FRAMEWORK FOR DESCRIBING AND EVALUATING SCOPE OF PRACTICE AND/OR NEW LICENSURE PROPOSALS FOR POLICYMAKERS

Introduction
This framework is designed to aide policymakers in the objective analysis of legislative proposals relating to scope of practice changes for regulated health professions/occupations.

The framework was developed for the State of Minnesota by a core team of professional health care associations, health licensing boards, state legislators, and the Minnesota Department of Health, Office of Rural Health and Primary Care in partnership with the National Governors Association and the National Conference of State Legislatures. The core team remains interested in the use and applicability of this framework. Please send any feedback on the framework and examples of its use to: Nitika.moibi@state.mn.us. Thank you.

The framework is organized into two parts:

- **Part 1 (Summary and Details):** This part is intended to summarize and organize key information about the scope of practice proposals to facilitate an objective review for legislators. It is intended to be completed by the author(s) of the proposed statutory change.

  Part 1 includes two sections:
  - **Section I (Proposal Summary/Overview):** This section is designed to provide an overview of the rationale for the proposal, including a summary (500-word count limit).
  - **Section II (Proposal Details):** This section includes a series of structured questions capturing and organizing key information on the proposed change and its impact on dimensions important to analyzing such changes. Proposal author(s) may complete only those questions relevant/pertinent to the proposal (not all questions will be applicable in all situations).

- **Part 2 (Legislator Review/Evaluation Tool):** This part is meant to support legislators in the process of reviewing and evaluating the proposed legislative changes. It includes a series of open-ended questions designed to provoke critical review of key information. It is meant to be completed by the legislator(s) reviewing the proposal and serve as a quick reference.

Part 1 Summary and Details

**Section 1- Proposal Summary/ Overview**

1) State the profession/occupation that is the subject of the proposal.

Dentistry: Dentist, dental hygienists and licensed dental assistants

2) For existing professions, briefly describe the proposed statutory change or expansion and its intended outcomes, including a brief statement of importance. For currently unregulated or emerging professions, briefly describe the proposed scope of practice and/or other regulatory requirements.

**Minnesota Statute 150A.10 – Limited Authorization for Dental Hygienists**

Legislation enacted in 2001 to establish collaborative dental hygiene practice to increase access to dental care for underserved Minnesotans. The core functions of this practice model include community-based risk assessment and referral for treatment, primary preventive services, and health education. Full implementation of the practice model will help enhance the patient experience, improve population health, reduce costs (the
Triple Aim of health reform and improve the work life of health care providers. The proposed statutory changes do not change the procedures that dental hygienists or assistants are currently able to perform but will address barriers that have resulted in underutilization of collaborative practice dental hygiene.

**Goal:** Expand access, particularly for under-served Minnesotans in urban and rural areas, to primary preventive and therapeutic oral health care beyond traditional dental office settings.

**Solution:** Clarify Minnesota Statutes 150A. 10, subd. 1a, to ensure that dental hygienists in collaborative practice can develop and implement sustainable practice models to reach underserved populations.

**Involvement of all stakeholders:** In fall 2015, the Collaborative Dental Hygiene Practice advisory committee was reactivated and expanded with the addition of representatives from multiple key stakeholder groups. The committee included representatives from:

- Minnesota Board of Dentistry
- Minnesota Dental Association
- Minnesota Dental Hygiene Association
- Department of Human Services
- Minnesota Department of Health, Office of Rural and Primary Care
- Minnesota Department of Health, Oral Health Division
- Delta Dental of Minnesota Foundation
- Minnesota Oral Health Coalition
- Advanced Dental Therapy
- Collaborative Practice Dental Hygienists
- Education Institutions with Dental Education
- Safety Net Clinics

The advisory committee is composed of compassionate individuals and organizations who realized dentists and dental hygienists who implement the care model enhanced by this law will provide additional and necessary access to dental care for underserved populations. The advisory committee met six times, and formed four additional subcommittees including policy and advocacy, radiation rule, prevention and education, and communications.

**Proposed Changes with key stakeholder agreement after discussion and deliberations:**

- Statute name change and clear definition.
- Allow dental hygienists to perform the entire dental hygiene scope of practice in alternative practice settings outside the traditional dental office.
- Allow dental hygienists to enter into a collaborative agreement without additional post-licensure clinical hours.
- Allow licensed dental assistants to provide preventive services within their scope of practice when providing care with a dental hygienist in alternative settings.
- Clearly, state in statute patients seen by the dental hygienists in alternative settings need not become ‘patients of record’ in the office of the collaborative dentist.
- Delete duplicative language already mandated by licensure.
Section 2 – Proposal Details

A. Public Safety and Well-Being

1) Describe, using evidence to the extent possible, how the proposed scope and regulation may improve or may harm the health, safety, and welfare of the public?

