

A History of Minnesota's Dental Therapist Legislation

Or...What the Heck Happened Up There?



*By: Patricia Glasrud, Carol Embertson, Tom Day,
and Richard W. Diercks **

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Preface

In late 2006, the Minnesota Dental Association was made aware of an initiative by a small, well-organized group of “safety net” (community clinics) and dental hygiene advocates seeking to change the Minnesota Dental Practice Act to create an “advanced dental hygiene practitioner” (ADHP). Although we knew that the American Dental Hygienists’ Association had been developing competencies and curriculum for the ADHP since 2004¹, it came as a surprise to many that an ADHP educational program was quietly being introduced in Minnesota in 2006 by a small number of Minnesota dental hygiene educators. It is critically important to recognize that the educational program was well underway *before* any attempt to change the Minnesota Dental Practice Act, and that sequence of events served to drive the legislative effort at a very intense pace over three legislative sessions. The events that unfolded over the next three years led to Minnesota becoming the first state in the country to create a new dental practitioner, called a dental therapist, who would be allowed to practice in any type of dental setting.**

This paper describes what happened at the “eye of the storm” from our perspective – that of the Minnesota Dental Association - as Minnesota created a new dental practitioner called a dental therapist (DT). As will be shown later in this paper, the 2009 statute actually created two new practitioners, the other being the advanced dental therapist (ADT),² about which confusion still exists. The 2009 Minnesota statute requires that a dental therapist work under the direct or indirect supervision of a dentist, while the advanced dental therapist may work without a dentist on-site. The scope of practice of the DT and the ADT differs only in that the ADT may extract mobile permanent teeth and may “provide” limited medications. Although the 2009 legislation requires the ADT to obtain the dentist’s authorization for services to be performed on each individual patient, it remains to be seen how that will be interpreted and implemented.

Dentists and others from around the country have questioned – and criticized – why Minnesota “allowed” this to happen. This paper seeks to provide the details in answer to those questions, and to allow others to gain from our experience.

This single controversial issue generated an enormous amount of legislative and media activity for our association. Early on, we sought and received assistance from the American Dental Association to deal with legislative and media messaging around the controversy that put Minnesota in the national spotlight. We know that a substantial amount of human and financial resources were required for us to “be at the table” throughout the process. We also believe, without a doubt, that had we **not** been part of that process, the outcome would have been very different and far more objectionable to most dentists.

Particularly at this time of economic uncertainty and escalating health care costs, the need to address access to affordable dental health care is ever more urgent. Our association has tried for decades to find innovative ways to improve dental access, but legislators and others have been unwilling or unable to commit the funding needed to enact meaningful dental reforms. Dental access has become the rallying cry of dental hygienists who do, indeed, have much to offer the public in the way of cost-effective **preventive** care...and who also strive to advance their profession by appealing to public need. Unfortunately, legislators, third-party payers and government bureaucrats may not appreciate or understand the complexities of providing safe and effective dental care.

Regardless of the circumstances surrounding why individual states might find themselves having to deal with the mid-level dental practitioner issue, it should be helpful at the outset to identify concepts that are most likely to be agreed upon by all stakeholders, dental and otherwise:

- All patients should receive the same high quality dental care, regardless of the type of

- dental practitioner rendering the care or whether the clinic setting is private fee-for-service, private non-profit, or public-government funded.
- Educational programs that teach dental surgical procedures should achieve appropriate accreditation consistent with other existing United States dental educational programs.
 - All allied dental professionals should function as part of the dental team, with the dentist as team leader, in order to maintain continuity of comprehensive patient care.

The mid-level practitioner situation in Minnesota continues to evolve. We've enjoyed successes and endured failures. While Minnesota was the first to deal with the creation of a new dental practitioner, other states may be facing this same issue. If you find that to be the case in your state, then perhaps our experiences can help you be better prepared to deal with the issue when the time comes.

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***Minnesota's dental therapist is distinguished from Alaska's "dental health aide therapist" (DHAT) in that the DHAT may only practice on Alaska Native, American Indians and on tribal reservations in Alaska (Alaska Dental Health Aide Program, www.phsdental.org/depac/akdentalhealthaide.html).*

Background: 2006-2008

The Minnesota Dental Association has been actively initiating and supporting ways to effectively address the access to care issues in Minnesota literally for decades. Our legislative agenda has included efforts to address low reimbursement rates, dental student loan forgiveness, rural recruitment initiatives, and expansion of the dental hygiene and dental assisting scopes of practice, and more. Those closest to the issue understand that there is no “silver bullet” that will solve the dental access issue: Rather, the problem is multi-factorial requiring many and varied approaches to work toward ameliorating the problem.

An ADHP Educational Program in Minnesota

The American Dental Hygienists' Association agenda to create an advanced dental hygiene practitioner was significantly advanced by a partnership in Minnesota between the dental hygiene program at Normandale Community College (two-year) and the nursing and health sciences program at the four-year Metropolitan State University, both in the Twin Cities. During 2006 a masters level ADHP educational program was developed by key faculty at those institutions and approved by the Board of Directors of the Minnesota State Colleges and Universities system (MNSCU). However, in order for graduates of the program to practice their intended expanded scope of practice, the Dental Practice Act had to be changed very substantially to include several irreversible procedures, including permanent tooth extractions and cutting hard tooth tissue.

Immediately upon learning of this development in December 2006, the MDA Executive Committee held a major meeting and informed all MDA members in the January 2007 issue of our newsletter, *MDA News*. Soon after, the MDA applied for and was accepted into the American Dental Association's public affairs program for assistance with what was sure to be a very controversial legislative battle.

Graduates of the masters ADHP educational program would have been allowed to diagnose oral conditions, perform numerous restorative procedures, extract primary and permanent teeth, place sutures, prescribe certain medications and more...all without a supervising dentist on the premises. Dentists in Minnesota became outraged, deeply concerned and ready to do whatever it took to prevent any legislative initiative to create an ADHP. But it took time, numerous communications to members, and a considerable effort to build a momentum that would become effective.

Recommendation to Legislature: Create A Mid-Level Dental Practitioner

During spring 2007 a coalition of community clinics, the Minnesota Dental Hygienists Association (MNDHA), a large health maintenance organization (Health Partners) and the Minnesota State Colleges and University system was formed calling itself the Safety Net Coalition. Led by a well-known, experienced health care attorney (who was responsible for drafting the legislation that created a public assistance program called MinnesotaCare in the 1990's), a proposal for a dental access grant wound its way into MDA legislation. The Safety Net group lobbied the Legislative Commission on Health Care Access behind the scenes, and the Commission came forward with a recommendation to create a new mid-level dental practitioner under the general supervision of a dentist, (meaning there would be no dentist on-site).³

ADA Focus Groups in Minnesota

During summer 2007, the ADA's public affairs program in Minnesota conducted focus groups designed to look at the public's attitudes about the possibility of being treated by an ADHP for tooth extractions, fillings and other irreversible procedures. These studies also examined what messages and dental access legislative proposals resonated best with the public. Findings from the focus groups and a telephone survey of Minnesotans conducted by the ADA's consulting firm were presented to the 2007 MDA House of Delegates. This served as a wake up call to members who had missed the significance of what was happening with the ADHP. Soon, the MDA enlisted the help of a local public affairs firm to assist with an increasingly difficult situation of ADHP supporters gaining favorable media attention.

ADHP Legislation in 2008

In February 2008 a bill was introduced by the Safety Net Coalition⁴ to codify the ADHP in the Minnesota Dental Practice Act. It included the following requirements:

- The ADHP license would be restricted to hygienists who complete a masters level ADHP program;
- A scope of practice would include diagnosing, prescribing certain medications, and any “simple” (non-surgical) extractions of primary and permanent teeth, along with many other procedures;
- The ADHP would be legally permitted to perform restorative and dental surgical procedures not only without a dentist’s diagnosis or treatment plan, but without a supervising dentist on the premises;
- The ADHP educational program would be accredited by the American Dental Hygienists’ Association, not by the ADA Commission on Dental Accreditation; and
- The ADHP licensure would not have required a clinical licensure examination constructed and administered by an independent organization separate from the educational institution. Instead, readiness for practice would be determined by the ADHP educational program.

The bill’s introduction prompted vigorous, relentless lobbying by both the opponents and the supporters throughout the legislative session and for the rest of the year. It became obvious to us that the proponents had been working diligently for quite some time to advance their cause without attracting the attention of the MDA. Legislative hearings were typically held with extremely little advance notice, certainly with inadequate time to prepare compelling testimony. Moreover, we often were afforded less time – if any – to even provide testimony! Our intense lobbying was characterized by our opponents as a “turf battle” between dentists and dental hygienists. Clearly, the deck was stacked against the MDA and Minnesota dentists.

