitted to the Minnesota Board of Dentistry annually.¹⁹

B. Dental Assistants

Following the 2017 change in the law, dental assistants may also be included in a collaborative practice agreement established between a licensed dentist and a dental hygienist. Under the amended statute, a dental assistant operating under general supervision of a collaborating dentist is authorized to perform the following services:


1. provide oral health promotion and disease prevention education;
2. take vital signs such as pulse rate and blood pressure;
3. obtain informed consent, according to Minnesota Rules, part 3100.9600, subpart 9, for treatments authorized by the collaborating dentist within the licensed dental assistant's scope of practice;
4. apply topical preventative agents, including fluoride varnishes and pit and fissure sealants;
5. perform mechanical polishing to clinical crowns not including instrumentation;
6. complete preliminary charting of the oral cavity and surrounding structures, except periodontal probing and assessment of the periodontal structure;
7. take photographs extraorally or intraorally; and
8. take radiographs.

Supporting the ability of dental assistants to use their most advanced skills may increase their satisfaction and boost retention rates, while enabling dental hygienists and dentists to work at the top of their respective licenses.²⁰ The Minnesota Dental Association has offered sample templates of collaborative practice agreements including dental assistants, which may be helpful to dental practices considering this type of collaborative agreement.²¹ The same strategies generally used to minimize risk and liability in collaborative practice agreements with dental hygienists are applicable to agreements including dental assistants.

C. Dental Therapists

Dental therapy is an emerging profession in the United States.²² Dental therapists are mid-level dental providers often compared to nurse practitioners or physician assistants in the medical context. Dental therapy was first recognized in the United States by the Alaska Native Tribal Health Consortium in 2005.²³ In 2009, Minnesota became the first state to authorize dental therapy.²⁴ There were no substantive changes to the dental therapy statute in the 2017 legislation in Minnesota which addressed collaborative practice dental hygiene.

In Minnesota, dental therapists must enter into a written "collaborative management agreement" with a licensed dentist. Dental therapists provide restorative and preventive services under supervision of a collaborating dentist. Minnesota law requires dental therapists to primarily practice in "settings that serve low-income, uninsured and underserved populations or in a dental health professional shortage area."²⁵ Dental therapists with a master's degree can earn certification as an advanced dental therapist. Advanced dental therapists must also have 2,000 hours of practice and pass a board approved exam. Advanced dental therapists can work more independently and have an expanded scope of practice.²⁶



Dental therapists make up a smaller portion of the workforce but they are well-integrated in Minnesota.²⁷ In 2017, 93 percent of licensed dental therapists were employed.²⁸ Dental clinics have reported that adding dental therapists to their staff has “increased access to care for children and adults, extended the reach of [their] dentists, and reduced [their] staffing costs.”²⁹ Having dental therapists provide routine restorative care can free dentists up to provide other needed services.³⁰

Because of the statutory design in Minnesota, dental therapists are more likely to work in a community-based setting or non-profit organization than any other dental profession in the state.³¹ Forty-six percent of dental therapists work in some type of community-based or non-profit setting, with 26 percent of dental therapists working for community or faith-based organizations and 12 percent working for Community Health Centers (CHCs) or Federally Qualified Health Centers (FQHCs).³² This suggests that dental therapists are increasing access to oral health care, and serving patients who might otherwise not receive dental care.

III. Medicaid Reimbursement

Over one million Minnesotans are enrolled in Minnesota Health Care Programs (MHCP), which is about 20% of the state’s population, and includes many children and adults who have difficulty accessing oral health care.³³ Minnesota law sets forth the MHCP core dental benefit set for both children and adults.³⁴ Minnesota’s Medicaid program covers “medically necessary” dental services for children and pregnant women.³⁵ At least three characteristics of Medicaid reimbursement in Minnesota would benefit from either policy change or improved understanding of the current policy.