This will improve access to oral health care services to those who face barriers or limitations. This is especially true for underserved and rural population groups such as children, frail elderly, and special needs individuals. This proposal does not change the procedures dental hygienists or dental assistants are currently able to perform, but allows them to provide preventive services, health education, and necessary referrals in community settings, like schools or head start programs, that are often more convenient for patients.

2) Is there any research evidence that the proposed change(s) might have a risk to the public? Please cite.

This proposal will improve access to preventive oral health care services for rural Minnesotans and underserved population groups such as children, frail elderly, and special needs individuals. There is no research evidence that the proposed changes to the dental hygiene care model will result in an increased risk to the public, especially since this will not change the procedures they are able to perform under the current licensure process.

- In Minnesota, from 2006-2009 Head Start programs utilizing collaborative practice reported improved compliance with federal performance standards for mandatory dental services.
- Nationally, the Center for Health Workforce Studies recommends that policy makers consider the impact of scope of practice when investigating strategies to increase the availability of preventive oral health services, especially for underserved populations. See “Expanded Scopes of Practice For Dental Hygienists Associated with Improved Oral Health Outcomes for Adults” in the December 2016 issue of Health Affairs (http://content.healthaffairs.org/content/35/12/2207)

3) Will a regulatory entity/board have authority to discipline practitioners?

Yes, the Minnesota Board of Dentistry will continue to have authority to discipline practitioners.

4) Describe any proposed disciplinary measures to safeguard against unethical/unfit professionals. How can consumers access this information?

The Board of Dentistry currently monitors and imposes disciplinary action, if necessary, on all dental professionals. If the proposed changes become law, the board will continue to monitor collaborative practice dental hygienists as well as other dental professionals. For more information, see the Minnesota Board of Dentistry Website: https://mn.gov/boards/dentistry/public/complaintresolutionprocess.jsp

On the Minnesota Board of Dentistry website, you can view public actions: https://mn.gov/boards/dentistry/public/actions/

B. Access, Cost, Quality, Care Transformation Implications

1) Describe how the proposed change(s) will affect the availability, accessibility, cost, delivery, and quality of health care.

Collaborative practice dental services are co-located in community-based locations such as schools, Head Start Centers, long-term care facilities or public health agencies. These locations reduce transportation barriers and
frequently offer translation and other supportive services necessary for underserved population groups. Delivering preventive services to more Minnesota residents, less emergency restorative and therapeutic care will result. This proposal will make oral health services more available and accessible for underserved Minnesotans by offering high quality of care at convenient locations to Minnesotans. With an increase in access to primary preventive and therapeutic services, and providing referrals when necessary, more patients will get the care they need, preventing emergencies. By allowing lower cost professionals to deliver services at the top of their license and delivering preventive and primary care, this model could save significant health care costs.

2) Describe the unmet health care needs of the population (including health disparities) that can be served under this proposal and how the proposal will contribute to meeting these needs.

Dental health disparities are well documented, disproportionately affecting low income and minority populations. As described above, collaborative practice dental services are co-located with other education, health and social services facilitating care coordination and supportive services that increase treatment completion.

3) Please describe whether the proposed scope includes provisions to encourage or require practitioners to serve underserved populations.

The statute language identifies a dental hygienist working with a collaborative agreement authorized by a dentist applies only to community settings outside of traditional dental practice. While the proposed changes re-align the statutory scope of practice to mirror the current licensure rules at the Board of Dentistry, these changes outlined allow more dental hygienists to participate in the model that specifically serves low-income and underserved Minnesotans that are hard to reach and have significant barriers to receiving oral health care.

4) Describe how this proposal is intended to contribute to an evolving health care delivery and payment system (e.g. interprofessional and collaborative practice, innovations in technology, ensuring cultural agility and competence in the profession, value based payment etc.)

Collaborative practice authorization allows a dental hygienist to work at the top of their license wherever they are delivering oral health care. Community-based services promote inter-professional collaboration with medical, social service, and education professionals. Proposed statutory language will allow dental hygienists the ability to team with licensed dental assistants in alternative settings, which increases efficiency, cost-effectiveness and the number of preventive services provided to all populations.

C. Regulation

1) If the services or individuals are currently unregulated, what is the proposed form of credentialing/regulation (licensure, certification, registration, etc.)? State the rationale for the proposed form/level of regulation. If there is a lesser degree of regulation available, state why it was not selected.

