VIRGINIA BOARD OF DENTISTRY
**Regulatory-Legislative Committee**
AGENDA
October 24, 2014

Department of Health Professions
Perimeter Center - 9960 Mayland Drive, 2nd Floor Conference Center
Henrico, Virginia 23233

| TIME | | PAGE |
|---|---|---|
| **1:00 p.m.** | **Call to Order –Bruce Wyman, DMD, Chair** | |
| | **Evacuation Announcement – Ms. Reen** | |
| | **Public Comment** | |
| | **Approval of Minutes**<br>May 2, 2014 minutes | **P1** |
| | **Status Report on Regulatory Actions – Ms. Yeatts** | **P6** |
| | **Billing for a Periodic Exam Performed by RDH** | **P7** |
| | **Changing the Education Requirement for Dental Licensure** | **P19** |
| | **Practice Ownership** | **P26** |
| | **DAII Registration Options for Qualifying** | **P49** |
| | **Advanced Dental Hygiene Practice** | **P62** |
| | **Electronic Dental Records** | **P118** |
| | **Teledentistry** | **P145** |
| | **Dental Role in Treating Sleep Apnea** | |
| | **Next meeting** | |
| **Adjourn** | | |

# VIRGINIA BOARD OF DENTISTRY
# MINUTES OF REGULATORY-LEGISLATIVE COMMITTEE
# May 2, 2014

**TIME AND PLACE:** The meeting of the Regulatory-Legislative Committee of the Board of Dentistry was called to order at 1:00 p.m., on May 2, 2014, Department of Health Professions, 9960 Mayland Drive, Suite 201, Board Room 4, Henrico, Virginia.

**PRESIDING:** Jeffrey Levin, D.D.S., Chair

**MEMBERS PRESENT:** Charles E, Gaskins, III., D.D.S.
Melanie C. Swain, R.D.H.

**MEMBERS ABSENT:** Evelyn M. Rolon, D.D.S.

**OTHER BOARD MEMBERS:** Al Rizkalla, D.D.S.
Bruce S. Wyman, D.M.D.

**STAFF PRESENT:** Sandra K. Reen, Executive Director
Kelley W. Palmatier, Deputy Executive Director
Huong Q. Vu, Operations Manager

**OTHERS PRESENT:** Elaine Yeatts, Senior Policy Analyst, Department of Health Professions

**ESTABLISHMENT OF A QUORUM:** With three members present, a quorum was established.

**PUBLIC COMMENT:** Steven Lindauer, DMD, Chair of VCU Department of Orthodontics, addressed the use of dental assistants in orthodontic practice and provided a list of duties for reference by the Board.

L. Warren West, DDS, of the Virginia Society of Oral Maxillofacial Surgeons, commented that the draft permit holder office inspection form does not ask the dentist and staff to demonstrate the ability to handle emergency situation and that the people who conduct the inspection should be clinicians who are knowledgeable about sedation.

Ms. Reen introduced Jamie Hoyle who is the new DHP Chief Deputy Director.

**APPROVAL OF MINUTES:** Dr. Levin asked if Committee members had reviewed the February 7, 2014 minutes. Dr. Gaskins moved to accept the minutes. The motion was seconded and passed.

**STATUS REPORT ON REGULATORY ACTIONS:**

Ms. Yeatts reported that the:

- Periodic Review of proposed regulations to establish four chapters are under review at the Secretary's office.
- Sedation and Anesthesia final regulations were approved by the Governor and will be effective on May 7, 2014.

**Final Report of 2014 General Assembly (GA)** - Ms. Yeatts stated this report includes the bills addressing health professions that passed this year, with one exception. She said that SB647 which would require DMAS to create a teledentistry pilot program for eligible school-age children was continued to 2015 in Appropriations Committee. She added that SB294 requires all prescribers, including dentists, to register with the Prescription Monitoring Program.

**FEE SPLITTING:**

Ms. Yeatts stated that the Committee asked her to develop a proposal to address concerns advanced through public comment about fee splitting between dentists and with third parties. She reviewed her findings in the following materials:

- American Dental Association (ADA) Principles of Ethics and Code of Professional Conduct
- ADA Legal Issues in Marketing a Dental Practice: Referral Gifts and Groupon Discounts
- New York Law Journal article on Internet Discounts On Health Care Services: Strictly Illegal (January 24, 2012, Volume 214 – NO. 7)
- California Business and Professions Code Sections 650-657
- Virginia Board of Dentistry Guidance Document 60-15
- Virginia Board of Medicine Code and Regulatory Provisions
- Draft Legislative Proposal for a Prohibition on Fee-Splitting or Rebates

Ms. Yeatts noted that currently there is nothing in the statue specific to fee splitting so if the Committee sees the need to forward this legislatively, the Board needs to act at its June meeting in order to meet the proposal deadline for the 2015 General Assembly.

Dr. Wyman stated that in Northern VA, it is a common practice for surgeons to provide restorative components to dentists for patients receiving implant treatment. He asked if this practice would be prohibited by the proposal and noted that the benefit is that the components are the appropriate size. He added patients may not be aware of this practice and may end up paying twice for the components. Dr. Rizkalla said that in his opinion this practice had become a financial incentive for patient referrals.

Dr. Wyman stated that he is also concerned about the practice of annual holiday gifts given by specialists to general dentists, the amount or value of which is frequently related to the number of patients referred. Ms. Yeatts commented that if a dentist receives a gift based on the number of referrals then the dentist is receiving a rebate.

Ms. Reen asked Ms. Yeatts if there is provision on inducement in her research and whether the Committee needs to add this language to the discussion draft. Ms. Yeatts stated that CA does have inducement language in its Code. Ms. Yeatts then suggested to add the following language to the discussion draft "***accept or tender compensation or inducement whether in the form of money or otherwise***" right after "*No dentist shall directly or indirectly accept or tender a rebate,*" By consensus, the Committee agreed.

Dr. Gaskins moved to recommend the proposed draft legislation to include inducement for consideration by the Board on June 13, 2014 meeting. The motion was seconded and passed.

**PRACTICE OWNERSHIP:**

Ms. Reen stated that the Committee is charged to work with a Regulatory Advisory Panel (RAP) to develop a proposal to address concerns advanced through public comment and through disciplinary cases regarding:

- Sole proprietorships
- Large corporate dental practices, and
- Practice management companies.

She added that the following materials are provided to facilitate discussion:

- A historical provision of law on what constitutes the practice of dentistry
- Excerpts from the Code of Virginia
- A policy statement adopted by the Tennessee Board of Dentistry
- The Department of Taxation's listing of business entity types
- The State Corporation Commission's listing of entity types and categories
- Congressional Joint Staff Report on the Corporate Practice of Dentistry in the Medicaid Program
- North Carolina's Law on Dental Management Arrangements, and
- Texas' Law and Regulations on Control of Dental Practice

Ms. Reen asked for guidance on the goals or concepts to be addressed with the the RAP to facilitate invitations to the appropriate agencies for technical assistance to assist the Board in identifying a strategy to address the concerns which is within the Board's scope of authority.
After discussion of the materials, by consensus, the Committee decided that the Board wants the authority to address ownership and practice management organizations. It agreed to use the Texas law and regulations as the model for discussion.

**PERMIT HOLDER OFFICE INSPECTIONS:**

**Revised Inspection Form** – Ms. Reen stated that, with the final sedation and anesthesia permit regulations becoming effective on May 7, 2014, it is time to institute the planned periodic inspections. She noted that board and enforcement staff developed the revised form and draft guidance document for discussion. She commented that this form is a multi-use form which can be

used for complaint investigations, compliance cases, and periodic inspections for permit holders. She asked the Committee to give direction to staff for developing the documents for presentation to the Board. Ms. Reen noted that the inspections will be conducted by DHP inspectors or investigators who will collect the information and forward the inspection results to the Board for review.

Several members of the public objected to the multi-use form as being too intrusive and unfair to permit holders. They also expressed concern about using DHP staff to conduct the inspections and that the form does not address emergency preparedness. The Committee discussed these concerns with them. During the discussion, Ms. Reen said the Board has the authority to look at the whole environment in order to protect the public, that review of emergency preparedness should be added to the form and that many of DHPs inspectors are health profession licensees.

Dr. Gaskins moved to forward the draft form with the addition of emergency preparedness to the Board for consideration. The motion was seconded and passed.

**Guidance Document (GD)** - Ms. Reen stated that the proposed guidance document addresses the scope and implementation of the periodic office inspections for permit holders. She added that the draft GD is presented for review and action by the Committee.

Dr. Gaskins moved to forward it to the Board for consideration on June 13, 2014 meeting. The motion was seconded and passed.

**NEW BUSINESS:**

Dr. Gaskins proposed a draft guidance document to address the record keeping requirements for endodontic root canal treatment. He stated that he has reviewed and heard numerous Board cases where root canal treatment and documentation has been of great concern. He added that his draft has been reviewed by seven board certified endodontists who confirmed these standards for endodontic treatment. He noted that the following optional items should be deleted from the list:

- Access Notes/Difficulties, Intra-Coronal Findings, etc.
- State of Pulp
- Trail Length (s)/Per Canal.

Dr. Gaskins agreed to include introductory information to the guidance document. By consensus, the Committee agreed to forward the draft to the Board for consideration at the June 13, 2014, meeting.

**NEXT MEETING:**

The dates of August 15 or 22, 2014 were identified as options for the next Committee meeting. Ms. Reen said the Committee members will be polled for availability. All agreed.

**ADJOURNMENT:**

With all business concluded, Dr. Levin adjourned the meeting at 3:41 p.m.

Jeffrey Levin, D.D.S., Chair

Date

Sandra K. Reen, Executive Director

Date

**Agenda Item:** **Regulatory Actions - Chart of Regulatory Actions**
**(As of October 15, 2014)**

| Chapter | | Action / Stage Information |
|---|---|---|
| [18 VAC 60 - 20] | Regulations Governing Dental Practice | Periodic review; reorganizing chapter 20 into four new chapters: 15, 21, 25 and 30 [Action 3252] |
| | | Final - *At Secretary's Office for 198 days* |

**Agenda Item: Billing for Periodic Exams Performed by Dental Hygienists**

The Board assigned this topic to the Committee. The Committee is to consider proposing a position on the practice of billing for periodic exams performed by dental hygienists and consideration of developing a guidance document on the subject.

Information included in the agenda package:

- E-mails between Dr. Watkins and Ms. Reen
- Regulations Governing Dental Practice sections 18VAC60-20-190 and 18VAC60-20-220
- September 30, 2002 Special Bulletin, Clarification of General Supervision (no longer in circulation)
- Correspondence about CDT Codes

The 2014 CDT Code will be available for projection at the meeting.

## Reen, Sandra (DHP)

**From:** Reen, Sandra (DHP)
**Sent:** Wednesday, April 02, 2014 5:06 PM
**To:** DDSJDW@aol.com
**Cc:** Palmatier, Kelley (DHP)
**Subject:** RE: Question

**Importance:** Low

Hi Jim:
Yes, this can be on the June Board meeting agenda for you to discuss. It would be helpful if you would provide any proposed language and identify any documents/reference material you would like included in the agenda package to facilitate the discussion **by May 22nd**.

Information that may be helpful to you is that:

- the list of non-delegable duties in 18VAC60-20-190 of our regs does not include "examination" or "evaluation" but it does list final diagnosis and treatment planning.
- 18VAC60-20-220 of our regs permits dental hygienists to perform an initial exam under indirect supervision and to perform a clinical exam under indirect or general supervision.
- CDT 2014 says in its introduction to Clinical Oral Evaluations: "The collection and recording of some data and components of the dental examination may be delegated: however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist.
- CDT 2014 lists D0120 as follows: "periodic oral evaluation- established patient An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation and periodontal screening where indicated ..."

Also, this e-mail I sent to you in August gives the Board's history on this subject:

> **Date:** 8/29/2013 6:00:45 PM
>
> **Attachments:**
> SDentistryC13082916090.pdf
>
> ---
>
> Hi Jim:
> Since Debbie will be out of the office until next Thursday, I discussed this with Kelley today and decided to respond directly to you. No guidance document or regulation addresses billing for an exam done by a dental hygienist under general supervision. The attached Special Bulletin on General Supervision was issued by the Board shortly after implementing the Emergency Regulations on General Supervision. There are three Q&As on the topic of billing for exams – on the second page (numbered 4) see the 3rd Q&A and on the 3rd page (numbered 5) see the 2nd and 6th Q&As. In the pending case, I checked the order for treatment under general supervision which did include "PeriodicX" in the services to be provided. I also looked at the CDT Code (2011-2012) introductory information on clinical oral evaluations as well as Code D0120. The Board has never discussed use of this Code and actually declined to do so as indicated in the Special Bulletin.
> Please let me know if you have any further questions about billing before you might respond to Debbie's questions in her August 22, 2013 e-mail.
> Smile,
> Sandy

Smile,
Sandy

**From:** DDSJDW@aol.com [mailto:DDSJDW@aol.com]
**Sent:** Tuesday, April 01, 2014 6:46 PM
**To:** Reen, Sandra (DHP)
**Subject:** Question

**Hi, Sandy.**

**I mentioned to Kelly on Friday that I was anxious to hear the IFC on our 11am case that day; only to find out that the Respondent signed the Consent Agreement the day before. It was the first case where there was a complaint about a dentist billing for a Periodic Exam when the exam was done by his hygienist while on General Supervision. I had reviewed the case and written it up as a violation as it was my understanding that hygienists could NOT bill for an exam under GS (because hygienists cannot diagnose). Debbie did not agree as she felt it was done in offices; and now, I have had hygienists that have worked with me part-time tell me that other offices routinely bill out a "periodic exam" by the DH when working under GS. I feel like there needs to be some type of clarification on this issue (possibly a Guidance Document); so Kelly recommended that I ask you if the issue can be placed on the agenda for our next meeting. Is that possible? Is this a valid concern? Have I overlooked something in my understanding of the guidelines?**

**Jim**

## Part VI. Direction and Delegation of Duties.

**18VAC60-20-190. Nondelegable duties; dentists.**

Only licensed dentists shall perform the following duties:

1. Final diagnosis and treatment planning;
2. Performing surgical or cutting procedures on hard or soft tissue;
3. Prescribing or parenterally administering drugs or medicaments, except a dental hygienist, who meets the requirements of 18VAC60-20-81, may parenterally administer Schedule VI local anesthesia to patients 18 years of age or older;
4. Authorization of work orders for any appliance or prosthetic device or restoration to be inserted into a patient's mouth;
5. Operation of high speed rotary instruments in the mouth;
6. Administering and monitoring general anesthetics and conscious sedation except as provided for in § 54.1-2701 of the Code of Virginia and 18VAC60-20-108 C, 18VAC60-20-110 F, and 18VAC60-20-120 F;
7. Condensing, contouring or adjusting any final, fixed or removable prosthodontic appliance or restoration in the mouth with the exception of packing and carving amalgam and placing and shaping composite resins by dental assistants II with advanced training as specified in 18VAC60-20-61 B;
8. Final positioning and attachment of orthodontic bonds and bands; and
9. Final adjustment and fitting of crowns and bridges in preparation for final cementation.

**18VAC60-20-220. Dental hygienists.**

A. The following duties shall only be delegated to dental hygienists under direction and may be performed under indirect supervision:

1. Scaling and/or root planing of natural and restored teeth using hand instruments, rotary instruments and ultrasonic devices under anesthesia.
2. Performing an initial examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for assisting the dentist in the diagnosis.
3. Administering nitrous oxide or local anesthesia by dental hygienists qualified in accordance with the requirements of 18VAC60-20-81.

B. The following duties shall only be delegated to dental hygienists and may be delegated by written order in accordance with § 54.1-2722 of the Code of Virginia to be performed under general supervision when the dentist may not be present:

1. Scaling and/or root planing of natural and restored teeth using hand instruments, rotary instruments and ultrasonic devices.
2. Polishing of natural and restored teeth using air polishers.
3. Performing a clinical examination of teeth and surrounding tissues including the charting of carious lesions, periodontal pockets or other abnormal conditions for further evaluation and diagnosis by the dentist.
4. Subgingival irrigation or subgingival application of topical Schedule VI medicinal agents.
5. Duties appropriate to the education and experience of the dental hygienist and the practice of the supervising dentist, with the exception of those listed in subsection A of this section and those listed as nondelegable in 18VAC60-20-190.

## SPECIAL BULLETIN

**September 30, 2002 ***

### Clarification of General Supervision

The Board has received numerous questions and statement of concern about the Emergency Regulations implementing General Supervision of Dental Hygienists. The questions cover diverse subjects ranging from billing to the procedures that may be delegated to the requirements for a prescription to the proximity of and the required relationship with the dentist. The Board its September 20, 2002 meeting reviewed these questions from dental hygienists and interested organizations.

The Board intended through the promulgation of the emergency regulations to enable dentists to order certain limited hygiene treatment to be performed by a dental hygienist when the treating dentist is not present. The Board is interpreting the emergency regulations consistent with this intent as reflected in the answers to the following questions and comments. The following questions are stated exactly as they were submitted in the correspondence received by the Board.

**Q. "Is placement of sub gingival medicament (i.e. arestin, periochip) permissible?"**

A. No, a dental hygienist practicing under general supervision may not place sub gingival medicaments. The Virginia Drug Control Act requires that the administration of Schedule VI topical drugs be under the direction and supervision of a dentist.

**Q. "Are x-rays permitted to be taken if the dentist prescribes?"**

A. Yes, a dental hygienist practicing under general supervision may take x-rays as ordered by the treating dentist.

**Q. "Must the prescription include if x-rays are to be taken? If so, can the prescription state "necessary x-rays?"**

A. The dentist may order x-rays to be taken under supervision. The x-rays to be taken should be specified in the order.

**Q. "Is placement of a 15% hydrogen peroxide gel and phst-activation component permissible under general supervision or direct supervision?"**

A. Placement of these medications is not permitted under general supervision but is permitted under direct supervision. Schedule VI topical drugs may only be administered by a dental hygienist under the direction and supervision of a dentist.

**Q. "A question has come up about free clinics and community health centers and how the low [translated the mean the Emergency Regulations] should be interpreted in those situations."**

A. A dentist practicing in a free clinic, volunteer clinic or a public health program may issue an order for hygiene treatment under general supervision. Any dental hygienist practicing in the free clinic, volunteer program or public health program may fill the order.

**Q. "The requirement that the patient must be seen by a dentist for the initial evaluation makes the timely provision of care in free clinics and community health programs nearly impossible."**

A. The statute providing for general supervision requires that a dentist complete an evaluation and prescribe authorized services. Dental hygienists may only provide treatment when a dentist has previously evaluated the patient and ordered hygiene treatment to be provided under general supervision.

**Q. "We are requesting clarification on the dentist-hygienist supervision ratio under general supervision."**

A. A dentist may not have more than two dental hygienists working under direction or general supervision at one and the same time in his private office/practice. If the dentist is present in the office then the hygienists providing treatment, must be under supervision. If the dentist has planned to be out of the office then he may have up to two hygienists working under general supervision. He may, through issuance of a written order for hygiene treatment authorized any dental hygienist to treat patients in a free clinic, volunteer program or public health program under general supervision.

**Q. "Both dentists and hygienists have raised questions about the application if topical anesthesia under general supervision. We contend that §54.1-3408 covers both the direction and general supervision of dental hygienists."**

A. The Virginia Drug Control Act requires that Schedule VI topical drugs may only he administered by a dental hygienist under the direction and supervision of a dentist.

**Q. "18 VAC 60-20-220.B.3 states a clinical exam can be performed under general supervision. Would this exam be considered equivalent to an ADA CDT code DOO120 Periodic Oral Evaluation?"**

A. The Board does not directly regulate billing practices. The Board's involvement in billing practices is triggered by receipt of a complaint that alleges false, deceptive or misleading billing activities that may constitute fraud. Patients and third party payers can file such complaints. The dentist is responsible for understanding and using codes such as the one referenced to accurately represent the service rendered.

**Q. "With regard to prescribed or prescription is there a new written standard form of communication that is an ASA accepted legal document? It sounds like a patient can now be transposed to have the recommended treatment performed in any dental office, which we know to be true, but what of differing opinions?"**

A. No, there is no standard form or format. The order may be entered in writing in the treatment notes for the patient or may be written on a separate document and included in the patient record. The order must be followed exactly. The dental hygienist or another dentist cannot alter it.

**Q. "With regard to consent of the hygienist, is the consent to be implied, written or oral, for each patient, before, during, or after the hiring of such hygienist employee? What if the hygienist refuses or denies giving the consent?"**

A. The agreement of the dental hygienist to practice under general supervision should be in writing and should be maintained on file by the dentist. The consent can be addressed before, during or after hiring at the discretion of the dentist and the dental hygienist. The dental hygienist's consent can be given generally and does not need to be documented in each patient's record. It is the dental hygienist's decision whether or not the consent to practice under general supervision.

**Q. "With regard to informing the patient/legal guardian prior to the appointment, in a sense obtaining informed consent, why would a dentist potentially undermine his/her own authority in the event of miscommunication either intended or not, by an employee hygienist or other staff member, thereby risking compromising the integrity of the doctor-patient relationship?"**

A. There is nothing in the regulations that would require a dentist to act in the manner you question. General supervision must be planned in advance of a patient visit based on the dentist's examination of the patient. The dentist may inform the patient of the proposal for general supervision or may delegate this responsibility to a staff member. A dentist is expected to establish the protocols to be used in his office in order to fully comply with the regulations for general supervision.

**Q. "With regard to emergency procedures, in the event of a life-threatening emergency, why would a dentist place him/herself in a risk exposure situation by placing the safety of the practice in the hands of a potentially lesser-trained employee? What are the basic emergency training guidelines or minimal standard requirements?"**

A. The dentist is not obligated to have dental hygienists practicing under general supervision. The dentist needs to decide whether treatment under direction or general supervision is appropriate for each patient. He must provide services under direction if necessary to meet the individual needs of the patient. The Board has not established guidelines or minimal standards for the required emergency procedures for general supervision. The Board charges the dentist with responsibility for planning for the management of emergencies in his absence.

**Q. "Is the dentist permitted to charge an examination fee to patients if the hygienist performs the examination?"**

A. The Board does not directly regulate billing practices. The Board's involvement in billing practices is triggered by receipt of a complaint that alleges false, deceptive or misleading billing activities that may be fraudulent. A dentist is free to charge for an examination to the extent that he has advised the patient about the nature of the examination and its costs. The willingness of third party payers to cover such costs should also be addressed with the patient and the payer.

**Q. "May the doctor leave the office building after completing the initial examination and then assign the remaining procedures to the dental hygienists to do in his or her absence?"**

A. Yes, provided the patient is properly noticed and does not object and there is an order for treatment under general supervision.

**Q. "Are hygienist allowed to take alginate impressions in the dentist's absence?"**

A. Yes, provided the order includes this services.

**Q. "Are hygienists allowed to deliver beaching trays to patients in the absence of the dentist?"**

A. Yes, but they may not deliver bleaching agents.

**Q. "Do the new regulations have any effect on billing procedures (i.e. should the dentist bill the patients and the insurance agency in the same manner as previously done?"**

A. The Board does not directly regulate billing practices. The Board's involvement in billing practices is triggered by receipt of a complaint that alleges false, deceptive or misleading billing activities that may be fraudulent. Patients and third party payers can file such complaints. The willingness of third party payers to cover such costs should be addressed with the payers.

**Q. "The committee (VDA Dental Practice Regulations Committee) would like to request a sample statement to patients informing them of the implementation of general supervision of hygienists."**

A. The Board declines to provide a sample statement. The Board charges the dentist with responsibility for meeting the requirements set forth in the regulations as he deems appropriate for his patients and his practice.

**Q. "I ask for a point of clarification regarding 18 VAC 60-20-200. Does this mean that a dentist can have 4 hygienists working simultaneously? Two hygienists working under his direction + being examined and 2 hygienists working under general supervision."**

A: No, a dentist may not have 4 hygienists working simultaneously. The dentist should only employ general supervision during planned absences. A dentist may only have 2 hygienists working in his office practice at one and the same time.

Questions and comments regarding the information in this bulletin should be directed to the executive director of the Board, Sandra K. Reen at (804) 662-9906 or 6603 West Broad Street, 5th Floor, Richmond, Virginia, 23230-1712 or sandra.reen@dhp.state.va.us.

This bulletin is posted on the Board of Dentistry web page at http://www.dhp.state.va.us/dentistry/default.htm.

*Minor editorial changes to correct spelling and to remove redundant language, etc. have been made to the Special Bulletin during the editing process for this publication.

## Reen, Sandra (DHP)

**From:** Reen, Sandra (DHP)
**Sent:** Monday, September 29, 2014 5:16 PM
**To:** 'Terry Dickinson'
**Subject:** CDT Codes

**Importance:** Low

Hi Terry:
One of the agenda items the Board's Regulatory/Legislative Committee will discuss on October 24, 2014 is whether a dentist might bill for a clinical examination performed by a dental hygienist who is practicing under general supervision. In preparation for the discussion, I have reviewed the 2014 and 2015 CDT Dental Procedure Codes (CDT) and found the following information in both editions:

- The Preface addresses **Using the CDT Code** and states this quoted information: "2. General practitioners, specialists, and other individuals may report any of the listed CDT Codes as long as they are acting within the scope of their state law."
- The CDT Code section addressing **Clinical Oral Evaluations** opens with a statement which includes this quoted information: " The collection and recording of some data and components of the dental examinations may be delegated; however, the evaluation, which includes diagnosis and treatment planning, is the responsibility of the dentist." It goes on to state "Report additional diagnostic and/or definitive procedures separately." This section includes codes for 7 types of evaluations including "D0120 periodic oral evaluation - established patient."
- There are two **Pre-diagnostic Services** codes without an opening statement. One is for **screening** (D0190) to determine if someone needs to see a dentist for diagnosis. The second one is for **assessment** (D0191) through "a limited clinical inspection" to identify conditions that may need "referral for diagnosis and treatment."
- The **Diagnostic Imaging** section does open with a statement similar to the one addressed in the second bullet. This statement does not address who may capture images but does say dentists should retain the original images.

After taking a fresh look at this information, I think the intent of the codes noted above are pretty clear. Would you please review and comment on my preliminary conclusions:

- A dentist must have completed any of the 7 types of evaluations including diagnosis and treatment planning before any of the Clinical Oral Evaluations codes can be billed.
- Diagnostic procedures may be performed by other individuals, i.e. dental hygienists, to be considered by the dentist in completing any of the evaluations and those procedures should be billed separately using an appropriate code.
- There is no indication that the diagnostic procedures performed by other individuals, i.e. dental hygienists, has to be done on the same day the dentist completes the evaluation so in Virginia a dentist could order such procedures not restricted to dentists to be performed under general supervision, i.e. taking radiographic images, or completing a limited clinical inspection of periodontal conditions.

If you have questions about the accuracy or completeness of any of these conclusions, would you please ask for clarification from someone at the ADA who works with the CDT?
Thank you for your assistance,
Sandy

Sandra K. Reen, Executive Director
Virginia Board of Dentistry
9960 Mayland Drive, Suite 300
Henrico, VA 23233-1463
804-367-4437

the public by providing reference to VBOD statutes and regulations; however, any such assistance provided by VBOD staff shall not be construed as legal advice for any particular situation, nor shall any such assistance be construed to communicate all applicable laws and regulations governing any particular situation or occupation. Please consult an attorney regarding any legal questions related to state and federal laws and regulations, including the interpretation and application of the laws and regulations of VBOD.

UNDER NO CIRCUMSTANCES SHALL VBOD, ITS MEMBERS, OFFICERS, AGENTS, OR EMPLOYEES BE LIABLE FOR ANY ACTIONS TAKEN OR OMISSIONS MADE IN RELIANCE ON ANY INFORMATION CONTAINED IN THIS EMAIL.

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October 3, 2014

Dr. Terry D. Dickinson
Executive Director
Virginia Dental Association
3460 Maryland Court, Suite 110
Richmond, VA 23233

Dear Doctor Dickinson:

Thank you for contacting ADA staff before responding to Ms. Reens' conclusions concerning the CDT Code. I offer the following comments for your use when responding to her request for feedback.

