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 Budget Subcommittee on Health and Human Services Appropriations

BILL:	SB 446
INTRODUCER:	Senators Hays, Sobel, and Gaetz
SUBJECT:	Dentistry and Dental Hygiene
DATE:	April 11, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Favorable**
2.	Bradford	Hansen	BHA	**Pre-meeting**
3.			BC	
4.			RC	
5.				
6.				

I. Summary:

This bill generally expands the scope and area of practice of dental hygienists by authorizing dental hygienists to perform certain duties unsupervised in health access settings, which includes school-based prevention programs and accredited dental hygiene programs. The bill requires dental hygienists, who perform remediable tasks without supervision, to provide a dental referral in compliance with federal and state patient referral, anti-kickback, and patient brokering laws; encourages the establishment of a dental home; and requires the dental hygienists to maintain a certain amount of professional malpractice insurance coverage.

This bill clarifies that the authorization for dental hygienists to perform some duties does not prevent a program operated by one of the health access settings or a nonprofit organization from billing and obtaining reimbursement for the services provided by a dental hygienist.

This bill has no fiscal impact on state or local government.

This bill substantially amends the following sections of the Florida Statutes: 466.003, 466.023, 466.0235, 466.024, 466.006, and 466.0067.

This bill also reenacts s. 466.00672, F.S., for the purpose of incorporating the amendment made to s. 466.003, F.S., in the bill.

II. Present Situation:

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 to 5 and half of those aged 12 to 15. Low-income children are hardest hit: about two-thirds of those aged 12 to 19 have had decay. Untreated cavities can cause pain, dysfunction, absence from school, difficulty concentrating, and poor appearance - problems that can greatly affect a child's quality of life and reduce a child's capacity to succeed in life.[1]

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 an increase in tooth retention, tooth loss remains a problem among older adults. One-fourth of adults over age 65 have lost all of their teeth - primarily because of tooth decay. Advanced gum disease affects 4 to 12 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.[2]

Shortage of Dentists

The pool of dentists to serve a growing population of Americans is shrinking. The American Dental Association found that 6,000 dentists retire each year in the U.S., while there are only 4,000 dental school graduates each year to replace them. The projected shortage of dentists is even greater in rural America. Of the approximately 150,000 general dentists in practice in the U.S., only 14 percent practice in rural areas, 7.7 percent in large rural areas, 3.7 percent in small rural areas, and 2.2 percent in isolated rural areas. In 2003, there were 2,235 federally designated dental supply shortage areas, 74 percent of which were located in non-metropolitan areas. In contrast, dental hygiene is predicted to be one of the top ten fastest growing health care professions over the next decade, growing by a projected 43 percent between 2006 and 2020.[3]

In 2010, there were 9,373 practicing dentists in Florida, meaning the ratio of dentists to the population in Florida is approximately 1 dentist for every 2,016 residents.[4] The estimated underserved population in 2008, in Florida, was 2.9 million people or 15.8 percent of the population.[5]

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[1] Centers for Disease Control and Prevention, *Oral Health: Preventing Cavities, Gum Disease, Tooth Loss, and Oral Cancers: At a Glance 2010*, available at: http://www.cdc.gov/chronicdisease/resources/publications/AAG/doh.htm (Last visited on March 11, 2011).
[2] *Id.*
[3] National Rural Health Association, *Issue Paper: Recruitment and Retention of a Quality Health Workforce in Rural Areas*, November 2006. A copy of this report is on file with the Senate Health Regulation Committee.
[4] Professional staff of the Senate Health Regulation Committee received this information via email from the Department of Health on March 11, 2011. A copy of the email is on file with the committee.
[5] The Henry J. Kaiser Family Foundation, *Florida: Estimated Underserved Population Living in Dental Health Professional Shortage Areas (HPSAs) as of September, 2008*, available at: http://www.statehealthfacts.org/profileind.jsp?ind=681&cat=8&rgn=11 (Last visited on March 11, 2011).

Access to Dental Services in Rural Areas

Most research indicates that access to dental care is significantly more limited in rural areas than in metropolitan areas. According to the National Rural Health Association:[6]

- 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 (toothless) 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; and
- 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 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

[6] National Rural Health Association, *Meeting Oral Health Care Needs in Rural America*, April 2005. A copy of this report is on file with the Senate Health Regulation Committee.

subsequent opening of only three new ones, more people want to become dentists than there are available slots. 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; and

- *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.[7]

The Florida 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 DOH has had difficulty in recruiting and retaining public health dentists. There were 106 full time equivalent (FTE) dentists in county health departments during the DOH's Fiscal Year 2009-10.[8]

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 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.

Dental Hygienists

In Florida, dental hygienists are regulated by ss. 466.023, 466.0235, and 466.024, F.S. 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; and remove calculus deposits, stains, and plaque above and below the gumline.[9] They also apply preventive agents such as fluorides and sealants to teeth when allowed by state regulations.[10]

[7] *Id.* (citing the National Advisory Committee on Rural Health and Human Services).
[8] *Supra* fn. 4.
[9] Section 466.023, F.S.
[10] *See* Rule 64B5-16.006, Remediable Tasks Delegable to a Dental Hygienist, F.A.C.