N/A- the services and individuals are currently, and will continue to be regulated

2) Describe if a regulatory entity/board currently exists or will be proposed. Does/will it have statutory authority to develop rules related to a changed/expanded scope or emerging profession, determine standards for education and training programs, assessment of practitioners’ competence levels? If not, why not?

The Minnesota Board of Dentistry (BOD) has the authority to develop rules related to changes and determine continuing education and competence levels. The MN BOD was part of discussion and development of the proposed statutory changes. On January 31, 2017, the MN BOD Policy Committee voted to support the statutory changes.
3) Is there model legislation for the profession available at the national level? If so, from what organization? Which states have adopted it? Briefly describe any relevant implementation information.

Nearly 40 states* besides Minnesota have some form of allowing dental hygienists to provide direct access to underserved and vulnerable populations. In 2001, Minnesota was the third state to initiate direct access for dental hygienists and the proposed changes will make the model more efficient, effective and better utilized in Minnesota. *States are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Montana, Nebraska, New Hampshire, New Mexico, New York, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

4) Does the proposal overlap with the current scope of practice for other professions/practitioners? If so, describe the areas of overlap. (This question is not intended to imply that overlap between professions is negative.)

There is some overlap in the current dental hygiene and dental therapy scope of practice for preventive services. There are currently few dental therapists licensed in the state, approximately 70, as the profession was enacted in 2009 with the first graduating class in 2011. The dental hygiene workforce is strong with over 5600 licensed dental hygienists.

D. Education and Professional Supervisions

1) Describe the training, education, or experience that will be required for this professional based on this proposal, including plans for grandfathering in prior qualifications and/or experience where appropriate.

The current education and professional supervision will continue, dental hygienists must have completed a CODA accredited dental hygiene program and licensed in Minnesota. Minnesota licensed dental assistants must have graduated from a CODA accredited program.

2) Is the education program available, or what is the plan to make it available? Is accreditation or other approval available or proposed for the education program? If yes, by whom?

No additional education required beyond what was identified in question D. 1.

3) Do provisions exist or are there being proposed to ensure that practitioners maintain competency in the provision of services? If so, please describe.

All dental professionals must maintain a professional portfolio with the required number of fundamental and voluntary hours, infection control courses, on-line self-assessment, and CPR certification. Additionally, a dental hygienist and dental assistant working in alternative settings must have a medical emergency course in each continuing education cycle required for licensure.

4) Is there a recommended level/type of supervision for this practitioner—independent practice, practice needing formal agreements or delegated authority, supervised practice? If this practitioner will be supervised, state by whom, the level, extent, nature, terms of supervision.

Dental hygienists working with a collaborative agreement authorized by a dentist are able to provide the entire dental hygiene scope of practice under general supervision. A dentist will always have the ability to use their own discretion when it comes to forming a collaborative agreement with a dental hygienist and specify if there are procedures, they do not want the dental hygienist to perform. Licensed dental assistants are to be identified in a collaborative agreement and will provide preventive services specified in the agreement under general supervision of the collaborative dentist.
E. Finance Issues – Reimbursement, Fiscal Impact to state, etc.

1) Describe how and by whom will the new or expanded services be compensated (e.g., Medical Assistance, health plans, etc.)? What costs and what savings would accrue and to whom (patients, insurers, payers, employers)?

Because collaborative practice reaches underserved populations, primary compensation will be from Minnesota Health Care Programs (MHCP) and grant funding. In order to realize these cost savings, the following administrative and reimbursement challenges for collaborative practice should be addressed:

- Allow dental hygienists to bill directly for services provided in collaborative practice
- Streamline and standardize credentialing and billing processes
- Reimburse screenings and assessments provided in collaborative practice
- Increase MHCP reimbursement rates

Patients will realize cost savings because transportation costs will be reduced when dental services are available at local community sites. Access to dental care can reduce inappropriate use of Emergency Departments for non-emergency dental conditions.

Payers will realize cost savings when increased prevention results in improved oral health and decreased treatment costs. Growing evidence shows that oral health affects overall health. Insurance companies have published studies showing significant savings for diabetes care and other chronic diseases when preventive dental care is provided.

2) Describe whether reimbursement is available for these services in other states? vi

Many of the states noted in C3 reimburse dental hygienists for preventive and therapeutic services provided in alternative settings. In Minnesota, the services delivered in alternative settings are currently reimbursed by MHCP to dental hygienists.

3) What are the projected regulatory costs to the state government, and how does the proposal include revenue to offset those costs?

N/A

4) Do you anticipate a state fiscal impact of the proposed bill?

