The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health and Human Services Appropriations Committee

BILL: CS/CS/SB 2760

INTRODUCER: Committee on Health and Human Services Appropriations, Health Regulation Committee and Senator Peaden

SUBJECT: Access to Oral Health Act

DATE: April 2, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Garner	Wilson	HR	**Fav/CS**
2.	Fabricant	Peters	HA	**Fav/CS**
3.				
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	x	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This committee substitute provides a definition for "health access settings" to mean programs and institutions of the Department of Children and Family Services, the Department of Health (DOH), the Department of Juvenile Justice, nonprofit community health centers, Head Start centers, and federally qualified health centers if such health access programs and institutions immediately report to the Board of Dentistry specified practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such settings.

The bill creates examination requirements, an application process, license renewal requirements, and license revocation requirements for a community-service dental license. The bill requires the Board of Dentistry to grant a community-service dental license to practice dentistry in health access settings if an applicant meets certain educational and practice standards, files appropriate application, and pays appropriate fees. The bill provides an individual with a health access dental license the ability to take the Florida dental license examination if these conditions are met. The bill specifies that the failure of an individual with a community-service dental license to limit the practice of dentistry to health access settings is the unlicensed practice of dentistry.

The bill requires the Board of Dentistry to adopt rules to administer the application process, renewal requirements, and revocation requirements for a health access dental license created under this act, and provides a sunset date of January 1, 2015, for the community-service dental license statute. Any health access dental license issued before January 1, 2015, remains valid, without effect from repeal.

The bill defines the scope and area of practice of dental hygienists in health access settings. The bill specifies that a dental hygienist may perform certain tasks, without supervision and without prior authorization of a dentist, in a health access setting. The bill also requires that patients receiving fluoride treatments, impressions for study casts, and medical and dental history from a hygienist without supervision or prior authorization must be examined by a dentist before the hygienist performs any additional services without supervision or prior authorization.

The bill requires dental laboratory owners, or at least one employee of each lab, to complete 18 hours of continuing education (CE) biennially beginning on or after July 1, 2010. The bill specifies the types of courses, the objective of CE for dental technicians, and the areas that must be addressed in the CE courses. A dental laboratory that is physically located within a dental practice operated by a dentist licensed under this chapter is exempt from these requirements and a dental laboratory in another state or country which provides service to a dentist licensed under chapter 466, F.S., is not required to register with the state and may continue to provide services to such dentist with a proper prescription.

This bill amends ss. 466.003, 466.006, 466.011, 466.021, 466.023, and 466.032, F.S., and creates ss. 466.0067, 466.00671, 466.00672, 466.00673, and 466.00775, F.S.

II. Present Situation:

The Importance of Oral Health Care

Mouth and throat diseases, which range from cavities to cancer, cause pain and disability for millions of Americans each year. In children, cavities are the most common form of chronic disease, which often begins at early age. Tooth decay affects more than one-fourth of U.S. children aged 2 – 5 and half of those aged 12 – 15. Low-income children are hardest hit: about half of those aged 6 – 19 have had decay. Untreated cavities can cause pain, dysfunction, absence from school, loss of weight, and poor appearance - problems that can greatly reduce a child's capacity to succeed in life.

Tooth decay is also a problem for U.S. adults, especially for the increasing number of older adults who have retained most of their teeth. Despite this increase in tooth retention, tooth loss remains a problem among older adults. One-fourth of adults over age 60 have lost all of their teeth - primarily because of tooth decay, which affects more than 90 percent of adults over age 40, and advanced gum disease, which affects 5 to 15 percent of adults. Tooth loss can affect self-esteem, and it may contribute to nutrition problems by limiting the types of food that a person can eat.[1]

[1] Centers f or Disease Control and Prevention. Found at: http://www.cdc.gov/nccdphp/publications/aag/oh.htm (last visited on March 17, 2008).

Access to Dental Services in Rural Areas

Most research and surveillance information indicates that access to dental care is significantly more limited in rural areas than in metropolitan areas. According to the National Rural Health Association:[2]

- Even after controlling for population density and income, non-metropolitan counties have lower dentist-to-population ratios (62 dentists per 100,000 population in large metropolitan areas versus 29 dentists per 100,000 population in the most rural counties).
- Rural persons are more likely to have lost all their teeth than their non-rural counterparts; in fact, adults aged 18 to 64 are nearly twice as likely to be edentulous if they are rural residents.
- Rural adults are significantly more likely than non-rural adults to have untreated dental decay (32.6 percent versus 25.7 percent).
- In 2001, 67.1 percent of urban residents had visited a dentist in the previous year, while only 58.3 percent of rural Americans had done so.
- Rural residents are less likely than their urban counterparts to have dental insurance.
- Of the 2,235 Dental Health Professional Shortage Areas, 74 percent are in non-metropolitan areas.