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.

Current law, s. 466.024, F.S., sets forth tasks that may be delegated and authorizes the board to identify additional tasks that are remedial and may be delegated. Other tasks cannot be performed by a dental hygienist without supervision. Delegable tasks under this section of law 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.

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.[11] 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:

This bill generally expands the scope and area of practice of dental hygienists by authorizing dental hygienists to perform certain duties unsupervised in health access settings.

Section 1 amends s. 466.003, F.S., to change the definition of the term "health access setting" to include a school-based prevention program and an accredited dental hygiene program. The term "school-based prevention program" is defined to mean preventative oral health services offered at a school by one of the entities included in the definition of a health access setting or by a

[11] *See* Rule 64B5-16.001, Definitions of Remediable Tasks and Supervision Levels, F.A.C.

nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c)(3) of the Internal Revenue Code.

Section 2 amends s. 466.023, F.S., to authorize dental hygienists to perform their duties in a health access setting and perform certain services without supervision, including apply fluorides, instruct a patient in oral hygiene care, and supervise the oral hygiene care of a patient.

Section 3 amends s. 466.0235, F.S., to authorize a dental hygienist, without supervision and within the lawful scope of his or her duties as authorized by law, perform dental charting of hard and soft tissues in health access settings.

Section 4 amends s. 466.024, F.S., to authorize dental hygienists licensed in Florida to perform certain remedial tasks in health access settings without the physical presence of, prior examination by, or authorization of, a dentist. Specifically, dental hygienists are authorized to:

- Perform dental charting, which is defined under s. 466.0235, F.S., as a recording of visual observations of clinical conditions of the oral cavity without the use of X-rays, laboratory tests, or other diagnostic methods or equipment, except the instruments necessary to record visual restorations, missing teeth, suspicious areas, and periodontal pockets;
- Measure and record a patient's blood pressure rate, pulse rate, respiration rate, and oral temperature;
- Record a patient's case history;
- Apply topical fluorides, including fluoride varnishes, which are approved by the American Dental Association or the Food and Drug Administration;
- Apply dental sealants; and
- Remove calculus (dental tartar) deposits, accretions, and stains from exposed surfaces of the teeth and from tooth surfaces within the gingival sulcus, if a dentist licensed under ch. 466, F.S., or a physician licensed under ch. 458 or ch. 459, F.S., gives medical clearance before the dental hygienist removes such deposits, accretions, and stains. A dentist is required to conduct a dental examination on a patient within 13 months after a dental hygienist removes such deposits, accretions, and stains and additional oral hygiene services of this type may not be performed without a clinical examination by a dentist who is licensed under ch. 466, F.S.

The authorization to perform the above services does not authorize a dental hygienist to perform root planing or gingival curettage[12] without supervision by a dentist.

A dental hygienist must provide to the patient in writing before any remediable task is performed in a health access setting without the physical presence of, prior examination by, or authorization of a dentist a disclaimer which must state that the services being offered are not a substitute for a comprehensive dental exam by a dentist and the diagnosis of caries, soft tissue disease, oral cancer, temporomandibular joint disease (TMJ), and dentofacial malocclusions will be completed only by a dentist in the context of delivering a comprehensive dental exam.

[12] Gingival curettage is a surgical procedure designed to remove the soft tissue lining of the periodontal pocket with a curet, leaving only a gingival connective tissue lining. American Academy of Periodontology, *The American Academy of Periodontology Statement Regarding Gingival Curettage*, available at: http://www.perio.org/resources-products/pdf/38-curettage.pdf (Last visited on March 10, 2011).

This section clarifies that authorization for dental hygienists to perform the above services does not prevent a program operated by one of the health access settings or a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code and described in s. 501(c)(3) of the Internal Revenue Code from billing and obtaining reimbursement for such services or from making or maintaining any records necessary to obtain reimbursement.

This section requires dental hygienists who perform, without supervision, the above-listed remedial tasks to provide a dental referral in strict compliance with federal and state patient referral, anti-kickback, and patient brokering laws and encourages the establishment of a dental home. A dental hygienist performing such tasks must also maintain professional malpractice insurance coverage that has minimum limits of $100,000 per occurrence and $300,000 in the aggregate through the employing health access setting or individual policy.

Section 5 amends s. 466.006, F.S., to make cross-reference corrections to conform to changes made by the bill and clarifies that an applicant for a dental license must successfully complete the National Board of Dental Examiners dental examination within 10 years after the date of application. Currently, an applicant can take the examination anytime within 10 years of the date of application, including prior to the application.

Section 6 amends s. 466.0067, F.S., to correct a cross-reference to conform to changes made by the bill.

Section 7 reenacts s. 466.00672, F.S., for the purpose of incorporating the amendment made by the bill to s. 466.003, F.S.

Section 8 provides that the bill shall take effect upon becoming a law.

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:

Patients particularly in rural areas my find improved access to dental services.

C. Government Sector Impact:

To the extent that patients have increased access to dental services, publically funded dental programs like Medicaid may see increased billings.

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.)

None.

B. Amendments:

None.