No

F. Workforce Impacts

1) Describe what is known about the projected supply/how many individuals are expected to practice under the proposed scope? vi If possible, also note geographic availability of proposed providers/services. Cite any sources used.

There were 5,625 actively licensed dental hygienists as of December 2015. Based on Minnesota Board of Dentistry data, over half of dental hygienists are 44 or younger, with few licensed dental hygienists 65 or older. The median age of dental hygienists is 42.

Just over two-thirds of those responding to the Minnesota Department of Health Dental Hygienist workforce survey plan to work as a dental hygienist for more than 10 years. Fifteen percent of dental hygienists plan to practice five years or less and of those, 78 percent planned to retire. In comparison, 24 percent of dentists, who are a demographically older group, plan to work five years or less, with higher rates in rural areas.
Additionally 87 percent of Minnesota licensed dental hygienists reported on the MDH questionnaire that they were working in a paid position. Five percent of dental hygienists were not seeking work in the field, five percent were not working at all, and three percent were seeking work in the field.

Looking at the size of the population for every one dental hygienist in urban, large rural, small town, and rural areas, dental hygienists are better distributed than dentists. For example, there are 1,467 people for every one dental hygienist in rural or isolated areas of Minnesota. In comparison, there are 3,938 people per dentist in rural or isolated areas.

Dental Hygienists by Minnesota Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minneapolis-Saint Paul</td>
<td>56%</td>
</tr>
<tr>
<td>Central Minnesota</td>
<td>13%</td>
</tr>
<tr>
<td>Southeast Minnesota</td>
<td>10%</td>
</tr>
<tr>
<td>Northwest Minnesota</td>
<td>9%</td>
</tr>
<tr>
<td>Northeast Minnesota</td>
<td>6%</td>
</tr>
<tr>
<td>Southwest Minnesota</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Minnesota Department of Health (MDH) geocoding and analysis of December, 2015 Minnesota Board of Dentistry address data. Percentages above are based on 4,826 valid Minnesota addresses.

Oral Health Professionals by Minnesota Region

Source: Minnesota Department of Health (MDH) geocoding and analysis of Minnesota Board of Dentistry address data. Percentages above are based on valid Minnesota addresses.

Dentists and Dental Hygienists by Minnesota Region
Slightly over half of dental hygienists (56 percent) are practicing in the Twin Cities metro area, with another 13 percent in Central Minnesota. The remainder of the state is home to smaller shares of dental hygienists. For reference, the Twin Cities metro area houses approximately 54 percent of the state’s population, with all other regions housing between 7 and 13 percent of Minnesotans. This suggests that the location of dental hygienists is somewhat similar to the population distribution in Minnesota. In comparison, 63 percent of dentists are located in the Twin Cities metro area. The map below shows the distribution of dental hygienists in Minnesota counties (data from Minnesota Board of Dentistry analyzed by Minnesota Department of Health).

Additionally, 228 dental hygienists graduated from Minnesota schools during the 2013-2014 school year (LMI...
The Health Resources and Services Administration (HRSA) projected estimates of the supply and demand of dentists and dental hygienists both nationally and by state in 2025. In Minnesota HRSA is projecting a shortage of dentists and an over-supply of dental hygienists in 2025. [https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/nationalstatelevelprojectionsdentists.pdf](https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/nationalstatelevelprojectionsdentists.pdf)

Taken together, this data indicates a good supply of dental hygienists in the current workforce and coming from schools to work in this expanded way in the state of Minnesota.

According to the Minnesota Board of Dentistry, as of December 2015, there were 7,445 actively licensed dental assistants. Dental assistants are a young profession with 64 percent under age 45. The median age of dental assistants is 39.

Based on data collected by the Minnesota Department of Health workforce survey, two thirds of Minnesota dental assistants planned to work for more than 10 years. Of those who planned to leave in five years or less, 62 percent planned to retire and 26 percent planned to change professions.

**Dental Assistants by Minnesota Region**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minneapolis-Saint...</td>
<td>53%</td>
</tr>
<tr>
<td>Central Minnesota</td>
<td>17%</td>
</tr>
<tr>
<td>Southeast Minnesota</td>
<td>9%</td>
</tr>
<tr>
<td>Northwest Minnesota</td>
<td>9%</td>
</tr>
<tr>
<td>Northeast Minnesota</td>
<td>5%</td>
</tr>
<tr>
<td>Southwest Minnesota</td>
<td>7%</td>
</tr>
</tbody>
</table>

*Source: Minnesota Department of Health (MDH) geocoding and analysis of 2015 Minnesota Board Dentistry address data. Percentages above are based on 6,739 valid Minnesota addresses.*

2) Describe, with evidence where possible, how the new/modified proposal will impact the overall supply of the proposed services with the current/projected demand for these services.