Please note that these comments concern the CDT Code's intent, and apply to all procedures listed in the Diagnostic category of service, as well as every category of service that follows (i.e., Preventive through Adjunctive).

a) The CDT Code is a documentation and reporting code set that is used for patient record-keeping and, as a named HIPAA national standard, must be used on the standard dental claim transaction.

b) The CDT Code provides any practitioner a means to document dental services delivered to a patient. A practitioner's authority to deliver such services is determined by applicable state law. Such law may establish a practitioner's level of independence or required supervision.

c) Descriptors, where present, are one component of a CDT Code entry and are intended to further describe the nature and scope of the procedure; descriptors do not specify time frames for individual procedure completion, or completion of related procedures. Such determinations are made by the practitioner.

d) Descriptors, where present, identify both necessary and optional (e.g., "...may include...") components of the procedure. The practitioner determines which of the optional components are appropriate for a specific patient.

e) Likewise, the CDT Code does not specify what interval, if any, should separate completion of the procedure and submission of a claim for reimbursement by the dental plan. Such timing requirements may be part of a participating provider contract.

I would like to link the comments listed above to Ms. Reen's three preliminary conclusions.

1) A dentist must have completed any of the 7 types of evaluations including diagnosis and treatment planning before any of the Clinical Oral Evaluations codes can be billed.

   Comments "b)" and "c)" are relevant. State law determines whether a practitioner may deliver a procedure and seek reimbursement. The practitioner determines which of the optional components are necessary based, for example, on the clinical condition of the patient's oral cavity (e.g., no perio charting a fully edentulous patient).

2) Diagnostic procedures may be performed by other individuals, i.e. dental hygienists, to be considered by the dentist in completing any of the evaluations and those procedures should be billed separately using an appropriate code.

   Comments "b)" and "d)" are relevant in terms of permissible actions by a given practitioner, and the "Clinical Oral Evaluations" descriptor recognizes that some procedures that allow the dentist to complete a diagnosis (e.g., radiographs) may be performed by individuals other than the dentist.

3) There is no indication that the diagnostic procedures performed by other individuals, i.e. dental hygienists, has to be done on the same day the dentist completes the evaluation so in Virginia a dentist could order such procedures not restricted to dentists to be performed under general supervision, i.e. taking radiographic images, or completing a limited clinical inspection of periodontal conditions.

   Comments "b)" and "d)" are also relevant to this conclusion.

Should there be any other questions, or points to clarify, concerning the CDT Code please contact Council staff, Mr. Frank Pokorny, senior manager, Center for Dental Benefits, Coding and Quality (312-440-2752 / pokornyf@ada.org).

Sincerely,

David Preble, DDS, JD, CAE
Vice-President, Practice Institute

DP/fp
cc: Dr. Krishna Aravamudhan, director, Council on Dental Benefit Programs
Mr. Dennis McHugh, manager, Center for Dental Benefits, Coding and Quality

## Agenda Item: Changing the Education Requirement for Dental Licensure

**18VAC60-20-60. Educational requirements for dentists and dental hygienists.**

A. Dental licensure. An applicant for dental licensure shall be a graduate and a holder of a diploma or a certificate from a dental program accredited by the Commission on Dental Accreditation of the American Dental Association, which consists of either a pre-doctoral dental education program or at least a 12-month post-doctoral advanced general dentistry program or a post-doctoral dental education program in any other specialty.

B. Dental hygiene licensure. An applicant for dental hygiene licensure shall have graduated from or have been issued a certificate by a program of dental hygiene accredited by the Commission on Dental Accreditation of the American Dental Association.

Information included:

- Dr. Wyman's request to address this topic
- Information on number of persons licensed with Advanced Education
- CA, VT and SD Provisions

## Reen, Sandra (DHP)

**From:** Reen, Sandra (DHP)
**Sent:** Tuesday, April 29, 2014 9:49 AM
**To:** Bruce Wyman
**Subject:** RE: Item for the June Board meeting

**Importance:** Low

Hi Bruce:
I will see if I can find any available info on other states' licensure requirements to include in the agenda package. It would be helpful for you to address what prompts your concerns and the sources of information you are relying on regarding the quality of the applicants.
Smile,
Sandy

**From:** Bruce Wyman [mailto:bswyman@gmail.com]
**Sent:** Monday, April 28, 2014 10:11 AM
**To:** Reen, Sandra (DHP)
**Subject:** Re: Item for the June Board meeting

II have had individual discussions with several board members and we all agree that one year is not enough to require, given the quality of some of the people that are being licensed with only one year of postgraduate training in United States. I do not have any written material.

Do you have any way of researching other states requirements in this matter?

Bruce Wyman
Sent from my iPhone

On Apr 28, 2014, at 9:31 AM, "Reen, Sandra (DHP)" <Sandra.Reen@DHP.VIRGINIA.GOV> wrote:

> Hi Bruce:
> I will include this on the Board's June 13 meeting agenda. Please send me any information you want included in the agenda package by May 20.
> Smile,
> Sandy
>
> **From:** Bruce Wyman [mailto:bswyman@gmail.com]
> **Sent:** Sunday, April 27, 2014 4:21 PM
> **To:** Reen, Sandra (DHP)
> **Subject:** Item for the June Board meeting
>
> Sandy,
> I know I had something similar to this was on a recent meeting agenda and then I dropped it, but I would like to again place on the agenda a requirement that any dentist who has a dental degree from anywhere other than the US or Canada be required to have at least 2 years of postgraduate studies in the US rather than the current 1 year requirement.
>
> Thanks again and I will see you on Friday when I will be attending the Regulatory Comm. Meeting.
>
> Bruce Wyman

## Reen, Sandra (DHP)

**Subject:** FW: Special Data Report

**Importance:** Low

**From:** Gallini, Mike (DHP)
**Sent:** Wednesday, November 27, 2013 12:37 PM
**To:** Reen, Sandra (DHP)
**Subject:** RE: Special Data Report

Sandy,
Attached are the numbers we've come up with, see Sarah's explanation below. To summarize, based on the data we have in L2K and our ability to identify those who only completed an advanced dental program we found 213 licensees of this type and only 1 with disciplinary action.

From Sarah:

Mike,

After talking with Kathy Lackey about how they identify these applicants for a Dentist license, we determined that on the Education tab in the Degree/Certificate field, Other is listed. We also determined that any Dentist with this entry who also had an Education entry with DDS or DMD in the Degree/Certificate field would be excluded from this group of licensees.

I found a total of 213 Dentist licenses based on this criteria. Only 1 of these Dentists had a Disciplinary Action on their record. The attached spreadsheet has the records. The tab that lists all of the Dentists has some multiple entries (total of 224) since some had multiple Education entries for Other.

Let us know if there is anything else you need.

Thanks,
Mike

# Dental License Applicants

## LICENSURE BY RESIDENCY

Effective February 1, 2008 individuals may qualify for dental licensure on the basis of completion of a minimum of 12 months of a general practice residency or advanced education in general dentistry program approved by the ADA's Commission on Dental Accreditation (CODA) and meeting the following requirements:

Requirements include a completed application and application fee of $100.00 with completed Residency 1(07/08) form and proof of:

- Graduation from a Commission on Dental Accreditation (CODA) of the ADA approved dental school or board approved dental school,
- Completion of a CODA-approved general practice residency OR advanced education in general dentistry program as certified by the program director on the Certification of Clinical Residency Completion form (07/08),
- Successful completion of Part I and Part II of the National Board Dental Examination of the Joint Commission on National Dental Examinations,
- Not failing the WREB or California clinical examination within the last five (5) years (A letter from WREB stating that the applicant has not failed the WREB clinical examination within the last five years is acceptable proof); and,
- Completion of fingerprinting requirements pursuant to Section 1629(b) of the Business and Professions code.

Additional requirements for issuance of a California dental license are:

- Successful completion of the California Law and Ethics exam, and
- Fingerprint clearances received from Dept. of Justice and the FBI, and
- Completion of Lic-2 (11/07) Application for Issuance of License and Registration of Place of Practice (will be mailed to the applicant upon completion of all other licensure requirements).

To find out if your general practice residency or advanced education in general dentistry program is CODA-approved, you may contact the American Dental Association at (312) 440-2500 or visit http://www.ada.org/en/home-ada/coda/find-a-program/search-dental-programs/dds-dmd-programs to search for either Advanced Education in General Dentistry 12 months or General Practice Residency 12 months programs that are approved by CODA.

## APPLICATIONS AND CERTIFICATIONS

Application for Determination of Licensure Eligibility (Residency)

Certification of Clinical Residency Completion

Application for Law and Ethics Examination

For more information, contact Jennifer Casey at (916) 263-2510 or jennifer.casey@dca.ca.gov.

Vermont Secretary of State
Office of Professional Regulation
89 Main Street, 3rd Floor
Montpelier VT 05620-3402

Diane Lafaille
Licensing Board Specialist
(802) 828 – 2390
diane.lafaille@sec.state.vt.us
www.vtprofessionals.org

## BOARD OF DENTAL EXAMINERS

### INSTRUCTIONS TO APPLICAN'TS APPLYING FOR LICENSURE AS A DENTIST BY EXAMINATION

1.) Completed Application

2.) Application fee of $225.00 made payable to the Vermont Secretary of State's Office. This fee is non-refundable.

3.) "Verification of Good Standing" form – Have every state in which you now hold or have ever held a license to practice complete this page.

4.) "Verification of Education" to be completed by a registrar where you received your degree

5.) Three letters of recommendation from licensed dentists or physicians on letterhead.

6.) National Board Examination Scores (photocopy)

7.) Regional Board Scores (photocopy) (NERB/ADLEX; CRDTS; CITA; SRTA, WREB)

8.) Proof of Emergency Office Procedure Course, OR a CPR course

9.) Jurisprudence Examination

10.) "Application for Endorsement to Administer General Anesthesia" form, if applicable.

### INSTRUCTIONS TO APPLICANT'S APPLYING FOR LICENSURE AS A DENTIST ON THE BASIS OF ENDORSEMENT

1.) Completed Application

2.) Application fee of $225.00 made payable to the Vermont Secretary of State's Office. This fee is non-refundable.

3.) "Verification of Good Sanding" form – Have every state in which you now hold or have ever held al license to practice complete this page.

4.) "Verification of Education" to be completed by a registrar where you received your degree

5.) Three letters of recommendation from licensed dentists or physicians on letterhead

6.) Proof of Emergency Office Procedure Course OR a CPR course

7.) Jurisprudence Examination

8.) "Application for Endorsement to Administer General Anesthesia" form, if applicable.

## HOW TO QUALIFY FOR LICENSURE

**I am licensed in another jurisdiction, Am I Eligible to Apply for Licensure as a Dentist in Vermont.**

There are several ways in which you may qualify for licensure as a Dentist in the Vermont. We have created a Yes/No questionnaire that you can go through to determine which avenue applies to you. If you are not eligible under any of the provisions below you may still be eligible under Rule 4.2, Licensure by Examination.

**1) Endorsement (Rule 4.5)**

| | | |
|---|---|---|
| 1. Are you currently licensed to practice dentistry in any jurisdiction of the U.S. or Canada whose licensing requirements are substantially equivalent to those of this state? | YES | NO |
| 2. Are you in good standing in those other jurisdictions? | YES | NO |
| 3. Have you been in active practice? (See Rule 2.1(a)1 or Rule 4.5(b)) | YES | NO |
| 4. Have you completed an "emergency office procedure" training as described in Rule 2.1(1)? | YES | NO |

If you have answered yes to all the questions above then you are eligible to apply for licensure based on Endorsement. You will have to complete the application, pay the fee, and take the Vermont Laws and Rules exam.

If the answer to any of these questions is "No", then you are not qualified for licensure, under this section.

**2) PGY Licensed Experience: Endorsement, 5 Year Rule (4.6)**

| | | |
|---|---|---|
| 1. Are you licensed in another jurisdiction where you obtained that license through a CODA approved PGY1 residency program? | YES | NO |
| 2. Are you in good standing in all jurisdictions where you are licensed? | YES | NO |
| 3. Have you been in practice full time (at least 1,200 hours per year) for a minimum of five years? | YES | NO |
| 4. Have you completed, an "emergency office procedure" training as described in Rule 2.1(1)? | YES | NO |

If you have answered yes to all the questions above then you are eligible to apply for licensure based on PGY Licensed Experience: Endorsement. You will have to complete the application, pay the fee, and take the Vermont Laws and Rules exam.

If the answer to any of these questions is "No", then you are not qualified for licensure, under this section.

**3) Licensed Experience, 5 Year Rule (4.7)**

| | | |
|---|---|---|
| 1. Are you currently licensed to practice dentistry in any jurisdiction of the U.S. or Canada? | YES | NO |
| 2. Are you in good standing in those other jurisdictions? | YES | NO |
| 3. Have you been in practice full time of at least 1,200 hours per year for a minimum of five years immediately preceding this application? | YES | NO |
| 4. Have you completed an "emergency office procedure" training as described in Rule 2.1(1)? | YES | NO |

If you have answered yes to all the questions above then you are eligible to apply for licensure based on Licensed Experience. You will have to complete the application, pay the fee, and take the Vermont Laws and Rules exam.

If the answer to any of these questions is "No", then you are not qualified for licensure, under this section.

www.sdboardofdentistry.com

605-224-1282

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**Brittany Novotny JD, MBA**
Executive Secretary

**Phone**: 605-224-1282
**Fax**: 1-888-425-3032

**contactus@sdboardofdentistry.com**

# Licensure

The South Dakota State Board of Dentistry licenses Dentists, Dental Hygienists, Advanced Dental Assistants and Dental Radiographers.

**Dentists and Dental Hygienists:**
Applicants may apply for licensure in South Dakota by using one of the following license applications:

*The Regular License Application* is for recent graduates of an accredited dental or dental hygiene school who are not currently licensed in another state or individuals that are licensed in another state but have been practicing less than three (3) years.

*The Application by Credential Verification* is for individuals that are currently licensed in another state and have been practicing at least three (3) out of the last five (5) years.

**Advanced Dental Assistants:**
Any dental assistant who performs expanded functions in a dental office must be licensed by the State Board of Dentistry as an Advanced Dental Assistant.

**Dental Radiographer:**
Any dental assistant who takes x-rays in a dental office must be licensed by the State Board of Dentistry as a dental radiographer.

**Licensing Information for Foreign-Trained Dentists/Dental Hygienists:**
**20:43:03:04.01. Requirements for foreign-trained dentists and dental hygienists.** A foreign-trained dentist or dental hygienist that has not graduated from a dental or dental hygiene school accredited by the American Dental Association Commission on Dental Accreditation must meet the following requirements:

(1) Meet all requirements of § 20:43:03:01 or 20:43:03:04 for a dentist or a dental hygienist; and

(2) In lieu of graduation from a dental or dental hygiene school accredited by the American Dental Association Commission on Dental Accreditation, the applicant must submit certification from a dental or dental hygiene school accredited by the American Dental Association Commission on Dental Accreditation stating that the applicant has been tested and received the training necessary for the school to certify, in writing, that the applicant is equal in knowledge and ability to a graduate of a dental or dental hygiene school accredited by the American Dental Association Commission on Dental Accreditation in the United States or Canada within the five years preceding the date of application.

*Note: The State Board of Dentistry does not accept certification from Educational Credential Evaluators, Inc. (ECE).



Privacy Policy

**Agenda item: Practice Ownership**

The Board charged the Regulatory/Legislative Committee to develop a proposal to address concerns advanced through public comment and through disciplinary case to address who might own a practice and to consider policies to address the accountability of corporate owners. The Committee is charged to work with a Regulatory Advisory Panel (RAP) to develop a proposal.

Formation of the RAP is still pending. Ms. Reen will report on a meeting with DMAS to address this topic which was coordinated by Dr. Brown, Director of DHP.

Information included in the agenda package for review and discussion:

- Association of Dental Support Organizations' Code of Ethics
- Texas Rules Addressing Control of Dental Practices
- A Proposed Classification of Dental Group Practices

Association of Dental Support Organizations

# ADSO Code of Ethics

Principles of Member Company Conduct

Member Company Governance

Amendments

## Preamble

America's dental services market is evolving to meet the dental needs of the nation's growing population. Dental Support Organizations (DSOs) help dental care professionals meet those needs by assisting dentists with non-clinical business and administrative functions of operating a dental office. Every year, an increasing number of practicing dentists maximize their professional potential by choosing to be supported by a DSO for non-clinical services, or deciding to work as an associate in a dental practice that has contracted for dental support services, so that they may focus on providing dental care to their patients.

The purpose of the Association of Dental Support Organizations (ADSO) CODE OF ETHICS (the Code) is to serve as a standard of conduct for all member companies. Company compliance with the ADSO Code of Ethics is a requirement for membership in the ADSO. This Code of Ethics embodies ADSO's mission and confirms that member companies shall act with fairness, honesty, and the highest ethical standards in all business activities; for ADSO member companies, upholding the highest ethical standards comes before everything else.

By abiding by the ADSO Code of Ethics, each ADSO member company affirms that its objective is to support dentists so that they may focus on improving the quality of dental care for their patients and the quality of life for themselves and their dental professional colleagues. ADSO member companies have an obligation to act in ways that will merit the trust, confidence, and respect of dental professionals and the general public. By engaging an ADSO member company, dental professionals can be sure they are dealing with an organization committed to providing quality business service and supporting ethical conduct at the highest levels.

## Code of Ethics

I. Principles of Member Company Conduct

A. ADSO Member Companies Act with Integrity

ADSO member companies act with honesty, integrity, fairness and respect towards all. It is important for ADSO member companies to act in a manner that supports the dental profession by performing administrative functions with the utmost care while refraining from engaging in activities that damage the credibility of the dental business support services industry. ADSO member companies will be truthful in all communications. All ADSO member companies must comply in good faith with all material requirements of law in any city, county and state in which they do business. Therefore, this Code does not restate all legal obligations.

B. ADSO Member Companies' Focus on Meeting the Needs of DentistsAs health professionals who dedicate their careers to meeting patients' oral health needs, dentists play a vital role in society. DSOs exist to provide non-clinical support services which enable dentists to serve their patients and communities as effectively and efficiently as possible and increase access to dental treatment.

C. ADSO Member Companies Never Interfere with Dentists' Clinical Decision-Making and Treatment Services

ADSO member companies recognize and support the clinical autonomy of dentists and respect that only licensed medical professionals should engage in clinical decision-making and the delivery of dental treatment services. DSOs provide administrative support services for providers. ADSO member companies never set quotas or support dental practices that set quotas on providers based on the number of procedures or types of procedures. ADSO member companies will never interfere with the efficient and effective access to patient records by a dentist or dental practice.

D. ADSO Member Companies Employ Qualified Staff and Use Proven Methods to Deliver Effective Support

Thousands of dentists engage ADSO member companies to provide state-of-the-art non-clinical support services. ADSO member companies view this relationship as both a privilege and a responsibility. As a result, ADSO member companies endeavor

to employ qualified, dedicated staff and deploy appropriate technologies, administrative methods, and supply-procurement and other processes and skills to enable their dentist-clients to operate supported practices as efficiently as possible.

E. ADSO Member Companies Provide a Variety of Business Support Services to meet the Needs of Dentists

ADSO member companies meet the needs of dentists in a variety of practice settings. As such, ADSO member companies serve dentists operating as solo providers, in small dental groups, and in large dental group practices. ADSO member companies provide a variety of models to meet dentists' unique needs.

F. ADSO Member Companies Are Dedicated to Supporting Dentists as They Meet Needs at Home and Abroad

ADSO member companies are privileged to support dentists who are committed to meeting critical societal needs. From charitable action in their communities, to addressing America's dental care access, to making a difference around the world, dentists play a vital role. ADSO member companies share this commitment and are proud to both support dentists in their charitable endeavors and engage directly in humanitarian action at home and abroad.

II. Member Company Governance

A. Self-Regulation

This Code of Ethics is not law, but its obligations require a level of ethical behavior from its member companies. Non-observance of this Code does not create any civil responsibility or liability whatsoever; however, suspension or termination of ADSO membership and the benefits thereto and the cessation of all references to or use of the ADSO name or logo may result.

B. ADSO Member Company Responsibilities and Duties

***1. ADSO Member Company Ethics Officer***

a. Each ADSO member company shall designate an ADSO Ethics Officer (DEO). The DEO is responsible for facilitating compliance with the ADSO Code of Ethics by their company and responding to inquiries by the Ethics Committee. He or she will also serve as the primary contact at the company

for communicating the principles of the ADSO Code of Ethics to their company officers, partners, employees, contractors, clients, vendors, clinicians and the general public.

b. Every year at renewal, member companies are asked to reaffirm the selected DEO or designate another individual to serve as DEO.

c. Each year at renewal, the DEO for each ADSO member company shall execute an attestation of the member's compliance with this Code.

***2. Internal Regulation***

a. Each ADSO member company shall establish, within the member company complaint handling procedures to assist prompt resolution of complaints regarding an ADSO member company's relationship with its supported dentists.

b. In the event any individual or entity complains directly to an ADSO member company that it believes that the member company has engaged in any improper course of conduct pertaining to the services provided or offered to its DSO supported dentists, the ADSO member company shall promptly investigate the complaint and shall take such corrective actions as it may find appropriate and necessary.

c. The ADSO member companies subscribing to this Code recognize that its success will require diligence in creating awareness among supported dentists, contractors, employees, officers, directors, partners, and/or agents of the ADSO member companies' obligations under the Code. No ADSO member shall in any way attempt to persuade, induce or coerce another ADSO member to breach this Code, and the ADSO members hereto agree that the inducing of the breach of this Code will be considered a violation of the Code.

C. ADSO Administration

***1. Interpretation and Execution***

The Board of Directors of the ADSO shall appoint an Ethics Committee to serve for a fixed term to be set by the Board prior to appointment. The Ethics Committee will be responsible directly and solely to the Board. The Board of

Directors will establish all procedures necessary to administer the provisions of this Code.

***2. Ethics Committee***

a. The Ethics Committee shall be comprised of an odd number between five and nine members of the Board of Directors, or others appointed in the discretion of the Board of Directors, and shall be appointed for staggered three-year terms.

b. The Ethics Committee shall review annually the Code of Ethics and make recommendations.

c. The Ethics Committee shall answer as promptly as possible all queries posed by member companies relating to the Code and its application, and, when appropriate, may suggest, for consideration by the Board of Directors, revisions to the Code to make it more effective.

d. The Ethics Committee shall participate in the new member application process by undertaking an ethics review of all applicant companies as directed by the Board of Directors.

***3. Complaint Processing***

a. The Ethics Committee may establish, publish and implement transparent complaint handling procedures to the ADSO member companies to ensure prompt resolution of all complaints regarding an ADSO member company's relationship with its supported dentists. In determining such complaint procedures, the Ethics Committee shall endeavor to ensure that the complaint handling procedures provide, in the Ethics Committee's opinion, fair notice to member companies of any complaints made against them and are afforded due process in the complaint handling procedures.

b. The Ethics Committee, in accordance with the complaint handling procedures, shall hear and determine all charges against member companies, affording such member company an opportunity to understand all allegations against the member and to be heard fully in response to the allegations.

c. Upon receipt of a complaint, the Ethics Committee shall undertake to determine whether a violation of the Code has occurred.

d. Upon completion of its review, the Ethics Committee shall make a recommendation to the Board of Directors. The recommendation may include one or more of the following actions.

i. If, in the judgment of the Ethics Committee, a complaint is beyond its scope of expertise or resources, the Ethics Committee may decline to exercise jurisdiction in the matter and may, in its discretion, recommend to the complainant another forum in which the complaint can be addressed.

ii. The Ethics Committee may determine that a complaint is invalid and dismiss it or may issue a "no finding" decision, if appropriate in the Ethics Committee's sole discretion.

iii. Require the accused member company to submit to the Ethics Committee a written commitment to abide by the ADSO Code of Ethics in future practices, behaviors and/or transactions and to exercise due diligence to assure there will be no recurrence of the practice leading to the subject Code complaint.

iv. Reprimand the Member.

iv. Suspension of the Member.

v. Termination of the Member.

## III. Amendments

This Code may be amended by a two-thirds vote of the Board of Directors.

**Association of Dental Support Organizations**

19751 East Mainstreet, Suite #340
Parker, CO 80138
Info@TheADSO.org
844.500.ADSO

OCCUPATIONS CODE

TITLE 3. HEALTH PROFESSIONS

SUBTITLE D. DENTISTRY

CHAPTER 254. BOARD POWERS AND DUTIES

Sec. 254.001. GENERAL RULEMAKING AUTHORITY. (a) The board may adopt and enforce rules necessary to:

(1) perform its duties; and

(2) ensure compliance with state laws relating to the practice of dentistry to protect the public health and safety.

(b) The board may adopt rules governing:

(1) the board's proceedings; and

(2) the examination of applicants for a license to practice dentistry.

Acts 1999, 76th Leg., ch. 388, Sec. 1, eff. Sept. 1, 1999.

Sec. 254.0011. RULES RELATING TO CONTROL OF DENTAL PRACTICE. (a) The board may adopt rules relating to the practice of dentistry as described by Section 251.003(a)(9) to prohibit a dentist from engaging in contracts that allow a person who is not a dentist to influence or interfere with the exercise of the dentist's independent professional judgment.

(b) Rules adopted by the board under this subtitle may not preclude a dentist's right to contract with a management service organization. Rules affecting contracts for provision of management services apply the same to dentists contracting with management service organizations and to dentists otherwise contracting for management services.

Added by Acts 2001, 77th Leg., ch. 1420, Sec. 14.074(a), eff. Sept. 1, 2001.

Sec. 254.002. RULES REGARDING ADVERTISING AND COMPETITIVE BIDDING. (a) Except as provided by Section 259.005, the board may not adopt rules restricting advertising or competitive bidding except

Sec. 254.019. DEFINITIONS. (a) In this section:

(1) "Dental service agreement" means an agreement between a dental service organization and a dentist under which the dental service organization will:

(A) provide services related to the nonclinical business aspects of a dental practice, including arranging or providing financing, performing billing or payroll tasks, processing patient insurance claims, scheduling or otherwise interacting with patients, and performing other administrative tasks;

(B) supervise or manage the employees or contractors of the dentist; or

(C) employ or otherwise contract with a dentist in the dentist's capacity as a dentist.

(2) "Dental service organization" means an entity that:

(A) is owned wholly or partly by a person who is or is not a dentist; and

(B) under a dental service agreement, provides or offers to provide services to a dentist or employs or otherwise contracts with a dentist in the dentist's capacity as a dentist.

(b) The board shall collect the following information from dentists licensed by the board in conjunction with the issuance and renewal of each dental license:

(1) the number and type of dentists employed by the license holder, if any;

(2) the name under which the license holder provides dental services and each location at which those services are provided by that license holder;

(3) whether the license holder is a participating provider under the Medicaid program operated under Chapter 32, Human Resources Code, or the child health plan program operated under Chapter 62, Health and Safety Code;

(4) whether the license holder is employed by or contracts with a dental service organization and, if so, the name and address of the dental service organization;

(5) whether the license holder owns all or part of a dental service organization and, if so, the name and address of the dental service organization and of each dental office at which the dental service organization provides services to patients;

(6) whether the license holder is a party to a dental service agreement and, if so, the name and address of the dental service organization that provides services under the agreement; and

(7) if the license holder owns all or part of a dental service organization, whether that practice is a party to a dental service agreement and, if so, the name and address of the dental service organization that provides services under the agreement.

(c) If requested by the board, a dental service organization shall provide to the board the address of the locations where the organization provides dental services in this state and the name of each dentist providing dental services at each location.

(d) The board shall provide an option for the electronic submission of the information required under this section.

(e) Not later than November 1 of each even-numbered year, the board shall provide a report to the legislature on the information collected under this section and on the board's use of the information in the exercise of the board's statutory authority to regulate the practice of dentistry.

Added by Acts 2013, 83rd Leg., R.S., Ch. 709 (H.B. 3201), Sec. 4, eff. September 1, 2013.