When news of the ADHP educational program and the subsequent legislation later broke, there were Minnesota dental hygiene educators who expressed as much surprise and dismay as we did. And the dental students at the University of Minnesota were extremely upset - and vocal - about needing to defeat this bill. The U of M dental students often turned out in huge numbers at hearings and were among our most effective spokespeople.

In 2008 it was noticed by lawmakers that a few dentists who practice in community dental clinics spoke against the ADHP. It slowly became obvious to legislators that the “shock and awe” tactic used by the bill’s supporters was not going to succeed exactly as they had planned. Even so, legislators remained determined to pass something – anything - that would create a mid-level dental practitioner.

ADHP Legislation Was Defeated...But the OHP Was Created

The MDA was able to substantially change the ADHP bill, having dealt with rapid-fire hearings followed by no less than 34 “Legislative Alerts” to our members over a few short weeks. Dentists across Minnesota contacted their legislators to urge defeat of this bill. But although our efforts succeeded in eliminating much of the original ADHP language, the bill that was passed mandated the Board of Dentistry and the Minnesota Department of Health to constitute a workgroup.⁵ The charge to this workgroup was to establish the educational and licensure requirements of a mid-level dental practitioner that would be called an “oral health practitioner (OHP),” thus eliminating the name “advanced dental hygiene practitioner.” We believed that the new name of this new dental worker signaled an opportunity for the MDA to have a meaningful impact on the eventual legislative outcome.

In response to the passage of this law, the MDA created its own OHP Task Force consisting of dentists in private practice and community clinics, along with dental student representation. The primary purpose of our own task force was to provide timely guidance and feedback for the two dentists who were appointed to the health department’s workgroup. The activities of these two groups demanded constant attention throughout the rest of 2008.

Traveling The World

Meanwhile, the University of Minnesota School of Dentistry, led by Dean Patrick Lloyd, recognized the need and opportunity to learn firsthand about how other countries educate and employ mid-level dental practitioners, particularly the dental therapist. Key administrators and faculty at the dental school began to create an alternative educational pathway to become a mid-level dental practitioner, one that would be distinctly different and separate from an advanced dental hygiene practitioner.

To advance their understanding, the dean led a group of five to Saskatchewan, Canada in May 2008; another group of 12 to New Zealand in July 2008, and finally a group of 12 to England in September 2008. Along with dental school representatives, the visiting groups included dentists from the MDA and from Metropolitan State University-Normandale Community College faculty; some of the travelers visited all three countries. The goal of the U of M was to learn how they might structure their own dental therapy educational program, including details about faculty, facilities, scope of practice, level of supervision and curriculum that would best prepare their dental therapy graduates for practice.⁶

In brief summary, these groups learned that the standard of care provided in the other countries is not consistent with that provided here in the U.S. Their care delivery systems, educational costs and geography are very different from ours. These differences must be taken into account when comparing the use of mid-level dental practitioners in other countries with what may be possible here in the U.S. It is naïve to think that one is simply comparing “apples to apples.”

University of Minnesota Dental Therapy Education Program

In 2008, the University of Minnesota School of Dentistry announced its proposed dental therapy program, the first in the country.⁷ Among many differences, one important distinction between this program and the ADHP program at Metropolitan State University is that applicants to the U of M program would **not** need to be licensed dental hygienists to be admitted. These dental therapy students would be taught alongside the dental students, as they are in England. In fact, the opportunity to learn the same things that dental students learn – in the same courses with the same faculty and facilities – was a main lesson learned when the dean and his traveling group talked with dental therapy students and faculty in other countries.⁶

Because this program will admit well-qualified students right out of high school, it is necessary for the program to include the prerequisites necessary to lay a firm science foundation before the student studies clinical dental therapy. This is one key distinction between the dental therapy program at the University of Minnesota School of Dentistry and the Oral Health Practitioner program established at Metropolitan State University. The Metropolitan State University students will already have earned a baccalaureate degree including prerequisites that may or may not be comparable to those required at the dental school. This was one primary reason why the MDA found it acceptable to support the dental school program as opposed to the Metropolitan State University program.

Minnesota Department of Health OHP Workgroup

The official Oral Health Practitioner workgroup of the health department consisted of 13 members – seven of whom were dentists - appointed by a variety of stakeholder groups including two MDA dentist appointees (one of whom had made the visits to New Zealand and Canada.) The group met a total of eight times during fall 2008 to address ten specific items mandated by the 2008 Minnesota Legislature, such as educational and licensure requirements, program accreditation, level of supervision and scope of practice.

The meetings were led by a facilitator who tried to help the group achieve consensus. The group members elected the one Board of Dentistry member who served on the workgroup as its chairperson. Meetings were public and typically were well-attended by those who wished to hear the discussions firsthand and learn how and what decisions were made.

A final report was submitted to the Legislature in January 2009.⁸ Despite an enormous amount of time and effort to reach agreement, the report (written by the Minnesota Department of Health in consultation with the Board of Dentistry) revealed not only that an agreement had not been achieved, but in fact, the Safety Net Coalition's primary points had been preserved, with few exceptions. In fact, much to our dismay, the final report was written as if consensus had been reached when it had not.

Dental Therapist and Oral Health Practitioner Legislation Introduced

During the 2009 legislative session, the University of Minnesota proceeded to get a dental therapy bill introduced in the legislature. Because this bill was consistent with our "core principles," the MDA came out in support of this dental therapy bill and against the oral health practitioner bill which the Safety Net Coalition introduced. These "dueling bills" are discussed later in this paper.

MDA's Original "Core Principles" (2008)

- Oral health practitioners (later, dental therapists) must receive the same high quality dental education as dental students by being integrated into a dental educational program.
- An OHP program must be taught in an educational institution that is accredited by the Commission on Dental Accreditation of the American Dental Association specifically to teach surgical dental procedures.
- When an oral health practitioner provides surgical dental procedures, the patient must first receive a dentist's examination, diagnosis and treatment plan.
- An OHP should be permitted to provide data collection (preliminary charting) solely for the purpose of assisting the dentist in examining, diagnosing and treatment planning.
- When an OHP provides surgical dental procedures, the OHP must be under the indirect (on-site) supervision of a Minnesota-licensed dentist in active practice in Minnesota.
- The OHP scope of practice must not include extractions of permanent teeth on either children or adults, but may include extractions of fully erupted primary teeth.
- A collaborative management agreement for an OHP is needed only to allow the OHP to provide basic preventive services in the absence of a dentist. (Because we recommend that when the OHP provides surgical procedures they be performed only under indirect supervision of the dentist – that is, on-site supervision – a collaborative management agreement is simply not required for such procedures.)
- An OHP must not be permitted to prescribe any kind of medication. The OHP may only recommend over-the-counter medications to patients.
- To fulfill the legislature's intent to address dental access by creating a new type of dental worker, the OHP must not be limited by practice setting, but must ensure that at least 50% of their patients are from underserved populations.
- The economic impact of the OHP should be positive in a variety of practice settings, the oral health of patients should improve, and the cost of care should either remain the same or decrease.
- Measure the extent to which dental access and long-term oral health improves for low- and no income uninsured and underserved patients by conducting evaluations within a defined population, i.e. patients enrolled in a public dental assistance program.
- Control the costs of OHP education and dental services by not requiring a graduate degree for OHP licensure and by not limiting admission solely to dental hygienists.
- Preserve the quality of care by conducting rigorous studies that include the use of control groups, random chart audits and clinical examinations, within a blind review process.
- Protect patients from harm by requiring OHPs to submit their collaborative management agreements to the Board of Dentistry, requiring the Board to enforce statutes and rules regarding grounds for discipline similar to those applied to dentists, and by requiring long-term outcome evaluations of dental and medical complications resulting from care rendered by OHPs.
- The same fundamental aspects of regulated practice that must be met by other licensed or registered dental professionals must be met by the OHP.

Issues and Challenges

Patient Safety

Ensuring patient safety is the most important fundamental principle when considering the creation of a new dental worker. In Minnesota, all discussions began with this in mind, regardless of whether the issue on the table was scope of practice, education, or supervision: What would it take to ensure that patients treated by a new dental professional would receive safe, quality care regardless of the clinical practice setting?

We established the following core principles centered on patient safety if a mid-level dental practitioner were to perform surgical dental procedures:

- the patient should first have received a clinical examination, diagnosis and treatment plan by a licensed dentist;
- a licensed dentist must be on-site at the time such procedures are performed in the event of unforeseen complications, and
- extractions must be limited to erupted primary teeth.