According to the National Advisory Committee on Rural Health and Human Services, several factors contribute to the problems of rural oral health:

- *Geographic isolation.* People in remote rural areas have farther to travel to obtain care and fewer dentists, hygienists, and other professionals to provide it.
- *Lack of adequate transportation.* In many parts of rural America, private automobiles are the only source of transportation. Public transit is non-existent, as are taxicabs and other transportation for hire. Consequently, many rural residents—especially low-income residents—face great difficulty in going to the dentist or any other service provider.
- *Lack of fluoridated community water supplies*. This most basic preventative treatment against tooth decay is unavailable in countless rural communities.
- *Higher rates of poverty*. Low-income status prevents many people from seeking and obtaining oral health care. It also prevents them from purchasing dental insurance. In addition, rural employers are less likely to purchase or offer dental insurance for their employees due to the smaller average size for most rural employers.
- *Larger percentage of elderly population*. With increasing age come increasing dental and oral health problems. The percentages of rural Americans who are older and sicker are greater than those of urban Americans, and Medicare does not provide dental benefits.
- *Lower dental insurance rates*. Insurance reimbursement rates—both public and private—for dental procedures are typically lower in rural areas than in urban. However, the actual costs of providing the services are often higher in rural areas.
- *Acute provider shortages*. As indicated above, the ratio of dentists per 100,000 population in non-metropolitan counties is less than half of what it is in metropolitan counties. The acute

[2] Found at: http://www.nrharural.org/advocacy/sub/policybriefs/OralHealth3-05.pdf (last visited on March 17, 2008).

shortage of dentists nationwide is expected to worsen in coming years as dental schools graduate fewer students, despite the fact that dental school applications were up some 18 percent between 2004 and 2005. With the closing of seven dental schools since 1986, and subsequent opening of only three new ones, more people want to become dentists than there are slots for. On top of that, many dentists are nearing retirement age - especially in rural areas. In addition, it can be predicted that the combination of increasing levels of dental school indebtedness and fee disparities between urban and rural locations will lead to a reduced percentage of the dental school graduates locating in rural locations.

- *Difficulty finding providers willing to treat Medicaid patients*. Because of low reimbursement rates, paperwork burdens, and a perception of a higher percentage of broken appointments, many dentists simply do not accept Medicaid or State Children's Health Insurance Program (SCHIP) patients - of which there are many in rural America due to the higher proportion of people living in poverty.

In Florida, many of these conditions are true, as well. The ratio of dentists per Florida residents is:

- 1 dentist per 1,961 residents;
- 1 dentist per 9,747 Medicaid children; and
- 1 dentist per 41,039 Medicaid adults.

According to the Florida Department of Health (DOH or department), sixteen counties have one or no Medicaid dentist provider. As of January 2008, seven Florida counties had no Medicaid dental providers (Bradford, Columbia, Franklin, Glades, Levy, Suwannee and Union Counties), and as of June 2007, three counties had no licensed dentists at all (Glades, Lafayette and Union Counties).

According to the DOH, the county health departments have several dental facilities that cannot serve patients because they do not have any dentists to provide dental care. Several other county health departments have some dentists but are in serious need of additional dentists to deliver care to low income and underserved Floridians. The department has had difficulty in recruiting and retaining public health dentists. There are 87 full time equivalent (FTE) dentists in county health departments as of February, 2008. The turnover rate of dentists in the county health departments in 2007 was 16 percent.

Florida Board of Dentistry

Section 466.004, F.S., establishes the Board of Dentistry within the DOH. The board consists of 11 members who are appointed by the Governor and subject to confirmation by the Senate. Seven members of the board must be licensed dentists actively engaged in the clinical practice of dentistry in this state; two members must be licensed dental hygienists actively engaged in the practice of dental hygiene in this state; and the remaining two members must be laypersons who are not, and have never been, dentists, dental hygienists, or members of any closely related profession or occupation.