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| TITLE 22 | EXAMINING BOARDS |
| PART 5 | STATE BOARD OF DENTAL EXAMINERS |
| CHAPTER 108 | PROFESSIONAL CONDUCT |
| SUBCHAPTER F | CONTRACTUAL AGREEMENTS |
| **RULE §108.73** | **Dental Service Organizations** |

Upon written request by the Board, a dental service organization, as defined by §254.019(c) of the Dental Practice Act, shall provide to the Board the address of the locations where the organization provides dental services in this state and the name of each dentist providing dental services at each location.

**Source Note:** The provisions of this §108.73 adopted to be effective August 25, 2013, 38 TexReg 5262

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| TITLE 22 | EXAMINING BOARDS |
| PART 5 | STATE BOARD OF DENTAL EXAMINERS |
| CHAPTER 108 | PROFESSIONAL CONDUCT |
| SUBCHAPTER F | CONTRACTUAL AGREEMENTS |
| RULE §108.70 | **Improper Influence on Professional Judgment** |

(a) For the purposes of this rule, the term dentist shall include the following:

(1) a dentist licensed by the State Board of Dental Examiners;

(2) a professional corporation wholly owned by one or more dentists;

(3) other entities that provide dental services and are owned by one or more dentists.

(b) Any dentist entering into any contract, partnership or other agreement or arrangement which allows any person other than a dentist any one or more of the following rights, powers or authorities shall be presumed to have violated the provisions of the Dental Practice Act, Section 251.003 regarding controlling, attempting to control, influencing, attempting to influence or otherwise interfering with the exercise of a dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition:

(1) Controlling, owning or setting any conditions for access to or the specific contents of dental records of patients of a dentist.

(2) Setting a maximum or other standardized time for the performance of specific dental procedures.

(3) Placing any limitations or requirements on treatments, referrals, or consultations except those based on the professional judgment of the dentist.

(4) Limiting or imposing requirements concerning the type or scope of dental treatment, procedures or services which may be recommended, prescribed, directed or performed, except that a dentist may limit the dentist's practice or the practice of a dentist employed by or contracting with the dentist to certain procedures or the treatment of certain dental diseases.

(5) Limiting or imposing requirements concerning the supplies, instruments or equipment deemed reasonably necessary by a dentist to provide diagnoses and treatment of the patients of the dentist.

(6) Limiting or imposing requirements for the professional training deemed necessary by the dentist to property serve the patients of the dentist.

(7) Directing or influencing the selection of specific diagnostic examinations and treatment or practices regarding patients without due regard to the recommended diagnostic examinations and treatment agreed upon by the dentist and the patient, except that a dentist having the responsibility for training or supervising another dentist may reasonably limit treatment or practices as a part of the training or supervision of a dentist based upon the training and competency of a dentist to perform certain treatment or practices

(8) Limiting or determining the duties of professional, clinical or other personnel employed to assist a dentist in the practice of dentistry.

(9) Establishing professional standards, protocols or practice guidelines which in the professional judgment of the dentist providing dental service to the dentist's patient, conflict with generally accepted standards within the dental profession.

(10) Entering into any agreement or arrangement for management services that:

(A) interferes with a dentist's exercise of his/her independent professional judgment;

(B) encourages improper overtreatment or undertreatment by dentists; or

(C) encourages impermissible referrals from unlicensed persons in consideration of a fee.

(11) Placing limitations or conditions upon communications that are clinical in nature with the dentist's patients.

(12) Precluding or restricting a dentist's ability to exercise independent professional judgment over all qualitative and quantitative aspects of the delivery of dental care.

(13) Scheduling patients of the dentist in a manner that may have the effect of discouraging new patients from coming into the dentist's practice, or postponing future appointments or that give scheduling preference to an individual, class or group.

(14) Penalizing a dentist for reporting violations of a law regulating the practice of dentistry.

(15) Conditioning the payment of fees to a dentist or the amount of management fees a dentist must pay, on the referral of patients to other health care providers specified by a non-dentist.

(c) The entry into one or more of the following agreements by a dentist shall not be presumed to have violated the Texas Dental Practice Act, Section 251.003.

(1) Leases, mortgages, ownership agreements or other arrangements regarding use of space for dental offices, based on a set, non percentage fee reasonably related to the fair market value of the office space provided at the time the lease or other arrangement is entered into.

(2) Agreements regarding the purchase, sale, financing or lease of dental equipment, instruments and supplies so long as the dentist maintains the complete care, custody, and control of the dental instruments and supplies and the lease does not provide for a payment or fee based upon a percentage of the revenue received by the dentist, or the dental practice.

(3) Agreements providing for accounting, bookkeeping, investment or similar financial services.

(4) The financing, lease, use or ownership of non-dentist business equipment such as telephones, computers, software, and general office equipment at reasonable, market related fees.

(5) Services regarding the pledge, collection or sale of accounts receivable from patients.

(6) Agreements regarding billing and collection services.

(7) Advertising and marketing services so long as the dentist remains solely responsible for the content of any advertising or marketing services and for ensuring that such conform to all applicable legal requirements.

(8) Agreements regarding consulting, professional development, business practices and other advisory agreements which do not limit the dentist's ability to use the dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition.

(9) Employment agreements which specify that the dentist shall continue to have the right to use the dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition, provided that in practice the dentist is allowed to use the dentist's professional judgment.

(d) The provisions of subsection (c) of this section herein may be rebutted and the entry into these agreements or other undertakings may be found to be in violation of the Dental Practice Act if it can be shown that the agreements or other undertakings result in the control, attempt to control, influence, attempt to influence or otherwise interfere with the exercise of a dentist's independent professional judgment regarding the diagnosis or treatment of any dental disease, disorder or physical condition.

(e) This rule shall not be applicable to dentists or others covered by the Dental Practice Act, Section 251.004, entitled Exceptions, Section 260.001, regarding administration of an estate and continuation of practice nor Sections 260.002 through 260.004, regarding employment of dentists.

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**Source Note:** The provisions of this §108.70 adopted to be effective February 20, 2001, 26 TexReg 1494

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HPI Health Policy Institute
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Research Brief

# A Proposed Classification of Dental Group Practices

**Authors:** Albert Guay, D.M.D; Matthew Warren, M.A.; Rebecca Starkel, M.A.; Marko Vujicic, Ph.D.

The Health Policy Institute (HPI) is a thought leader and trusted source for policy knowledge on critical issues affecting the U.S. dental care system. HPI strives to generate, synthesize, and disseminate innovative research for policy makers, oral health advocates, and dental care providers.

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## Key Messages

- *The number of group practices in the United States is increasing; they are expanding and changing in character and structure. Understanding the evolution of group practices has been difficult because past discussions and research have suffered from a lack of specificity, and the information gathered was less insightful.*
- *A classification system for group dental practices is needed that would allow studies to be done and comparisons made in a more useful manner and allow a better understanding of contemporary dental group practice.*
- *Six basic types of group practice are identified and described.*

## Introduction

Dentistry is a profession in transition; change is occurring in many aspects of the profession. We are currently experiencing one of the more significant changes in the dental practice environment – the growth of large, multisite, group practices. Historically, a group practice was held to be a practice comprised of three or more dentists. Not only are group practices in the United States expanding, their character and structure are changing as well. This evolution is of great interest at this time. Unfortunately, there has been little research on this subject.

Kent Nash, Ph.D. wrote in the *Journal of the American Dental Association* in 1991, "Most dentists in private practice today own or share in the ownership of their practice. The dentist in most cases is a solo practitioner, a sole owner, and the only dentist in the practice treating patients. Dentists in ownership positions represent about 91.0 percent of all practicing dentists, and solo practitioners account for about two-thirds (67.0 percent) of all dentists."[1] The *Distribution of Dentists* survey conducted by the American Dental Association Health

Policy Institute in 2012 updated that information, finding a reduction in the proportion of dentists who were owners from 91.0 percent to 84.8 percent and a reduction of the proportion of dentists who were solo practitioners from 67.0 percent to 57.5 percent.[2]

Data from the 2007 Economic Census conducted by the U.S. Census Bureau,[3] the latest data available, show the number of office sites controlled by multiunit dental companies increased by 49.0 percent to 8,442 in 2007. Dental firms with more than ten offices and the number of offices they controlled increased from 157 in 1992 to 3,009 in 2007. Growth is continuing.

Not only has there been an increase in the number of group practices and the number of dentists involved in group practices, but there has also been a change in the configuration of some, with nonprofessional corporations managing practices and private equity groups investing significant funds in group practices.[4] Questions of "ownership" of practices have arisen and are being tested in some states.[5] In addition, entry of these entities into the practice of dentistry has stirred interest among traditional stakeholders in the potential impact on the quality of care patients receive. Some believe they exert pressure on practices to provide expensive and sometimes unnecessary care, especially for beneficiaries of government assistance programs,[6,7] while others do not.[8,9]

Past research on group practices has yielded some information of interest, but suffered from a lack of specificity in the various types of group practices in developing the sample used in the gathering of data. The information that was gathered clumped various types of practice together rendering the analyses and conclusions less meaningful. More broadly, there is no definitive, accepted framework for classifying the alternative practice models that would fall under the umbrella of "group practice," "corporate practice" or "retail dentistry."

A classification system for dental group practices is needed in order to proceed with research aimed at understanding the implications of alternative organizational set-ups. This system must be simple and general enough to be useful. It should recognize the cardinal feature or features which provide the commonality that practices in any category possess to place them into a distinct category. Besides being useful for guiding further research, this system will help provide a common lexicon to facilitate the understanding of the group practice arena by dental students, new dentists and dentists seeking to transition from their current state of practice to group practice.

In this research brief, we propose a new classification system for dental group practices, with the aim of disentangling the complex factors that are most important to understanding how dentists organize into groups.

## Methods

*The Classification*

In understanding the overall classification scheme, it may be useful to consider its structure as similar to a biological classification system: the system as the "family," each of the six classifications as a "genus," and the individual plans within the six classifications as the "species."

No practical system for classifying group dental practices can be precise, since there are unique variations among group practices even within general categories. However, based on the nature of group dental practices, they appear to cluster by significant *sine qua non* commonalities. We focus on a few key characteristics that we believe are of interest to the dental care community and have also been posited by others as important when it comes to various outcomes of interest such as practice efficiency, provider satisfaction and patient outcomes.

## Results

We group dental practices into six categories. Throughout our classification, 'group' refers to two or more dentists that are somehow affiliated with each other.

**Table 1:** Classification of Dental Group Practices

| | |
|---|---|
| Dentist Owned and Operated Group Practice | An aggregation of a variable number and/or type of dentists in a single practice that may be located at a single or multiple sites completely owned and operated by dentists, usually organized as a partnership or professional corporation. |
| Dental Management Organization Affiliated Group Practice | A group practice that has contracted with a dental management organization to conduct all of the business activities of the practice that do not involve the statutory practice of dentistry, sometimes including the ownership of the physical assets of the practice. There are several types of dental management organizations and there can be significant variations in the nature of the agreements between the dentist and the dental management organization. |
| Insurer-Provider Group Practice | A group practice that is part of an organization that both insures the health care of an enrolled population and also provides their health care services. |
| Not-for-Profit Group Practice | A group practice that is operated by a charitable, educational or quasi-governmental organization that often focuses on providing treatment for disadvantaged populations or training healthcare professionals. |
| Government Agency Group Practice | A group practice that is part of a government agency. It is organized and managed completely by the agency. All dentists are government employees or contractors and operate according to agency policies. |
| Hybrid Group Practice | A group practice that does not clearly fit into any of the above categories and can exhibit some characteristics of several of them. |

*Dentist Owned and Operated Group Practice*

This type of dental group practice is most familiar to dentists and the dental care system because it has been the most common form of group practice historically. These groups are aggregations of a variable number and/or type of dentists within a single dental practice that is completely owned and operated solely by dentists. The size of the groups varies widely, from two dentists working at one office location to a large number of dentists working across multiple office locations. These dentists could be any combination of general practitioners and/or specialists.

The distinguishing characteristic of these groups is that they are completely owned by dentists and the operation of the group practice is under the control of those owner dentists. The legal structure of these groups may be a single proprietorship, a partnership or a professional corporation. Dentists working in a group

may be the proprietor, a partner, a co-owner, an employee or a contract dentist. Some minor administrative services can be outsourced to vendors, but the vast majority of business functions are carried out by the practice owners.

*Dental Management Organization Affiliated Group Practice*

This type of group consists of a variable number or type of dentists that are affiliated with dental management organizations. These management organizations are known by a variety of names (e.g., dental service organization, dental management service organization, group dental organization, franchise). But their core function is the direct provision of or significant support in decision making related to the management of activities of a dental practice that do not involve the statutory practice of dentistry.

Laws in many states prohibit the ownership of dental practices by nondentists and/or restrict the influence nondentists can have on clinical care treating patients.[10] For this reason, dental practices within this category are commonly organized into two separate corporations—a professional corporation that is made up of the dentists in the practice and a management corporation that operates or provides services to the practice. The relationship between the two corporations is determined by a contract or series of contracts that vary from group to group.

This category of group practice is fairly new to the dental care sector and is still not very well understood by the dental community. The responsibilities of the management company in providing services to the dental practice vary according to the agreements between it and the professional corporation of dentists. In some instances, the management company owns all of the physical assets of the practice. In North Carolina, the true ownership status of some practices organized in this manner has been challenged; this case documents the complex arrangements between the two corporations that allegedly cloud the ownership issue. The central issue is the extent to which the management corporation, through its control over the operations of the practice, might be considered as engaging in the practice of dentistry.[11]

Irrespective of the challenges to ownership status, most management agreements involve responsibility for personnel management, supplies and equipment purchases, office space, patient flow, office policies, practice analytics and fee setting, revenue management and marketing—in essence, all of the major non-professional aspects of a practice.

One new development that has garnered media attention,[12] as well as the interest of policy makers, is the involvement of private equity firms in dentistry. A few high profile investments of this nature have raised the issue of the influence of investors, who typically require significant returns, on management corporations and, in turn, on clinical decision making.[13,14,15,16]

In examining the nature of group practices that are affiliated with dental management organizations and how it varies, seven basic characteristics are useful to examine:

- The type of practice organization
- The ownership structure of the professional organization affiliated with the management organization
- The ownership structure of the management organization
- The status of dentists in the professional organization
- The involvement of private equity firms
- The number of dentists and number office sites in the practice

**Table 2:** Key Characteristics of Dental Management Organization Affiliated Group Practices

| Characteristic | Description | Options |
|---|---|---|
| Type of Practice Organization | This captures the general set-up and branding arrangements. Franchise practices have agreements for the practice to identify itself under the franchise brand name, regardless of the ownership of the practice, and to abide by the specific franchise specifications and rules regarding use of the franchise name. Management affiliate practices are able to identify and brand the practice as they wish but have access to a suite of managerial services. Mixed practices is a category reserved for those practices that do not easily fall into the aforementioned categories. | Franchise<br>Management Affiliate<br>Mixed |
| Ownership Structure of the Professional Organization | The ownership of the professional organization is restricted to dentists in most states. The ownership may be held by a dentist who is an entrepreneur or by a group of participating dentists, with the remaining dentists employed by the corporation in various categories. Some professional organizations have a path for nonowner dentists to become owners and some do not, or they have restrictions on who may become owners. There may be different categories of ownership. | Entrepreneur<br>Participating dentists<br>Path to ownership |
| Ownership Structure of the Management Organization | The owners of the management organization need not be dentists, although there are some that happen to be owned by dentists. The owner may be an entrepreneur or a corporation, investment fund or a private equity firm. There may or may not be an opportunity for dentists to become owners of the management organization from within the cadre of involved dentists. | Entrepreneur<br>Corporation<br>Private equity group<br>Path to ownership |
| Status of Dentists in the Professional Organization | Dentists in these types of group practices may be owners, partners if there are multiple owners, and employees or private dentists who contract with the group practice to provide care for patients. | Owner<br>Partner<br>Employee<br>Contractor |
| Involvement of Private Equity Firms | There may or may not be participation of private equity firms in the management organization, or that information may not be available. In the event that private equity firms do participate, it will be good to know just what their involvement is if it goes beyond just passive investing. | Involved<br>Not involved<br>Uncertain |
| Number of Dentists and Number of Office Sites in the Practice | This information will be helpful in better understanding the nature and the market effects of group practices that are affiliated with management organizations that will most probably be influenced by practice size and the number of dentists within the group. This division of group practices by size will enhance any analysis of observations and facilitate any analysis within categories. | Fewer than 25<br>25 to 50<br>51 to 100<br>101 or more |

*Insurer-Provider Group Practice*

Within this category, the group practice is part of an organization that is both a dental insurer and provider of dental care. Health Maintenance Organizations (HMO) are examples of these insurer-provider organizations. These organizations contract with groups to provide or arrange for all the necessary health care each beneficiary needs, at a fixed cost per person for a fixed period of time, while still allowing for some cost-sharing through co-payments, etc. When dental care is included as a benefit, it is provided either through a Dental Health Management Organization (DHMO) or an in-house group dental practice.

A DHMO consists of a network of independent dental practices assembled by an insurer, some of which may be group practices, that agree to provide care for a fixed per patient amount per month. Each beneficiary must select a primary dentist for their routine care and for referral to specialists. Dentists receive periodic payments from all patients for whom they are the designated primary dentist, regardless of the services performed.

Larger HMOs frequently organize a dental group practice within the HMO to provide dental care or contract for that care with their own sponsored professional corporation. The HMO dentists are employees of the HMO, directly or through the professional corporation, and are generally salaried employees. The financial risk for the integrity of each beneficiary group is directly borne by the HMO.

The development of DHMOs began during the managed care era in health care and peaked when managed care peaked. As managed care came into general disfavor, DHMOs also lost favor with the public and plan purchasers. Their number has steadily eroded in the marketplace.[17]

A new organizational structure, developed through the Patient Protection and Affordable Care Act (ACA) has recently emerged within this category—the Accountable Care Organization (ACO). While dental care is not generally included within current ACOs, there could be increased opportunities for such integration in later phases of health reform. This is particularly true within the pediatric population where dental benefits are mandatory under the ACA.[18]

*Not-for-Profit Group Practice*

Dental group practices that are organized on a not-for-profit basis are generally devoted to treat disadvantaged populations, with a secondary mission to train healthcare professionals. They could be founded locally and associated with charitable organizations, educational institutions or part of the quasi-governmental safety net structure. These groups vary, reflecting the nature and mission of the sponsoring organization.

Through grants, the federal government has subsidized the development and operation of a national network of independent community health centers that comply with a comprehensive set of requirements related to services, organization, reimbursement and population served. Their governance must include patients of a Center. Federally Qualified Health Centers (FQHC) are required by federal law to provide dental care. They do so by hiring dentists to staff a Center's on-site clinic or by contracting with local dentists in their private practices. Clinics sponsored and funded by state and local governments also establish group practices at their treatment facilities.

*Government Agency Group Practice*

The United States government has several agencies that provide direct oral health care to individuals, as well as educational opportunities for health care providers. These are the U.S. Army, Navy, Air Force,

Public Health Service, Veteran's Administration and others. These organizations operate one category of group practices that are fully owned and managed within the agency and are responsible for providing care for a specific population, such as the armed forces.

Dental treatment facilities are managed by the agency, which also determines policies for all aspects of care. Dentists are employees of the U.S. Government and can be employed for varying lengths of time, for a specific tour of duty, until they retire from service. There is generally a cadre of career dentists who are supplemented by a variable number of shorter-term employed dentists as needed. It is not uncommon for newly-educated dentists to join the federal services for a relatively short period of time to enhance their transition from dental student to practitioner.

*Hybrid Group Practice*

There may be group practices that do not fit exactly into any other category in this classification scheme. We expect new types of group practice to develop in the future, since the organization of dental practices is evolving, as is the profession in the dental marketplace. This category provides a place for them.

## Discussion

Recent years have brought considerable change to the way dental practices are organized and this is an extremely complex issue. Accordingly, there are numerous ways to approach the classification of group practices. This classification system is one attempt to disentangle the myriad of characteristics and issues to focus on the few that are most germane in capturing the issues debated today. These issues focus on the impact of alternative group practice arrangements on dentists and patients. We have tried to preserve what we feel are important distinctions while keeping the number of types to a practical and manageable level. As the evolution of group practice models continues, some practices may not fall easily into any category.

This classification system will hopefully facilitate continued study of the impact of practice configuration on patients and dentists, and practice operating efficiency. It also provides a common lexicon and nomenclature for referring to group practices of different kinds.

As the dental marketplace and dental group practices evolve, it will be interesting to observe which types expand and which types do not. It seems unlikely that any one form of dental practice will overwhelm the market. More likely, a variety of practices will evolve to satisfy the varied demands of patients and other stakeholders in the dental care system. Changes will inevitably occur; key factors for successful innovation are the changes that will enhance quality of care, efficiency of care delivery and availability of care for all who seek it.

## Acknowledgements

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**Agenda item: Dental Assistants II**

The Board assigned review of the qualifications required to register as a Dental Assistant II to the Regulatory/Legislative Committee.

Information included in the agenda package for review and discussion:

- Dental Assistant II application
- Dental Assistant II regulations
- Minnesota Board of Dentistry provisions for restorative functions

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## APPLICATION REQUIREMENTS FOR REGISTRATION AS A DENTAL ASSISTANT II

A completed application shall include the following unless otherwise stated below. An incomplete application and or fee will delay the processing or your application. Incomplete applications are kept for one year then destroyed.

____ **1.** Application. (2 pages) Please be sure that all information and questions are completed on the application. You must select only one of the two options for qualifying for registration.

____ **2.** Application Fee. $100. Certified check, cashier's check or money order, made payable to the **Treasurer of Virginia.** Pursuant to 18VAC60-20-40, all fees are non-refundable. A processing fee of $35 will be charged for any check or money order returned unpaid by your bank.

____ **3.** Name change. Documentation must be provided to show name change(s) if your name has ever been changed from the time you attended school or were registered in other jurisdictions or was other than what is listed on your application. Photocopies of marriage licenses or court orders are accepted.

____ **4.** Current DANB certification as a Certified Dental Assistant (CDA) is required. Submit a copy of your current certificate.

____ **5. (Form A)** Original documentation of your completion of an expanded function dental assisting training program which was obtained from an educational program accredited by the Commission on Dental Accreditation of the American Dental Association is required.

____ **6. Transcript** or other documentation from the expanded function dental assisting program which specifies the number of hours and the content of the didactic instruction, laboratory training and clinical experience you completed. Review 18VAC60-20-61.B.1, 2, 3, and 4 in the attached Dental Assistant II Regulations for Virginia's education requirements. To qualify for registration by education your training must meet these requirements.

____ **7. (Form C)** Original verification from each jurisdiction in which you currently hold registration or have ever been registered as a dental assistant. Verification must include that authorization was given to perform expanded duties. Copies are not acceptable. Verifications cannot be older than 6 months from date prepared.

____ **8.** If you are qualifying by endorsement and your expanded function dental assisting program was not substantially equivalent to Virginia's education requirements you must submit **(Form B)** or documentation from a supervising dentist of your experience in performing each of the following duties you are applying to perform in Virginia. You

must document that you performed the selected procedures for at least 24 of the past 48 months preceding your application for registration in Virginia:

1. Performing pulp capping procedures
2. packing and carving of amalgam restorations;
3. Placing and shaping composite resin restorations;
4. taking final impressions;
5. Use of a non-epinephrine retraction cord;
6. Final cementation of crowns and bridges after adjustment and fitting by the dentist

____ **9.** Please be aware that your application signature affirms that you have read and understand and will remain current with the applicable Virginia dental, dental hygiene and dental assistant laws and the regulations of the Virginia Board of Dentistry.

**NOTES:**

- If your registration is not issued within six months of the board's receipt of parts of the application, certain portions of the application may need to be updated or resubmitted before registration can be issued.
- Within approximately 10 business days of receipt of an application, applicants will be notified of missing application items.
- Documents submitted with an application are the property of the Board and cannot be returned.
- Consistent with Virginia law and the mission of the Department of Health Professions, addresses of licensees are made available to the public. Normally, the Address of Record is the publically disclosable address. If you do not want your Address of Record to be made public, state law allows you to provide a second, publically disclosable address. Typically, this other address is the work or practice address. If you would like for your Address of Record to be made available to the public, complete both sections with the same address.

Accredited Program Information
American Dental Association
Commission on Dental Accreditation
211 East Chicago Avenue
Chicago, IL 60611-2678
312-440-2500
www.ada.org

Dental Assisting National Board, Inc.
444 N. Michigan Avenue
Suite 900
Chicago, IL 60611-3985
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www.danb.org
danbmail@danb.org

Effective March 2, 2011
Revised March 23, 2011
Revised Nov. 15, 2012
Revised May 31, 2013

**VIRGINIA BOARD OF DENTISTRY**

Excerpts from the **Regulations Governing Dental practice on the**

**Registration and Practice of Dental Assistants II**



**18VAC60-20-61. Educational requirements for dental assistants II.**

A. A prerequisite for entry into an educational program preparing a person for registration as a dental assistant II shall be current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board.

B. To be registered as a dental assistant II, a person shall complete the following requirements from an educational program accredited by the Commission on Dental Accreditation of the American Dental Association:

1. At least 50 hours of didactic course work in dental anatomy and operative dentistry that may be completed on-line.

2. Laboratory training that may be completed in the following modules with no more than 20% of the specified instruction to be completed as homework in a dental office:

a. At least 40 hours of placing, packing, carving, and polishing of amalgam restorations;

b. At least 60 hours of placing and shaping composite resin restorations;

c. At least 20 hours of taking final impressions and use of a non-epinephrine retraction cord; and

d. At least 30 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.

3. Clinical experience applying the techniques learned in the preclinical coursework and laboratory training that may be completed in a dental office in the following modules:

a. At least 80 hours of placing, packing, carving, and polishing of amalgam restorations;

b. At least 120 hours of placing and shaping composite resin restorations;

c. At least 40 hours of taking final impressions and use of a non-epinephrine retraction cord; and

d. At least 60 hours of final cementation of crowns and bridges after adjustment and fitting by the dentist.

4. Successful completion of the following competency examinations given by the accredited educational programs:

a. A written examination at the conclusion of the 50 hours of didactic coursework;

b. A practical examination at the conclusion of each module of laboratory training; and

c. A comprehensive written examination at the conclusion of all required coursework, training, and experience for each of the corresponding modules.

C. All treatment of patients shall be under the direct and immediate supervision of a licensed dentist who is responsible for the performance of duties by the student. The dentist shall attest to successful completion of the clinical competencies and restorative experiences.

**18VAC60-20-70. Licensure examinations; registration certification.**

C. Dental assistant II certification. All applicants for registration as a dental assistant II shall provide evidence of a current credential as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another certification from a credentialing organization recognized by the American Dental Association and acceptable to the board, which was granted following passage of an examination on general chairside assisting, radiation health and safety, and infection control.

**18VAC60-20-72. Registration by endorsement as a dental assistant II.**

A. An applicant for registration by endorsement as a dental assistant II shall provide evidence of the following:

1. Hold current certification as a Certified Dental Assistant (CDA) conferred by the Dental Assisting National Board or another national credentialing organization recognized by the American Dental Association;
2. Be currently authorized to perform expanded duties as a dental assistant in another state, territory, District of Columbia, or possession of the United States;
3. Hold a credential, registration, or certificate with qualifications substantially equivalent in hours of instruction and course content to those set forth in 18VAC60-20-61 or if the qualifications were not substantially equivalent the dental assistant can document experience in the restorative and prosthetic expanded duties set forth in 18VAC60-20-230 for at least 24 of the past 48 months preceding application for registration in Virginia.

B. An applicant shall also:

1. Be certified to be in good standing from each state in which he is currently registered, certified, or credentialed or in which he has ever held a registration, certificate, or credential;
2. Be of good moral character;
3. Not have committed any act that would constitute a violation of § 54.1-2706 of the Code of Virginia; and
4. Attest to having read and understand and to remain current with the laws and the regulations governing dental practice in Virginia.