In the end, we learned that there were ways to modify our position while still ensuring that patient safety was not jeopardized.

Cutting a tooth to prepare it for restoration is “surgery,” but we learned that that is not a universally held understanding among non-dental people. It was necessary to educate legislators, the public, and even other healthcare professionals to this fact. As we continuously referred to certain functions as “surgical” or “irreversible,” others viewed this as a “scare tactic.” Nevertheless, this language served to help others appreciate the significance of what was being proposed.

Our core principles were strongly opposed by those whose expressed purpose for creating a mid-level dental practitioner was to provide dental care in situations *where there was no dentist*. As dentists fully appreciate, if people have not received routine dental care – especially no preventive care – the care needed becomes far more complicated and costly. The nature of oral diseases is that they do not resolve over time: They get worse. Moreover, this population would also be much more likely to be medically compromised as well. Thus, the populations for whom care was most needed were those who would need the skills and expertise of dentists - not that of mid-level practitioners.

We repeatedly heard arguments against our position of patient safety based on the contention that other mid-level dental practitioners (dental therapists) have practiced safely in numerous countries all over the world for decades.⁹ Granted, their scopes of practice differ from place to place, but many do perform surgical dental procedures. Even in the United States there are examples of mid-level practitioners in other health professions who are performing “irreversible” procedures. The medical and nursing professions have been relying on physician assistants and nurse practitioners for many years, and many perform surgical procedures. When medical mid-level practitioners were first proposed years ago, medicine fought the change just as vigorously then as dentistry is fighting this idea now, a fact that was not lost on long-time Minnesota legislators, a few of whom had healthcare education and experience.

Indeed, supporters of the bill compared the creation of a mid-level dental practitioner to that of nurse practitioners and physician assistants. However, the practice acts governing those professionals are very dissimilar to the dental practice act.^{10, 11} Stated simply, those acts indicate that a properly credentialed advanced practice nurse or physician assistant may perform (a) whatever he or she has been taught in an accredited educational program and (b) whatever is delegated by the physician with whom he or she is employed or has a “collaborative management agreement (CMA).” (The CMA concept is discussed below.)

Scope of Practice

We learned early on that scope of practice and level of dentist supervision are inextricably intertwined: It is impossible to discuss one without the other.

A detailed list of functions was generated to encompass the procedures that (a) would most likely be needed by underserved patients, and (b) could reasonably be taught in a program shorter than a dentistry program. That process forced Minnesota dentists to closely re-examine long-held beliefs about what only a dentist is legally able to do:

1. Diagnose oral diseases;
2. Cut hard or soft tissues; and
3. Prescribe medications.

Discussions to determine what could safely be delegated were necessarily detailed because of the specificity of Minnesota's Dental Practice Act.¹² The only functions a Minnesota-licensed dentist may delegate to an allied dental professional are those listed in statutes or rules: If a function is not listed, it may not be delegated. The effort to use existing CDT (Current Dental Terminology) procedure billing codes to generate a list of possible functions served to further complicate an already difficult exercise.

Several provocative discussions were held when trying to determine what procedures a dental therapist should be allowed to perform. What we traditionally considered "dentist-only" procedures became less clear-cut when various conditions or scenarios were applied. For instance, if a mid-level dental practitioner is educated alongside dental students in a CODA accredited dental program, does that change what the DT may be allowed to perform? If the DT is required to practice a certain length of time under the direct or indirect supervision of a dentist, should that provide assurance that the limited scope of services rendered will be safe and equivalent to that provided by dentists? If prescribing is limited to only certain types of medications like analgesics, anti-inflammatories and antibiotics, would that provide adequate patient protection? Or, what if mid-level practitioners could only perform certain limited types of extractions? These mitigating circumstances - the "what if's" - helped shape the compromises leading to the final language in the Minnesota statute.

Early on, it was agreed by the MDA, the U of M and the health department's OHP workgroup that there was no need to include dental hygiene functions in the scope of practice for dental therapists. Educators viewed this as wise and, indeed, necessary: The dental therapy educational program would have to be longer if it had to include all of the dental hygiene functions along with the restorative and surgical dental therapy functions. Dental therapists and advanced dental therapists may perform only very basic preventive procedures which are already in the Minnesota Dental Practice Act for licensed dental hygienists and dental assistants – excluding scaling and other periodontal therapies. Thus, in Minnesota, a licensed dental therapist who also wishes to perform "traditional" dental hygiene procedures must obtain and maintain both a dental hygiene license and a dental therapist license.

Supervision by Collaborative Management Agreement

A collaborative management agreement (CMA) is a written and signed document that outlines the mutually agreed upon functions that the dental therapist can provide – within the legal scope of practice as provided in statute. Some have called it "paper supervision." From the very start of the ADHP legislation, the Safety Net Coalition declared that the proposed new dental worker would be under a dentist's supervision – without revealing that it would be "paper supervision" with no dentist on-site. The MDA strongly opposed the CMA on the basis that only indirect or direct supervision by a dentist would provide adequate patient protection when surgical dental procedures were performed.

The concept of a "collaborative management agreement" is comparatively new to dentistry, but has been around for a long time in medicine and nursing. Today it is well accepted in those professions, allowing nurse practitioners and physician assistants to function without a physician on-site, with considerable decision making authority and responsibility granted to those mid-level practitioners.

The components that must be included in a written CMA with a Minnesota-licensed dental therapist and an advanced dental therapist are found in Minnesota Statute 150A.105, Subd.3. (Appendix A) The 2009 statute requires the redundancy that a written collaborative management agreement be in place for dental therapists even though they can only practice under direct or indirect supervision of a dentist. The CMA becomes much more critical for the advanced dental therapist because a dentist need not be on-site when the ADT provides care.

Some procedures can be performed safely without a dentist on-site. For instance, Minnesota (like many other states) has “collaborative agreement” provisions under which qualified, experienced dental hygienists can provide necessary preventive care – including the use of local anesthesia – to underserved patients in the absence of a dentist outside of the traditional dental office.

Minnesota’s “collaborative dental hygiene practice” law was created in 2001, but to date, relatively few dentists and dental hygienists have entered such agreements. Many of these agreements have been formed by dental hygienists and dentists working for Health Partners (Minnesota’s large HMO). Despite MDA efforts to educate and communicate to our members how such collaborative practice works, the concept is little understood by dentists and even by hygienists. Perhaps the lack of understanding about collaborative agreements helped to cause Minnesota dentists to believe that the opponents wanted to practice totally independently - “to hang out their own shingle.” This may have paved the way for the MDA to fuel professional and public concerns about the proposed legislation.

In reality, dentists may exercise control over a collaborative agreement by determining the practice protocols and boundaries of such agreements, not to exceed the limits of the law. Whether such practice agreements in dentistry succeed will depend on well-written statutes and trust between the parties directly involved...not on the will, desire or needs of a mid-level dental practitioner, a managed care administrator or organization.

Role of the Dentist

Under the new statute dentists must diagnose and formulate treatment plans when delegating procedures to a dental therapist. Further, the dentist must provide either direct or indirect supervision when dental surgical procedures are performed by the DT, meaning that the dentist will have to be on-site at the time procedures are performed. This is particularly important if the therapist unexpectedly encounters a situation requiring expertise beyond their own limited scope of practice.

However, the role of the dentist may be different when supervising the advanced dental therapist. Here, the ADT practices under general supervision of a dentist within the parameters of the collaborative management agreement. According to statute, the dentist need not be on-site when the ADT performs dental procedures (including surgical). However, the dentist must authorize the care that the ADT intends to provide each individual patient. Treatment and practice boundaries are determined not only by statute, but further delineated in the written collaborative management agreement. Since it is the dentist who is ultimately responsible for the care rendered by the DT or the ADT, dentists have the discretion to use their own judgment about which procedures they delegate and under what circumstances.

Certainly, there are concerns about liability that dentists must be aware of, regardless of whether the mid-level practitioner carries his or her own malpractice insurance. Mandatory liability coverage was discussed as the legislation was crafted, but is not currently in statute for either dentists or allied dental professionals. The very idea that the dentist will be held responsible for surgical procedures--the need for which may not have been personally diagnosed by the dentist and will be performed in the absence of the dentist—brings forth challenging questions that are certain to be faced by mid-level practitioners and their dentist employers.