A. Align Medicaid Benefit Coverage with Scope of Practice

First, understanding the type of providers and services eligible for reimbursement is critical for efficient and cost-effective deployment of dental services.³⁶ In general, services provided by dental hygienists are not eligible for Medicaid reimbursement directly to the dental hygienist. That is, the dental hygienist may be the rendering provider, but is generally not the pay-to provider. However, collaborative practice dental hygienists who provide dental services may receive payment through a health care facility, program, or nonprofit organization, and a collaborative practice dental hygienist may lead one of these entities.³⁷ In Minnesota, Medicaid reimbursement is also available for covered services provided by dental therapists and advanced dental therapists.³⁸ Understanding the nuances of Medicaid reimbursement can assist dental teams to maximize both payments received and services provided. Minnesota’s Medicaid program pays one reimbursement rate for a given service, independent of the provider type rendering the service. For example, a dental prophylaxis is paid at the same reimbursement rate whether it was rendered by a dental hygienist, dental therapist or dentist. This policy incentivizes the utilization of dental hygienists and dental therapists to serve more Medicaid patients.³⁹

Oral health screenings, such as those covered under Early Periodic, Screening, Diagnostic and Treatment (EPSDT), are an important component of care provided by MHCP. In Minnesota, EPSDT is known as Child and Teen Checkups. However, Minnesota’s coverage for oral health evaluations and applications of fluoride varnish under Child and Teen Check-ups is for services provided by primary care providers.⁴⁰ Examination, diagnosis, and other preventive and restorative services provided to children by a dental provider are covered, if at all, within the program’s dental benefit set, rather than within Child and Teen Check-ups. Even though oral health assessments are within the scope of practice of a dental hygienist, the MHCP dental benefit does not cover this service.⁴¹ This gap in coverage for services provided by collaborative practice dental hygienists decreases financial viability of providing care to Medicaid recipients and contributes to gaps in oral health care. One strategy for improving access to dental care could be greater alignment of the Medicaid benefit set with the scope of practice for each provider type, and increased education about Medicaid coverage for both providers and program participants.



B. Increase Medicaid Reimbursement Rates, Including for Managed Care

Second, despite some recent increases, Minnesota Medicaid reimbursement rates for dental services are among the lowest in the nation, creating an economic barrier for dental practices to treat Medicaid patients.⁴² Increasing Medicaid reimbursement rates for dental services must be part of any comprehensive solution to improve access to oral health services.⁴³ In 2017, the federal Centers for Medicare and Medicaid Services (CMS), cited “indications both that Minnesota children enrolled in Medicaid do not currently have sufficient access to dental services and that not enough dental providers participate in Minnesota Medicaid to ensure access to dental care for the state’s child enrollees.”⁴⁴ CMS noted that in federal fiscal year 2015, the national average of Medicaid-enrolled children who received a preventive dental service was 46 percent, while in Minnesota, where reimbursement rates were the lowest in the nation, only 37 percent of Medicaid-enrolled children received a preventive dental service. In response to the CMS letter, the Minnesota legislature raised reimbursement rates for dental services provided to certain Medicaid-enrolled individuals under the age of 21. The legislation raised reimbursement rates for dental services for children furnished by some types of Minnesota providers by 23.8 percent. Importantly, the rate increase did not apply to managed care plans as well as several other exceptions such as Federally Qualified Health Centers. Minnesota’s low MHCP dental reimbursement rates prior to the limited increase, substantial exceptions to the increase itself, and the comparison to Medicaid dental rates of other states means Minnesota continues to rank among the lowest reimbursement rates for pediatric dental services nationally.

C. Implement Streamlined Enrollment with the Minnesota Department of Human Services for Managed Care Providers

A third important characteristic of Medicaid reimbursement is the high number of Minnesotans enrolled in managed care organizations (MCOs), and the administrative burden this has historically placed on providers. About 80 percent of Minnesota Health Care Program enrollees have their Medicaid benefit administered through a managed care organization.⁴⁵ The Minnesota Department of Human Services contracts with several managed care organizations to provide oral health services to individuals enrolled in Minnesota Health Care Programs. In such cases, dental providers must enroll with each MCO from whom they wish to receive reimbursement.⁴⁶ Enrollment, sometimes also referred to as “credentialing,” is the process through which MCOs ensure that participating providers meet professional, certification, and licensure requirements under applicable state and federal laws.⁴⁷ Providers have reported that enrolling and maintaining enrollment with multiple MCOs can be cumbersome.

In 2016, CMS published a new final Medicaid rule.⁴⁸ Among other things, the final rule requires states to enroll persons or entities that provide services under that state’s Medicaid plan, including through the Medicaid managed care program.⁴⁹ Minnesota has a continuance while it moves to implement this requirement. When completed in 2020 or 2021, this centralized enrollment may streamline the process for providers, reduce the administrative burden of participating in managed care and enable more dental providers to participate with multiple managed care organizations. This streamlining benefit will be greatest if individualized requirements to participate with a particular managed care organization are limited.