**18VAC60-20-230. Delegation to dental assistants.**

A. Duties appropriate to the training and experience of the dental assistant and the practice of the supervising dentist may be delegated to a dental assistant under the direction or under general supervision required in 18VAC60-20-210, with the exception of those listed as nondelegable in 18VAC60-20-190 and those which may only be delegated to dental hygienists as listed in 18VAC60-20-220.

B. Duties delegated to a dental assistant under general supervision shall be under the direction of the dental hygienist who supervises the implementation of the dentist's orders by examining the patient, observing the services rendered by an assistant and being available for consultation on patient care.

C. The following duties may only be delegated under the direction and direct supervision of a dentist to a dental assistant II who has completed the coursework, corresponding module of laboratory training, corresponding module of clinical experience, and examinations specified in 18VAC60-20-61:

1. Performing pulp capping procedures;
2. Packing and carving of amalgam restorations;
3. Placing and shaping composite resin restorations;
4. Taking final impressions;
5. Use of a non-epinephrine retraction cord; and
6. Final cementation of crowns and bridges after adjustment and fitting by the dentist.

# MINNESOTA BOARD OF DENTISTRY

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## RESTORATIVE FUNCTIONS

Before performing any or all restorative procedures limited to placing, contouring, and adjusting amalgam restorations, glass ionomers, and class I and class V supragingival composite restorations where the margins are entirely within the enamel; and adapting and cementing stainless steel crowns, a licensed dental hygienist or dental assistant must successfully complete a board-approved course on these specific restorative procedures. Licensees must follow all provisions for restorative procedures under Minnesota Statute Section 150A.10, sub.4.

### SECTION 1

I certify that I have successfully completed the Restorative Functions course approved by the Board.

Name (*Please Print*) _____ License Number _____

Signature _____ Date _____

### SECTION 2

Please complete the information requested below relating to the board-approved course you completed on restorative functions.

Name of Institution _____ Address of Institution _____

Date Course Completed _____ City, State, Zip code _____

( ) _____
Phone Number of Institution

### SECTION 3

In addition to completing Sections 1 and 2, you **MUST** submit the following supporting documentation with this form:

1) A copy of a certificate of completion

2) Other official record from the institution listed in Section 1 of this form, verifying your completion of a course in restorative functions.

# Restorative Functions

## Restorative Functions Board Approved Course Guidelines

**Instructor Requirements**

1. Trainers of educators must have taught these procedures in an accredited dental education program.
2. Allied Restorative Functions Educators must have completed a course taught by trainers
3. Supervising dentist is present in the lab and clinic while the procedures are being performed
4. A contract between the school and an outside clinic is utilized.
    a. A contract must be utilized between the school and the school's outside-instructing-staff for continuity/consistency of instruction, evaluation requirements and communication with the school's course instructors.
    b. The contract stresses personal supervision. Both the dentist and student sign the contract.
    c. The instructors do a final evaluation.

**Admission Requirements**

1. Qualifications for participants include:
    a. Licensed Dental Assistant
    b. Licensed Dental Hygienist
    c. Current student in an accredited hygiene program

2. Qualifications for School/course:
    a. The course shall be provided by an CODA accredited school

**Curriculum Components**

1. The restorative procedures include:
    a. Place, contour, and adjust amalgam restorations
    b. Place, contour, and adjust glass ionomer
    c. Adapt and cement stainless steel crowns
    d. Place, contour, and adjust Class I and V supragingival composite restorations where the margins are entirely within the enamel.

2. The course contains three sections: 1) Didactic; 2) Pre-clinical/Laboratory; 3) Clinical
    a. There are two testings for demonstration of competency
        i. After completion of didactic and laboratory/preclinic
        ii. Final Clinical Test
    b. The participant can go no longer than a year between sections, and/or must prove competence upon entrance to each section.
    c. The participant must complete clinical and the final exam within one year. If more time is needed, then an extension request must be submitted to the Board of Dentistry and school. See Extension Request listed below.

d. Pre-clinical or Laboratory - these numbers are guidelines; the main criteria is the student must prove competency in primary as well as permanent dentition. Competency is determined by the instructing staff.

| | | | |
|---|---|---|---|
| i. Amalgam | Class I, II, V | 12 primary | 28 permanent |
| ii. Glass Ionomer | Class I, II, V | 10 primary | 16 permanent |
| iii. S S Crowns | | # needed to obtain competency | |
| iv. Composite | Class I, V | 6 primary | 18 permanent |

e. Clinical – requirements must include a minimum 12 patient experiences which involves primary and permanent dentition:

| | | |
|---|---|---|
| i. Amalgam | Class I, II, V | 10 surfaces |
| ii. Glass Ionomer | Class I, II, V | 5 surfaces |
| iii. S S Crowns | | 4 teeth |
| iv. Composite | Class I, V | 5 surfaces |

3. Must include a component that sufficiently prepares the student to adjust the occlusion on the newly placed restorations.
4. A Dentist does the prepping of the tooth which is to receive the restorative material.

**Registering Requirements of School and Participant**

1. The school shall send a course syllabus to the Board of Dentistry.
2. The school shall submit a list of course participants to the Board of Dentistry
3. The school shall request from the Board of Dentistry the required Restorative Function Registration Form for the student to fill out upon completion of the course requirements.
4. The student shall submit to the Board office the required Board of Dentistry Restorative Function Form.
5. The student shall submit to the Board of Dentistry a certificate of completion
6. The Board of Dentistry shall send recognition of completion to the student.

**Time Involvement**

Education will dictate time involved. Completion depends on how fast the student completes and passes all the evaluation requirements of the course and patient experiences.

**Extension Requests**

The Course provider will decide on the request validity and monitor. The clinical and competency requirements must be completed within one year and only upon approved demonstrated circumstances to the course provider will one extension of six months be granted.

Rev. 1/27/10

# DELEGATED DUTIES LIST - DENTAL HYGIENISTS AND LICENSED DENTAL ASSISTANTS

**(effective 9/27/2010)**

**From Minnesota Rules 3100.8500 and 3100.8700; Minnesota Statute Section 150A.10**

| General Supervision | | Indirect Supervision | | Direct Supervision | | Personal Supervision | | PROCEDURE |
|---|---|---|---|---|---|---|---|---|
| HYG | | | | | | | | Perform preliminary charting of the oral cavity and surrounding structures to include case histories, perform initial and periodic examinations and assessments to determine periodontal status, and formulate a dental hygiene treatment plan in coordination with a dentist's treatment plan. |
| HYG | | | | | | | | Make referrals to dentists, physicians, and other practitioners in consultation with a dentist. |
| HYG | | | | | | | | Complete prophylaxis to include scaling, root planing, polishing of restorations. |
| HYG | | | | | | | | Dietary analysis, salivary analysis and preparation of smears for dental health purposes. |
| HYG | | | | | | | | Replacement, cementation, and adjustment of intact temporary restorations extraorally or intraorally. |
| HYG | LDA | | | | | | | Recement intact temporary restorations. |
| HYG | LDA | | | | | | | Place temporary fillings (not including temporization of inlays, onlays, crowns, and bridges). |
| HYG | LDA | | | | | | | Cut arch wires, remove loose bands, or remove loose brackets on orthodontic appliances. |
| HYG | | | | | LDA | | | Remove excess bond material from orthodontic appliances. |
| | | | | HYG | LDA | | | Remove bond material from teeth with rotary instruments after removal of orthodontic appliances. 5 |
| HYG | | | LDA | | | | | Etch appropriate enamel surfaces, apply and adjust pit and fissure sealants. 1 |
| HYG | | | | | | | | Administer local anesthesia. 2 |
| HYG | | | | | LDA | | | Administer nitrous oxide inhalation analgesia pursuant to the rule provisions. 3 |
| HYG | | | LDA | | | | | Monitor a patient who has been induced by a dentist into nitrous oxide-oxygen relative analgesia. |
| | | HYG | LDA | | | | | Perform restorative procedures limited to placing, contouring, and adjusting amalgam restorations, glass ionomers, and supragingival composite restorations (class I & V); and adapting and cementing stainless steel crowns. 6 |
| HYG | | | | | | | | Remove marginal overhangs. |
| | | | | HYG | LDA | | | Place and remove matrix bands. |
| | | | | HYG | LDA | | | Fabricate, cement, and adjust temporary restorations extraorally or intraorally. |
| | | | | HYG | LDA | | | Remove temporary restorations with hand instruments only. |
| | | | | HYG | LDA | | | Etch appropriate enamel surfaces before bonding of orthodontic appliances by a dentist. |
| HYG | | | LDA | | | | | Perform mechanical polishing to clinical crowns not including instrumentation. Removal of calculus by instrumentation must be done by the dentist or dental hygienist before mechanical polishing. |

# DELEGATED DUTIES LIST - DENTAL HYGIENISTS AND LICENSED DENTAL ASSISTANTS

**(effective 9/27/2010)**

**From Minnesota Rules 3100.8500 and 3100.8700; Minnesota Statute Section 150A.10**

| General Supervision | | Indirect Supervision | | Direct Supervision | | Personal Supervision | | PROCEDURE |
|---|---|---|---|---|---|---|---|---|
| HYG | LDA | | | | | | | Take radiographs. |
| HYG | | | LDA | | | | | Remove excess cement from inlays, crowns, bridges and orthodontic appliances with hand instruments only. |
| HYG | | | LDA | | | | | Apply topical medications such as, but not limited to, topical fluoride, bleaching agents, and cavity varnishes in appropriate dosages or quantities as prescribed by a dentist. |
| HYG | LDA | | | | | | | Take impressions for casts and appropriate bite registration. 4 |
| HYG | | | LDA | | | | | Place and remove rubber dam. |
| HYG | | | LDA | | | | | Preselect orthodontic bands. |
| HYG | LDA | | | | | | | Place and remove elastic orthodontic separators. |
| | | | | HYG | LDA | | | Attach prefit and preadjusted orthodontic appliances |
| HYG | | | LDA | | | | | Remove and replace ligature ties and arch wires on orthodontic appliances. |
| | | | | HYG | LDA | | | Remove fixed orthodontic bands and brackets. |
| HYG | LDA | | | | | | | Deliver vacuum-formed orthodontic retainers. |
| HYG | | | LDA | | | | | Remove sutures. |
| HYG | | | LDA | | | | | Place and remove periodontal packs. |
| HYG | | | LDA | | | | | Dry root canals with paper points. |
| HYG | | | LDA | | | | | Place cotton pellets and temporary restorative materials into endodontic openings. |
| | | HYG | LDA | | | | | Maintain and remove intravenous lines under supervision of dentist holding a valid general anesthesia or moderate sedation certificate. 7 |
| | | HYG | LDA | | | | | Monitor a patient during each phase of general anesthesia or moderate sedation using noninvasive instrumentation under supervision of dentist holding a valid general anesthesia or moderate sedation certificate. 8 |
| | | | | HYG | LDA | | | Initiate and place an intravenous infusion line in preparation for intravenous medications and sedation under supervision of dentist holding a valid general anesthesia or moderate sedation certificate. 9 |
| | | | | | | HYG | LDA | Concurrently perform supportive services if the dentist holds a valid general anesthesia or moderate sedation certificate, is personally treating a patient, and authorizes the allied dental personnel to aid in treatment including the administration of medications into an existing intravenous line, an enteral agent, or emergency medications in an emergent situation. 10 |

HYG = Dental Hygienists
LDA = Licensed Dental Assistants

**Notes and Definitions of Levels of Supervision: See Attached Sheet**

## LEVELS OF SUPERVISION – DENTAL HYGIENISTS AND LICENSED DENTAL ASSISTANTS
## (Per Minnesota Rule 3100.0100, subpart 21):

**GENERAL** - The dentist has prior knowledge and has given consent for the procedures being performed during which the dentist is not required to be present in the dental office or on the premises.

**INDIRECT** - The dentist is in the office, authorizes the procedures, and remains in the office while the procedures are being performed by the allied dental personnel.

**DIRECT** - The dentist is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and before dismissal of the patient, evaluates the performance of the allied dental personnel.

**PERSONAL**– The dentist is personally operating on a patient and authorizes the allied dental personnel to aid in treatment by concurrently performing supportive procedures.

### NOTES

1. Before the application of pit and fissure sealants, a licensed dental assistant must successfully complete a course in pit and fissure sealants at a dental, dental hygiene, or dental assisting school accredited by the Commission on Accreditation.

2. Before administering local anesthesia, a dental hygienist must successfully complete a didactic and clinical program sponsored by a dental or dental hygiene school accredited by the Commission on Accreditation, resulting in the dental hygienist becoming clinically competent in the administration of local anesthesia.

3. Before administering nitrous oxide inhalation analgesia, a dental hygienist or licensed dental assistant must successfully complete a course on the administration of nitrous oxide inhalation analgesia. The course must include a minimum of 12 hours of didactic instruction and supervised clinical experience using fail-safe anesthesia equipment capable of positive pressure respiration. Forms must be sent to the Board office verifying the training received. Each licensee must follow the appropriate provisions for administration described within Minnesota Rule 3100.3600.

4. Dental hygienists and licensed dental assistants shall not take impressions and bite registrations for final construction of fixed and removable prostheses.

5. Before utilizing rotary instruments for the removal of bond material, a dental hygienist or licensed dental assistant must successfully complete a course in the use of rotary instruments for the express purpose of the removal of bond material from teeth. The course must be presented by a dental, dental hygiene, or dental assisting school accredited by the Commission on Accreditation.

6. Before performing any or all restorative procedures limited to placing, contouring, and adjusting amalgam restorations, glass ionomers, and class I and class V supragingival composite restorations where the margins are entirely within the enamel; and adapting and cementing stainless steel crowns, a dental hygienist or dental assistant must successfully complete a board-approved course on these specific restorative procedures. The course must be presented by a dental, dental hygiene, or dental assisting school accredited by the Commission on Accreditation. Licensees must follow all provisions for restorative procedures under Minnesota Statute Section 150A.10, subd. 4.

7. Before managing and removing intravenous lines, a dental hygienist or licensed dental assistant must have successfully completed board-approved allied dental personnel courses comprised of intravenous access and general anesthesia and moderate sedation training.

8. Before monitoring a sedated patient, a dental hygienist or licensed dental assistant must have successfully completed board-approved allied dental personnel courses comprised of intravenous access and general anesthesia and moderate sedation training.

9. Before initiating and placing an intravenous infusion line, a dental hygienist or licensed dental assistant must have successfully completed board-approved allied dental personnel courses comprised of intravenous access and general anesthesia and moderate sedation training.

10. Before administering any medications or agents, a dental hygienist or licensed dental assistant must have successfully completed board-approved allied dental personnel courses comprised of general anesthesia and moderate sedation training.

*Note: This guide is an accurate summary as of the date of this printing. It is not intended to be a substitute for Minnesota dental professionals' responsibility for fully knowing current laws and rules, which can be accessed via the Board's website at www.dentalboard.state.mn.us*

# MINNESOTA BOARD OF DENTISTRY

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## *DENTAL THERAPIST SCOPE OF PRACTICE*

*According to Minnesota 2009 Session Laws, Chapter 95, Article 3, Subd. 4, the **scope of practice** for a Dental Therapist includes the following:*

(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 reline;
(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; and
(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.

**Agenda item: Advanced Dental Hygiene Practice**

The Board assigned to the Committee consideration of the JCHC's request to establish a new license type for dental hygienists such as an advanced dental hygienist to set training standards for a dental hygienist to qualify to perform the duties now permitted to be performed by dental assistants II.

Information included in the agenda package for review and discussion:

- JCHC Request and information provided to JCHC on October 8, 2014
- Minnesota Board of Dentistry's report on Dental Therapists in Minnesota and information from the website

**Reen, Sandra (DHP)**

**Subject:** FW: JCHC Oral Health Study

**From:** Michele Chesser [mailto:mchesser@jchc.virginia.gov]
**Sent:** Tuesday, September 09, 2014 12:29 PM
**To:** Reen, Sandra (DHP)
**Subject:** Re: JCHC Oral Health Study

Hello Sandy,

Thank you again for taking the time to speak with me the other day. You mentioned that the next Board of Dentistry meeting is September 12, and I am hoping you can bring up the issue of a more appropriate set of educational requirements for dental hygienists to perform DA II duties.

Specifically, instead of requiring the full (1.5?) years of educational training for DA II, in which much of the material has already been covered in the educational requirements for dental hygienists, allow licensed dental hygienists to take continuing education classes to obtain the training they need to perform the duties specified in 18VAC60-20-230.

Dental hygienists who complete the additional training could receive the designation of "advanced dental hygienist" or "expanded function dental hygienists."

If this change in regulations were to be made, would more schools begin to offer the training? My understanding is that there is only one, or no, community college in the state that offers DA II. Would some of the training/courses be available online?

It would be helpful to receive feedback regarding any concerns or questions that Board members may have about the issue.

Please give my thanks to the Board members for being willing to revisit this issue.
Michele

**Reen, Sandra (DHP)**

**Subject:** FW: request for information

**Importance:** Low

The Joint Commission on Health Care is developing information for a report this fall to the General Assembly.

The policy option that is being studied is to:

"Include in the JCHC Work Plan for 2014, a targeted study of the dental capacity *and educational priorities* of Virginia's *oral health care safety* net providers – *to include an in depth look at ways to more proactively divert patients from ERs to dental resources within their communities and to include discussion on alternative settings where additional providers (such as registered dental hygienists) can practice to access additional patient populations that are not being reached. The study and its objectives should be led by the many and diverse stakeholder in the oral health community:* The Virginia Department of Health, Virginia Association of Free Clinics, Virginia Community Healthcare Association, *the Virginia Dental Hygienists' Association, the Virginia College of Emergency Physicians,* Virginia Dental Association, *Virginia Commonwealth University School of Dentistry,* Virginia Health Care Foundation, *Old Dominion Dental Society,*Virginia Oral Health Coalition, *Virginia Health Care Association*, and Virginia Rural Health Association will be asked to work with JCHC staff in determining the need for any *additional funding and resources to take care of Virginia's most vulnerable citizens. Furthermore, the group would be charged with taking a longer view of resources needed to improve education, awareness and proactivity for changing oral hygiene habits. The group would also collaborate with the Department of Education and other education stakeholders to expand oral health education in public schools.* **(This approved Option combines the amendments proposed by VDA, VDHA, VBPD, and VACEP.)"**

# DENTAL SAFETY NET CAPACITY AND OPPORTUNITIES FOR IMPROVING ORAL HEALTH

Joint Commission on Health Care
October 8, 2014 Meeting

Michele Chesser, Ph.D.
Senior Health Policy Analyst

## Study Mandate

- In 2012, Senate Joint Resolution 50 (Senator Barker) directed the Joint Commission on Health Care (JCHC) to conduct a two year study of the fiscal impact of untreated dental disease in the Commonwealth of Virginia
- The study resulted in a policy option to include in the 2014 JCHC Work Plan a targeted study of the dental capacity of Virginia's oral health care safety net providers, and the option was approved by JCHC members during the Decision Matrix meeting last November

# Expansion of the Remote Supervision of Dental Hygienists Model

## Expansion of Remote Supervision of Dental Hygienists Model

- In 2009, the General Assembly enacted legislation to reduce the dentist oversight requirement for hygienists employed by VDH in selected dentally underserved areas
  - VDH dental hygienists are allowed to work under the remote, rather than general or direct, supervision of a dentist
  - Remote supervision means "a public health dentist has regular, periodic communications with a public health dental hygienist regarding patient treatment, but who has not done an initial examination of the patients who are to be seen and treated by the dental hygienist, and who is not necessarily onsite with the dental hygienist when dental hygiene services are delivered." Under remote supervision, VDH hygienists may perform:
    - Initial examination of teeth and surrounding tissues, charting existing conditions
    - Prophylaxis of natural and restored teeth
    - Scaling using hand instruments and ultrasonic devices
    - Providing dental sealant, assessment, maintenance and repair
    - Application of topical fluorides
    - Educational services, assessment, screening or data collection for the preparation of preliminary records for evaluation by a licensed dentist

## Expansion of Remote Supervision of Dental Hygienists Model

- Remote supervision dental hygienists provide services in elementary schools utilizing portable equipment
- In 2012, additional legislation was passed allowing a dental hygienist employed by VDH to practice throughout the Commonwealth under the protocol established for the pilot program
- The program has "improved access to preventive dental services for those at highest risk of dental disease, as well as reduced barriers and costs for dental care for low-income individuals"*

*Report on Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a "Remote Supervision" Practice Protocol, 2013

## Expansion of Remote Supervision of Dental Hygienists Model

- The Board of Health Professions is currently considering the expansion of the remote supervision of dental hygienist model, but no action has been taken at this point
  - The Board met on September 27, but did not have a quorum and; therefore, was unable to call a vote on the issue
- Options to expand the model include allowing dental hygienists not currently employed by VDH to practice via remote supervision in other settings such as safety net facilities, hospitals, nursing homes or all dental sites, including the private sector, in order to provide access to a greater portion of Virginia's at-risk, underserved population
- Our work group considered the range of expansion options and the majority of members support an incremental approach with initial expansion to safety net facilities

## Expansion of Remote Supervision of Dental Hygienists Model

- Further, it was suggested that a work group of primary stakeholders, including Virginia Dental Association, Virginia Dental Hygienists' Association, Virginia Department of Health, Virginia Association of Free and Charitable Clinics, Virginia Community Healthcare Association, Virginia Oral Health Coalition, Virginia Board of Dentistry, Old Dominion University's School of Dental Hygiene, and Virginia Commonwealth University's School of Dentistry, be created to develop a pilot program for the expansion of the remote supervision model, giving stakeholders the chance to be involved in determining the bounds/scope of the model and the specific protocol

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# Early Impacts of Dental Therapists in Minnesota

## Minnesota Department of Health
## Minnesota Board of Dentistry
## *Report to the Minnesota Legislature 2014*

**February 2014**

# Early Impacts of Dental Therapists in Minnesota

**February 2014**

**For more information, contact:**

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As requested by Minnesota Statute 3.197: This report cost approximately $137,607 to prepare, including staff time, printing and mailing expenses.

## Table of Contents

## I. Executive Summary

The 2009 Minnesota Legislature directed the Board of Dentistry (BOD), in consultation with the Minnesota Department of Health (MDH) and the Department of Human Services (DHS), to evaluate dental therapists' impact on the delivery of and access to dental services. Given that dental therapists have only been practicing in Minnesota since mid-2011, this report is an early assessment of this still-emerging profession's impacts in the state.

**Background**

In 2009, Minnesota became the first state government in the U.S. to authorize the licensing of dental therapists. Minnesota's law created two levels of dental therapist practice – the Dental Therapist and the Advanced Dental Therapist – and required that these providers primarily serve underserved patients.

**Methods**

Fifteen clinics employing dental therapists participated in the evaluation, from August 2012 through December 2013. The assessment drew on (1) a survey of 1,382 dental therapist patients; (2) interviews with staff at clinics employing dental therapists; (3) clinic administrative data; (4) oral health-related emergency room usage data; and (5) dental therapist licensing data.

**Findings**

**A. Dental therapy workforce**

- There were 32 licensed dental therapists in Minnesota as of early February 2014, six of whom also held certifications as advanced dental therapists. Dental therapists work in a variety of settings, including community clinics, hospitals and private practices.
- Since licensing commenced in 2011, four complaints have been filed against dental therapists. Two have been resolved without Board action and two are pending. None have been directly related to patient safety issues. No disciplinary actions have been taken by the Board of Dentistry against dental therapists.

**B. Dental therapy services reimbursed by state programs**

- Data provided directly by the study clinics indicated that the majority (84 percent) of patients served by dental therapists were enrolled in public health insurance programs.
- Data on dental therapist services and payments were not available from DHS for the study period, as DHS data systems were not yet able to distinguish whether a service was provided by a dentist or a dental therapist.

**C. Assessment of impact**

- Dental therapists at the study clinics, many working part-time, served 6,338 new patients. On average, 84 percent of these new patients were enrolled in public programs.
- Overall, nearly one-third of all patients surveyed experienced a reduction in wait times for an appointment since the dental therapist was employed, with the impact more pronounced in rural areas.
- Some patients saw a reduction in travel time for their appointment with the dental therapist compared to their last appointment, again most notably in rural areas.

- Preliminary findings suggest that dental therapists may reduce emergency room (ER) use by expanding capacity at dental clinics serving vulnerable populations.
- Clinics report additional impacts of dental therapists, including personnel cost savings, increased dental team productivity, and improved patient satisfaction. The savings to clinics resulting from the lower costs of dental therapists are also allowing clinics to expand capacity to serve more underserved and public program patients.

**Evaluation limitations**

As the first evaluation of state-licensed dental therapists, this project faced challenges and limitations, including small numbers of dental therapists and patients served, the start-up nature of the field, designing research before practice began, and lack of DHS public programs data.

**Conclusions and recommendations**

A. The dental therapy workforce is growing and appears to be fulfilling statutory intent by serving predominantly low-income, uninsured and underserved patients.
B. Dental therapists appear to be practicing safely, and clinics report improved quality and high patient satisfaction with dental therapist services.
C. Clinics employing dental therapists are seeing more new patients, and most of these patients are public program enrollees or from underserved communities.
D. Dental therapists have made it possible for clinics to decrease travel time and wait times for some patients, increasing access.
E. Benefits attributable to dental therapists include direct costs savings, increased dental team productivity, improved patient satisfaction and lower appointment fail rates.
F. Savings from the lower costs of dental therapists are making it more possible for clinics to expand capacity to see public program and underserved patients.
G. Start-up experiences have varied, and employers expect continuing evolution of the dental therapist role.
H. Most clinics employing dental therapists for at least a year are considering hiring additional dental therapists.
I. Dental therapists offer potential for reducing unnecessary ER visits for non-injury dental conditions.
J. With identical state public program reimbursement rates for dentist and dental therapist services, there is not necessarily an immediate savings to the state on each claim paid; however, the differential between DHS rates and clinics' lower personnel costs for dental therapists appears to be contributing to more patients being seen.

**Recommendations**

A. Research and evaluation by state government and others must continue to document the growth and development of dental therapy in Minnesota, as more dental therapists and advanced dental therapists enter practice.
B. Payers should work to develop consistent approaches to identify, enroll and credential dental therapists and advanced dental therapists as providers in their systems.
C. State government and others should collect best practices and disseminate lessons learned to support prospective employers in more quickly becoming ready to hire dental therapists.

## II. Introduction

This report evaluates the early impact of dental therapists, as required in Minnesota Laws 2009, Chapter 95, Article 3, section 31 (see Appendix A). Specifically, the Minnesota Legislature directed the Minnesota Board of Dentistry (BOD), in consultation with the Minnesota Department of Health (MDH) and the Department of Human Services (DHS), to evaluate dental therapists' impact on the delivery of and access to dental services, as follows:

1. **Information on the number, settings, complaints and disciplinary actions involving dental therapists.**
2. **Evaluation (in consultation with the Minnesota Department of Health) of dental therapists' impact in terms of patient safety, cost-effectiveness and access to dental services, focusing on five outcome measures.**
3. **Information (in consultation with the Department of Human Services) on the number and type of dental services performed by dental therapists and reimbursed by Minnesota state health care programs.**

This report addresses items 1 and 2 to the extent possible given the short period of time dental therapists have been practicing in Minnesota. Item 3 is not yet available from the Department of Human Services, however partial estimates on dental services provided by dental therapists through the state's health care programs are included based on interviews with clinics currently employing dental therapists.

## III. Background

In 2009, Gov. Tim Pawlenty signed legislation that made Minnesota the first state government in the U.S. to authorize the licensing of dental therapists and the credentialing of advanced dental therapists. This section summarizes the legislation's background, Minnesota's current dental therapy law and scope of practice, and how the profession has developed since the law was passed.