Dentists who are likely to be first to hire dental therapists and advanced dental therapists are those outside of private practice, that is, those in community or public health clinics and those in large managed care organizations (as we have already seen with the collaborative agreements

with dental hygienists). The 2009 law limits where a dental therapist may practice. The law also allows dental therapy practice in non-defined areas if at least 50 percent of the dental therapist's patient load – not 50 percent of the dentist's patient load - consist of underserved people as defined in statute.¹³ Dentists in private practice – particularly those in rural areas and those who serve patients on public dental assistance programs – may wish to find ways to utilize these new allied professionals. For example, dental therapists may help meet rural dentists' needs where recruiting a dentist associate becomes difficult. Perhaps dental therapists can be “shared” by more than one dentist, thereby ensuring that the individual dental therapist's patient load meets the 50 percent minimum of underserved patients.

Education

As noted previously, dental hygiene professionals and educators had been planning an “advanced dental hygiene practitioner” education program for the past several years. Metropolitan State University in St. Paul, Minnesota, now offers a master of science degree in dental therapy, which it calls its Oral Health Care Practitioner Program, and requires that an applicant be licensed as a dental hygienist for admission to the program. Completion of that master's program (along with other statutory requirements) will allow the graduate to become licensed as a dental therapist.¹⁴

The dental therapy program at the University of Minnesota School of Dentistry will admit high school graduates (and those who have completed college credits) who meet certain admissions criteria - they are not required to be dental hygienists. That program will offer both a baccalaureate and a master's degree in dental therapy. Regardless of whether one graduates with a baccalaureate or masters degree, the graduate will only be licensed as a dental therapist.¹⁵

Legislation dictates only the conditions for licensure: It does not determine curricula for educational programs. In Minnesota, the advanced dental hygiene practitioner program was well into the planning stages (not implementation) before legislation was introduced. It was necessary for the Dental Practice Act to be changed not so that the program could be taught, but so that future graduates could practice as mid-level dental practitioners. At this point, further discussion is needed with the Board of Dentistry to determine what additional education will be needed in order for the board to grant the certification necessary to practice as an advanced dental therapist. This issue has become controversial as faculty and administrators from the Metropolitan State University program contend that the statute allows students who graduate from their “oral health practitioner” masters program to become certified as advanced dental therapists. Those involved with the actual drafting of the legislation contend that the statute requires training for dental therapy and advanced dental therapy to be sequential – not concurrent. Again, revisiting what was enacted in 2009 may be necessary in 2010 or beyond.

Until and unless other states change their dental practice acts, the graduates of these dental therapy programs will be legally able to practice only in Minnesota.

Program Accreditation

The MDA took the position that surgical dental procedures should only be taught in a dental program that is accredited to teach such procedures, and that the accreditation must be granted by the Commission on Dental Accreditation. Our rationale was that the program would have proper faculty, curricula and facilities to ensure that the education was commensurate with that of dentists, as these new practitioners would be performing a limited set of procedures previously taught only to dental students. When dental therapists are educated alongside dentists, not only is the quality of education assured to be the same, but the two are more likely to be mutually respectful of their clinical skills and abilities to work as a team.

The resulting Minnesota statute does not, however, require exclusively that programs in dental therapy be accredited by CODA. Rather, the law states that one must graduate from a “dental

therapy education program that has been approved by the board [of dentistry]" or accredited by the ADA's CODA or another board-approved national accreditation organization. At this point, CODA has not established criteria for accrediting dental therapy programs, but that may be in process. In the meantime, it is up to the Minnesota Board of Dentistry to determine the criteria for program accreditation.

Licensure Requirements

To obtain a dental therapy (DT) license in Minnesota (Appendix A), one must meet all of the following requirements:

- Graduate with either a baccalaureate or master's degree from a dental therapy education program that is accredited either by the Board of Dentistry, CODA or another board-approved national accreditation organization;
- Pass a comprehensive, competency-based clinical examination that is approved by the Board, and that is administered independently of an institution that provides dental therapy education;
- Pass an examination testing the applicant's knowledge of the Minnesota laws and rules relating to the practice of dentistry (the "jurisprudence exam").

To practice as an advanced dental therapist (ADT), one must meet all of the qualifications listed above – be licensed as a dental therapist - and obtain certification in advanced dental therapy from the Board of Dentistry. (Appendix A) Those requirements include:

- Completing 2,000 hours of dental therapy clinical practice under direct or indirect supervision;
- Graduating from a master's advanced dental therapy education program;
- Passing a board-approved certification examination to demonstrate competency under the advanced scope of practice, and
- Submitting an application for certification.

Minnesota's dental therapists and advanced dental therapists need to complete essentially the same basic licensure requirements as other dental professionals regulated by the Board of Dentistry. In addition to initial licensure and renewal fees, continuing education requirements after licensure, and being subject to discipline based on the same grounds for all other dental professionals.

It is necessary to hold a separate license if one wishes to practice as a dental hygienist. That is also true for dental therapists or advanced dental therapists: A dental therapist may not provide dental hygiene functions unless he or she holds a current license in dental hygiene. The therapy and hygiene scopes of practice remain separate and distinct.

Patients of a Dental Therapist

Introduced as a measure to address dental access, the legislation contains definitions of practice settings where dental therapists and advanced dental therapists may treat patients, along with criteria regarding patients they may treat.

Specifically, these new dental practitioners may work in practice settings that serve low-income and underserved populations including:

- private and public "safety net" practices that provide most of the care to those on public assistance programs, i.e. special designation as "critical access dental providers;"
- places already defined in the "Limited Authorization for Dental Hygienists" statutes (such as nursing homes, Head Start programs, nonprofit organizations, correctional facilities, school- and community clinics), along with medical facilities, assisted living facilities, federally qualified health centers, and any organization eligible to receive a community clinic grant as defined by Minnesota statute;
- military and veterans administration hospitals, clinics and care settings;

- a patient's home or residence when the patient is home-bound or receiving or eligible to receive home care services or home and community-based waived services regardless of the patient's income;
- oral health educational institutions;
- practices located in a dental health professional shortage area; or
- any other clinic or practice setting, including mobile dental units in which at least 50 percent of the dental therapist's total patient base consists of patients who meet the criteria below.

The statute defines "underserved" patients as those who:

- are enrolled in a Minnesota health care program;
- have a medical disability or chronic condition that creates a significant barrier to receiving dental care;
- do not have dental health coverage, either through a state public health care program or private insurance, and whose family gross income is equal to or less than 200 percent of the federal poverty guidelines.

The MDA wanted to ensure that private practice dentists who wanted to employ a DT or an ADT could do so. Many dentists across Minnesota provide care to underserved patients, but do not meet the state's percentage criteria (20%, as set by the Minnesota Department of Human Services) to be designated as "critical access dental providers," (even though those dentists may indeed be the sole "critical access dental provider" for their rural community!) It was important to specify that the 50 percent patient base was that of the dental therapist – not that of the dentist. In this way, a DT or an ADT could be shared by several dentists and allow them to help address the access problem in their own practices.

Financial Considerations

This topic received less discussion throughout the process than any other, presumably because it was the most difficult to understand and define. One assumption that continues to date is that the DT or ADT will earn a salary that falls between that of a dentist and dental hygienist. Another possibility that has been mentioned is that the reimbursement for services provided by the new practitioner to enrollees in public programs will be lower than that provided to dentists for the same services.

One scenario assumed that the new mid-level practitioner would be practicing independently, having to start from scratch their own practice as some dentists do. Financial scenarios showed clearly that the mid-level practitioner would encounter the same woes as dentists because of high overhead and low reimbursement for public assistance patients.

In the end, the law requires that at least 50 percent of the dental therapist's patient base consist of those from underserved populations as defined in statute.

Outcome Measures

The Board of Dentistry is required to evaluate the use of dental therapists on the delivery of and access to dental services. Appendix C shows the outcome measures listed in statute. It is reasonable to assume that other organizations, particularly professional dental associations and educational institutions will want to design long-term studies to better understand the impact of a new dental worker not only on patient utilization of services, but on access to care and on patients' oral health status.

Public Relations

Media Relations

Throughout the 2009 legislative session, the MDA worked proactively, utilizing a local public relations consulting firm, to create public awareness of the MDA's position regarding a new mid-level dental practitioner. Several press releases, opinion editorials and letters-to-the-editor from member dentists were used to geographically target messages to media outlets, especially those in districts of key legislators. While media coverage was widespread throughout the state, the most frequent coverage occurred in Rochester, Minnesota (Post Bulletin), home district of the authors of both the OHP bill (Senator Ann Lynch) and the dental therapist bill (Representative Kim Norton). This unique situation of dueling legislators from the same district made for interesting media fodder and colorful (generally well-balanced) reporting.