Each member of the board who is a licensed dentist must have been actively engaged in the practice of dentistry primarily as a clinical practitioner for at least 5 years immediately preceding

the date of her or his appointment to the board and must remain primarily in clinical practice during all subsequent periods of appointment to the board. At least one member of the board must be 60 years of age or older. Members shall be appointed for 4-year terms, but may serve no more than a total of 10 years.

Currently, the only requirement of the seven dental members of the board who are dentists is that they must have a valid license and be actively engaged in the clinical practice of dentistry in Florida. There is no requirement that they have any public health experience or an advanced degree in public health.

Licensure by Credentials

Until the early 1900s, dental education was not standardized and there were "dentists" with and without formal training delivering care to patients. Licensure was initiated by states to protect the public from those practitioners without adequate education.

Many changes have occurred since the early 1900s in dental education, accreditation and licensure. For example, currently all states require graduation from a dental school accredited by the American Dental Association's Commission on Dental Accreditation, successful completion of a written national board examination and a state or regional clinical examination in order to be eligible for licensure.

The licensure process continues to evolve. In recent years, there has been a steady increase in the number of state dental boards that grant licensure by credentials and accept results from more than one clinical examination for the purpose of initial licensure. Also, many state boards now accept results of National Board Part II in lieu of a separate written examination. Most importantly, all members of the examination community continue to work together to increase standardization of the examination and the examination process.

Licensure by credentials (also known as Licensure by Recognition) is a process by which a state board of dentistry grants a dental license to an individual based on its determination that the candidate has previously met requirements for initial licensure in another jurisdiction, is currently licensed in another jurisdiction, has practiced for a minimum specified amount of time prior to application (usually 5 years) and that the state has licensure standards equivalent to the one where licensure by credentials is being sought. If the candidate meets all required criteria, clinical licensure examinations are not necessary and a license is granted. Interchangeable terms are used for licensure by credentials including licensure by reciprocity endorsement or criteria.

Currently, Florida is one of only two states that do not offer licensure by credentials.[3] Temporary certificates under s. 466.025(2), F.S., are offered to out of state dentists willing to serve in state and county government facilities; however, they must work under the general supervision of a Florida licensed dentist. Further, the criteria for receiving the temporary certificate is basic, in that the dentists must only show a diploma from an accredited dental school to qualify.

[3] http://www.adha.org/governmental_affairs/downloads/credentials.pdf (last visited on March 17, 2008).

Temporary certificate-holders do not have to hold a dental license from any state, do not have to show passage of licensure or board examinations, and do not have to have any years of experience practicing dentistry. In other words, the current proposal creates additional requirements of experience, licensure and examination, as seen above.

There are 33 temporary certificate-holders at this time. Certificates are valid only for such time as the dentist remains employed by the state or county facility. Temporary certificates are renewable each biennium and continuing education is required. Pursuant to rule 64B5-7.0035, Florida Administrative Code, state and county facilities must report terminations and/or transfers to the board office.

Operation of Dental Laboratories in Florida

Dental laboratories operate for the purpose of constructing, altering, repairing, or duplicating dentures, partial dentures, bridge splints, and other orthodontic or prosthetic appliances for oral health care or aesthetic purposes. Florida dental laboratories are regulated by the DOH pursuant to s. 466.032, F.S. Florida law requires all persons, firms or corporations operating a dental laboratory in Florida to register biennially with the DOH, and, at the same time, pay to the department a registration fee not to exceed $300 for which the department shall issue a registration certificate entitling the holder to operate a dental laboratory for a period of 2 years.

Currently, a dentist submits a prescription for a particular appliance with the laboratory. The dentist's license number is not currently required on the prescription. The dental laboratory is not required to disclose in writing the materials and all certificates of authenticity that constitute each product manufactured, the point of origin of manufacture, or the address and contact information of the dental laboratory. The dental laboratory is not statutorily liable for damages caused by inaccuracies in the material disclosures or certificates of authenticity. There are also no requirements for continuing education for owners or dental technicians that work in dental laboratories.

Dental Hygienists

Dental hygienists are focused on preventing dental disease. They are educated and trained to evaluate the patient's oral health, expose, process and interpret dental X-ray films, remove calculus deposits, stains, and plaque above and below the gumline. They also apply preventive agents such as fluorides and sealants to teeth when allowed by state regulations.