Conclusion

Collaborative practice presents a critical opportunity to improve access to oral health care among underserved populations and those least likely to access routine preventive care from a dentist in a private practice setting. Collaborative practice has the potential to provide greater utilization of the most abundant members of the oral health workforce (particularly dental hygienists and dental assistants) as well as greater satisfaction to members of the entire dental team, who may each be enabled to utilize the highest level of their skills at a lower overall cost. More effective alignment of Medicaid benefits with the scope of practice for various members of the dental team, including those in collaborative practice, as well as higher reimbursement rates and a streamlined managed care enrollment process would enable Minnesota to maximize the potential contribution of collaborative practice to oral health. Through changes in law

and policy to strengthen innovative oral health workforce models such as collaborative practice, Minnesota and other states have begun to expand access to oral health care.

SUPPORTERS

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This document was developed by Brittney Crock Bauerly, J.D., former Staff Attorney at the Network for Public Health Law–Northern Region, and Laura McLain, Senior Research Analyst in the Office of Rural Health and Primary Care of the Minnesota Department of Health and reviewed by Jill Krueger, J.D., Northern Region Director at the Network for Public Health 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.

Minnesota’s Amended Collaborative Practice Statute – 2017 Revisions,
Minn. Stat. § 150A.10⁵⁰

	Prior Law (effective July 1, 2014 to July 31, 2017)	Current Law (effective August 1, 2017)	Comment
Authorizing Section for Dental Hygienists	Title: “Limited Authorization for Dental Hygienists”	Title: “Collaborative practice authorization for dental hygienists in community settings”	The change indicates the legislative intent to clarify and expand collaborative practice from its initial limited authorization.
Clinical Hour Requirement	In order to engage in collaborative practice dental hygiene, the prior law required that dental hygienists be engaged in “clinical dental hygiene for not less than 2,400 hours in the past 18 months or a career total of 3,000 hours, including a minimum of 200 hours of clinical practice in two of the past three years.”	None listed.	The amended law removes the clinical hours requirement.
Required Courses	Dental hygienists must have documented participation in courses on infection control and medical emergencies within each continuing education cycle as well as current CPR certification.	Dental hygienists must have documented completion of a course on medical emergencies within each continuing education cycle.	The change simplifies the additional educational requirements of collaborative practice dental hygienists.
Authorized Dental Hygiene Services	The dental hygiene services authorized to be performed by a dental hygienist were limited to: (1) oral health promotion and disease prevention education; (2) removal of deposits and stains from the surfaces of the teeth; (3) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants; (4) polishing and smoothing restorations; (5) removal of marginal overhangs; (6) performance of preliminary charting; (7) taking of radiographs; and	Collaborative practice dental hygienists can perform all duties that fall under the general supervision category of Minnesota Rules, part 3100.8700, subpart 1, without the patient first being examined by a licensed dentist. ⁵¹	Under the amended law, collaborative practice dental hygienists are no longer restricted to a more limited set of procedures and can perform all duties that fall under the general supervision category set forth in Minnesota Rules.