Media Strategy

In an attempt to be as proactive as possible in getting statements out to the public during key junctures of the legislative process, the MDA used various media approaches. Some approaches were more successful than others in terms of story placements, but in general the media were aware of the legislation and eager to present both sides of the controversy to readers. Therefore, even when pitches were made by the OHP proponents, media would generally contact the MDA for a position statement and/or interview with a spokesperson. For this reason, we found it very helpful to have prepared spokespersons that were well versed in the legislation (usually a member of the leadership team or legislative task force). Throughout the session, position statements, talking points, and spokesperson coaching were utilized to help prepare this group for media interviews.

The following approaches were used at various stages of the legislative process:

- *Pitches for Editorial Meetings:* Mainly used early in the session in an attempt to educate editors in key markets about the mid-level dental practitioner legislation. At this early stage, all editors declined our offer, feeling that the issue had already been adequately covered (during the previous year's session). These media outlets all ran stories at a later date, though, when the debate became more heated and, therefore, more newsworthy to them.
- *Press Releases:* Used primarily to issue position statements at the beginning and end of the session. We also assisted with drafting releases on behalf of our bill's authors in the House and Senate. While the releases were seldom used as a stand-alone story, we often referred media to these releases (posted on our website), which they would usually incorporate into a larger story they were publishing.
- *Opinion Editorials:* Used to present opinions by MDA and other dental community leaders, either in support of the dental therapist legislation as the best plan for Minnesota or to oppose the OHP plan. Unfortunately, depending on timing, these op-eds were sometimes ignored by a media outlet that had been targeted, requiring us to change strategy and resubmit elsewhere. In the end, we did get op-eds published, but not always where and when we preferred.
- *Letters to the Editor:* MDA member dentists were engaged to write letters to the editor of their local papers throughout the session. Templates of letters with key messages were offered to dentists in targeted media markets, sometimes in response to a previously published article or letter by the OHP proponents. Members were very receptive to submitting a letter to their local papers, especially if we personally contacted them with a request to do so.

Strategy Results

Media coverage of the mid-level dental practitioner debate was widespread throughout the 2009 legislative session. Dozens of stories appeared in newspapers, TV broadcasts, websites and blogs in Minnesota. In addition, the legislation was followed closely nationally, with stories regularly appearing in ADA News, as well as other dental specialty and dental education journals. To track coverage, the MDA subscribed to a news clipping service and posted links to all news articles on the association's website for members and others to review throughout the session.

Special Advertising Campaign

For several months in 2009 the MDA engaged in a public relations campaign (press releases, media interviews, etc.) to deliver a message to the general public and key legislators about the serious implications of the proposed oral health practitioner legislation. While we were able to gain ground and the ears of some legislators, it was not clear whether the general public had a good enough understanding of the differences between the OHP and the MDA-supported dental therapist proposals and how the outcome could impact their own dental care. Therefore, approximately one month prior to the end of the '09 legislative session, the MDA made the determination that an aggressive statewide advertising campaign was the best way to reach a broader audience about what was at stake.

Campaign Strategy

The ad campaign was designed to be edgy and attention-grabbing, with the hope of creating a public outcry about the potential dangers of the OHP legislation, (harkening back to our concerns about patient safety). The intended outcome was for the public to contact their legislators and insist that any legislation passed would include specific patient safety parameters (in particular, dentist supervision of surgical procedures and education at an accredited dental school).

Therefore, the key message and call-to-action in the ad was:

Call your local legislators today and tell them that unsupervised workers doing dental surgery is a bad idea. The ad was referred to as the "uh-oh" campaign, in reference to the attention-grabbing headline: *The last thing you want to hear when getting dental care is "uh-oh."* The visual under the headline was a close up of a male patient, lying back in a vulnerable position, with dental instruments in his mouth. (Appendix B)

Risks and Benefits of a Public Appeal

Utilization of any type of issues campaign carries inherent risks, along with the intended benefits. Much discussion occurred between MDA leadership, public affairs consultants, and lobbyists about the expected outcome of the campaign. In the end, it was determined that the benefits of such a campaign outweighed any potential negative consequences. Below are some of the areas of consideration that were debated:

Potential Benefits

- Greater public awareness of the pending legislation
- Better understanding by the public of how legislation could affect their family
- MDA member dentists would see efforts being made to prevent passage of the OHP bill
- Public concern about Minnesota's high-quality health care being compromised
- Realization that tooth extractions could be performed by an unsupervised dental worker
- Public outcry from constituents to their legislators
- Potential change in position of key legislators

Potential Negative Consequences

- Would look like turf-guarding by dentists, eroding professional image
- Would be viewed as using scare tactics to unnecessarily frighten public

- Could appear desperate
- Cost of advertising could be criticized by public and member dentists
- Public might not still understand the issue well enough to communicate to legislators
- Not enough people would actually call legislators to have an adequate impact
- Might appear to legislators as a lack of cooperation from the dental community
- Might incite opposition to take public action, escalating the on-going war of words

Media Components

The major advertising campaign ran for eight days during the 2009 session, using radio and print newspaper ads in major Minnesota markets, including Minneapolis/St. Paul, Duluth, Rochester, Saint Cloud and the Iron Range (northern Minnesota).

Radio Ads

The radio ads were 60 second spots that began with the sound of a dental drill and the lead-in phrase: "The last thing you want to hear when getting dental care is 'uh-oh.'" The call to action was for listeners to contact their legislator and tell them that unsupervised workers doing dental surgery is a bad idea. A phone number for the general information line at the state legislature was provided so listeners could call to locate their legislator.

Newspaper Ads

The print ads were a combination of half-page and full-page ads that ran in key media markets. The headline (in very large type) was: "The last thing you want to hear when getting dental care is uh-oh." The visual was a close up of a male patient's face, with dental instruments in his mouth.

The print ads had quite an impact resulting in nearly instantaneous response by the public and the media. The phone number listed on the ads for the Minnesota Dental Association was a special voice mail box established for this campaign, so as not to overwhelm the normal association phone lines. Messages left in this mail box were mixed: some were angry about what they referred to as "alarmist, inflammatory, and dishonest" tactics being used and others were quite concerned about the legislation being proposed and promised to contact their legislators.

When members of the public contacted the MDA through the association's regular phone number, guidelines for triaging calls were established to assist the phone receptionists with directing calls to the appropriate MDA staff person. While we felt well prepared to handle any number of calls that might come in this way, the number of calls was minimal.

Web Ads

Banner ads were also placed on three major Twin Cities media websites: Star Tribune.com, WCCO.com, and KARE11.com. These ads linked back to the MDA website*, with more detailed information about the legislation, including facts sheets and the print and radio ads. Over a 12 day period, there were 900 hits to this page.

Facebook

As a further way to spread the word among the general public, the popular social networking site Facebook was employed. A special fan page was created on Facebook for the "Uh-oh" campaign with information about the legislation and a link back to the MDA website.

<http://www.facebook.com/home.php?ref=home#/pages/Uh-oh-is-not-what-I-want-to-hear-when-getting-dental-care/82575026453?ref=mf>

Results of Special Appeal to the Public

While difficult to accurately assess the effect of advertising, including pre- and post-awareness and opinion ratings (without doing qualitative surveys, which time and budget didn't allow), the overall effect was a significant increase in attention to the issue with key audiences. The media began calling almost immediately asking for information about the purpose of the campaign and requesting interviews; several newspapers ran stories, including an Associated Press story that was widely distributed in both print and electronic media. In anticipation of such response, the MDA did spokesperson training with six members of the leadership team, providing them with fact sheets and answers to anticipated questions.

While most post-campaign media stories gave balanced views about the two sides to the controversial legislation, the Minneapolis Star Tribune printed an editorial opinion piece¹⁶ in favor of the opponents' oral health practitioner legislation as a solution to the dental access crisis in our state. While disappointing to have such an influential newspaper take this position, we were pleased that the paper offered us the opportunity to publish a counterpoint editorial, which ran concurrently with their op-ed piece.

Legislators also began to pay closer attention following the ad campaign. Many received calls from their constituents, resulting in the desire to talk further with our lobbyists. While some lobbyists were initially skeptical about the value of the ad campaign (especially with the potential risks involved), the campaign actually became a turning point in legislative negotiations, ultimately leading to a significant change in the language of the bill—in our favor!

Legislative Initiatives and Challenges

Legislative Initiatives With MDA Members

Actively engaging members in all phases of the legislative debate was always a critical element of our overall strategy. It was extremely important that members understood what was happening at the legislature, what the MDA's position was and why we were making various decisions. While many members were initially very angry, or at best skeptical, about the proposed mid-level practitioner legislation, we found that providing them with continual updates, engaging them in discussions, and asking for their involvement in grassroots lobbying were vital components in garnering their support.