### Need

Despite Minnesota's overall high rankings nationally in health generally and oral health specifically, significant disparities exist for the state's low-income residents, people of color and the elderly, with these populations suffering disproportionately from oral diseases. Inadequate access to affordable oral health care is one of the primary factors contributing to these disparities.[1]

Significant numbers of Minnesotans lack access to basic oral health care. Over 70 percent of Minnesota counties (62 of 87) are fully or partially designated as Health Professional Shortage Areas (HPSAs) for dental care.[2] In total, 656,184 Minnesotans live in areas lacking sufficient

[1] Minnesota Department of Health (MDH). *The Status of Oral Health in Minnesota*. St. Paul: MDH; September 2013. Available from: http://www.health.state.mn.us/oralhealth/pdfs/MNOralHealthStatus2013.pdf

[2] Health Professional Shortage Area (HPSA) is a designation given by the Department of Health and Human Services (DHHS) to identify shortages of primary medical, dental or mental health providers within a geographic area, population group or facility. For more information on HPSAs, see the DHHS Dental HPSA Designation Overview webpage and MDH's Health Professional Shortage Areas & Medically Underserved Areas/Populations page.

dental clinicians. The state's dentist workforce, like its health workforce overall, reflects the aging of the baby boomers: as of August 2012, nearly half (45 percent) of Minnesota's licensed dentists were 55 years or older.[3]

Access for low-income Minnesotans is still more challenging, as many dentists do not serve significant numbers of uninsured or publicly insured individuals. In 2012, roughly 75 percent of Minnesota dentists were enrolled as service providers in the state's public health care programs, but an estimated 26 percent of these providers treated only 3 to 20 Medical Assistance (MA) recipients per year, and 10 percent treated only 1 or 2 MA patients per year.[4] Nearly one third (32 percent) of the dentists surveyed in the state said they do not treat MA recipients at all, or are not accepting new patients.[5]

Policymakers, advocacy organizations and dental professionals have recommended action to address these access issues and the poor health outcomes that result. In Minnesota, the Minnesota Oral Health Plan for 2013-2018 calls for enhancing workforce models and creating new providers, including expanded use of dental therapists.[6]

These calls for action in the oral health sector have occurred within the broader context of major health reform. Minnesota passed landmark health reform legislation in 2008, and health policy and delivery changes have continued since in response to state, federal and market trends. Workforce policy has been integral to these developments, with policymakers and health providers focusing on expanding team care, integrating new providers, and reconfiguring scopes of practice to expand access and address anticipated provider shortages.

**Dental therapy law and scope**

Following authorizing legislation in 2008, the Minnesota Legislature passed legislation in May 2009 that created two levels of dental therapist practice: the Dental Therapist and the Advanced Dental Therapist (see Appendix B for full statutes).[7] Under the law, dental therapists and advanced dental therapists in Minnesota practice as part of a dental team to provide educational, clinical and therapeutic services. They are sometimes referred to as "mid-level" providers – akin to nurse practitioners, other Advanced Practice Registered Nurses and physician assistants in medical settings – because their scope of practice falls between other allied dental professionals'

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[3] Minnesota Department of Health, Office of Rural Health & Primary Care, based on data from the Minnesota Board of Dentistry. *Minnesota Health Workforce Data Reporting Tool: Licensing Board Data*. Available from: http://www.health.state.mn.us/divs/orhpc/workforce/database/healthsum.cfm

[4] State of Minnesota, Office of the Legislative Auditor. *Evaluation Report: Medical Assistance Payment Rates for Dental Services*. St. Paul: Minnesota Department of Health; March 2013. Available from: http://www.auditor.leg.state.mn.us/ped/pedrep/madentalrates.pdf

[5] Ibid. Reasons include insufficient reimbursement (with MA payment rates covering only a small portion of dentists' costs) and concerns that the services covered by MA do not meet standards of care – that is, dentists feel the scope of MA-covered services puts them in the position of either providing less care than is needed, or providing the appropriate care but not being reimbursed for all services provided.

[6] Minnesota Department of Health, Oral Health Program. Minnesota Oral Health Plan: Advancing Optimal Oral Health for All Minnesotans, 2013-2018. St. Paul: MDH; January 2013. Available at: http://www.health.state.mn.us/divs/hpcd/chp/oralhealth/pdfs/StatePlan2013.pdf

[7] Minnesota law also allows expanded functions for dental assistants and dental hygienists, including limited authorization for dental hygienists in certain settings (such as Head Start sites, nursing homes, group homes, and tribal and community clinics) under collaborative practice agreements with dentists. *Minnesota Statutes section 150A.10*. Available at: https://www.revisor.mn.gov/statutes/?id=150A.10

scopes and a dentist's scope.[8] Minnesota's dental therapist and advanced dental therapist model builds on the use of dental therapists in 54 countries worldwide, beginning in 1921.[9] The model was first deployed in the U.S. by the Alaska Native Tribal Health Consortium, which introduced dental health aide therapists under tribal authority in 2005.

Minnesota law defines specific educational, examination and practice requirements for licensed dental therapists and advanced dental therapists. One of the most distinctive is the provision that dental therapists practice in settings serving primarily low-income, uninsured and underserved patients, or in areas designated as Health Professional Shortage Areas (HPSAs) for dental care.[10] The table below summarizes the scope of practice and other requirements for dental therapists and advanced dental therapists. See Appendix B for a more detailed description of the scope of practice defined under Minnesota law.

**Table 1. Minnesota requirements for dental therapists**

| | Educational/ credential requirements | Scope of practice | Level of supervision |
|---|---|---|---|
| *Dental therapist* | ▪ Bachelor's degree in dental therapy.<br>▪ Competency and licensure exam.<br>▪ Jurisprudence examination. | A licensed dental therapist may perform certain dental services under "indirect supervision." See Appendix B for a full list of these services.<br><br>A dental therapist may perform additional services under "general supervision" unless restricted or prohibited from doing so in the collaborative management agreement. See Appendix B for a full list of these services.<br><br>A dental therapist may also dispense certain medications and supervise up to 4 dental assistants. | Practices under the supervision of a dentist, with whom they must have a collaborative management agreement. Some dental therapy services can be provided under "indirect supervision" (the dentist is on-site and authorizes procedures) and others under "general supervision" (the dentist is not necessarily on-site during procedure but does authorize its performance). |
| *Advanced dental therapist* | ▪ Dental therapist license.<br>▪ Master's degree in advanced dental therapy.<br>▪ 2,000 hours of clinical practice.<br>▪ Certification exam for advanced practice. | An advanced dental therapist certified by the Board of Dentistry may perform the following services and procedures, pursuant to a written collaborative management agreement (and any limitations therein):<br>▪ All services a dental therapist provides (see above).<br>▪ Oral evaluation and assessment.<br>▪ Treatment plan formulation.<br>▪ Routine, nonsurgical extractions of certain diseased teeth. | Like a dental therapist, the advanced dental therapist practices under the supervision of a dentist, with whom they must have a collaborative management agreement, but all advanced dental therapy services can be provided under "general supervision." The dentist does not need to see the patient first or be on-site during procedure. |

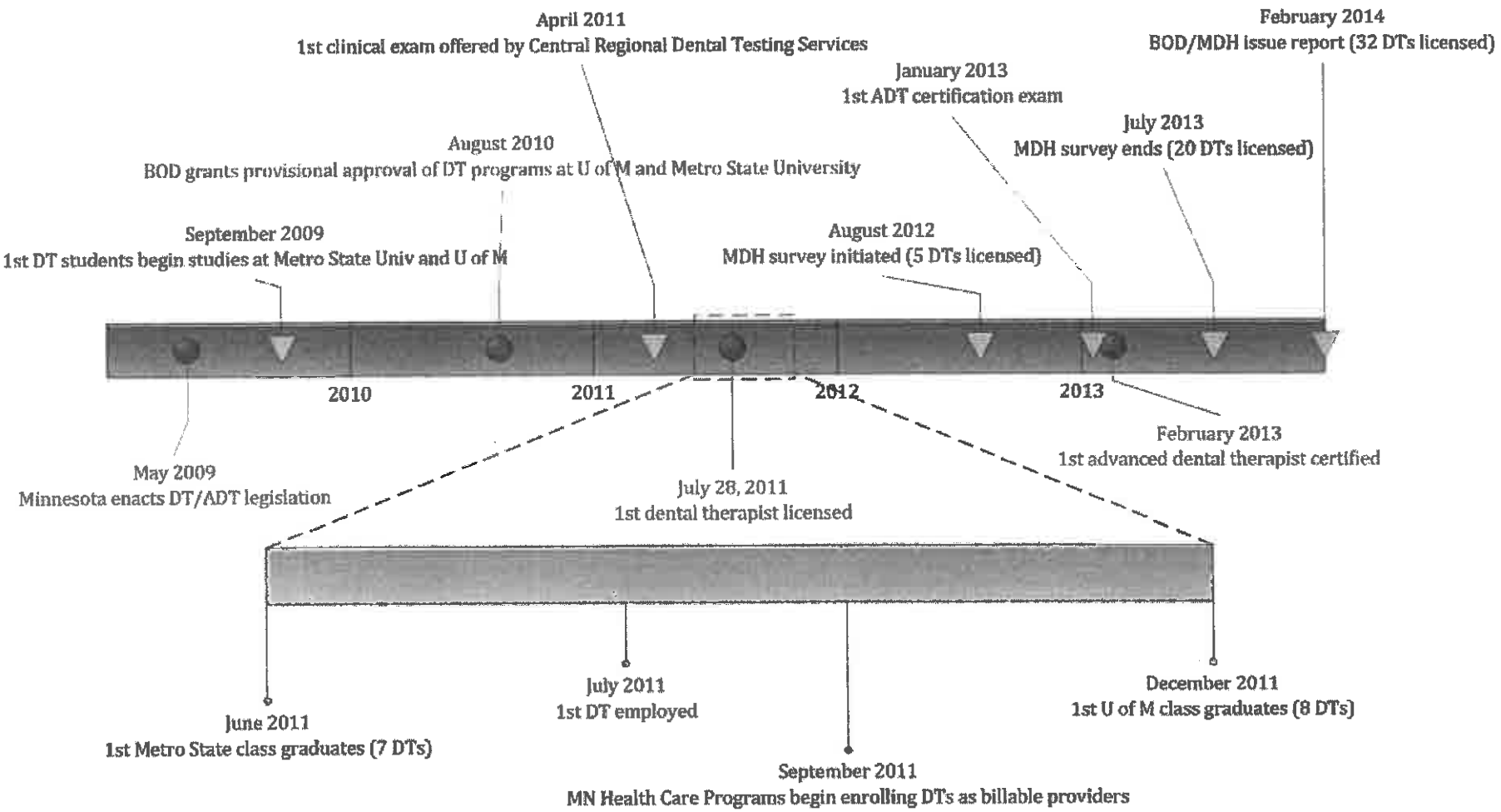
[8] Other allied dental professionals include expanded-function dental hygienists and dental assistants.
[9] David A. Nash et al., *A Review of Global Literature on Dental Therapists*. Battle Creek, MI: W.K. Kellogg Foundation. April 2012. Available from: http://www.wkkf.org/resource-directory/resource/2012/04/nash-dental-therapist-literature-review.
[10] Minnesota Statutes Sections 150A.105-.106 (2009). See 150A.105, subdivision 8 (Definitions) in Appendix A for full definition of "practice settings that serve the low-income and underserved."

**Development of Minnesota's dental therapy profession since 2009**
The dental therapy profession is still in its infancy in the U.S., and Minnesota's oral health community has had to build basic foundations of the profession: educational programs and cohorts of students; licensing and certification procedures, materials and exams; collaborative management agreements; reimbursement systems; and changes at the individual clinic level, as dental practices work to understand the new role and integrate it into day-to-day operations and teams.

As a result, the profession is still emerging. As of early February 2014, Minnesota had a total of 32 licensed dental therapists, six of whom were certified as advanced dental therapists. This compares to 4,027 licensed dentists and 5,542 licensed dental hygienists statewide. The enabling legislation was passed in May 2009, and the state issued its first dental therapist license more than two years later, in July 2011 (after the first cohorts of dental therapists had graduated and the Board of Dentistry had established its licensing procedures). The first advanced dental therapist was certified one year ago, in February 2013. The Minnesota Department of Human Services (DHS) began enrolling dental therapists as billable providers in the state's public insurance programs (Minnesota Health Care Programs, which include Medical Assistance and MinnesotaCare) in September 2011. DHS established identical payment rates for dentist and dental therapy services.

Figure 1 illustrates both the progress that has been made in building the occupation and its status as a still-emerging profession.

**Figure 1: Timeline, dental therapy in Minnesota since 2009**



## IV. Methods

To conduct the three-part analysis of dental therapy impact directed by the 2009 Legislature, data were drawn from multiple sources. Fifteen clinics employing dental therapists (the "study clinics") participated in the evaluation, listed below (see also Appendix D for maps of these clinics):

**Table 2: Study Clinics**

| Clinic Name | City | Location |
|---|---|---|
| ADT Dental | Minneapolis | Twin Cities metro |
| Apple Tree Dental | Coon Rapids | Twin Cities metro |
| Apple Tree Dental | Madelia | Greater Minnesota |
| Children's Dental Services | Minneapolis | Twin Cities metro |
| Community Dental Care | Maplewood | Twin Cities metro |
| Family Dental Care (part of People's Center Health Services) | Minneapolis | Twin Cities metro |
| Hennepin County Medical Center | Minneapolis | Twin Cities metro |
| HealthPartners | Como Clinic | Twin Cities metro |
| HealthPartners | Coon Rapids | Twin Cities metro |
| HealthPartners | Midway Clinic | Twin Cities metro |
| Main Street Dental Care | Montevideo | Greater Minnesota |
| Metropolitan State University Dental Clinic | Maplewood | Twin Cities metro |
| Minnesota State Community and Technical College - Moorhead[11] | Moorhead | Greater Minnesota |
| St. Joseph's Community Dental Clinic | Park Rapids | Greater Minnesota |
| Union Gospel Mission | St. Paul | Twin Cities metro |

The following are the specific sources and methods included in the evaluation:

### A. Minnesota Department of Health patient survey

MDH designed a survey to capture the impact of dental therapists on the oral health access measures defined in the 2009 dental therapy law (such as reduction in patient wait and travel times). The survey questions were developed by MDH, reviewed by several stakeholders and pilot tested before distribution. A sample of the survey instrument is provided in Appendix C.

MDH recruited 15 clinics employing dental therapists to participate in the survey, 14 of which returned completed surveys.[12] The survey was designed in English and translated into five other languages (Amharic, Hmong, Oromo, Somali and Spanish) in consultation with study sites based on clinic patient population(s).[13]

The surveys were designed to be given to patients at their first appointment with the dental therapist. (There was considerable variation in how study clinics actually administrated the

[11] This site did not participate in the survey or data collection, but did participate in the interview portion of the study.

[12] Collaborative management agreements filed with the Minnesota Board of Dentistry were used to identify the first cohort of clinics in Minnesota that hired dental therapists. Minnesota State Community and Technical College – Moorhead did not participate in the survey, but did participate in the interview portion of the evaluation.

[13] To ensure survey integrity, the surveys were back-translated into English by language experts and reviewed.

surveys. See Evaluation Limitations for more detail.) Patients were encouraged to complete the survey on site and either return it to clinic staff or send it to MDH in a provided postage-paid envelope.

The patient surveys were distributed by the clinics as early as August 2012 at one of the sites, and all sites were instructed to discontinue surveys by mid-July 2013. A total of 1,382 surveys were completed, 55 percent of which were completed by adults and 45 percent on behalf of patients who were children. Of the patients who visited a rural dental clinic, 60 percent were under age 18, while 24 percent of those who visited an urban clinic were under 18 years of age.

**B. MDH clinic interviews**
MDH conducted interviews with clinic managers/supervisors, supervising dentists and/or dental therapists at each of the participating sites to further assess how the introduction of dental therapists affected key measures including patient flow, oral health team/clinic productivity, clinic costs and patient access.

**C. Administrative data from clinics.**
MDH also requested that study clinics provide data on the numbers of patients served since hiring a dental therapist. Specifically, each clinic was asked to report the number of patients served by each dental therapist from the time they began employment through the end of the survey (July 2013), the insurance type of those patients and the average number of hours worked by the dental therapist.[14]

**D. Emergency room data.**
To assess the impact of dental therapists on ER usage, the Minnesota Hospital Association provided data on emergency room services for non-injury oral health conditions in 2012.

**E. Licensing and other professional data.**
The Minnesota Board of Dentistry provided data on the number of dental therapists licensed in Minnesota and the settings in which they were practicing. The Board also provided information on any complaints filed against dental therapists and any disciplinary actions taken in that period. All data are current as of February 4, 2014.

## V. Findings: Dental therapy workforce status

The 2009 dental therapy law directed the Board of Dentistry to provide the following information regarding the dental therapy workforce. All data are through January 15, 2014.

A. **Number of dental therapists annually licensed since 2011.** As of February 4, 2014, there were 32 licensed dental therapists in Minnesota. Of the 32, six also hold certifications in advanced dental therapy. The following table indicates the number of dental therapists by year since licensure began in 2011:

[14] MDH did not receive any patient-related data from Family Dental Care.

**Table 3: Number of dental therapists licensed, by year**

| Year | Number of new dental therapists licensed in Minnesota |
|---|---|
| 2011 | 6 |
| 2012 | 12 |
| 2013 | 11 |
| 2014 | 3 |
| Total as of February 2014 | 32 |

**B. Settings where dental therapists are practicing and populations being served.** Dental therapists work in a variety of settings. The majority of these settings are in urban underserved areas, but a growing number are located in rural and suburban communities.

**Table 4: Dental therapist employers and settings**

| Dental Therapist License # | Employer Name | City | Location | Employer Type |
|---|---|---|---|---|
| DT1* | Hennepin County Medical Center (HCMC) | Minneapolis | Twin Cities metro | Hospital |
| DT2* | Children's Dental Services (CDS) | Minneapolis | Twin Cities metro | Community-based clinic |
| DT3 | ADT Dental/ADT Kids | Minneapolis | Twin Cities metro | Private practice |
| DT4* | Apple Tree Dental | Mobile (multiple locations) | Multiple locations | Community-based clinic |
| DT5* | Apple Tree/ Union Gospel Mission (UGM) | Mobile (multiple locations) | Multiple locations | Community-based clinic |
| DT6 | Family Dental Care (part of People's Center Health Services) | Minneapolis | Twin Cities metro | Community-based clinic/ Federally Qualified Health Center (FQHC) |
| DT7 | University of MN/ Community University Health Care Center (CUHCC) /Community Dental Care | Minneapolis | Twin Cities metro | Community-based clinic/ FQHC |
| DT8 | HealthPartners | Maplewood St. Paul | Twin Cities metro | Health system/HMO |
| DT9 | N/A† | N/A† | N/A† | N/A† |
| DT10 | Main Street Dental Care | Montevideo | Greater Minnesota | Private practice |
| DT11 | N/A† | N/A† | N/A† | N/A† |
| DT12 | St. Joseph's Community Dental Clinic | Park Rapids | Greater Minnesota | Hospital/Community-based clinic |
| DT13 | Lake Superior | Duluth | Greater Minnesota | Community-based |

| Dental Therapist License # | Employer Name | City | Location | Employer Type |
|---|---|---|---|---|
| | Community Health Center | | | clinic/ FQHC |
| DT14* | HCMC/Metropolitan State University Dental Clinic | Minneapolis | Twin Cities metro | Hospital/Community-based clinic |
| DT15 | Open Cities Health Center, Inc. | St. Paul | Twin Cities metro | Community-based clinic/ FQHC |
| DT16 | N/A† | | | N/A† |
| DT17 | Excel Dentistry | St. Louis Park | Twin Cities metro | Private practice |
| DT18 | UGM/CUHCC/Mission of Mercy‡/University of Minnesota | Minneapolis St. Paul | Twin Cities metro | Community-based clinic/ FQHC /Hospital |
| DT19 | Northland Smiles | Deerwood | Greater Minnesota | Private practice |
| DT20 | Woodland Dental | Wadena | Greater Minnesota | Private practice |
| DT21 | Northland Smiles (not Melrose) | Deerwood | Greater Minnesota | Private practice |
| DT22 | Apple Tree Dental | Mobile unit (multiple locations) | Multiple locations | Community-based clinic |
| DT23 | Open Door Health Center | Mankato | Greater Minnesota | Community-based clinic/ FQHC |
| DT25 | Southern Heights Dental Group | Faribault | Greater Minnesota | Private practice |
| DT26 | Family Dental Care (part of People's Center Health Services) | Minneapolis | Twin Cities metro | Community-based clinic/ FQHC |
| DT27 | Metropolitan State University Dental Clinic | Maplewood | Twin Cities metro | Community-based clinic |
| DT28 | Metropolitan State University Dental Clinic/CDS | Maplewood | Twin Cities metro | Community-based clinic |
| DT 33 | N/A† | N/A† | N/A† | N/A† |
| DT 35 | Children's Dental Services | Minneapolis | Twin Cities metro | Community-based clinic |
| DT 36 | N/A† | N/A† | N/A† | N/A† |
| DT 37 | N/A† | N/A† | N/A† | N/A† |
| DT 38 | Children's Dental Services | Minneapolis | Twin Cities metro | Community-based clinic |

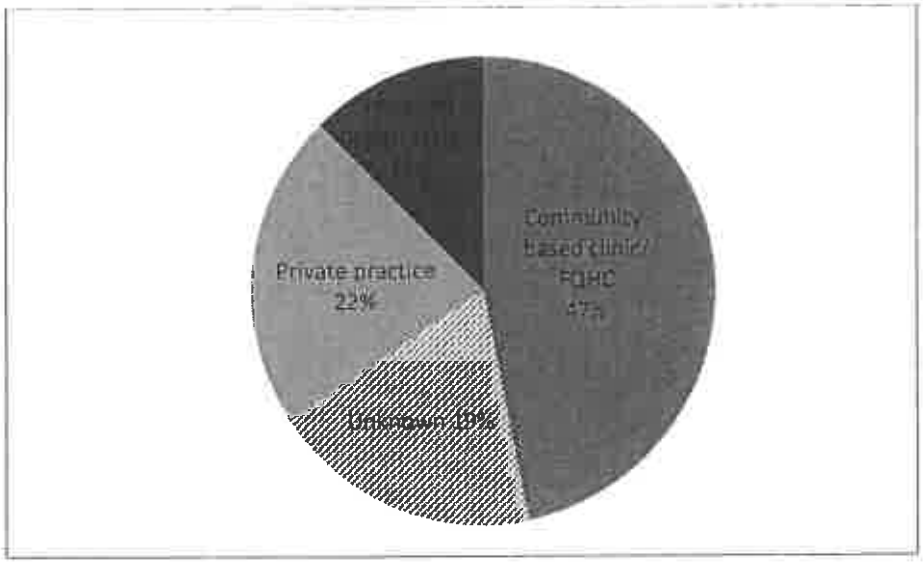
Notes: License numbers not currently assigned to a practicing dental therapist: DT24, DT29, DT30, DT31, DT32, DT34. These numbers were used by the Board of Dentistry for testing purposes only.

* Advanced Dental Therapist certifications.

†No Collaborative Management Agreement on file with the Board of Dentistry as of Jan 15, 2014, so no additional information available.

‡Mission of Mercy is a one-day annual volunteer event sponsored by the Minnesota Dental Association.

**Figure 2. Practice settings of Minnesota dental therapists (N=32)**




Administrative data provided by clinics indicated that the majority of the patients served by dental therapists to date are enrolled in public insurance programs (see Findings, below). In the interviews conducted by MDH, study sites also reported an increase in access to oral health services for those traditionally underserved – patients with medical complexities, pregnant women, immigrants, children and seniors.

C. **Number of complaints filed against dental therapists and the basis for each complaint.** In 2012, two complaints were filed against dental therapists. Both of these cases have been resolved without Board action. In 2013, two complaints were filed against dental therapists, both of which are pending. None of the complaints have been directly related to patient safety issues.

D. **Number of disciplinary actions taken against dental therapists.** No disciplinary actions have been taken by the Board against dental therapists.

## VI. Findings: Dental therapy services reimbursed by state programs

The 2009 dental therapy law also directed the Board of Dentistry, in consultation with the Minnesota Department of Human Services (DHS), to report "the number and type of dental services that were performed by dental therapists and reimbursed by the state under the Minnesota state health care programs for the 2013 fiscal year."

At the beginning of the study period (mid-2012), DHS data systems could not distinguish whether a service was provided by a dentist or a dental therapist, so data on dental therapist services and payments were not available. DHS did gain the capacity to directly enroll dental therapists as providers in its fee-for-service programs, but few have been enrolled. DHS is aware that most of its managed care plans are not individually credentialing dental therapists. Likewise, other dental payers have been slow to credential dental therapists, and it appears claims are mostly being submitted under the supervising dentist's provider identification number.

As a substitute, MDH sought and received information from the study clinics regarding the insurance status of the patients served by dental therapists. These administrative data indicated that the majority of the patients served by dental therapists to date are enrolled in public insurance programs (Minnesota Health Care Programs such as Medical Assistance or MinnesotaCare). Of the 12 clinics that provided information on payers for dental therapy services, the average percentage of dental therapist patients enrolled in public programs was 84 percent.

## VII. Findings: Assessment of impact

The 2009 dental therapy law also directed the Board of Dentistry, in consultation with MDH, to develop and report the results of an evaluation process "assessing the impact of dental therapists in terms of patient safety, cost-effectiveness and access to dental services." Specifically, the evaluation was to focus on five outcome measures:

**A. Number of new patients served.**
**B. Reduction in waiting times for needed services.**
**C. Decreased travel time for patients.**
**D. Impact on emergency room usage for dental care.**
**E. Costs to the public health system.**

Each of these measures is addressed below, with the caveat that this is a preliminary evaluation, given the relatively short period of time that dental therapists have been practicing in Minnesota and the even briefer time advanced dental therapists have been in the field (see also Evaluation Limitations section). The assessment uses a combination of the data sources described in the Methods section above.

### A. Number of new patients served.

The total number of new patients served by dental therapists at study clinics since the time the dental therapists were hired (first hired in August 2011) through the end of the survey period (July 2013) was 6,338.[15] The average hours worked by the dental therapist over the survey period[16] ranged from 1 hour/week to 36 hours/week at multiple study sites,[17] which equals approximately seven full-time equivalents (FTEs). At clinics with few dentists, the addition of the dental therapist led to a significant increase in access for new patients directly attributable to the therapist, in one clinic doubling new patients seen. In large clinics with many dentists, dental therapists also expanded access to new patients, but the relative increase has been a smaller share of total clinic patients.

Many of the study clinics also referred to the increase in new patients in their interviews with MDH, and confirmed that this increase was largely attributable to the addition of a dental

[15] Each patient is counted once. Repeat visits to the clinic, and dental therapist services provided at nearby schools, are not included. Children's Dental Services has significant activity at its clinic and at numerous schools.
[16] Survey period ranges from August 2012 through July 2013.
[17] Many clinics initially hired dental therapists on a part-time basis, increasing hours as routines were established and capacity to accept new patients grew.

therapist. The staff at one clinic, which has seen a 24 percent increase in patients, noted: "The increase in new patients is mostly because of the dental therapist's productivity. We've been able to add a chair[18] to accommodate the clinic's new patients. Patients want to get in with her."[19]

Many of the clinics noted an increase not just in the overall number of patients, but an increased ability to serve greater numbers of underserved and special populations. Several clinics noted that most of the new patients being seen since the dental therapist started are public program enrollees or are uninsured.[20] One rural private clinic hadn't accepted many Medical Assistance patients before their dental therapist started, but now sees significant numbers.[21] Clinics noted the dental therapist has expanded their capacity to serve children, and one has added services at a nearby elementary school (which their advanced dental therapist visits three times each week) and another hopes to begin providing pediatric dental therapy services in schools as well.[22] A hospital site is using a dental therapist to provide oral health services to low-income pregnant women directly in its OB department. In the past, these patients were referred to the hospital's emergency room. The dental staff explained these services are only possible because of the dental therapist; the grant-funded program could not afford to employ a dentist.[23]

Several clinics noted an ability to serve more medically complex individuals – including more elderly, immigrant and refugee patients – in part because of the cost savings[24] they've realized through the dental therapist.[25] One such clinic plans to begin providing advanced dental therapist home visits to seniors, particularly elderly immigrant patients who live nearby but have difficulty getting to the clinic.[26]

MDH also requested information from the study clinics regarding the insurance status of the patients served by dental therapists. These administrative data indicated that, on average, 84 percent of the patients seen by dental therapists were on public insurance programs (Minnesota Health Care Programs such as Medical Assistance or MinnesotaCare). This is a slightly higher proportion than the average for all providers at the clinics (76 percent), suggesting that dental therapists are seeing greater numbers of low-income patients than other providers.