	<p>(8) performance of scaling and root planing.</p> <p>The dental hygienist may administer injections of local anesthetic agents or nitrous oxide inhalation analgesia as specifically delegated in the collaborative agreement with a licensed dentist.</p>		
<p>Collaborative Practice Agreement Requirements</p>	<p>The collaborative agreement must include:</p> <p>(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services;</p> <p>(2) age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by a dentist should occur;</p> <p>(3) copies of consent to treatment form provided to the patient by the dental hygienist;</p> <p>(4) specific protocols for the placement of pit and fissure sealants and requirements for follow-up care to assure the efficacy of the sealants after application; and</p> <p>(5) a procedure for creating and maintaining dental records for the patients that are treated by the dental hygienist. This procedure must specify where these records are to be located.</p>	<p>The collaborative agreement must include:</p> <p>(1) consideration for medically compromised patients and medical conditions for which a dental evaluation and treatment plan must occur prior to the provision of dental hygiene services;</p> <p>(2) age- and procedure-specific standard collaborative practice protocols, including recommended intervals for the performance of dental hygiene services and a period of time in which an examination by a dentist should occur;</p> <p>(3) copies of consent to treatment form provided to the patient by the dental hygienist;</p> <p>(4) specific protocols for the placement of pit and fissure sealants and requirements for follow-up care to assure the efficacy of the sealants after application; and</p> <p>(5) the procedure for creating and maintaining dental records for patients who are treated by the dental hygienist under Minnesota Rules, part 3100.9600, including specifying where records will be located.</p>	<p>The amended law includes a cross-reference to the dental record keeping rule (Minnesota Rule 3100.9600, which was itself revised in November, 2018). Note that while it is not required by the statute, the statute does not appear to prevent collaborative practice agreements from addressing liability insurance coverage to be obtained by the parties.</p>
<p>Consent</p>	<p>Before performing any services authorized under this subdivision, a dental hygienist must provide the patient with a consent to treatment form which must include a statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist.</p>	<p>Before performing any services authorized under this subdivision, a dental hygienist must provide the patient with a consent to treatment form which must include a statement advising the patient that the dental hygiene services provided are not a substitute for a dental examination by a licensed dentist.</p>	<p>The amended law does not change the consent requirement.</p>
<p>Referral Process</p>	<p>If the dental hygienist makes any referrals to the patient for further</p>	<p>When the patient requires a referral for additional dental services, the dental</p>	<p>The amended law specifies the</p>



	<p>dental procedures, the dental hygienist must fill out a referral form and provide a copy of the form to the collaborating dentist.</p>	<p>hygienist shall complete a referral form and provide a copy to the patient, the facility, if applicable, the dentist to whom the patient is being referred, and the collaborating dentist, if specified in the collaborative agreement. A copy of the referral form shall be maintained in the patient's health care record. The patient does not become a patient of record of the dentist to whom the patient was referred until the dentist accepts the patient for follow-up services after referral from the dental hygienist.</p>	<p>process when a patient requires a referral for additional dental services. A copy of the referral form shall be maintained in the patient's health care record.</p>
<p>Setting Type</p>	<p>The collaborative practice authorization applies to dental hygienists “employed or retained by a health care facility, program, or nonprofit organization.”</p> <p>For the purposes of this subdivision, 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.</p>	<p>The collaborative practice authorization applies to dental hygienists “employed or retained by a health care facility, program, or nonprofit organization.”</p> <p>For the purposes of this subdivision, a “health care facility, program, or nonprofit organization” includes 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.</p>	<p>The change modifies the limitation on the definition of a “health care facility, program, or nonprofit organization.” Under the amended law, the setting types include—but are not limited to—the particular settings listed in the statute. However, it appears that the overall intent of the legislature in this section is to provide dental care in community and “non-traditional”⁵² settings.</p>
<p>Authorizing Section for Dental Assistants</p>	<p>N/A</p>	<p>Collaborative practice authorization for dental assistants in community settings. A licensed dental assistant may be employed or retained by a health care facility, program, or nonprofit organization as defined in subdivision 1a to perform the dental assisting services described in [Minn Stat. 150A.10 subd. 2a (b) without the patient first being examined by a licensed dentist, without a dentist's diagnosis or treatment plan, and without the dentist being present at the</p>	<p>This new statutory section provides that dental assistants may be included in a collaborative agreement between a dentist and dental hygienist, and can perform a</p>



		location where services are being performed, if: (1) the dental assistant has entered into a collaborative agreement with a licensed dentist, which must be part of a collaborative agreement established between a licensed dentist and a dental hygienist under subdivision 1a, that designates authorization for the services provided by the dental assistant; and (2) the dental assistant has documented completion of a course on medical emergencies within each continuing education cycle.	specified list of services.
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¹ Pew Charitable Trusts, Disparities in Dental Health and Access to Care (Jun. 27, 2016), <http://www.pewtrusts.org/en/research-and-analysis/articles/2016/06/disparities-in-dental-health-and-access-to-care>.

² Henry J. Kaiser Family Foundation, Dental Care Health Professional Shortage Areas (HPSAs) (Dec. 31, 2017), <https://www.kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³ Minn. Dep't of Health, Dental Workforce Shortage Areas, <https://data.web.health.state.mn.us/hpsa-access> (last visited May 3, 2019).