Legislative Communications

The MDA provided regular and frequent updates to members utilizing print and electronic methods:

- *Newsletters:* *MDA News*, a print newsletter, and *MDA News & Views*, an electronic newsletter, were used regularly to provide updates about legislative proceedings, status of bills, and other important developments.
- *Legislative Alerts:* Members were encouraged to sign up for an online legislative alert system (powered by CapWiz and embedded in the MDA website) in order to stay up-to-date on legislative proceedings. This automatic alert system would send messages to all enrollees at critical junctures, asking them to contact their legislators by phone or email and encourage them to vote for or against an upcoming bill. Templates of letters and contact information for their legislators were provided to make the process as simple as possible for members. It was even used to target specific committees and legislators.
- *MDA Website:* The MDA website included legislative issues briefs, weekly updates with status of bills, information on grassroots efforts, important news items, past issues of newsletters, and links to media news clips. This section of the newsletter was password-restricted, thus allowing us to post confidential information that could be accessed by members at any time.

Meetings With MDA Members

The MDA worked diligently to engage members by holding face-to-face meetings with the general membership and MDA leaders.

The MDA's OHP Task Force

A special MDA task force of 11 dentists and one dental student had been formed at the end of the 2008 legislative session when the statute was enacted mandating the Board of Dentistry to license "oral health practitioners." That '08 statute required the Minnesota Department of Health to convene a special workgroup to make recommendations about the OHP scope of practice, educational standards, and so forth. The purpose of the MDA task force was not only to monitor the work of the health department's workgroup, but also to help the MDA establish its own core principles and to provide guidance to the two MDA members appointed to the OHP Workgroup. Our task force, consisting of MDA members, representatives of dental specialty groups, and the University of Minnesota School of Dentistry, continued throughout the 2009 session, serving as an advisory board for the MDA.

MDA Leadership Conferences

The MDA held two leadership conferences specifically to deal with the OHP: One in November 2008 when the health department's OHP Workgroup concluded its work, and another midway through the 2009 legislative session in March. That one focused on safety net dentists' concerns. MDA and district officers, trustees, committee chairs, and officers of several dental specialty organizations attended our Leadership Conferences. The meetings provided an opportunity for

leaders to learn more about the status of the legislation, ask questions, provide feedback and, most importantly, bring information back to their district members.

District Meetings

Over a dozen meetings were held across the state to bring our message directly to the membership. Grassroots meetings were held in key cities, and with most of our district societies. These meetings gave us an opportunity to address and alleviate the fears that many had regarding a new mid-level practitioner. We were able to demonstrate that we had thoroughly thought this through and had determined the core set of principles with which the membership was generally in agreement. While there often was hesitancy at the beginning of these meetings, they always concluded with a great deal of positive discussion and questions, as well as a better understanding of the topic and support of the MDA's direction and leadership.

Grassroots Lobbying in 2009

Our highest priority was ensuring that our members had the right information and were relaying it to their legislators. We are very proud of the fact that on a daily basis we heard from legislators who had been contacted by dentists in their district. In addition to printed and electronic Legislative Alerts, CapWiz and other communications, our grassroots efforts included:

- *2009 Dental Day at the Capitol:* Nearly 150 dentists and dental students met at the Capitol to discuss this issue face to face with their elected officials. This was the largest Dental Day at the Capitol that we had ever had and members were very enthusiastic about how receptive legislators were.
- *2009 Star of the North Meeting:* This is the largest annual gathering of dentists and dental health professionals in the state, so during this three-day event a special meeting was held to update members on our progress. In addition, nearly 1,200 dentists, hygienists and dental assistants signed a large petition board opposing the OHP. We also had computer terminals and printers available so that dentists, hygienists, assistants and others opposing the OHP could choose from several different paragraphs to personalize a letter to their elected officials, quickly print it off and sign it. Over 300 letters were then mailed to state legislators.
- *Patch-thru Phone Calls:* A telemarketing company was hired to conduct scripted patch-thru phone calls to constituents in 28 targeted legislative districts. The goal was to call a constituent, get them concerned about the OHP language, and encourage them to talk to their legislator. The operator would then give them a sample message to give to their legislator and would patch them directly through to the legislator's office. A total of 1500 patch-thru calls were competed to 28 legislators giving each of them roughly 50 calls from constituents in their districts.

Lobbying Campaign

Our lobbying campaign was an aggressive effort that employed staff and contract lobbyists utilizing a divide-and-conquer approach to ensure all key legislators were repeatedly contacted throughout the session. With the OHP proponents' lobbyists also aggressively working these same legislators, it was extremely important to be ahead of the curve at all times in order to overcome the many challenges we faced.

Key Challenges

There were many factors to be overcome in order to create a successful lobbying campaign, including:

- *Democratic-controlled House and Senate:* Both the Minnesota House of Representatives and Minnesota Senate are controlled by the Democratic party (DFL) by nearly a two-thirds margin. While there is a Republican Governor, we knew that we would have to work within the DFL caucuses in order to be successful.
- *Legislative determination to solve access problem:* Many legislators were determined to pass some sort of mid-level practitioner legislation in order to solve a perceived severe dental access problem, especially in low-income and rural areas of the state. Due to a very significant budget deficit, there was absolutely no way a bill could pass that would have required taxpayer funding. From legislators' perspectives, passing *anything* related to "dental access" would be perceived as a win-win situation. While we could have challenged their perceptions of an access problem, we instead chose to focus on the education, scope and supervision of a mid-level practitioner.
- *Perception of dentists' uncooperativeness:* The most significant obstacle that we overcame in 2009 (from the 2008 session) was that we were unwilling to compromise on any new dental worker legislation: A "just say no" approach clearly was not going to work. Even though we had support from key legislators, ultimately we were told that had we had only two choices: Come to the table ready to compromise, or step away from the battle. Because we were now coming forward with a solution and proactively supporting legislation that would create a mid-level practitioner (as proposed at the University of Minnesota), legislators were very appreciative of how the MDA was on board with something that they could consider supporting.
- *Need to build a support coalition:* We needed to significantly strengthen our coalition to offset what the other side was doing. The hygienists/safety net /MNSCU/HMO group had built a larger coalition of lobbyists that outnumbered our group by a 2 to 1 margin. Our coalition included the University of Minnesota School of Dentistry and the Minnesota Dental Assistants Association, providing a unified approach that gave all of us on the dental therapist side enhanced credibility.
- *Two disparate proposals:* Because there were two significantly different and complicated proposals being introduced – the University of Minnesota dental therapist approach that we supported and the OHP Workgroup bill that we strongly opposed – we had to work tenaciously for one and against the other.
 - In the Senate, the legislator leading the fight for the OHP was a very tenacious hard charger (Sen. Ann Lynch). She was determined to pass her bill regardless of the testimony given against it. In order to counter her, we had to find moderate Democrat legislators to author our DT bill. In the House we found a true champion who let the coalition lead on the strategy of the fight (Rep. Kim Norton), but really took the initiative herself to lobby her peers on behalf of the dental therapist bill.
 - Since there was no opposition to our bill, we spent the majority of our time pointing out the flaws in safety, supervision and education in the other bill.
 - Since the Senate and a number of its committees were stacked against us, we made numerous challenges to the scope and supervision contained in the OHP bill. We lost several tie votes in committee and by only two votes in the full Senate to make vital parts of the OHP language mirror the dental therapist program. These unexpectedly close calls were what began to slowly erode the confidence of the other side.
- *Negative perception of dentists:* A major obstacle to overcome was from legislators who were critical of dentists who do not take medical assistance patients. The perception of

rich doctors who only work four days a week and drive BMW's was a common theme with legislators. We had to work very hard to demonstrate that in addition to dentists paying a 2% provider tax to pay for various state programs, they also provided a great deal of free and reduced-cost oral health care to the public. One of the strategies we used was to get safety net dentists to testify in opposition to the OHP bill – and against some of their fellow safety net coalition members.

- *Success of other countries' mid-level providers:* A significant argument used by the OHP proponents was that mid-level dental practitioners have been used in 50 other countries with little or no negative impact. Between May and September 2008, two MDA representatives went to Canada, New Zealand and England with at most ten others, with the trips being organized and led by the University of Minnesota School of Dentistry. The purpose was to get an in-depth, firsthand, accurate assessment of how dental therapists are educated and utilized in the work force. The primary messages learned from these trips were: oral health statistics were not improving as a result of mid-level providers; without a dental school-based program, dentists did not embrace dental therapists; educating dental therapy students with dental students creates a professional partnership; and having the dentist "on site" builds patient confidence and trust in dental therapists. In addition, it was also very clear that what the OHP legislation proposed for Minnesota was much more aggressive than what was being done anywhere else in the world.