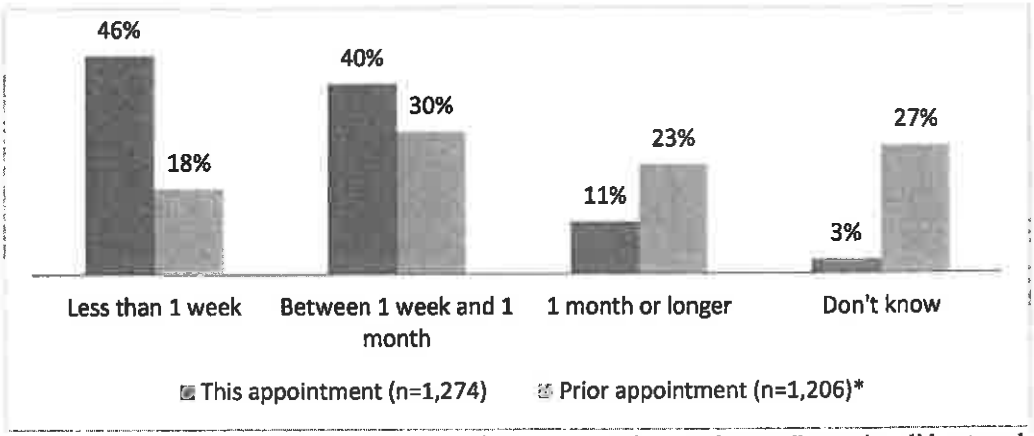
**B. Reduction in waiting times for needed services.**

Overall, nearly one-third of all patients surveyed experienced a reduction in wait times for an appointment since the dental therapist was employed (Figure 3). Over 80 percent of patients

[18] This report uses the term "chair" as the industry shorthand for a dental operatory. A dental operatory is the treatment room or work area of the dental team. Common operatory equipment includes the dental chair, dental unit, dental operating light, x-ray machine, operating stools, mobile carts, and cabinets and tools such as air abrasion cavity preparation systems, lasers, CAD/CAM systems, computers and associated equipment, curing lights, digital radiographic equipment, and intraoral cameras (American Dental Association, ADA CE Online).
[19] Interview with ADT Dental interview.
[20] Interviews with Children's Dental Services; ADT Dental; Apple Tree Dental; Main Street Dental; HealthPartners; and Family Dental Care.
[21] Interview with Main Street Dental.
[22] Interviews with ADT Dental and HCMC.
[23] Interview with HCMC.
[24] See sections VII.E. and VIII.A. for further discussion of dental therapist costs.
[25] Interviews with Apple Tree Dental and Family Dental Care.
[26] Interview with Family Dental Care.

stated it took less than one month to get their first appointment with the dental therapist. More than 20 percent said they had waited one month or more for a previous appointment (before the dental therapist was available). Of the patients who reported it had taken at least two months to get a previous appointment, 77 percent reported getting the current appointment in less than one month. (As noted in the Limitations section, these survey results may have been affected by the predominance of follow-up visits as the first encounter with a dental therapist. During the interviews, MDH probed for other changes at the study sites [such as additional dentists/hygienists/assistants/operatories] that may have impacted patient wait times, and the interviews confirmed a reduction in wait time attributable to the presence of dental therapists.)

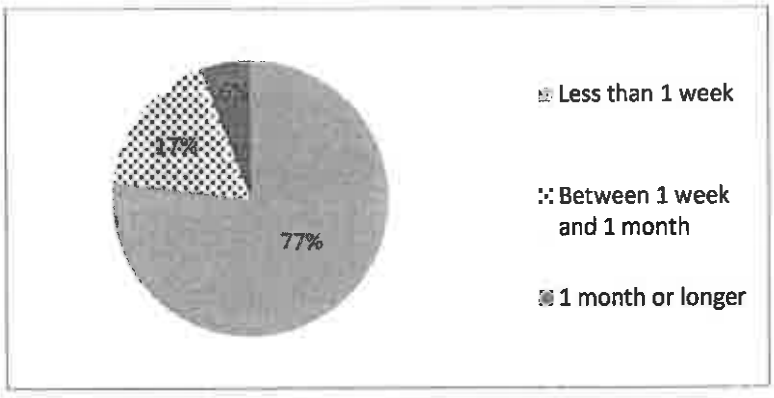
**Figure 3. Wait times for appointment, with DT vs. pre-DT**




*For 32 patients, this was their first dental appointment, so "prior appointment" question did not apply.

Of note is the short wait time for an appointment when pain or other dental emergency was the presenting problem (Figure 4). Combined with the overall reduction in wait times, this finding is an early indicator of the potential for dental therapists to reduce hospital emergency department use for dental pain. Clinic interviews also yielded similar indicators of a reduction in ER use. This is an issue ripe for future research.

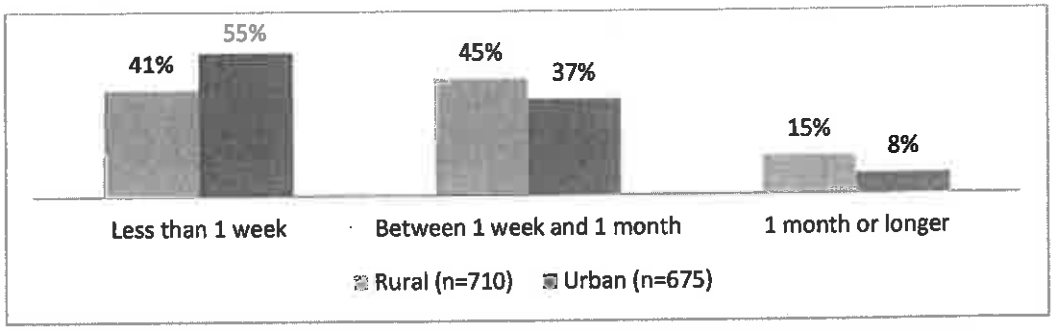
**Figure 4. Wait time when reason for visit was for pain or other dental emergency (n=135)**




The impact of the dental therapist on wait time appears to be greater in the rural areas (Figure 5). Patients visiting rural clinics were nearly two times more likely to experience a reduction in wait

time compared to their urban counterparts, although it appeared that the wait time was still longer for the current appointment at a rural clinic than it was at an urban clinic.

**Figure 5. Wait times for dental therapist appointment, rural vs. urban**




The interviews with clinic staff confirmed that having a dental therapist on staff appeared to decrease wait times, with all of the clinics interviewed reporting a reduction in wait times for appointments since hiring a dental therapist. One clinic director said their wait time for an appointment has been reduced from 4 weeks to 1.5 weeks maximum.[27] Another noted that children who see the dental therapist are now being scheduled in three weeks (compared to 10 weeks for a dentist).[28] Others noted that wait times have decreased particularly for restorative care appointments or more complex treatments, and some noted a drop in appointment failures (no shows) as well.[29]

The director of a rural community clinic stated they had always had a long waiting list for appointments, but since hiring the dental therapist, there is now no waiting list; the dental therapist eliminated "pages of people who were waiting for appointments."[30] This clinic is in the same facility as the hospital, and because of their expanded capacity with the dental therapist, the hospital is now referring dental emergencies directly to the dental clinic from the emergency room, reducing emergency room use for dental-related care and for drug seeking couched as dental pain.

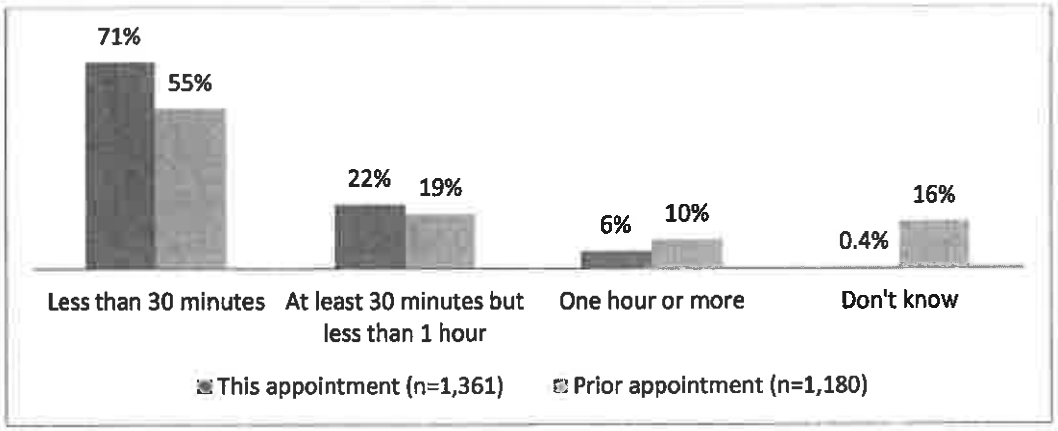
Clinic staff observed several reasons for this impact on wait times. One clinic explained they can shift patients around in the schedule and get procedures done in a more timely way, because the dental therapist adds flexibility to the teams.[31] Having a dental therapist gives the care coordinator and scheduler more options. Many cases get done the same day, and the procedure is simpler because the decay has not progressed as it might with a longer wait. One clinic director reported that using the dental therapist also opens up appointment times for the dentist, as many restorative procedures can now be accomplished by the dental therapist instead.[32]

[27] Interview with Family Dental Care.
[28] Interview with HCMC.
[29] Interviews with Children's Dental Services, Apple Tree Dental and Moorhead State Technical and Community College Dental Clinic.
[30] Interview with St. Joseph's Area Health Services-Community Dental Clinic.
[31] Interview with Apple Tree Dental.
[32] Interview with Moorhead State Technical and Community College Dental Clinic.

**C. Decreased travel time for patients.**

The survey results indicate that at least for some patients, there was a reduction in travel time for their appointment with the dental therapist compared to their last appointment (Figure 6). For 93 percent of respondents, it took less than one hour to travel to the current dental appointment with the dental therapist, compared to 74 percent who traveled less than an hour to their last appointment. Similarly, a slightly lower percentage (6 percent) of patients had to travel at least an hour to the current appointment, compared to the 10 percent who traveled at least that far to their prior dental appointment. Most of the respondents (94 percent) stated it was somewhat or very easy to get transportation to this appointment.

**Figure 6. Travel times for appointment, with dental therapist vs. pre-dental therapist**




A reduction in travel time was more pronounced for certain populations. Patients who reported having visited an emergency room in the past two years were nearly twice as likely to experience a reduction in travel time from a previous visit to a dental clinic compared to the current appointment with a dental therapist.[33] Of those patients who had not visited the current dental clinic before, 24 percent experienced a reduction in the time it took to travel to the current dental appointment with the dental therapist.

Geographic location of the clinic also seems to have affected reductions in travel times, with change in travel time more notable in rural areas. Of the respondents who stated they experienced a reduction in travel time, 59 percent were seen at rural clinics and 41 percent at urban clinics.

It should be noted that travel time to a clinic is somewhat confounded by the type of dental insurance a patient has. The closest clinic that takes public program patients may be more than one or two hours away. As an example, one of the study clinics was a single-owner private dental clinic in Montevideo that has significantly increased its share of public programs patients since the hiring of the dental therapist. Many of its patients would have to drive an additional 30 minutes to one hour to be seen by another clinic that takes their insurance.[34] In two other cases, clinics have served patients referred from as far away as Iowa and South Dakota; these are the closest clinics that will accept public insurance.

[34] Interview with Main Street Dental in Montevideo.

Several of the clinics are using or plan to use dental therapists to address travel barriers more directly, by bringing their services to nontraditional patient settings outside the dental clinic, including elementary schools, medical settings and elderly patients' homes.[35]

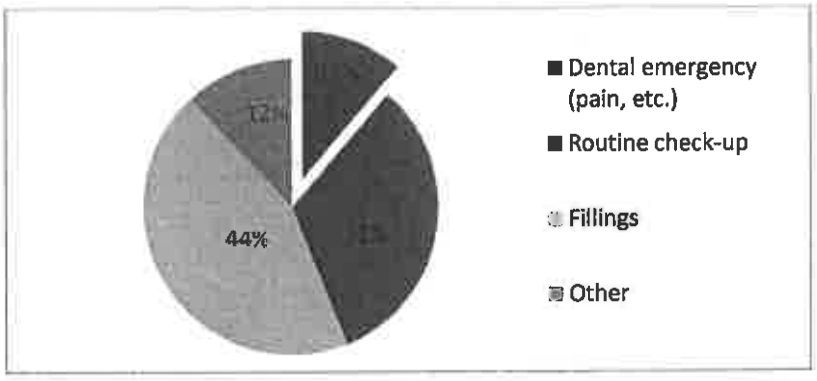
**D. Impact on emergency room usage for dental care.**

According to the Minnesota Hospital Association (MHA), non-injury oral health-related visits accounted for 28,115 emergency room claims in 2012. The costs for these ER visits totaled $15,520,215, of which 37 percent ($5,663,760) was charged to public assistance programs. Dental caries alone accounted for 3,350 of these emergency room claims and $1,534,678 in charges.[36] Adults account for the great majority of these visits; 85 percent of the 2012 ER visits for dental conditions were adults between the ages of 19 and 65.[37] As noted above, the current study also found adults who saw a dental therapist were far more likely to have visited an ER in the past two years than children who saw a dental therapist.

It is too early to definitively answer how dental therapists may affect the use of emergency rooms for dental treatment. With only 32 dental therapists in the field (and fewer during the time period of this study), it is difficult to discern their impact on the utilization of the emergency room statewide. However, the survey and interviews conducted in this preliminary evaluation suggest dental therapists may be helping serve patients who have visited the ER in the past for dental issues, and may also be preventing current ER use by expanding capacity at dental clinics serving vulnerable populations that might otherwise resort to the ER.

A relatively small number (11 percent) of patients were seeing the dental therapist for a dental emergency. The great majority (89 percent) had made the appointment for either a routine check-up (32 percent) or other treatment, with fillings accounting for 44 percent of the visits.

**Figure 7. Reason for dental visit (n=1,373)**




Of the patients visiting a clinic for a dental emergency, 27 percent had tried to get an appointment at another clinic before they were able to secure the current appointment with the

[35] Interviews with ADT Dental, Apple Tree Dental, Family Dental Care and HCMC.
[36] Minnesota Hospital Association, Data on Hospital-based Outpatient ED Care for Dental Conditions by Principal Diagnosis, 2006-2012. Data prepared on September 12, 2013.
[37] Ibid.

dental therapist. Just over half (53 percent) of those making the appointment for a dental emergency had not had a dental appointment for over a year, while 42 percent had visited a dental clinic in the past year, and 6 percent had never visited a dental clinic before.

Only 4 percent of survey respondents indicated they had been to an emergency room in the past two years for dental pain not caused by an injury. The majority of these patients (85 percent) were adults; adults were nearly five times more likely to have visited an emergency room in the past 2 years for dental pain compared to those under 18 years of age (OR= 4.61, CI = 2.24 to 9.49).

Those who visited an emergency room in the past two years were over three times more likely than those who hadn't visited an ER to have tried to get an appointment at another dental clinic before securing this appointment with the dental therapist. It is possible at least some of these patients may have resorted to going to the emergency room after failed attempts to get an appointment at a dental clinic; the current appointment with the dental therapist may have prevented their going to an emergency room again for care.

Patients who had visited the emergency room in the past two years were nearly three times more likely to have moved within the past year (OR=2.9, CI 1.6 to 5.2), after controlling for the time it took to get to the appointment. It appears that those individuals who move more frequently may experience a greater challenge in gaining access to care at a dental clinic, even if travel time is not an issue.

Several of the clinic interviews also referred to the impact of dental therapists on emergency care. Several noted that dental therapists are reducing emergency room visits (and the associated costs) by allowing more patients to be seen earlier.[38] As one clinic director noted in an interview, the procedure is simpler if decay isn't allowed to progress, and with dental therapists they are able to treat more patients sooner, many now even with same-day treatment.[39] This is especially important in those cases where the patient might not be treated elsewhere; as the same clinic director noted, their patients may have been to an emergency room or another clinic for an exam, but no other clinic would take them for the restorative care they needed.

At two other sites, the addition of a dental therapist has directly allowed re-direction of patients who would otherwise go to emergency rooms. Both are clinics associated with hospitals. At Hennepin County Medical Center, the dental therapist has a chair in the Obstetrics department and treats pregnant women who would have been sent to the emergency room for care.[40] At St. Joseph's Area Health Services in Park Rapids, emergency room staff now refer patients with dental pain directly to the dental clinic located within the hospital.[41] St. Joseph's believes some of these patients are actually drug-seeking patients without serious dental emergencies, and it has seen a decline in drug-seeking patients since beginning diversion of emergency room dental patients to the dental therapist. At both HCMC and St. Joseph's, the diversion procedures became possible because of the capacity added by the dental therapist.

[38] Interviews with Apple Tree Dental, Family Dental Care, and HealthPartners.
[39] Interview with Apple Tree Dental.
[40] Interview with Hennepin County Medical Center.
[41] Interview with St. Joseph's Area Health Services – Community Dental Clinic.

### E. Costs to the public health system.

As noted above, data on payments and services billed to Minnesota public programs by dental therapists were unavailable for the current assessment. In addition, consistent all-payer standards and procedures for identifying dental therapists as treating providers are needed.

With state public program reimbursement rates for dental therapist services the same as the rates for dentist services, there is not necessarily an immediate savings to the state on each claim paid; however, the differential between DHS rates and clinics' lower personnel costs for dental therapists appears to be contributing to more patients being seen.

## VIII. Additional findings

In addition to the specific measures of impact outlined in the 2009 Minnesota dental therapy law, the following are supplemental findings that emerged from the assessment. These findings offer additional information on the early impact of dental therapists on the delivery of and access to dental services in the state.

### A. Clinics report additional impacts of dental therapists, including personnel cost savings, increased dental team productivity, and improved patient satisfaction.

Two thirds of the clinics interviewed noted the significant savings in personnel costs that come with employing a dental therapist compared to a dentist.[42] Several pointed out that a dental therapist costs roughly half as much as a dentist; one clinic calculated their savings at $62,000 per dental therapist when malpractice insurance and other differentials are factored in, while others estimated the savings to be $35,000-$50,000 per dental therapist.[43] All but one clinic that reported malpractice premiums for dental therapists reported premium prices significantly below dentist malpractice premiums; premiums at the outlier clinic were similar to dentist premiums.

Many of the clinic directors also observed the versatility and flexibility dental therapists have brought to their dental teams, and reported this has led to an overall increase in productivity. Clinics also reported that having a dental therapist frees up the dentist to focus on more complex procedures.[44] This has allowed for more appropriate and more accessible scheduling, brought financial benefits to the clinic, and in some cases led clinics to begin (or resume) offering more complicated services than they were able to offer without the dental therapist.

Clinics also referred to more intangible ways the dental therapist has improved the work of their teams and practices. "Dental therapists are the 'glue' that hold dental clinics together, like a nurse at a hospital does," said a director at Family Dental Care. "Dental therapists also help everyone become better professionals by providing dental education and a quality experience for

[42] Interviews with Children's Dental Services, ADT Dental, Apple Tree Dental, Main Street Dental, HealthPartners, HCMC and St. Joseph's.
[43] Interviews with Children's Dental Services, Apple Tree Dental and Family Dental Care.
[44] Interviews with Children's Dental Services, ADT Dental, Apple Tree Dental, Main Street Dental, HealthPartners, Metropolitan State University Dental Clinic, Family Dental Care, Moorhead State Technical College, HCMC and St. Joseph's.

patients." Another clinic director stated: "Dental therapists are doing a lot toward evidence-based dentistry – a hidden benefit."

Finally, several clinics reported high levels of patient satisfaction with dental therapists, in part because they are able to spend more time with patients, and can offer chairside education and prevention information.[45] "We look carefully at patient satisfaction and the quality is wonderful with the dental therapist," a director at HealthPartners noted.

**B. The savings resulting from the lower costs of dental therapists are allowing clinics to expand capacity to serve more underserved and public program patients.**

Clinics have been able to use the savings made possible from a dental therapist to "add chairs" (and related equipment and supplies) to serve more patients.[46] Clinics also noted that the cost differential has made it possible for them to recoup capital expansion costs faster. In one case the clinic has hired 1.2 full-time equivalent (FTE) dental therapists to serve underserved patients, and noted it would not have been able to afford 1.2 FTE dentists.[47] Another clinic noted that the savings yielded from having the dental therapist has made the difference in terms of sustainability for the clinic overall: as recently as last year, the rural hospital-based clinic – whose clientele is nearly all enrolled in public programs – was losing significant amounts in uncompensated care, even with long waiting lists. Adding a dental therapist has doubled their capacity, erased their waiting list and allowed the clinic to begin accepting direct referrals from the nearby emergency room.[48]

**C. Start-up experiences with dental therapists have varied, and employers expect continuing evolution of the profession's role and impact.**

Dental therapists' ability to perform routine procedures is freeing up dentists' time for complex procedures. Because most patients first see a dental hygienist and receive a dentist's exam, most dental therapist patients have been follow-up/restorative care patients. Dental therapists give the clinics more flexibility to juggle schedules to fit patients in and to assign procedures on the fly to the most fitting and most available member of the team. This has increased flexibility and efficiency.

Time to achieve break-even employing a dental therapist has varied. Many clinics began using dental therapists on a part-time basis, increasing hours as routines were established and capacity to accept new patients grew. Clinics feel they are "writing the book" on employing dental therapists.

Many of the clinics noted that introducing a dental therapist involved a ramp-up period, as team members defined and became comfortable with the new patient flow and roles. "There is a learning curve effect," said a director at Apple Tree Dental. "The first and second year can be rocky as the team ramps up. The dentists on the team may not be referring as much as possible.

[45] Interviews with HealthPartners, Family Dental Care and St. Joseph's.
[46] Interviews with ADT Dental, Apple Tree Dental and Family Dental Care.
[47] Interview with Family Dental Care.
[48] Interview with St. Joseph's in Park Rapids.

We expect additional productivity as the practice gets up to speed."[49] Another director likened it to "the invention of electricity...the gates have just barely opened. It's hard to know what can be done until it has been applied and accepted."[50]

### D. Most clinics that have employed dental therapists for at least one year are considering hiring additional dental therapists.

Many of the clinics, particularly those with longer experience with dental therapists, said they would like to hire more or were in the midst of hiring more dental therapists at the time of the interview.[51] Several were limited only by space and equipment, and would hire more dental therapists if they could increase the number of chairs. Others would hire more if they could find advanced dental therapists in particular, as their ability to work without a dentist on site would open up more possibilities. A small rural clinic noted that it currently must close the clinic if its one dentist isn't available, because its dental therapist cannot perform her full scope of practice without a supervising dentist on site; if it had an advanced dental therapist, the clinic could remain open to meet the needs of some patients.[52] Another clinic (also rural) suggested that the scope of practice for dental therapists should be expanded, for similar reasons.[53]

## IX. Evaluation limitations

As the first evaluation of state-licensed dental therapists, this study faced challenges and limitations, and must be understood in context. Because the assessment took place at the very beginning of the introduction of dental therapists in Minnesota - there were five dental therapists employed in the state at the beginning of the survey component of the project and 20 at its end - it is a first snapshot of dental therapist impacts. In addition to producing preliminary findings, MDH considers this effort in part to be formative research, intended to inform a learning process by identifying questions and approaches for future research.

The timing of the evaluation led to several key challenges. Although the 2009 Legislature set the report deadline five years into the future, the profession has yet to reach maturity. The first dental therapist began work in 2011, and hiring statewide began slowly. Thus, the study had limited numbers of dental therapists, clinics and patients available as subjects. It is also important to note that no clinics employed advanced dental therapists when the study began; the first advanced dental therapist was certified in February 2013, and only three were certified as of the end of the study (December 2013). Thus data and observation in this report are almost exclusively about dental therapists. With a broader scope of practice and less confining supervisory requirements, there is not yet a significant basis to evaluate the impacts of advanced dental therapists. Results of this project cannot be generalized and applied to the impacts advanced dental therapist will have as their numbers grow.

This timing also meant that the survey was by necessity developed before any patterns of practice were established by clinics employing dental therapists. The survey included certain

[49] Interview with Apple Tree Dental.
[50] Interview with HealthPartners.
[51] Interviews with Children's Dental Service, Community Dental Care, Apple Tree Dental and HealthPartners.
[52] Interview with St. Joseph's in Park Rapids.
[53] Interview with Main Street Clinic in Montevideo.

assumptions about scheduling, sequence of visits for exams, prophylaxis and restorative services, and division of labor among the members of the dental team. Actual practice patterns developed differently as early employers "wrote the book" - or at least first chapters - on dental therapy practice.

Specifically, this timing misalignment limited the evaluation as follows:

- **Patient flow**. The survey protocol was designed with the assumption that patients seeking oral health services, especially public program enrollees, would be routed directly to the dental therapist as the first point of access. However, as clinics have integrated dental therapists into their teams, the sequence typically calls for the patient to be seen first by a dental hygienist, then examined by a dentist, and then scheduled for a return visit with a dental therapist for fillings and other restorative services. Thus, a patient's first visit with a dental therapist was most often a return trip to a clinic they had visited recently for intake and initial services. This may have affected certain survey answers. For example, many (72 percent) answered that they had been to a dental clinic less than one year ago, possibly referring to their previous dental appointment with the hygienist or dentist at the study site. Once this became clear, MDH sought and obtained additional information on patient characteristics directly from clinic leadership. Clinic interviews confirmed a reduction in wait times as reported by survey respondents.
- **Gradual ramp-up of patients**. The first cohort of dental therapists faced significant challenges in finding employment, and almost all worked part time at the start of the study as clinics figured out how to integrate this new team member into established oral health teams and patient flow. Their part-time status affected how many patients they were able to see. Study sites also noted that it took time to build the practice and publicize that public program enrollees were being accepted at private clinics and wait times were much shorter at community clinics.
- **Lack of public programs data**. As noted earlier, at the time of the study period (mid-2012 through 2013), Department of Human Services data systems could not yet distinguish whether a service was provided by a dentist or a dental therapist, so data on dental therapist services and payments was not available. MDH sought and received information from study clinics about their Medical Assistance and other payer mix as a substitute.

Finally, patients at some of the clinics may have had literacy challenges. Although the survey was translated into five languages in addition to English, a determination could not be made as to whether or not individuals were able to read. In addition, some of the questions may have been affected by the ability of the patient to correctly recall information from the past.

## X. Conclusions and recommendations

The following are general conclusions and recommendations based on this initial evaluation of dental therapist impact at a very early stage of the profession's development.

### Conclusions

A. **The dental therapy workforce is growing and appears to be fulfilling statutory intent by serving predominantly low-income, uninsured and underserved patients.** In three years,

the number of licensed dental therapists grew from 0 to 32, with additional graduates soon to enter the workforce in 2014. Licensing information confirms the dental therapists are working in rural and underserved urban settings, and initial administrative data from clinics employing dental therapists confirm that the great majority of patients treated by these providers are on public insurance programs.

B. **Dental therapists appear to be practicing safely, and clinics report improved quality and high patient satisfaction with dental therapist services.** To date, no safety complaints have been made or Board actions taken against dental therapists.

C. **Clinics employing dental therapists are seeing more new patients than before the arrival of the dental therapists, and most of the patients are enrolled in public programs or otherwise underserved.** The increase in patients appears largely attributable to the productivity of dental therapists, the improved efficiency of teams as they integrate dental therapists, and the economics of dental therapy.

D. **Dental therapists have made it possible for clinics to decrease travel time and wait times for some patients, increasing access.**

E. **Benefits attributable to dental therapists include direct costs savings, increased dental team productivity, improved patient satisfaction and lower appointment fail rates.** Clinics also report higher quality, with better team communication and specialization of roles.