⁴ Normandale Community College, *Community Dental Team: Team Member Roles in the 21st Century Team*, available at <http://www.normandale.edu/departments/health-sciences/dental-hygiene/minnesota-21st-century-dental-team--toward-access-for-all/community-dental-team> (last visited May 23, 2019).

⁵ MINN. DEP'T OF HEALTH, OFFICE OF RURAL HEALTH AND PRIMARY CARE, *Strengthening the Oral Health System in Rural Minnesota: Findings and Recommendations from the Rural Health Advisory Committee* 15 (2018), available at <https://www.health.state.mn.us/facilities/ruralhealth/rhac/docs/2018ruraloral.pdf>.

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⁷ Normandale Community College, *Community Dental Team: Collaborative, Competent Care and Health Equity for All*, available at <http://www.normandale.edu/departments/health-sciences/dental-hygiene/minnesota-21st-century-dental-team--toward-access-for-all/community-dental-team> (last visited May 6, 2019).

⁸ MINN. STAT. § 150A.10, subd. 1a(e).

⁹ Oral Health Workforce Research Center, *Variation in Dental Hygiene Scope of Practice by State*, available at <http://www.oralhealthworkforce.org/resources/variation-in-dental-hygiene-scope-of-practice-by-state> (last visited May 20, 2019). See also Rachel Jane Kashani-Legler, *Minnesota Collaborative Agreement: Potential for Dental Hygienists to Increase Direct Access for Underserved Populations*, ALL THESES, DISSERTATIONS, AND OTHER CAPSTONE PROJECTS (2016), available at <https://cornerstone.lib.mnsu.edu/etds/613/> (unpublished Master's thesis from Minnesota State University Mankato.)

¹⁰ Laura McLain, Minn. Dep't of Health (forthcoming report).

¹¹ Minn. Session Laws, 2017 Regular Session, Chapter 30 §§ 1-2, available at <https://www.revisor.mn.gov/laws/2017/0/30/>. See also Minn. Session Laws, 2017 Special Session, Chapter 6, Article 11, § 51, available at <https://www.revisor.mn.gov/laws/2017/1/6/>.

¹² MINN. STAT. § 150A.10, subd. 1a(a).

¹³ MINN. STAT. § 150A.10, subd. 1a(d).

¹⁴ MINN. STAT. § 150A.10, subd. 1a(e).