Dental hygienists provide education about oral health care, selecting toothbrushes, the use of dental floss, and oral health problems related to diet or use of tobacco products. Additionally, dental hygienists receive training in assisting and reception responsibilities so they can be comprehensive team members in the dental practice.

In Florida, dental hygienists are regulated by ss. 466.023, 466.0235, and 466.024, F.S. Dental hygienists may be delegated the task of removing calculus deposits, accretions, and stains from exposed surfaces of the teeth and from the gingival sulcus and the task of performing root planing and curettage. In addition, dental hygienists may expose dental X-ray films, apply topical

preventive or prophylactic agents, and perform all tasks delegable by the dentist in accordance with s. 466.024, F.S.

Current law, s. 466.024, F.S., sets forth tasks that may be delegated and those that must be supervised. Remedial tasks established by this section, under current law, cannot be performed by a dental hygienist without supervision. Delegable tasks under this section include:

- Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance;
- Placing periodontal dressings;
- Removing periodontal or surgical dressings;
- Removing sutures;
- Placing or removing rubber dams;
- Placing or removing matrices;
- Placing or removing temporary restorations;
- Applying cavity liners, varnishes, or bases;
- Polishing amalgam restorations;
- Polishing clinical crowns of the teeth for the purpose of removing stains but not changing the existing contour of the tooth; and
- Obtaining bacteriological cytological specimens not involving cutting of the tissue.

These limits on delegable tasks prevent the maximization of the existing workforce by prohibiting dental hygienists from providing preventive services, such as placing sealants, in public health settings without a dentist present or without prior authorization. Florida is one of only nine states that does not already permit a dental hygienist to place sealants without a dentist on site.

Other factors also limit the ability of the state to use dental hygienists to expand access to dental care. Currently, a dental hygienist may not treat a patient that has no record within the past 13 months with a facility dentist. This means that, for example, when a child shows up to receive a dental hygiene cleaning or fluoride treatment, the dental hygienist on staff may not provide these routine services without a dentist first authorizing the treatment. In effect, this means that the county health department must turn away patients at facilities that have no dentist, or limited dentists, on staff. This also means that the department's dental hygiene workforce is not being fully utilized.

III. Effect of Proposed Changes:

Section 1. Amends s. 466.003, F.S., to define the term "health access settings" to mean programs and institutions of the Department of Children and Family Services, the DOH, the Department of Juvenile Justice, nonprofit community health centers, Head Start centers, and federally qualified health centers if such health access programs and institutions immediately report to the Board of Dentistry all violations of s. 466.027, F.S. (sexual misconduct) and s. 466.028, F.S. (general grounds of disciplinary action), and other practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, or dental assistant engaged in the delivery of dental care in such settings.

Section 2. Amends s. 466.006, F.S., specifying that an applicant is entitled to take the dental licensure examination if the applicant has:

- An active health access license in this state; and
    - Has at least 5,000 hours within 4 consecutive years of clinical practice experience providing direct patient care in a health access setting;
    - Is a retired veteran dentist of any branch of the United States Armed Services who has practiced dentistry while on active duty and has at least 3,000 hours within 3 consecutive years of clinical practice experience providing direct patient care in a health access setting; or
    - Has provided a portion of his or her salaried time teaching health profession students in any public education setting, including, but not limited to, a community college, college, or university, and has at least 3,000 hours within 3 consecutive years of clinical practice experience providing direct patient care in a health access setting.;
- Not been disciplined by the board, except for citation offenses or minor violations;
- Not filed a report of a malpractice claim pursuant to s. 456.049, F.S.; and
- Has not been convicted or pled guilty or nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession.

Section 3. Creates s. 466.0067, F.S., establishing an application process for a health access dental license. The bill states that the Legislature finds that there is an important state interest in attracting dentists to practice in underserved health access settings, and as such, notwithstanding the requirements of s. 466.006, F.S., the Board of Dentistry shall grant a health access dental license to practice dentistry in this state in health access settings to an applicant that:

- Files an appropriate application approved by the board;
- Pays an application license fee for a health access dental license, laws-and-rule exam fee, and an initial licensure fee, that may not differ from an applicant seeking licensure pursuant to s. 466.006, F.S.;
- Has not been convicted or pled guilty or nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Submits proof of graduation from a dental school accredited by the Commission on Dental Accreditation of the American Dental Association or its successor agency;
- Submits documentation that she or he has completed, or will obtain prior to licensure, continuing education equivalent to this state's requirement for dentists licensed under s. 466.006, F.S., for the last full reporting biennium before applying for a community-service dental license;
- Submits proof of her or his successful completion of parts I and II of the dental examination by the National Board of Dental Examiners and a state or regional clinical dental licensing examination that the board has determined effectively measures the applicant's ability to practice safely;
- Currently holds a valid, active, dental license in good standing which has not been revoked, suspended, restricted, or otherwise disciplined from another of these United States, the District of Columbia, or a United States territory;

- Has never had a license revoked from another of these United States, the District of Columbia, or a United States territory;
- Has never failed the examination specified in s. 466.006, F.S., unless the applicant was reexamined pursuant to s. 466.006, F.S., and received a license to practice dentistry in this state;
- Has not been reported to the National Practitioner Data Bank;
- Submits proof that he or she has been engaged in the active, clinical practice of dentistry providing direct patient care for 5 years immediately preceding the date of application, or in instances when the applicant has graduated from an accredited dental school within the preceding 5 years, submits proof of continuous clinical practice providing direct patient care since graduation; and
- Has passed an examination covering the laws and rules of the practice of dentistry in this state as described in s. 466.006(4)(a), F.S.

Section 4. Creates s. 466.00671, F.S., providing a process for renewal of the health access dental license. The bill requires a health access dental licensee to apply for renewal of his/her license each biennium. At the time of renewal, the licensee shall sign a statement that she or he has complied with all continuing education requirements of an active dentist licensee. The Board of Dentistry shall renew a health access dental license for an applicant that:

- Submits documentation, as approved by the board, from the employer in the health access setting that the licensee has at all times pertinent remained an employee;
- Has not been convicted or pled guilty or nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Has paid a renewal fee set by the board which may not differ from the renewal fee adopted by the board pursuant to s. 466.013, F.S.;
- Has not failed the examination specified in s. 466.006, F.S., since initially receiving a health access dental license or since the last renewal; and
- Has not been reported to the National Practitioner Data Bank.

The Board of Dentistry may undertake measures to independently verify the health access dental licensee's ongoing employment status in the health access setting.

Section 5. Creates s. 466.00672, F.S., providing a process for revocation of a health access dental license. The bill requires the Board of Dentistry to revoke a health access dental license upon:

- The licensee's termination from employment from a qualifying health access setting;
- Final agency action determining that the licensee has violated any provision of s. 466.027, F.S. (sexual misconduct), or s. 466.028, F.S. (general grounds for disciplinary action), other than infractions constituting citation offenses or minor violations; or
- Failing the Florida dental licensure examination.

The bill specifies that the failure of an individual with a health access dental license to limit the practice of dentistry to health access settings is the unlicensed practice of dentistry.

Section 6. Creates s. 466.00673, F.S., establishing a sunset provision for the health access dental license statute created under this act. The bill specifies that, effective January 1, 2015, ss. 466.0067-466.00673, F.S., are repealed unless reenacted by the Legislature. Any health access dental license issued before January 1, 2015, shall remain valid according to ss. 466.0067-466.00673, F.S., without effect from repeal.

Section 7. Creates s. 466.00775, F.S., requiring the Board of Dentistry to adopt rules to administer ss. 466.003(14)(definition of health access setting), 466.0067(application for a health access setting license), 466.00671(renewal of a health access setting), 466.00672(revocation of a health access setting), 466.00673(repeal of the health access setting), 466.021(retention of dental laboratories), and 466.032 (continuing education requirements for dental laboratories' owners and employees), F.S., as amended or created in this act.

Section 8. Amends s. 466.011, F.S., requiring the Board of Dentistry to certify for licensure by the DOH any applicant who satisfies the requirements of s. 466.0067, F.S., as created by this act.

Section 9. Substantially amends s. 466.021, F.S., revising multiple provisions related to the employment of unlicensed persons by dentists. The bill replaces the term "unlicensed person" with "dental laboratories." The amended language requires a licensed dentist who uses the services of a dental laboratory to furnish the laboratory a written prescription that, in addition to existing requirements, must include the license number of the dentist and a specification of materials to be contained in each work product. The bill requires the laboratory to disclose to the prescribing dentist in writing, the materials used and all certificates of authenticity for each product with the point of origin of manufacture and the address and contact information of the dental laboratory. The amended language also replaces the term "work order" with "prescription."