There is good distribution of dental hygienists around the state in comparison to dentists where there are concerns about their availability as more and more dentists retire. The concern about dentists retiring is especially true in rural areas. Dental hygienists on the other hand are more evenly distributed around the state and younger. While dental hygienists cannot perform the advanced scope of dentists, this change will provide a stable workforce able to work in more roles and organizations than they currently do to better meet Minnesota’s oral health needs, including the extreme lack of access to primary preventive oral health care for low-income patients statewide.

G. Proposal Supporters/Opponents

1) What organizations and groups have developed or reviewed the proposal?

- Minnesota Board of Dentistry
- Minnesota Dental Association
- Minnesota Dental Hygiene Association
2) Note any associations, organizations, boards, or groups representing the profession seeking regulation and the approximate number of members in each in Minnesota.

- Minnesota Dental Hygienists’ Association (350 members)
- Minnesota Dental Hygiene Educators Association (60 members)
- Minnesota Board of Dentistry

3) Please describe the anticipated or already documented position professional associations of the impacted professions (including opponents) will/have taken regarding the proposal.

- Throughout the last 15 months, this proposal has gained broad support throughout the oral health community. As of now, there is no known opposition.

4) State what actions have been undertaken to minimize or resolve any conflict or disagreement with those opposing/likely to oppose the proposal.

- The advisory committee began meeting in November 2015 and included multiple key stakeholders all working to reach a consensus to increase access to oral health care in Minnesota. In order to arrive at the proposed legislation, all communications and actions have been taken in consultation with the committee and other external stakeholders.

5) What consumer and advocacy groups support/oppose the proposal and why?

- Support:
  - Many consumer organizations support the proposal including Head Starts, community clinics, safety net organizations, the Minnesota Oral Health Coalition, and others.

H. Report to the Legislature

1) Please describe any plans to submit a report to the legislature describing the progress made in the implementation and the subsequent impacts (if measurable) of the scope of practice changes for regulated health professions/occupations. Describe the proposed report’s focus and timeline. Any proposed report schedule should provide sufficient time for the change to be implemented and for impacts to appear.

- A HRSA grant awarded to Normandale Community College has provided funding for a follow-up collaborative practice survey to be completed by 2019. The survey will be developed with stakeholder participation and the results of the survey will be submitted to the legislature in 2023 regarding the impact of this legislation.
Part 2- Proposal Summary Notes
To be completed by legislators reviewing the proposal. This section serves as a companion to the information provided by authors (Part 1), and is designed for legislators to complete to serve as a guide/facilitate evaluation of proposed statutory changes.

Bill # (if introduced):

Title:

Author(s):

Proposal Summary Notes:

Public Safety and Well Being
   Review Notes:

Access, Cost, Quality, Care Transformation Implications
   Review Notes:

Regulation
   Review Notes:

Education and Professional Supervision
   Review Notes:
Finance Issues – Reimbursement, fiscal impacts to state government, etc.

Review Notes:

Fiscal impact of the proposed bill:
☐ No ☐ Yes

<table>
<thead>
<tr>
<th>Fund (specify)</th>
<th>FY2017</th>
<th>FY2018</th>
<th>FY2019</th>
<th>FY2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If, yes, describe briefly:

Workforce Impacts

Review Notes:

Proposal Supporters and Opponents

Review Notes:

Reporting Requirements, if applicable:

Review Notes:

Other
Does the bill promote health equity?

Does the bill positively impact my constituents?
NOTES:

ii Minn Stat 214.002 Subd. 2. (3)
iii Federation of State Medical Boards. “Assessing Scope of Practice in Health Care Delivery: Critical Questions in assuring Public Access and Safety.” 2005
v Federation of State Medical Boards. “Assessing Scope of Practice in Health Care Delivery: Critical Questions in assuring Public Access and Safety.” 2005
ix Legislative Questionnaire for new or expanded regulation of health occupations. Submitted to the Minnesota Legislature by the Minnesota Advanced Practice Registered Nurse (APRN) in collaboration with the Minnesota Board of Nursing. January 29, 2014. This document includes more questions in addition to those required by Minn. Stat. 214.002. Only the new questions are included in the table.

x Legislative Questionnaire for new or expanded regulation of health occupations. Submitted to the Minnesota Legislature by the Minnesota Advanced Practice Registered Nurse (APRN) in collaboration with the Minnesota Board of Nursing. January 29, 2014. This document includes more questions in addition to those required by Minn. Stat. 214.002. Only the new questions are included in the table.