Political Decisions and Final Negotiations

Throughout the entire 2009 session, it was apparent that the OHP language had strong support in the Senate and that their plan was to pass both the OHP and the Dental Therapist bills. The MDA's coalition felt confident, however, that if this came to a full House of Representatives vote our side would be successful in defeating the OHP language and passing the U of M's dental therapist bill alone. Therefore, the House author of the OHP bill did not call for a floor vote.

Toward the end of the session, however, leadership in both bodies began to get more active in this debate. Since such a large divide was opening up in the DFL party, and the Republicans were ready to exploit it, the Speaker of the House demanded that the two sides get together and come up with compromise language that would put forward just one bill instead of the two that were moving. Although the MDA had garnered the support of key legislators to "just say 'No,'" they later pulled back their support and advised us to be at the table or to step out of the way.

In addition, as a final push, the House Chairman of the Omnibus Higher Education Committee threatened to put both the OHP and DT language in the Omnibus bill – despite the fact that the House had never had the opportunity to discuss the topic. At one point during this particular hearing he even pointed to the MDA lobbyists and said, "work this out or this is what you will end up with."

After a number of failed negotiation meetings, the first between representatives of the two sides and the second between legislators for the two sides, the MDA was approached by the Safety Net lobbyist with a good first step toward an agreement. After 24 hours of going back and forth with this initial offering, we came to an agreement. The agreement language was rolled into the Omnibus Higher Education bill, passed and debated with little fanfare, and signed into law by the Governor in May 2009.

Unresolved Issues

There are two issues that have arisen since the passing of this bill that give the MDA cause for concern and that we continue to work on.

- *Advanced Dental Therapist*: As part of the final negotiations, it was determined that the educational institutions, the MDA and the Minnesota Board of Dentistry would work out the implementation of educating the *advanced* dental therapist. Regrettably, by all indications, Metropolitan State University has decided to go ahead and teach the OHP program (formerly called the advanced dental hygiene practitioner “ADHP”) they had been meaning to teach all along. Indeed, the American Dental Hygienists’ Association has generated much publicity about “succeeding” to create an ADHP in Minnesota, but in fact, Minnesota’s law is very different from the original ADHP legislation proposed in 2007.
- *Sequential advancement*: Metropolitan State is also planning to teach the ADT and DT programs concurrently. This clearly violates the compromise agreement for sequential educational programs, which would require a dental therapist to have 2000 clinical hours before becoming an advanced dental therapist. Fortunately, at the September 25, 2009 public Board of Dentistry meeting, the Board successfully passed a motion to require that the two programs be taught sequentially. To date, we have not learned how Metro State will modify their program to satisfy the Board’s requirement.

While we are disappointed in the concept of the advanced dental therapist and the weak interpretation of the sequencing question, we believe that the dental therapist language meets 80% of the MDA’s required principles.

Our goal is to continue to work with the educational entities to ensure that high quality graduates enter the dental workforce, and that this law is implemented in a way that will protect the public and work as one of the tools to reduce the access problem.

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List of Abbreviations

ADA	American Dental Association
ADHA	American Dental Hygienists Association
ADHP	Advanced Dental Hygiene Practitioner
ADT	Advanced Dental Therapist
CMA	Collaborative Management Agreement
CODA	Commission on Dental Accreditation (of the ADA)
DT	Dental Therapist
MDA	Minnesota Dental Association
MDH	Minnesota Department of Health
MNDHA	Minnesota Dental Hygienists Association
MNSCU	Minnesota State Colleges and Universities
OHP	Oral Health Practitioner

150A.105 DENTAL THERAPIST.

Subdivision 1. **General.** A dental therapist licensed under this chapter shall practice under the supervision of a Minnesota-licensed dentist and under the requirements of this chapter.

Subd. 2. **Limited practice settings.** A dental therapist licensed under this chapter is limited to primarily practicing in settings that serve low-income, uninsured, and underserved patients or in a dental health professional shortage area.

Subd. 3. **Collaborative management agreement.** (a) Prior to performing any of the services authorized under this chapter, a dental therapist must enter into a written collaborative management agreement with a Minnesota-licensed dentist. A collaborating dentist is limited to entering into a collaborative agreement with no more than five dental therapists or advanced dental therapists at any one time. The agreement must include:

- (1) practice settings where services may be provided and the populations to be served;
- (2) any limitations on the services that may be provided by the dental therapist, including the level of supervision required by the collaborating dentist;
- (3) age- and procedure-specific practice protocols, including case selection criteria, assessment guidelines, and imaging frequency;
- (4) a procedure for creating and maintaining dental records for the patients that are treated by the dental therapist;
- (5) a plan to manage medical emergencies in each practice setting where the dental therapist provides care;
- (6) 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;
- (7) protocols for administering and dispensing medications authorized under subdivision 5, and section 150A.106, including the specific conditions and circumstance under which these medications are to be dispensed and administered;
- (8) criteria relating to the provision of care to patients with specific medical conditions or complex medication histories, including requirements for consultation prior to the initiation of care;
- (9) supervision criteria of dental assistants; and
- (10) a plan for the provision of clinical resources and referrals in situations which are beyond the capabilities of the dental therapist.

(b) A collaborating dentist must be licensed and practicing in Minnesota. The collaborating dentist shall accept responsibility for all services authorized and performed by the dental therapist pursuant to the management agreement. Any licensed dentist who permits a dental therapist to perform a dental service other than those authorized under this section or by the board, or any dental therapist who performs an unauthorized service, violates sections 150A.01 to 150A.12.

(c) Collaborative management agreements must be signed and maintained by the collaborating dentist and the dental therapist. Agreements must be reviewed, updated, and submitted to the board on an annual basis.

Subd. 4. **Scope of practice.** (a) A licensed dental therapist may perform dental services as authorized under this section within the parameters of the collaborative management agreement.

(b) The services authorized to be performed by a licensed dental therapist include the oral health services, as specified in paragraphs (c) and (d), and within the parameters of the collaborative management agreement.

(c) A licensed dental therapist may perform the following services under general supervision, unless restricted or prohibited in the collaborative management agreement:

- (1) oral health instruction and disease prevention education, including nutritional counseling and dietary analysis;
- (2) preliminary charting of the oral cavity;
- (3) making radiographs;
- (4) mechanical polishing;
- (5) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;
- (6) pulp vitality testing;
- (7) application of desensitizing medication or resin;
- (8) fabrication of athletic mouthguards;
- (9) placement of temporary restorations;
- (10) fabrication of soft occlusal guards;
- (11) tissue conditioning and soft relines;
- (12) atraumatic restorative therapy;
- (13) dressing changes;

- (14) tooth reimplantation;
- (15) administration of local anesthetic; and
- (16) administration of nitrous oxide.

(d) A licensed dental therapist may perform the following services under indirect supervision:

- (1) emergency palliative treatment of dental pain;
- (2) the placement and removal of space maintainers;
- (3) cavity preparation;
- (4) restoration of primary and permanent teeth;
- (5) placement of temporary crowns;
- (6) preparation and placement of preformed crowns;
- (7) pulpotomies on primary teeth;
- (8) indirect and direct pulp capping on primary and permanent teeth;
- (9) stabilization of reimplanted teeth;
- (10) extractions of primary teeth;
- (11) suture removal;
- (12) brush biopsies;
- (13) repair of defective prosthetic devices; and
- (14) recementing of permanent crowns.

(e) For purposes of this section and section 150A.106, "general supervision" and "indirect supervision" have the meanings given in Minnesota Rules, part 3100.0100, subpart 21.

Subd. 5. **Dispensing authority.** (a) A licensed dental therapist may dispense and administer the following drugs within the parameters of the collaborative management agreement and within the scope of practice of the dental therapist: analgesics, anti-inflammatories, and antibiotics.

(b) The authority to dispense and administer shall extend only to the categories of drugs identified in this subdivision, and may be further limited by the collaborative management agreement.

(c) The authority to dispense includes the authority to dispense sample drugs within the categories identified in this subdivision if dispensing is permitted by the collaborative management agreement.

(d) A licensed dental therapist is prohibited from dispensing or administering a narcotic drug as defined in section 152.01, subdivision 10.

Subd. 6. **Application of other laws.** A licensed dental therapist authorized to practice under this chapter is not in violation of section 150A.05 as it relates to the unauthorized practice of dentistry if the practice is authorized under this chapter and is within the parameters of the collaborative management agreement.

Subd. 7. **Use of dental assistants.** (a) A licensed dental therapist may supervise dental assistants to the extent permitted in the collaborative management agreement and according to section 150A.10, subdivision 2.