The bill specifies that the failure by the dental laboratory that has accepted a prescription to have the original or electronic copy of each prescription and to ensure the accuracy of each product's material disclosure at the time it is delivered to the prescribing dentist constitutes a violation of the chapter. This section further establishes that a dental laboratory accepting prescriptions from dentists is liable for damages caused by inaccuracies in material disclosure, certificates of authenticity, or point of origin provided by the dental laboratory to the prescribing dentist.

Section 10. Amends s. 466.023, F.S., defining the scope and area of practice of dental hygienists in health access settings. The bill specifies a dental hygienist may perform the following tasks, without supervision and without prior authorization of a dentist, in a health access setting:

- Conducting services listed in s. 466.023(3), F.S. (current scope of practice for dental hygienists);
- Doing dental charting listed in s. 466.0235, F.S.;
- Applying fluoride treatments, including the use of fluoride varnishes;
- Doing impressions for study casts which are not being made for the purpose of fabricating any intra-oral appliances, restorations, or orthodontic appliances and which are conveyed to a dentist for review and development of a treatment plan; and
- Taking medical and dental history conveyed to a dentist for review and development of a treatment plan.

The bill requires that a patient receiving fluoride treatments, impressions for study casts, and medical and dental history from a hygienist without supervision or prior authorization must be examined by a dentist before the hygienist performs any additional services without supervision or prior authorization. Furthermore, the bill specifies that a dental hygienist may perform the following tasks under general supervision:

- Applying dental sealants.
- Placing subgingival resorbable chlorhexidine, doxycycline hyclate, or minocycline hydrochloride.

Section 11. Amends s. 466.032, F.S., requiring dental lab owners, or at least one employee of each laboratory, to complete 18 hours of continuing education (CE) biennially beginning on or after July 1, 2010. The bill specifies the types of courses, the objective of CE for dental technicians, and the areas that must be addressed in the CE courses. The Florida Dental Laboratory Association and the Florida Dental Association may develop and offer CE courses to dental technicians without being approved by the department. The bill requires the dental lab to submit a sworn affidavit attesting to the completion of the required continuing education hours as part of each registration renewal, listing the date, location, sponsor, subject matter and hours completed. The dental laboratory is also required to retain records to document completion of the courses that are subject to request by the department with or without cause, at random. A dental laboratory that is physically located within a dental practice operated by a dentist licensed under ch. 466, F.S., is exempt from these requirements.

A dental laboratory in another state or country which provides service to a dentist licensed under ch. 466, F.S., is not required to register with the state and may continue to provide services to such dentist with a proper prescription. A dental laboratory in another state or country, however, may voluntarily comply with this subsection.

Section 12. Provides that the act takes effect on January 1, 2009.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill would likely increase access to dental care for Florida residents, particularly in rural areas. This would reduce the cost of receiving care and lower costs associated with co-morbidities caused by the lack of dental care.

The bill could potentially increase the number of dentists operating in the state. Depending on where these dentists locate, it could put pressure on local markets where dentists are in greater supply, ultimately causing a loss of income. The full fiscal effect is indeterminate at this time.

The requirement that owners and staff of dental laboratories complete 18 hours of continuing education (CE) biennially beginning on or after July 1, 2010, and the documentation requirements for reporting these CEs will be an additional, indeterminate administrative cost to the laboratories.

C. Government Sector Impact:

(The DOH did not have an opportunity to provide an updated fiscal analysis of this committee substitute. The fiscal analysis for the original bill is still included to provide an example of how the new health access license processes would have a fiscal effect on the DOH depending on how many individuals apply for the license.)

According to the DOH, the impact of this proposal is budget positive, with more revenue generated than expenditures.

Consistent with adding any new profession, the DOH would be required to update the COMPAS licensure system to accommodate an additional class of licensure known as the Public Health Dentist *(community-service dentist)*. The DOH is required to provide a method of enforcement relating to licensed and unlicensed practice by Public Health Dentists *(community-service dentists)*, which would require additional administrative resources. The DOH currently contracts services for processing of initial and renewal applications and related fees. The cost of the contracted service is based on a per application rate. All initial applicants and renewal applicants for the proposed Public Health Dentist licensure will increase the number of initial and renewal applications processed under the contract.