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- 15 Note, however, that current templates may not include a provision addressing liability insurance, and the parties may wish to add one. Relevant details may include name and contact information for the insurance provider, name of the insured, policy number, most recent policy renewal date (or attached copy of policy renewal), services covered, locations covered, providers covered, and whether collaborative practice is included in coverage provided.
- 16 Minn. Dep't of Health and Minn. Bd. of Dentistry, Dental Therapy in Minnesota Issue Brief (June 12, 2018), <https://www.health.state.mn.us/data/workforce/oral/docs/2018dtb.pdf>.
- 17 The Minnesota Dental Association has created a template for a collaborative agreement, available at <https://www.mndental.org/files/Collaborative-Practice-Authorization-for-Dental-Hygienist-including-Licensed-Dental-Assistant-Template.pdf> (last visited May 3, 2019).
- 18 Participants in a collaborative practice agreement may register it with the Minnesota Board of Dentistry on its Collaborative Agreement webpage, available at <https://mn.gov/boards/dentistry/onlineservices/onlicecollaborativagreement.jsp> (last visited May 3, 2019).
- 19 MINN. STAT. § 150A.105, subd. 3(c).
- 20 MINN. DEP'T OF HEALTH, OFFICE OF RURAL HEALTH AND PRIMARY CARE, *Strengthening the Oral Health System in Rural Minnesota: Findings and Recommendations from the Rural Health Advisory Committee* at 6-7 and 40-41 (2018), available at <https://www.health.state.mn.us/facilities/ruralhealth/rhac/docs/2018ruraloral.pdf>.
- 21 Minn. Dental Ass'n, Collaborative Practice Authorization for Dental Hygienist including Licensed Dental Assistant, <https://www.mndental.org/files/Collaborative-Practice-Authorization-for-Dental-Hygienist-including-Licensed-Dental-Assistant-Template.pdf> (last visited May 3, 2019).
- 22 Minn. Dep't of Health and Minn. Bd. of Dentistry, Dental Therapy in Minnesota Issue Brief (June 12, 2018), <https://www.health.state.mn.us/data/workforce/oral/docs/2018dtb.pdf>.
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- 24 Neil Pederson, *Pathways to Improved Access to Dental Health Services*, Network for Public Health Law, (June 2014), https://www.networkforphl.org/_asset/1rl760/MN-Dental-and-Oral-Health-Fact-Sheet.pdf.
- 25 MINN. STAT. § 150A.105. See especially MINN. STAT. § 150A.105, subd. 8(b) defining “practice settings that serve the low-income and underserved.”
- 26 Minn. Dep't of Health and Minn. Bd. of Dentistry, Dental Therapy in Minnesota Issue Brief at 2 (June 12, 2018), <https://www.health.state.mn.us/data/workforce/oral/docs/2018dtb.pdf>.
- 27 Minn. Dep't of Health and Minn. Bd. of Dentistry, Dental Therapy in Minnesota Issue Brief at 4 (June 12, 2018), <https://www.health.state.mn.us/data/workforce/oral/docs/2018dtb.pdf>.
- 28 Minn. Dep't of Health and Minn. Bd. of Dentistry, Dental Therapy in Minnesota Issue Brief at 4 (June 12, 2018), <https://www.health.state.mn.us/data/workforce/oral/docs/2018dtb.pdf>.
- 29 Apple Tree Dental, Dental Therapists Expand Access to Care for Children and Adults (Feb. 21, 2018), <http://www.appletreedental.org/dental-therapists-expand-access-care-children-adults/>.
- 30 An Advanced Dental Therapist in Rural Minnesota: Jodi Hager's Case Study 7 (Feb. 21, 2018), <http://www.appletreedental.org/wp-content/uploads/2018/02/ADT-Rural-Jodi-Hagers-Case-Study-022118.pdf>.
- 31 Laura McLain, Minn. Dep't of Health, Poster Presentation: Innovative Oral Health Professions in Minnesota (Apr. 2018).
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- 33 Centers for Medicare and Medicaid Services, Medicaid and CHIP in Minnesota, Centers for Medicare and Medicaid Services, available at <https://www.medicare.gov/state-overviews/stateprofile.html?state=Minnesota> (last visited May 20, 2019).
- 34 MINN. STAT. § 256B.0625, subd. 9.
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- 36 A similar discussion of this issue was included in a previous issue brief in this series, Brittney Crock Bauerly, *Policy Frameworks Supporting School-Based Dental Sealant Programs and Their Application in Minnesota* at 8, Network for Public Health Law, (Apr. 2019), available at https://www.networkforphl.org/_asset/5f6fx0/Issue-Brief---Policy-Frameworks-Supporting-School-Based-Dental-Sealant-Programs-and-Their-Application-in-Minnesota.pdf.
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- 38 MINN. STAT. § 256B.0625, subd. 59.
- 39 Minn. Dep't of Health and Minn. Bd. of Dentistry, *Dental Therapy in Minnesota Issue Brief* at 3 (June 12, 2018), <https://www.health.state.mn.us/data/workforce/oral/docs/2018dtb.pdf>.
- 40 Minn. Dep't of Human Services, Minnesota Health Care Programs (MHCP) Provider Manual, *Child and Teen Checkups* (March 21, 2019), available at https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&DocName=DHS16_150092#oral. See also, Minnesota Child and Teen Checkups (C & TC) Early Periodic Screening Diagnosis and Treatment (EPSDT): Schedule of Age-Related Dental Standards (August, 2017), available at <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5544-ENG>.
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- 44 Letter to Marie Zimmerman, Minn. Dep't of Human Services, from Anne Marie Costello, Centers for Medicare and Medicaid Services (April 26, 2017), available at <https://www.mndental.org/files/Letter-from-CMS-Director-Anne-Marie-Costello.pdf>.
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- 48 *Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care; CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability*, 81 Fed. Reg. 27498 (May 6, 2016).
- 49 42 C.F.R. §§ 438.600, 438.602(b), 455.410. <https://www.medicare.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf>
- 50 MINN. STAT. § 150A.10; Minn. Session Laws 2017 Regular Session, Chapter 30 §§ 1-2, available at <https://www.revisor.mn.gov/laws/2017/0/30/>. See also Minn. Session Laws, 2017 Special Session, Chapter 6, Article 11, § 51, available at <https://www.revisor.mn.gov/laws/2017/1/6/>.
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