(b) Notwithstanding paragraph (a), a licensed dental therapist is limited to supervising no more than four registered dental assistants or nonregistered dental assistants at any one practice setting.

Subd. 8. **Definitions.** (a) For the purposes of this section, the following definitions apply.

(b) "Practice settings that serve the low-income and underserved" mean:

(1) critical access dental provider settings as designated by the commissioner of human services under section 256B.76, subdivision 4;

(2) dental hygiene collaborative practice settings identified in section 150A.10, subdivision 1a, paragraph (e), and including medical facilities, assisted living facilities, federally qualified health centers, and organizations eligible to receive a community clinic grant under section 145.9268, subdivision 1;

(3) military and veterans administration hospitals, clinics, and care settings;

(4) a patient's residence or home when the patient is home-bound or receiving or eligible to receive home care services or home and community-based waived services, regardless of the patient's income;

(5) oral health educational institutions; or

(6) any other clinic or practice setting, including mobile dental units, in which at least 50 percent of the total patient base of the dental therapist or advanced dental therapist consists of patients who:

(i) are enrolled in a Minnesota health care program;

(ii) have a medical disability or chronic condition that creates a significant barrier to receiving dental care;

(iii) do not have dental health coverage, either through a public health care program or private insurance, and have an annual gross family income equal to or less than 200 percent of the federal poverty guidelines; or

(iv) do not have dental health coverage, either through a state public health care program or private insurance, and whose family gross income is equal to or less than 200 percent of the federal poverty guidelines.

(c) "Dental health professional shortage area" means an area that meets the criteria established by the secretary of the United States Department of Health and Human Services and is designated as such under United States Code, title 42, section 254e.

History: 2009 c 95 art 3 s 24

150A.106 ADVANCED DENTAL THERAPIST.

Subdivision 1. **General.** In order to be certified by the board to practice as an advanced dental therapist, a person must:

- (1) complete a dental therapy education program;
- (2) pass an examination to demonstrate competency under the dental therapy scope of practice;
- (3) be licensed as a dental therapist;
- (4) complete 2,000 hours of dental therapy clinical practice under direct or indirect supervision;
- (5) graduate from a master's advanced dental therapy education program;
- (6) pass a board-approved certification examination to demonstrate competency under the advanced scope of practice; and
- (7) submit an application for certification as prescribed by the board.

Subd. 2. **Scope of practice.** (a) An advanced dental therapist certified by the board under this section may perform the following services and procedures pursuant to the written collaborative management agreement:

- (1) an oral evaluation and assessment of dental disease and the formulation of an individualized treatment plan authorized by the collaborating dentist;
- (2) the services and procedures described under section 150A.105, subdivision 4, paragraphs (c) and (d); and
- (3) nonsurgical extractions of permanent teeth as limited in subdivision 3, paragraph (b).

(b) The services and procedures described under this subdivision may be performed under general supervision.

Subd. 3. **Practice limitation.** (a) An advanced practice dental therapist shall not perform any service or procedure described in subdivision 2 except as authorized by the collaborating dentist.

(b) An advanced dental therapist may perform nonsurgical extractions of periodontally diseased permanent teeth with tooth mobility of +3 to +4 under general supervision if authorized in advance by the collaborating dentist. The advanced dental therapist shall not extract a tooth for any patient if the tooth is unerupted, impacted, fractured, or needs to be sectioned for removal.

(c) The collaborating dentist is responsible for directly providing or arranging for another dentist or specialist to provide any necessary advanced services needed by the patient.

(d) An advanced dental therapist in accordance with the collaborative management agreement must refer patients to another qualified dental or health care professional to receive any needed services that exceed the scope of practice of the advanced dental therapist.

(e) In addition to the collaborative management agreement requirements described in section 150A.105, a collaborative management agreement entered into with an advanced dental therapist must include specific written protocols to govern situations in which the advanced dental therapist encounters a patient who requires treatment that exceeds the authorized scope of practice of the advanced dental therapist. The collaborating dentist must ensure that a dentist is available to the advanced dental therapist for timely consultation during treatment if needed and must either provide or arrange with another dentist or specialist to provide the necessary treatment to any patient who requires more treatment than the advanced dental therapist is authorized to provide.

Subd. 4. Medications. (a) An advanced dental therapist may provide, dispense, and administer the following drugs within the parameters of the collaborative management agreement, within the scope of practice of the advanced dental therapist practitioner, and with the authorization of the collaborating dentist: analgesics, anti-inflammatories, and antibiotics.

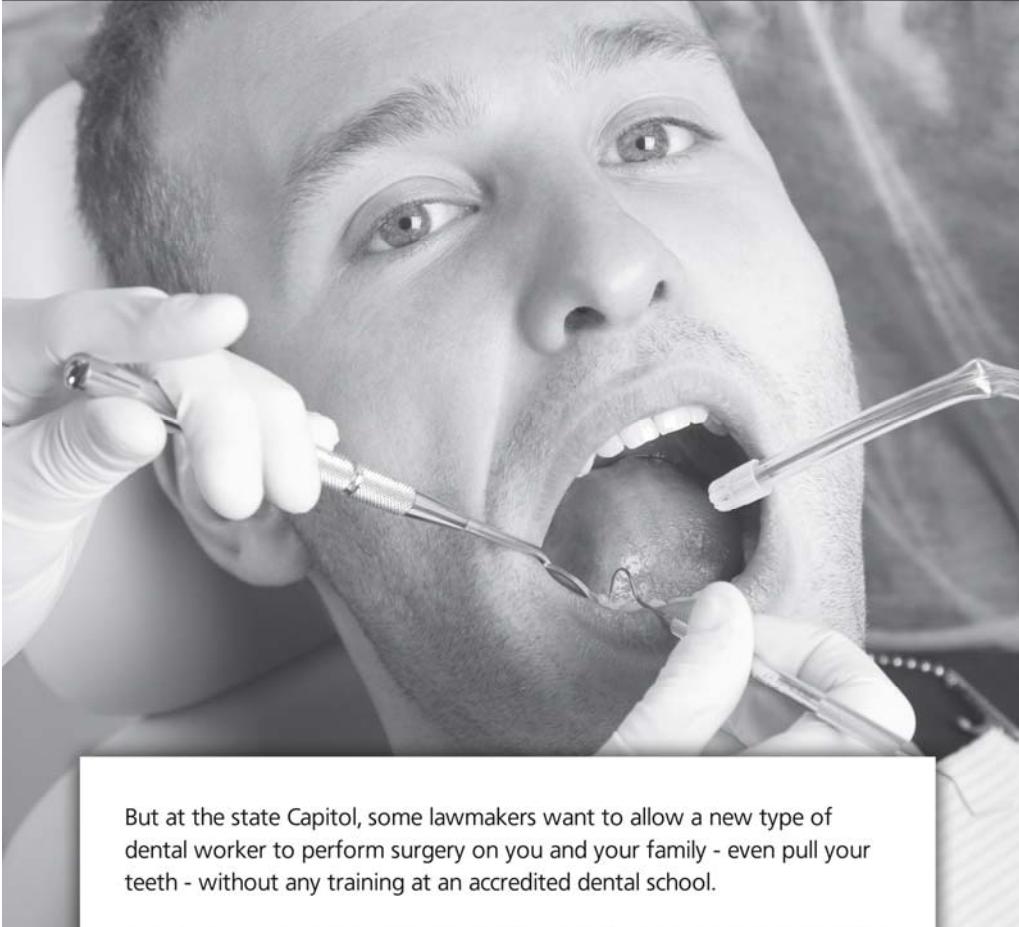
(b) The authority to provide, dispense, and administer shall extend only to the categories of drugs identified in this subdivision, and may be further limited by the collaborative management agreement.

(c) The authority to dispense includes the authority to dispense sample drugs within the categories identified in this subdivision if dispensing is permitted by the collaborative management agreement.

(d) Notwithstanding paragraph (a), an advanced dental therapist is prohibited from providing, dispensing, or administering a narcotic drug as defined in section 152.01, subdivision 10.

History: 2009 c 95 art 3 s 25

The last thing you want to hear when you're getting dental care is "uh-oh."



But at the state Capitol, some lawmakers want to allow a new type of dental worker to perform surgery on you and your family - even pull your teeth - without any training at an accredited dental school.

Even worse, a dentist wouldn't even have to be in the building if something goes wrong.

Minnesota's lawmakers must ensure that only supervised, dental school trained professionals perform surgery.

Call your local legislator today and tell them that unsupervised workers doing dental surgery is a bad idea.

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