The exact fiscal impact depends on the number of persons who will apply for licensure as a public health dentist *(community-service dentist)*. Although this number is unknown, estimates are based on the number of dentist FTE positions in county health departments (87), plus an additive of 25 percent to estimate positions available within DOH, DJJ, nonprofit community centers, Head Start centers, and federally qualified health centers.

For the purposes of this analysis, the total projected number of public health dentists who will apply for licensure is estimated as 109. It is further estimated the population of the licensee pool will grow at the same rate as the dental licensure pool. The growth rate of the dental licensure pool from FY 2005-06 to FY 2006-07 was 2 percent, which equates to two public health dentists per year.

The DOH is authorized to conduct random continuing education audits and approve additional continuing education providers. If the department elects to conduct audits of dental laboratories, there will be additional operating costs.

Estimated Expenditures:
As of June 30, 2007, the dentistry board office managed an active/inactive licensure pool size of 12,147. Five (5) FTEs are assigned to board office functions. The board office processes initial applications, issues licenses, and generally maintains a licensee pool at a rate of 2,429 per FTE (12,147 licensee pool/5 FTEs). The projected increase in licensee pool size handled by the board office will increase over a 2-year period by only 111 licensees which would require .5 FTEs.

The DOH is required to enforce laws and rules relating to licenses and unlicensed practice by Public Health Dentists. Based on FY 2006-07 data, the percent of complaints received to the total dentistry licensee pool is approximately 7.7 percent (934 complaints/12,147 licensees). It is expected that 54 percent (502 complaints/934 legally sufficient) of all complaints received will be found legally sufficient for investigation. Therefore, it is expected nine complaints will be received in a two year period (111 x .077), of which 5 (9 x .54) will be legally sufficient for investigation.

The DOH currently contracts services for processing of initial and renewal applications and related fees. The cost of the contracted service is based on a $7.89 per application rate. It is projected 109 new applications will be processed in year 1 and that two new applications will be processed in each subsequent year. It is further projected that all initial registration applications will renew biennially. Based on these assumptions, there is an expected expenditure of $860 in the first year.

Estimated Revenues:
Revenues are calculated based on year 1 applications of 109 and subsequent year applications of two. Further, it is projected that each initial licensee will submit a renewal application biennially. The bill provides for initial and renewal licensure fees equal to those assessed to dentists by rule. The current initial licensure fee is $100. The current renewal fee is $300. Based on these assumptions, there is an expected revenue increase of $10,900 in the first year.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Committee on Health and Human Services Appropriations on April 2, 2008:
The committee substitute:

- Removes the requirement that an applicant must not have been convicted or pled guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction.
- Requires applicants to not have been convicted or pled guilty or nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession.
- Changes the term "community service setting" to "health access setting" and provides a definition. The new definition does not include "or other similar entity, and any other public health dental safety net provider designated by the board".
- Removes changes to the examination of dental hygienists.
- Removes the repeal of Section 466.008, F.S.

CS by Health Regulation on March 26, 2008:
The committee substitute:

- Removes all "Whereas" clauses;
- Changes the term "public health setting" to "community service setting" and provides a definition. The new definition does not include "or other similar entity, and any other public health dental safety net provider designated by the board";
- Requires community service settings to report standard of care violations to the Board of Dentistry;
- Removes changes to the membership of the Board of Dentistry;
- Creates processes for the application for, renewal of, revocation of, and sunset of the community-service dental license as created in this act;
- Deletes an obsolete section in the dental practice act regarding certification of foreign-trained schools;
- Requires the Board of Dentistry to adopt rules to administer ss. 466.003(14) (definition of community service setting), 466.0067(application for a community service setting license), 466.00671(renewal of a community service setting), 466.00672(revocation of a community service setting), 466.00673(repeal of the community service setting), 466.021(retention of dental laboratories), and 466.032 (continuing education requirements for dental laboratories' owners and employees), F.S., as amended or created in this act;
- Removes all provisions related to unsupervised practice of dental hygienists, particularly cleanings, and gives the Board of Dentistry authority to expand more areas of unsupervised practice;

- Allows a dental hygienist to perform unsupervised activities already allowed in law in community health settings;
- Allows a dental hygienist to apply varnishes, create certain impressions, and conduct medical histories without supervision, provided the information is reviewed by a dentist; and,
- Allows a dental hygienist to apply sealants under general supervision in all settings and allows placement of certain antibiotics under general supervision.

B. Amendments:

None.