F. **Savings from the lower costs of employing dental therapists are making it possible for clinics to expand capacity to see public programs and underserved patients.**

G. **Start-up experiences have varied, and employers expect continuing evolution of the dental therapist role.** Dental therapists' ability to perform routine procedures is freeing up dentists' time for complex procedures. Dental therapists give a clinic more flexibility to juggle schedules to fit patients in and to assign procedures on the fly to the most fitting and most available member of the team, increasing efficiency. Time to achieve break-even employing a dental therapist has varied.

H. **Most clinics employing dental therapists for at least a year are considering hiring additional dental therapists.** Clinics are also anticipating the availability of advanced dental therapists once early dental therapy graduates complete their 2,000 hours of practice and become eligible for certification as advanced dental therapists.

I. **Dental therapists offer potential for reducing unnecessary ER visits for non-injury dental conditions.** Clinic interviews documented innovative ways dental therapists are being used to prevent ER visits, in one case through direct referrals from the emergency room and in another by working in a hospital's obstetrics department.

J. **With identical state public program reimbursement rates for dentist and dental therapist services, there is not necessarily an immediate savings to the state on each**

**claim paid; however, the differential between DHS rates and clinics' lower personnel costs for dental therapists appears to be contributing to more patients being seen.**

**Recommendations**

**A. Research and evaluation by state government and others must continue to document the growth and development of dental therapy in Minnesota, as more dental therapists and advanced dental therapists enter practice.**

In addition to its early findings about the impact of dental therapists in Minnesota, this evaluation serves as formative research that can inform future directions and approaches of research and inquiry. Future research should continue to quantify the nature and impact of dental therapists on the outcome measures of interest to the legislature. Future research should also consider additional dimensions such as oral health team productivity, patient satisfaction, peer and patient acceptance challenges, employer preference and labor market dynamics for dental therapists prepared with and without a hygiene background, and numerous other issues that emerged through the initial field observations of this evaluation. Finally, future research should include advanced dental therapists as a priority topic, as their scope of practice and ability to work more independently will likely lead to additional impacts.

MDH plans to continue to evaluate dental therapists with oral health workforce funding from the U.S. Health Resources and Services Administration. The University of Minnesota, Delta Dental of Minnesota, Normandale Community College and Metropolitan State University, and several national organizations also have evaluations planned or underway. Such efforts should be encouraged.

**B. Payers, both public and private, should work to develop consistent approaches to identify, enroll and credential dental therapists and advanced dental therapists as providers in their systems. Insurers and other stakeholders could bring these issues to the Administrative Uniformity Committee, housed in MDH, where they can work on them together.**

The availability of uniform and consistent claims data is essential to capture costs and benefits to the public health care system and to society. Development of data elements and data systems takes time and coordinated effort. As a voluntary, broad-based group representing Minnesota health care public and private payers, health care providers and state agencies working to standardize, streamline, and simplify health care administrative processes, the Administrative Uniformity Committee has potential as a forum where progress on these important issues can be made.

**C. State government and others should collect and share best practices and disseminate lessons learned by early adopters to support prospective employers in more quickly becoming ready to hire dental therapists.**

Delta Dental of Minnesota is currently making start-up funding available to private practices and will be collecting those case studies. MDH, through its federally funded State Innovation Model

(SIM) grant, will also be collecting and disseminating best practices from the first cohorts of dental therapist employers. These and similar efforts can help address "fear of the unknown" barriers for prospective employers, speed the development of job opportunities for coming classes of dental therapy graduates, and contribute to the research base. Should funds be available, investments in start-up grants to willing employers, especially in underserved settings, could further realize the potential of dental therapy to expand access.

## Appendix A: Study charge

Laws of Minnesota for 2009, Ch. 95, Art. 3, Sec. 31

**IMPACT OF DENTAL THERAPISTS**

1. The Board of Dentistry shall evaluate the impact of the use of dental therapists on the delivery of and access to dental services. The board shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care by January 15, 2014:

(1) the number of dental therapists annually licensed by the board beginning in 2011;

(2) the settings where licensed dental therapists are practicing and the populations being served;

(3) the number of complaints filed against dental therapists and the basis for each complaint; and

(4) the number of disciplinary actions taken against dental therapists.

(b) The board, in consultation with the Department of Human Services, shall also include the number and type of dental services that were performed by dental therapists and reimbursed by the state under the Minnesota state health care programs for the 2013 fiscal year.

(c) The Board of Dentistry, in consultation with the Department of Health, shall develop an evaluation process that focuses on assessing the impact of dental therapists in terms of patient safety, cost-effectiveness, and access to dental services. The process shall focus on the following outcome measures:

(1) number of new patients served;

(2) reduction in waiting times for needed services; (3) decreased travel time for patients;

(4) impact on emergency room usage for dental care; and (5) costs to the public health care system.

(d) The evaluation process shall be used by the board in the report required in paragraph (a) and shall expire January 1, 2014.

## Appendix B: Minnesota dental therapist statutes

### 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 reline;
(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 licensed dental assistants or nonlicensed 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 waivered 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; 2012 c 180 s 7*

**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 and fee 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; 2012 c 180 s 8*

## Appendix C: Survey instrument

### Dental Therapist Patient Survey

**Please complete this survey and give it to the dental office staff or return it in the postage paid envelope.**

The Minnesota Department of Health is evaluating the impact of licensed dental therapists on access to dental care. This survey has 12 questions and will take about 5 minutes of your time. Your answers are important.

**Please mark a response for every question or draw a line through the question if you choose not to answer.**

This survey may be completed by a dental patient who has received services from a dental therapist or by the parent or guardian of a patient under the age of 18 years.

**Data Privacy**

- The Minnesota Department of Health is required by the Minnesota Data Practices Act to maintain privacy of personal health information. All information collected in this study that identifies individual patients will remain completely private. We are aggregating the results by clinic; only the clinic ID number will be used for reporting.
- Any published reports will not contain identifying information, and there will be no information identifying any individual.

**Voluntary Participation**

- Participation in this research is voluntary.
- Choosing not to participate will not affect your future relations with any of the persons, clinics or offices involved in this effort.
- Completion of this questionnaire implies consent to participate.
- You are free to skip questions you choose not to answer.

**Questions**

- Contact Leslie Nordgren, Minnesota Department of Health Research Specialist, at

  651-201-3856 if you have questions.
- If you have questions about your rights pertinent to this research, contact Peter Rode, Minnesota Department of Health IRB, 651-201-5942.

**PLEASE PLACE THE SURVEY IN THE POSTAGE-PAID RETURN ENVELOPE**

**AND LEAVE AT THE FRONT DESK.**

## Thank You!

Leslie Nordgren, RDH, MPH, PhD

Office of Rural Health and Primary Care

Minnesota Department of Health

P.O. Box 64882, St. Paul, MN 55164-0882

651-201-3856

leslie.nordgren@state.mn.us

**Please give survey to the dental office staff or return survey in postage-paid return envelope.**

**DENTAL THERAPIST PATIENT SURVEY** 01 DT10

**FILL OUT A SEPARATE SURVEY FOR EACH DENTAL PATIENT SEEN TODAY.**

1. **Who** received dental care today?

   CHECK ONE

   ☐ Myself
   ☐ My child under age 18
   ☐ My dependent for whom I am a legal guardian. Explain relationship:_____
   ☐ Other. Please explain: _____

**ANSWER THE FOLLOWING QUESTIONS FOR THE PERSON RECEIVING DENTAL CARE TODAY.**

2. **When** did you last go to a dental clinic?

   CHECK ONE

   ☐ Less than 1 year ago.
   ☐ 1 year ago or longer. How many years? _____
   ☐ This is my first dental appointment.

3. What was **the reason** for your dental visit today?

   CHECK ONE

   ☐ Dental emergency (pain, etc.)
   ☐ Routine dental check-up
   ☐ Other. Please explain:_____

4. **How long** did it take for you **to get this appointment**?

   CHECK ONE

   ☐ Less than 1 week
   ☐ At least 1 week but less than 1 month
   ☐ At least 1 month but less than 2 months

☐ At least 2 months but less than 3 months

☐ 3 months or longer

☐ I don't know

5. **How long** did it take for you to get a **dental appointment at the last dental clinic you visited** prior to this appointment? CHECK ONE

☐ Less than 1 week

☐ At least 1 week but less than 1 month

☐ At least 1 month but less than 2 months

☐ At least 2 months but less than 3 months

☐ 3 months or longer

☐ I don't know

☐ This is my first dental appointment.

6. Before making this appointment did you **try to get an appointment at another dental clinic** to take care of the dental needs you had today?

☐ Yes ☐ No

7. Have you been to **this dental clinic for your last dental appointment**?

☐ Yes ☐ No

☐ This is my first dental appointment.

8. **How long** did it take you to **travel to this appointment?**

CHECK ONE

☐ Less than 30 minutes

☐ At least 30 minutes but less than 1 hour

☐ At least 1 hour but less than 2 hours

☐ More than 2 hours

☐ I don't know

9. **How long** did it take you to **travel to the last dental clinic or dental office you visited** prior to this appointment?

CHECK ONE

☐ Less than 30 minutes

☐ At least 30 minutes but less than 1 hour

☐ At least 1 hour but less than 2 hours

☐ More than 2 hours

☐ I don't know

☐ This is my first dental appointment.

10. **How easy or difficult** was it to **get transportation** to this appointment?

CIRCLE YOUR ONE BEST ANSWER

Very easy Somewhat easy Somewhat difficult Very difficult

11. Did you need to **visit a hospital emergency room** in the last 2 years for dental pain which was not caused by an injury?

☐ Yes ☐ No

If yes, how many times in the last two years?_____

12. What is the **zip code where you live?**_____

**How long** have you lived at this location? CHECK ONE

☐ Less than 1 year

☐ 1 year or more. How many years? _____

## Thank You!

Please give survey to the **dental office staff** or return survey in **postage-paid return envelope**

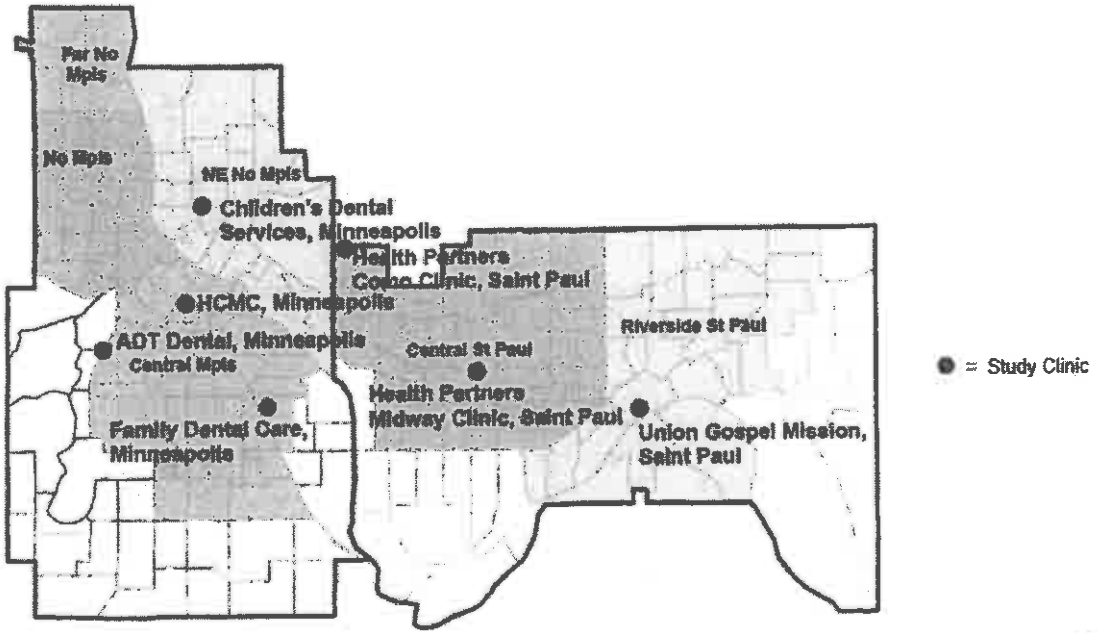
## Appendix D: Maps of study clinic locations

**Map 1: Study clinics outside Minneapolis-St. Paul, in relation to designated Dental Health Professional Shortage Areas**


Note: All areas are low-income designations.

Data source: Minnesota Department of Health, Office of Rural Health and Primary Care
January 2014

**Map 2: Study clinics within Minneapolis-St. Paul, in relation to designated Dental Health Professional Shortage Areas**




Note: All areas are low-income designations and each color represents a different shortage area.

Data source: Minnesota Department of Health, Office of Rural Health and Primary Care
January 2014

# Dental Therapists & Adv. Dental Therapists

## Background & Updates on Implementation

**Minnesota** has become the first state to establish licensure of Dental Therapists. The Dental Therapist (DT) is a mid-level provider with distinct educational, examination, and practice requirements.

Licenses may be granted in Dental Therapy, permitting a prescribed scope of practice to be performed under either the GENERAL or INDIRECT supervision of a licensed dentist. With additional education and testing, a Dental Therapist may be eligible for certification as an Advanced Dental Therapist (ADT), permitting many functions to be delegated under GENERAL supervision. The delegation of duties is governed under a Collaborative Management Agreement, essentially a contract between the supervising dentist and the Dental Therapist or Advanced Dental Therapist. This agreement may further limit the procedures that an individual DT or ADT may perform.

There are currently two educational programs in Minnesota providing training for DTs. Each of these programs is currently pursuing initial approval of the Board in anticipation of an eventual nationally recognized academic accreditation. Both programs anticipate that their first classes will graduate in 2011.

The Board is working with the Commission on Dental Accreditation (CODA) toward program standards and accreditation. The Board is also working with the Central Regional Dental Testing Service (CRDTS) on the development of a clinical examination. Steps in the process of regulating this new profession are identified in the Implementation Timeline.

Information and documents related to Dental Therapist licensure will be updated on this site as it becomes available.

To view the items below just click on them.

Enabling Legislation

Scope of Practice

- Dental Therapist
- Advanced Dental Therapist
- Delegated Duties of Dental Therapist and Advanced Dental Therapist

Time Line (Draft)

Collaborative Management Agreements

- Dental Therapist
- Advanced Dental Therapist

Advanced Dental Therapy Certification

- Advanced Dental Therapy Certification Process
- Advanced Dental Therapy Patient Record Summary

Application Forms

- Dental Therapist Application Form
- Advanced Dental Therapy Certification Application Form

**UPDATES:**

2014 Report to the Minnesota Legislature - "Early Impacts of Dental Therapists in Minnesota"

# MINNESOTA BOARD OF DENTISTRY

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## *DENTAL THERAPIST SCOPE OF PRACTICE*

*According to Minnesota 2009 Session Laws, Chapter 95, Article 3, Subd. 4, the **scope of practice** for a Dental Therapist includes the following:*

(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 reline;
(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; and
(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.

# MINNESOTA BOARD OF DENTISTRY

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## *ADVANCED DENTAL THERAPIST SCOPE OF PRACTICE*

*According to Minnesota 2009 Session Laws, Chapter 95, Article 3, Section 25, the* ***scope of practice*** *for an Advanced Dental Therapist includes the following:*

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 [the Dental Therapist scope of practice] 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.

# DELEGATED DUTIES: DENTAL THERAPISTS and ADVANCED DENTAL THERAPISTS

**Approved 9/24/2010**

| General Supervision | | Indirect | CDT CODE | SCOPE OF PRACTICE | Description and notes |
|---|---|---|---|---|---|
| | ADT | | D0120 | Periodic Oral evaluation and assessment | |
| | ADT | | D0140 | Limited Oral evaluation and assessment | |
| | ADT | | D0145 | Oral evaluation for a patient under 3 years of age and counseling with primary caregiver | |
| DT | ADT | | D0210 | Intraoral complete series (including bitewings)Dddd | |
| DT | ADT | | D0220 | Intraoral-periapical first film | |
| DT | ADT | | D0230 | Intraoral-periapical each additional film | |
| DT | ADT | | D0240 | Intraoral-occlusal film | |
| DT | ADT | | D0250 | Extraoral-first film | |
| DT | ADT | | D0260 | Extraoral-each additional film | |
| DT | ADT | | D0270 | Bitewing-single film | |
| DT | ADT | | D0272 | Bitewing-two films | |
| DT | ADT | | D0273 | Bitewing-three films | |
| DT | ADT | | D0274 | Bitewing-four films | |
| DT | ADT | | D0330 | Panoramic Film | |
| DT | ADT | | D0340 | Cephalometic Film | |
| DT | ADT | | D0350 | Oral/facial photographic images | |
| DT | ADT | | D0425 | Caries susceptibility tests | |
| DT | ADT | | D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities | |
| DT | ADT | | D0460 | Pulp vitality tests | |
| DT | ADT | | D0475 | Decalcification procedure | |
| | ADT | DT | D0486 | Laboratory accession of brush biopsy sample, | |
| DT | ADT | | D1203 | Topical application of Fluoride-Child | |
| DT | ADT | | D1204 | Topical application of Fluoride-Adult | |
| DT | ADT | | D1206 | Topical Fluoride Varnish | |
| DT | ADT | | D1310 | Nutritional counseling for control of dental disease | |
| DT | ADT | | | Disease Prevention Education | |
| DT | ADT | | D1330 | Oral Hygiene Instructions | |
| DT | ADT | | D1351 | Sealant per tooth | |
| | ADT | DT | D1510 | Space Maintainer-fixed-unilateral | |
| | ADT | DT | D1515 | Space Maintainer-fixed-bi-lateral | |
| | ADT | DT | D1520 | Space Maintainer-removal-bilateral | |
| | ADT | DT | D1550 | Re-cementation of space maintainer | |
| | ADT | DT | D1555 | Removal of fixed space maintainer | |
| | ADT | DT | D2140 | Amalgam-one surface, primary or permanent | |
| | ADT | DT | D2150 | Amalgam-two surfaces, primary or permanent | |
| | ADT | DT | D2160 | Amalgam-three surfaces, primary or permanent | |
| | ADT | DT | D2161 | Amalgam-four or more surfaces, primary or permanent | |
| | ADT | DT | D2330 | Resin-based composite-one surface, anterior | |
| | ADT | DT | D2331 | Resin-based composite-two surfaces, anterior | |
| | ADT | DT | D2332 | Resin-based composite-three surfaces, anterior | |
| | ADT | DT | D2335 | Resin-based composite-four or more surfaces or involving incisal angle | |
| | ADT | DT | D2390 | Resin-based composite crown, anterior | |
| | ADT | DT | D2391 | Resin-based composite-one surface, posterior | |
| | ADT | DT | D2392 | Resin-based composite-two surfaces, posterior | |
| | ADT | DT | D2393 | Resin-based composite-three surfaces, posterior | |
| | ADT | DT | D2394 | Resin-based composite-four or more surfaces, posterior | |
| | ADT | DT | D2920 | Recement crown | |
| | ADT | DT | D2930 | Prefabricated stainless steel crown - primary | |
| | ADT | DT | D2931 | Prefabricated stainless steel crown - permanent | |
| | ADT | DT | D2932 | Prefabricated resin crown | |
| | ADT | DT | D2933 | Prefabricated stainless steel crown with resin window | |
| | ADT | DT | D2934 | Prefabricted esthetic coated stainless steel crown-primary teeth | |
| DT | ADT | | D2940 | Sedative Filling (intended to relieve pain) | |

DT = Dental Therapist
ADT = Advanced Dental Therapist

# DELEGATED DUTIES: DENTAL THERAPISTS and ADVANCED DENTAL THERAPISTS

**Approved 9/24/2010**

| General Supervision | | Indirect | CDT CODE | SCOPE OF PRACTICE | Description and notes |
|---|---|---|---|---|---|
| | ADT | DT | D2970 | Temporary Crown | |
| | ADT | DT | D3110 | Pulp cap-direct (excluding final restoration) | |
| | ADT | DT | D3120 | Pulp cap-indirect (excluding final restoration) | |
| | ADT | DT | D3220 | Therapeutic pulpotomy ( Primary teeth only) | |
| | ADT | DT | D3221 | Pulpal Debridement (primary teeth only) | |
| | ADT | DT | D5520 | Replace missing or broken teeth-complete denture (each tooth) | |
| | ADT | DT | D5640 | Replace broken teeth-per tooth | |
| DT | ADT | | D5850 | Tissue conditioning maxillary | |
| DT | ADT | | D5851 | Tissue conditioning mandibular | |
| | ADT | DT | D7111 | extraction, coronal remnants-deciduous tooth | |
| | ADT | | D7140 | Extraction, erupted tooth or exposed periodontally involved permanent teeth | |
| | ADT | DT | D7140 | Extraction, erupted tooth or exposed root, primary teeth | |
| DT | ADT | | D7270 | Tooth reimplantation of accidentally evulsed or displaced tooth | implantation is general/stabilization is indirect |
| | ADT | DT | D7270 | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth | implantation is general/stabilization is indirect |
| | ADT | DT | D7287 | Exfoliative cytological sample collection | |
| | ADT | DT | D7288 | Brush biopsy-transepithelial sample collection | |
| | ADT | DT | D9110 | Palliative (emergency) treatment of dental pain- minor procedure | |
| DT | ADT | | D9210 | Local anesthesia not in conjunction with operative or surgical procedure | |
| DT | ADT | | D9211 | Regional block anesthesia | |
| DT | ADT | | D9212 | Trigeminal division block anesthesia | |
| DT | ADT | | D9215 | Local anesthesia | |
| DT | ADT | | D9230 | Analgesia, inhalation of nitrous oxide | |
| DT | ADT | | D9910 | Application of desensitizing medicament | |
| DT | ADT | | D9911 | Application of desensitizing resin for cervical or root surface per tooth | |
| DT | ADT | | D9930 | Treatment of complication (post-surgical) dry socket dressing | |
| DT | ADT | | D9940 | Occlusal guard soft | |
| DT | ADT | | D9941 | Fabrication fo athletic mouthguard | |
| DT | ADT | | | Atraumatic restorative therapy | |
| DT | ADT | | D9971 | Odontoplasty 1-2 teeth, includes removal of enamel projections | |
| DT | ADT | | | Mechanical Polish (not for preventive services) | |
| | ADT | DT | | Suture Removal | |
| | | | | | |

DT = Dental Therapist
ADT = Advanced Dental Therapist

**Agenda item: Electronic Dental Records**

The Board assigned to the Committee consideration of the software and templates being used to maintain patient records and gathering information about alterations of electronic records and safeguards to protect patient information.

Information included in the agenda package for review and discussion:

- Statute on Record Storage
- Board Resolution to Dr. Brown
- Presentation on Electronic Patient Record Issues Facing Dental Practice

**Agenda Item: Electronic Dental Records**

Dr. Rizkalla is requesting Board discussion because he is concerned that computerized data entry can impact the quality and safety of patient care. The introduction of the Electronic Medical Record (EMR) and the continuous software innovations can have unintended consequences including changes in staff roles, responsibilities and patient outcomes.

It is proposed that we investigate the possible role of the Board of Dentistry in safeguarding patient care.

**§ 54.1-2403.2. Record storage.**

A. Health records, as defined in § 32.1-127.1:03, may be stored by computerized or other electronic process or microfilm, or other photographic, mechanical, or chemical process; however, the stored record shall identify the location of any documents or information that could not be so technologically stored. If the technological storage process creates an unalterable record, a health care provider licensed, certified, registered or issued a multistate licensure privilege by a health regulatory board within the Department shall not be required to maintain paper copies of health records that have been stored by computerized or other electronic process, microfilm, or other photographic, mechanical, or chemical process. Upon completing such technological storage, paper copies of health records may be destroyed in a manner that preserves the patient's confidentiality. However, any documents or information that could not be so technologically stored shall be preserved.

B. Notwithstanding the authority given in this section to store health records in the form of microfilm, prescription dispensing records maintained in or on behalf of any pharmacy registered or permitted in Virginia shall only be stored in compliance with §§ 54.1-3410, 54.1-3411, and 54.1-3412.

(1994, c. 390; 1998, c. 470; 2004, c. 49; 2012, c. 336.)

Virginia Board of Dentistry
Board Business Meeting
June 13, 2014

To: Dr. David E. Brown, Director
Va. Dept. of Health Professions

## Electronic Dental Records Resolution:

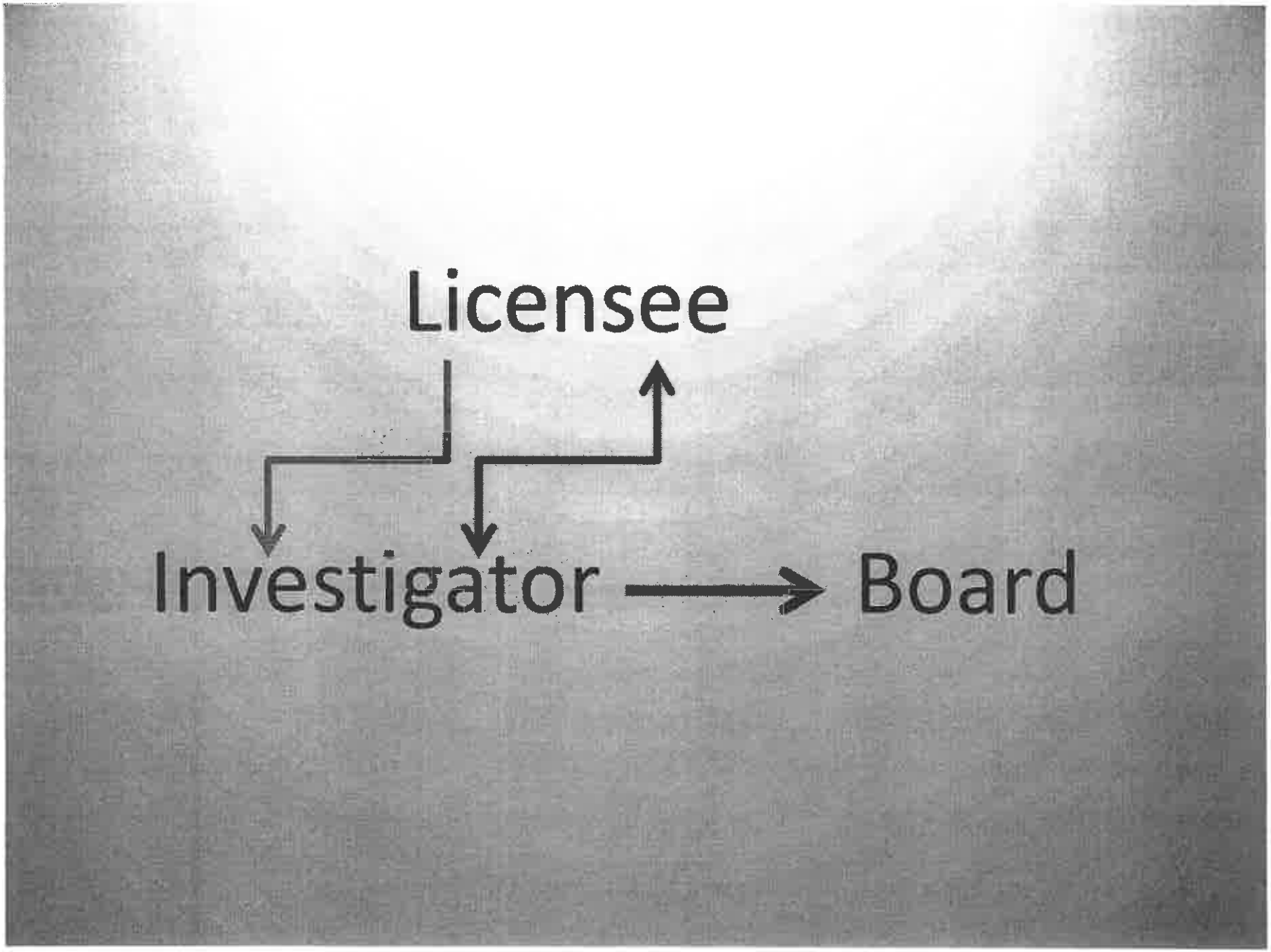
**Background:** In the face of a significant electronics / IT "arena" of dental (and other professional offices) opportunities for modification of treatment records; records which need to be / remain accurate and truthful when used as evidence in investigations and / or hearing phases before the DHP:

**Be It Resolved**, that the Board of Dentistry seeks future help from the DHP to provide forensic IT ("expert witness") personnel and assistance, whenever needed, to determine veracity and any evidence of electronic records tampering; relevant to any cases in investigation and / or disciplinary hearing phases before the Board of Dentistry.

Approved, BoD Bus. Meeting, 06/13/2014

# Electronic Patient Record Issues Facing Dental Boards

Paul Kleinstub, D.D.S., M.S.
Dental Director/Chief Investigator
Oregon Board of Dentistry


Licensee
Investigator
Board

# Necessary tools for the investigator.

Authority to initiate an investigation and to get original records, and then rules ensuring cooperation with the Board during an investigation.

# A Possible Model for Statutes

**ORS 679.250 Powers and duties of board; rules.** The powers and duties of the Oregon Board of Dentistry are as follows:
(3) To employ such inspectors, examiners, special agents, investigators, clerical assistants, assistants and accountants as are necessary for the investigation and prosecution of alleged violations and the enforcement of this chapter and for such other purposes as the board may require. Nothing in this chapter shall be construed to prevent assistance being rendered by an employee of the board in any hearing called by it. However, all obligations for salaries and expenses incurred under this chapter shall be paid from the fees accruing to the board under this chapter and not otherwise.

## Electronic Record Challenges for the Investigator:

Templates
Check boxes
Log-ins
Authorship of treatment notes
Dating of treatment notes
Deletion and Modification of treatment notes
PDF or JPEG vs. direct printout of treatment notes

# What is the difference between a PDF and a JPEG file?

**PDF** (Portable Document Format) is a document standard developed by Adobe. It allows scalable text, vector images, and bitmaps to be combined in one document. PDFs can also have multiple pages and embedded fonts. If you open a PDF in Acrobat Reader, for example, you can scale the document to be much larger than the actual size. Because PDFs save the actual text with the document (it is not rasterized), the text will look clean and sharp no matter how much you scale the page.
(**Rasterize** - convert (an image) into pixels)

**JPEGs** (Joint Photographic Experts Group) are bitmap images. This means they will look blocky if you scale them larger than their actual size. They are also compressed, meaning they are not quite as clear as BMP, TIFF, PICT, or other bitmap files, but they take up significantly less space. JPEGs cannot include paths, text, or embedded fonts like PDFs can. For this reason, PDFs are the best choice for saving documents that include text or vector images (paths). Bitmap images, such as those taken with a digital camera, are typically saved in the JPEG format. Most pictures you see on the Web are JPEGs.
(**Bit** - A fundamental unit of information having just two possible values, as either of the binary digits 0 or 1.)
(**Bitmap** - A set of bits that represents a graphic image, with each bit or group of bits corresponding to a pixel in the image.)

(8) Upon its own motion or upon any complaint, to initiate and conduct investigations of and hearings on all matters relating to the practice of dentistry, the discipline of licensees, or pertaining to the enforcement of any provision of this chapter. In the conduct of investigations or upon the hearing of any matter of which the board may have jurisdiction, the board may take evidence, administer oaths, take the depositions of witnesses, including the person charged, in the manner provided by law in civil cases, and compel their appearance before it in person the same as in civil cases, by subpoena issued over the signature of an employee of the board and in the name of the people of the State of Oregon, require answers to interrogatories, and compel the production of books, papers, accounts, documents and testimony pertaining to the matter under investigation or to the hearing.

# A Possible Model for Rules

**OAR 818-012-0060 Failure to Cooperate with Board**

No licensee shall:
(5) Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records.
(6) Make an untrue statement on any document, letter, or application submitted to the Board.
(7) Fail to temporarily surrender custody of original patient records to the Board when the Board makes a written request for the records. For purposes of this rule, the term records includes, but is not limited to, the jacket, treatment charts, models, radiographs, photographs, health histories, billing documents, correspondence and memoranda.

No person shall:
(8) Deceive or attempt to deceive the Board with respect to any matter under investigation including altering or destroying any records.
(9) Make an untrue statement on any document, letter, or application submitted to the Board.

**OAR 818-012-0070 Patient Records**

(1) Each licensee shall have prepared and maintained an accurate record for each person receiving dental services, regardless of whether any fee is charged. The record shall contain the name of the licensee rendering the service and include:

(a) Name and address and, if a minor, name of guardian;

(b) Date and description of examination and diagnosis;

(c) An entry that informed consent has been obtained and the date the informed consent was obtained. Documentation may be in the form of an acronym such as "PARQ" (Procedure, Alternatives, Risks and Questions) or "SOAP" (Subjective Objective Assessment Plan) or their equivalent.

(d) Date and description of treatment or services rendered;

(e) Date and description of treatment complications;

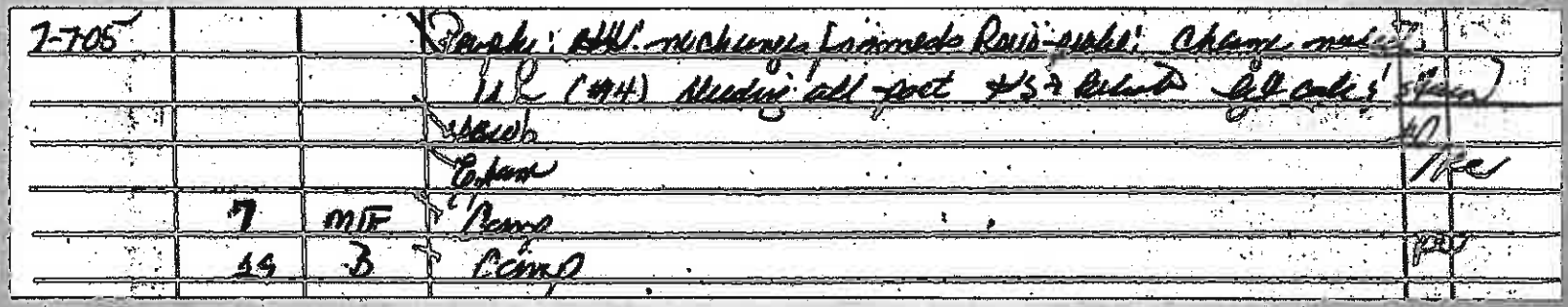
(f) Date and description of all radiographs, study models, and periodontal charting;

(g) Health history; and

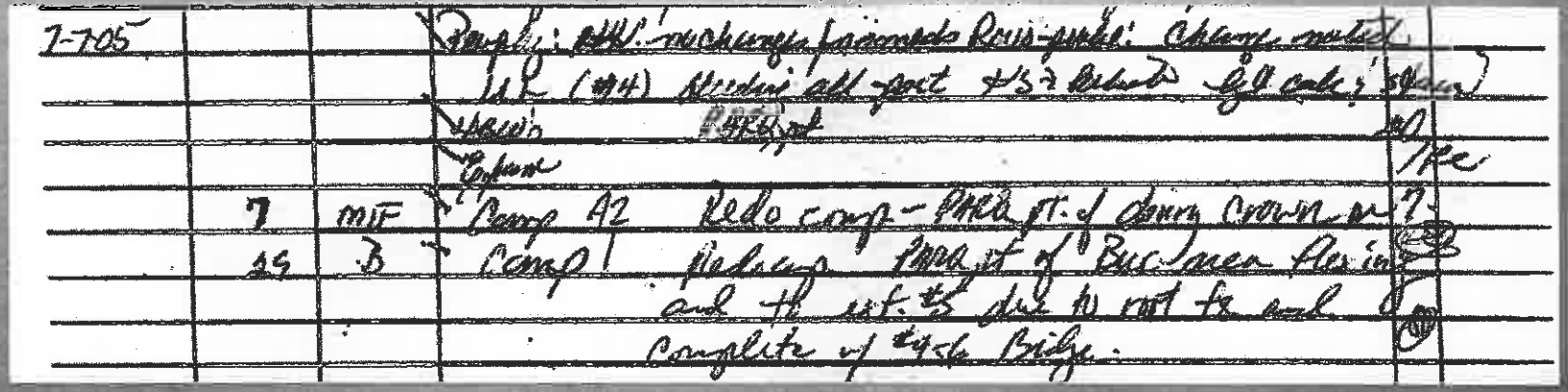
(h) Date, name of, quantity of, and strength of all drugs dispensed, administered, or prescribed.

(2) Each dentist shall have prepared and maintained an accurate record of all charges and payments for services including source of payments.

Record copies provided to the Board by the patient:

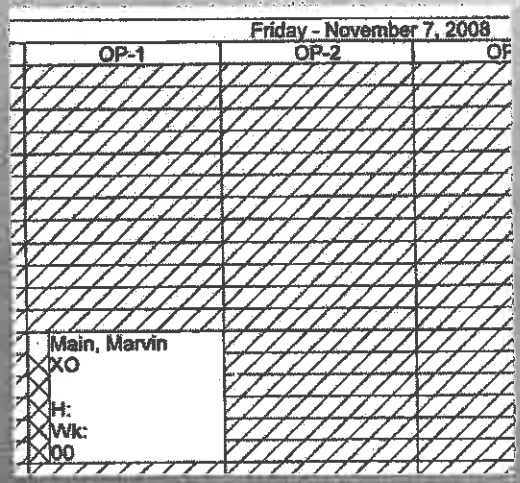


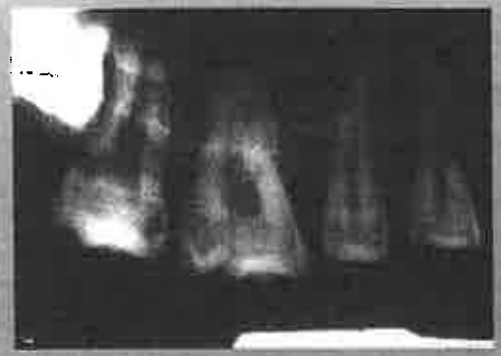
"Original" records provided to the Board by the dentist:



## Progress Notes

| Date | Tooth | Surf | Proc | Prov | Description | Stat |
|---|---|---|---|---|---|---|
| 11/02/2008 | | | D0140 | OC12 | Limited oral evaluation » | C |
| | PA reveals unrestorable decay. Anxious Pt. with no financial ability from volunteer screaning. Discussed Halcion sedation and will give Pt. Rx. day before Tx. Apt. set for 5:30 AM on the 7th. Pt. will have driver. -oc | | | | | |
| 11/07/2008 | | | | | Clinical Note | |
| | ---------- Fri - Nov 7th, 2008 13:53:05 ---------- | | | | | |
| | S: RMH PARQ Pt. presents with TAUL<br>O: Gross caries M+D<br>A: Unrestorable<br>P: Consent, surgical XO #2, 1 suture placed. POI's Rx. -oc (DO NOT BILL) | | | | | |
| 11/07/2008 | | | D9630 | OC12 | Other drugs/medicaments, B/R » | C |
| | Pre - BP 110/78, pulse 65<br>Post - BP 115/82, pulse 78 | | | | | |
| | Pt. alert and full functioning. driver escorted Pt. from premisis. -oc | | | | | |
| 11/07/2008 | 3 | | D7210 | OC12 | Extraction-surgical/erupt toot | C |



# Licensee's subsequent letter to the Investigator:

I need to advise you that I have not been candid with you in the ongoing investigation of me. I truly apologize. I know this has generated more work for you, and for that I am truly sorry. I am also deeply embarrassed and ashamed.

Mr. Main was not a real patient. At that point I had not had surgery yet, and my Left knee failed in late October/early November resulting in a fall and torn cartilage. Dr. G or one of his associates prescribed me some pain medication however it would not be refilled before my surgery. I realize it was terrible judgment on my part to have this prescription filled; however I was barely able to walk and was being awakened at night from pain every time I moved my legs at night.

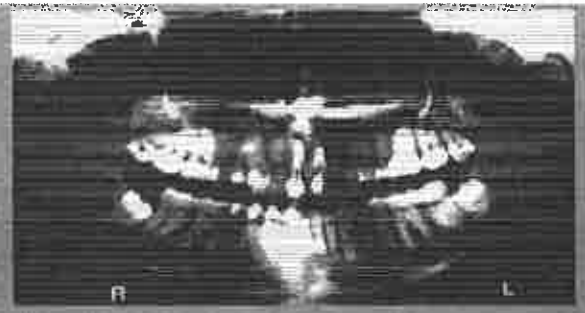
## Progress Notes

| Date | Tooth | Surf | Proc | Prov | Description | Stat |
|---|---|---|---|---|---|---|
| 02/07/2009 | | | | | Clinical Note | |
| | | | | | S: RMH, No changes, PARQ, ASA 1, Pt. presents with UATA pointing to #8 keeping him up at night. Also reports that we wants 3rds out and is having TA in upper 3rds | |
| | | | | | O: #8 Perc (+++), Cold = NR, Palp = (-), PARL evident, no rec. caries or RL noted. #1-16 gross caries occlusal extending to pulp, RL apparent on PANO. | |
| | | | | | A: #1 &16 apical perio with irriv. pulpitis. #8 Pheonix abscess of endodontic origin doe to failing RCT. | |
| | | | | | P: Rx. called in & Ref. to Endo for Tx. #8. Sched XO 3rds for next weekend. Pt. requested something a little stronger than vicodin as he is 300+ lbs -oc | |
| 02/11/2009 | | | | | Clinical Note | |
| | | | | | Faxed in Rx. replacement. -oc | |
| 02/14/2009 | | | | | Clinical Note | |
| | | | | | PARQ'd Pt. consent. | |
| | | | | | 4 carp 2% lido 1-100 K epi PSA/IA. | |
| | | | | | Dx: 1&16 caries to pulp, still H+C sensitive, irriversible pulpitis and supererupting. Pt biting cheek. 17&32 are mesially impacted. Pt. elects to have these done at the same time. | |
| | | | | | Large flap layed on bottom, bilateral surgical XO lowers sectioning teeth into 3 pieces, removed sig. bone around 17&32. Simple elev/xo #1&16 and crowns broke off of both. Removed buccal bone 16&32, elev/XO root tips after sectioning. 2 sutures placed in each socket. POI's | |

Continued on Next Page

## Progress Notes Continued

| Date | Tooth | Surf | Proc | Prov | Description | Stat |
|---|---|---|---|---|---|---|
| 02/14/2009 | 1 | | D7140 | OC12 | Extract,erupted th/exposed rt | C |
| 02/14/2009 | 16 | | D7140 | OC12 | Extract,erupted th/exposed rt | C |
| 02/14/2009 | 17 | | D7140 | OC12 | Extract,erupted th/exposed rt | C |
| 02/14/2009 | 32 | | D7140 | OC12 | Extract,erupted th/exposed rt | C |
| 02/17/2009 | | | | | Clinical Note | |
| | | | | | Pt. called stating that he was taking more than the reccomended SIG due to level of pain. Warned Pt. that too many could cause acetaminophen toxicity. New Rx. given, spoke with phamacist and due to nationwide shortage of 10mg Oxy reccomnded 5mg and doubling dose. Spoke with Gary at Paulson's. Inf. Pt. no other Rx. would be given. -oc | |



# Licensee's subsequent letter to the Investigator:

I do know DF. He is a friend. I wrote prescriptions in his name, and I took the drugs from him for my personal use. While I know it is no excuse, I do feel I owe you an explanation. After I had bilateral knee replacement surgery on December 19th, I had significant ongoing post-op pain. My doctors would not give me additional amounts of pain medication. Therefore, I wrote the three prescriptions for D. I never saw him as a patient. His chart is completely fabricated. The panorex and films were not his. This is not his fault. He knew I was in pain and only did what I asked him to do, and I am sorry to have involved him in this. I would beg you to please leave Mr. F out of this and level whatever punishment you see fit on me. I told Mr. F that there was nothing wrong with him filling the Rx. and giving it to me, as a result he complied with my request not knowing he was doing anything wrong.

With regards to altering the six charts you requested in May, I know that I reviewed them with the intent of making them more accurate after you requested them. I did this only to ensure compliance with appropriate charting requirements. I understand that that was inappropriate. My intent was to add information that might be missing to make the charts themselves look more acceptable to you. This was wrong. It is possible in Dentrix to add a procedure code, then edit the "procedural notes" associated with that code and then back date that entry, so any modifications in Dentrix would have been made that way. I do not remember the specific details of the modifications I made at this time for each of these charts, or even how many charts might be modified. I do recall bringing home the physical charts and going through each of them while being logged into Dentrix via Remote Desktop. When reviewing the Dentrix charts for these patients I printed them out to PDF files. These can be edited, and then printed on paper appearing to have been printed directly from Dentrix. My PDF software allows me to edit all PDF files; I do not remember if any of these six charts were edited in this way. I have provided my attorney with unedited copies of all six charts. I would like the opportunity to go over these charts with you and be honest with you about any discrepancies that might exist between the print outs my attorneys have compared to yours.

PDF

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JPEG

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## "Original" treatment note provided to the Board by the dentist:

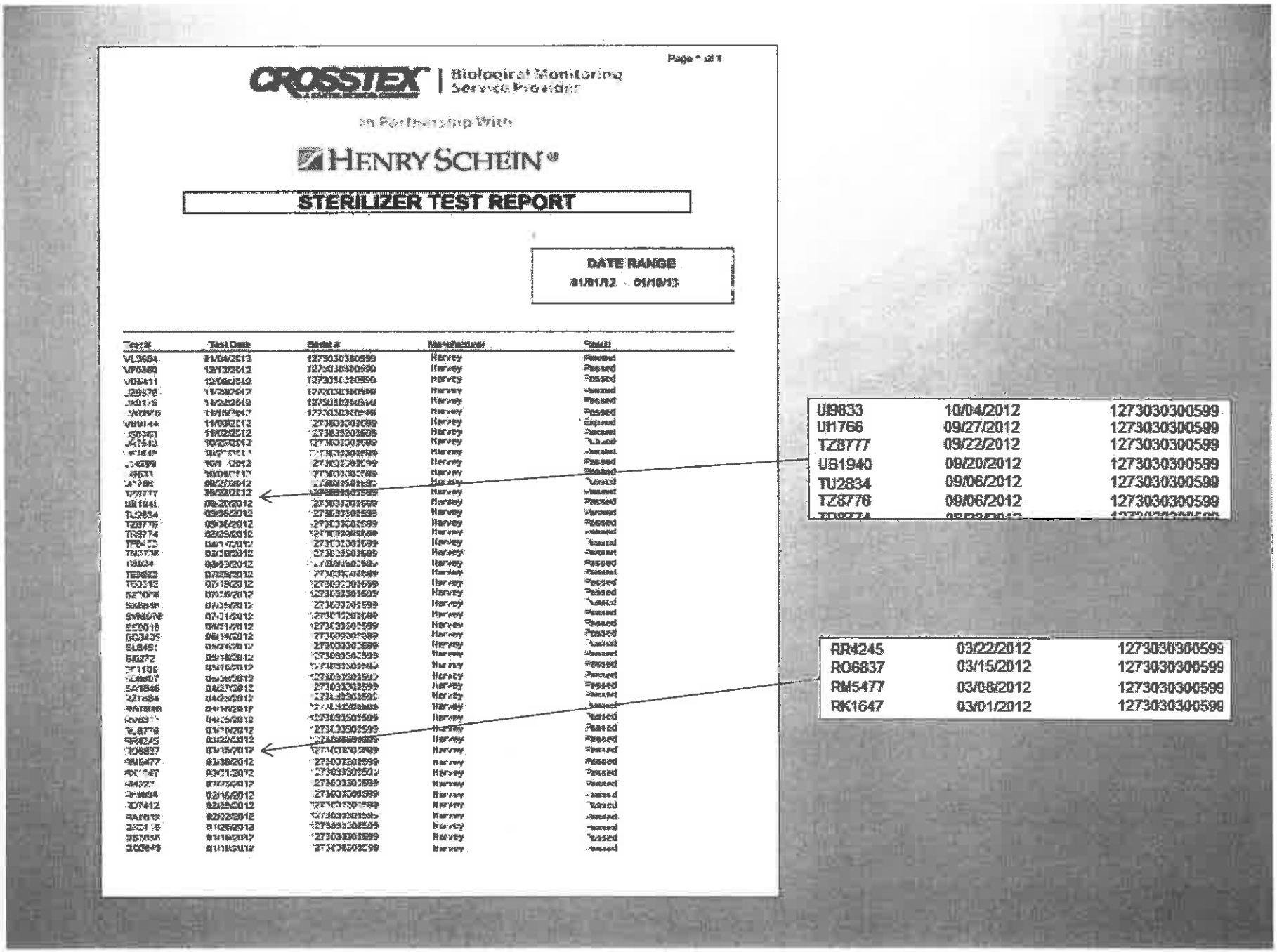
| Date Entered | Format | Type | Tooth | Status | User | | |
|---|---|---|---|---|---|---|---|
| 09/24/12 12:00 AM | Text | Chart | 28-29,31 | Verified | Jason | **Modified By: Jason PM** | **On: 07/15/13 4:11** |

DOS. 9/19/12
Pt presents for composite restoration #: 28-DO, 29-MOD, 31-MOD
RMH - No changes
PARQ
N20 given for 25min. w 35% nitrous and 65% oxygen. 5 min 100% oxygen
Anesthetic: 1 x 1.7 ml carps Lidocaine 2% 1:100,000 w/ epi
Removed decay
Matrix placed
Etch, bond
Filled w/ Esthet-X, light cured
Smoothed & polished, articulated.
Post op instructions given.
Shade: A2
Asst/Dr: SF & JY

## The actual "Original" treatment note before modification.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 09/24/12 12:00 AM | Text | Chart | 28-29,31 | Deleted | Grace | **Deleted By: Jason PM** | **On: 07/15/13 4:11** |

~~DOS: 9/19/12~~
~~Pt presents for composite restoration #: 28-DO, 29-MOD, 31-MOD~~
~~RMH - No changes~~
~~PARQ~~
~~N20~~
~~Anesthetic: 1 x 1.7 ml carps Lidocaine 2% 1:100,000 w/ epi~~
~~Removed decay~~
~~Matrix placed~~
~~Etch, bond~~
~~Filled w/ Esthet-X, light cured~~
~~Smoothed & polished, articulated.~~
~~Post op instructions given.~~
~~Shade: A2~~
~~Asst/Dr: SF & JY~~


CROSSTEX | Biological Monitoring Service Provider
In Partnership With
HENRY SCHEIN
STERILIZER TEST REPORT
DATE RANGE
01/01/12 - 01/10/13
UI9833 10/04/2012 1273030300599
UI1766 09/27/2012 1273030300599
TZ8777 09/22/2012 1273030300599
UB1940 09/20/2012 1273030300599
TU2834 09/06/2012 1273030300599
TZ8776 09/06/2012 1273030300599
RR4245 03/22/2012 1273030300599
RO6837 03/15/2012 1273030300599
RM5477 03/08/2012 1273030300599
RK1647 03/01/2012 1273030300599

CROSSTEX | Biological Monitoring Service Provider

In Partnership With

HENRY SCHEIN®

# STERILIZER TEST REPORT

CL

**DATE RANGE**

01/01/12 - 12/31/12

| Test # | Test Date | Serial # | Manufacturer | Result |
|---|---|---|---|---|
| QQ5849 | 01/10/2012 | 1273030300599 | Harvey | Passed |
| RU6776 | 03/30/2012 | 1273030300599 | Harvey | Passed |
| RW0990 | 04/16/2012 | 1273030300599 | Harvey | Passed |
| RZ1684 | 04/23/2012 | 1273030300599 | Harvey | Passed |
| SA1946 | 04/27/2012 | 1273030300599 | Harvey | Passed |
| SD9607 | 05/08/2012 | 1273030300599 | Harvey | Passed |
| SF1100 | 05/10/2012 | 1273030300599 | Harvey | Passed |
| SI0272 | 05/18/2012 | 1273030300599 | Harvey | Passed |
| SS9019 | 06/21/2012 | 1273030300599 | Harvey | Passed |
| SW6976 | 07/01/2012 | 1273030300599 | Harvey | Passed |
| SX8888 | 07/05/2012 | 1273030300599 | Harvey | Passed |
| SZ3066 | 07/09/2012 | 1273030300599 | Harvey | Passed |
| TI8024 | 08/03/2012 | 1273030300599 | Harvey | Passed |
| TP8453 | 08/17/2012 | 1273030300599 | Harvey | Passed |
| TU2834 | 09/05/2012 | 1273030300599 | Harvey | Passed |
| TZ5775 | 09/06/2012 | 1273030300599 | Harvey | Passed |
| TZ9777 | 09/22/2012 | 1273030300599 | Harvey | Passed |
| UB1940 | 09/20/2012 | 1273030599 | Harvey | Passed |
| UI1766 | 09/27/2012 | 1273030599 | Harvey | Passed |
| UK1615 | 10/21/2012 | 1273030300599 | Harvey | Passed |
| US9083 | 11/02/2012 | 1273030300599 | Harvey | Passed |
| UW6880 | 11/15/2012 | 1273030300599 | Harvey | Passed |
| UZ9578 | 11/29/2012 | 1273030300599 | Harvey | Passed |
| VB9144 | 11/08/2012 | 1273030300599 | Harvey | Invalid |
| VD5411 | 12/06/2012 | 1273030300599* | Harvey/MDT | Passed |
| VF0960 | 12/13/2012 | 1273030300599 | Harvey | Passed |

The Board voted to issue a Notice of Proposed Disciplinary Action and offer the Licensee a Consent Order in which the Licensee would agree to be reprimanded; to pay a $25,000.00 civil penalty; to complete 80 hours of community service within 18 months; to not employ her husband at the physical location of her practice or allow him any access to patients or patient records; to personally appear before the Board, or its designated representative(s) at a frequency to be determined by the Board, but initially at a frequency of two times per year; and monthly submission of spore testing results for a period of one year from the effective date of the Order.

Доверяй, но проверяй

(Trust, but verify)

Contact Information:

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150 American Dental Association®

**Agenda item: Teledentistry**

The Board asked the Committee to investigate permitting the practice of teledentistry within Virginia by addressing a definition, guidelines, and scope of practice.

Information included in the agenda package for review and discussion:

- Federation of State Medical Boards' Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine
- Information provided to the JCHC on 10/8/2014

Federation of
STATE
MEDICAL
BOARDS

# Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

April 2014

Federation of STATE MEDICAL BOARDS

# MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

*Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup*

## INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

# MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

## Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

### Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

**Section Two. Establishing the Physician-Patient Relationship**

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

**Section Three. Definitions**

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

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**Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice**

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

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Continuity of Care:
Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:
An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:
The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:
Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

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Prescribing:

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

**Section Five. Parity of Professional and Ethical Standards**

Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.

A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

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# MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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# DENTAL SAFETY NET CAPACITY AND OPPORTUNITIES FOR IMPROVING ORAL HEALTH

Joint Commission on Health Care
October 8, 2014 Meeting

Michele Chesser, Ph.D.
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## Study Mandate

- In 2012, Senate Joint Resolution 50 (Senator Barker) directed the Joint Commission on Health Care (JCHC) to conduct a two year study of the fiscal impact of untreated dental disease in the Commonwealth of Virginia
- The study resulted in a policy option to include in the 2014 JCHC Work Plan a targeted study of the dental capacity of Virginia's oral health care safety net providers, and the option was approved by JCHC members during the Decision Matrix meeting last November

# Teledentistry

## Teledentistry

- Questions remain regarding the range of appropriate uses for teledentistry and the obstacles that may need to be addressed in order to facilitate teledentistry in Virginia
  - *The Code of Virginia* includes a section on reimbursement for telemedicine; however, it does not specifically mention teledentistry
    - As a result, it is unclear whether, and what types of, teledentistry can be billed for reimbursement
- The Virginia Oral Health Coalition created a teledentistry work group in September, 2013 and its members are currently investigating these issues
  - JCHC study work group members recommend encouraging the efforts of the Coalition's work group and suggest a report of its findings be submitted to JCHC by October 2015