

Florida Oral Health Workforce Workgroup  
May 1, 2009 Face to Face Meeting-Palm Beach, Florida

May 1, 2009 - The purpose of the second face to face meeting was to discuss changes to supervision levels for dental assistants and dental hygienists in health access settings.

**Housekeeping**

Douglas Manning opened the meeting and advised participants and guests that the meeting was held according to the Sunshine Laws.

Nancy Zinser Associate Dean of Health Sciences of Palm Beach Community College welcomed the Workgroup and guests to Palm Beach Community College (PBCC) and discussed the facility, housekeeping and arrangements.

Jackie Rogers, Dean of Health Science of Palm Beach Community College welcomed the Workgroup and guests to PBCC.

Rory Reese distributed In Kind forms for participants so they could document their time for 2 (possibly 3) teleconferences (March 6, 2009; April 3, 2009; and a Medicaid subcommittee teleconference on April 24, 2009) as well as this face-to-face meeting of May 1, 2009.

**Roll Call and introductions**

**Workgroup members present:**

Steve Abel, D.D.S., M.S.D., Nova Southeastern University College of Dental Medicine (for Dean Uchin)

Michael Bolin, Agency for Health Care Administration

Cathy Cabanzon, R.D.H., Florida Public Health Institute (for Dr. Fox)

Frank Catalanotto, D.M.D., University of Florida College of Dentistry (for Dean Dolan)

Glen Davis, Department of Health, Office of Health Professional Recruitment

Howard Fisher, D.D.S., Florida Society of Oral & Maxillary Facial Surgery

Inge Ford, D.M.D., M.S., Martin County Department of Health

Charles Hoffman, Ph.D., D.M.D., Florida Dental Association

Holly Kahler, C.D.A., R.D.H., Ed.D, Department of Education

Douglas Manning, D.M.D., J.D., M.P.H., Department of Health

Karen Miller, M.S.W., M.P.A., Health Foundation of South Florida

J. Thaddeous Morgan, D.M.D., Florida Board of Dentistry

Maria Pardo, D.D.S., Area Health Education Center Network

Nancy Zinser, R.D.H., M.S., Florida Dental Hygiene Association

**Workgroup members not present:**

Teresa (Terri) A. Dolan, D.D.S., M.P.H, University of Florida College of Dentistry

Claude Earl Fox, M.D., M.P.H., Florida Public Health Association

Representative Alan Hays

Robert Uchin, D.D.S., Nova Southeastern University College of Dental Medicine

**Department staff:**

Amy Cober, R.D., L.D., M.P.H.

Rory Reese, R.D.H., B.H.S.

**Facilitator:**

Dee Jeffers, R.N., M.P.H.

**Guests and Workgroup members attending by conference call:**

*Callers on the phone:*

Teresa (Terri) A. Dolan, D.D.S., M.P.H, University of Florida College of Dentistry  
Bob Macdonald, M.S., Florida Dental Association

*Guests in attendance:*

Karen Allen, Associate Professor of Dental Assisting of Indian River State College  
Evelyn Miller, R.D.H, private practice dental hygienist  
Tami Miller, R.D.H., Executive Director of Florida Dental Hygiene Association  
Paula Schad, R.D.H., President of the Florida Dental Hygiene Association

**Old Business**

Dr. Manning reviewed the Medicaid Administrative burdens Subcommittee call of April 24, 2009 – and explained that the minutes of the call were sent to all Subcommittee and Workgroup participants and were available upon request as the website was not yet up and running.

**New Business**

Survey

Dr. Manning distributed a survey to all participants. This survey was a gross evaluation tool to measure participant's opinions of Florida current and future status as related to scope of practice and supervision levels for dental auxiliaries. The worksheet called Florida scope of Practice and Supervision levels for Dental Auxiliaries had 2 linear scales (one for current status and one for future status) numbered from -9 through 0 to a +9, with -9 being Direct Supervision limited duties (prevention and education only) up to +9 being no supervision expanded duties and some restorative allowed. Participants were asked to place an X on the scale where they felt Florida currently is regarding scope of practice and supervision levels for auxiliaries. Dr. Manning mentioned the scale and numbers had no value, but were chosen just to indicate change with a total of 18 levels of difference (-9 to +9). Eleven participants provided workable responses with 2 surveys improperly filled out and unworkable.

While the survey was very basic, the results of the survey indicated some distinct findings:

- 1) There was wide variation on where individuals perceived Florida's current status to be (range of -7 to +3) with an average of -3.09.
- 2) There was wide variation as to where individuals wanted to see Florida's near future status to be (with a range of 0 to +9) with an average of +5.36.
- 3) The general trend indicated the group wished to see a significant change towards liberalizing scope of practice and supervision levels.
- 4) Not one individual indicated there should be no change or a lessening of scope of practice or supervision levels – every individual indicated some degree of change towards increasing liberalization (with a range of increasing towards liberalization of a low of 3 levels to a high of 15 levels with an average of 8.45 levels).

**Presentations**

The Florida Dental Hygiene Association (FDHA), the Florida Dental Assisting Association (FDAA), and the Florida Dental Association (FDA) gave presentations related to their organization's positions regarding scope of practice and supervision levels of dental auxiliaries.

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FDHA

Nancy Zinser presented a PowerPoint presentation for the FDHA. Nancy offered that the Workgroup needed to look at Delivery of Care and Direct Access to Care. She emphasized that it is not a scope of practice issue; hygienists are not asking to be able to perform more duties, just to be able to perform those duties that they already are providing in private practice, in other health care settings under more liberal or no supervision levels.

Key Points of the presentation:

29 states offer direct access

Need to be more collaborative

Need to be able to go into different settings to provide preventative care

Need to stay focused on the patient

She concluded that “investigation is over—we need to act now”.

FDAA

Dr. Kahler presented a PowerPoint presentation for the FDAA.

Florida has 24 dental assisting programs that graduate approximately 839 dental assistants a year. Some of the schools have the didactic portion of their course online (Brevard) which allows students to come in 2 nights a week (for 2 semesters) for anatomy and other hands on course work.

To address access to care, there are a large number of dental assistants (over 10,000) in Florida. She proposed allowing them to perform more services with less supervision by creating a new dental assistant – the Restorative Dental Assistant (RDA). Such a dental assistant could provide expanded duties under general supervision (Fluoride varnish, sealants, polishing) and some duties under direct supervision - without a high speed handpiece, assistants could place and finish composite restorations as well as placing and carving amalgam restorations.

The proposal included an educational program which would allow graduates from an accredited ADA Dental Assisting Program to take an additional 96 hours of education of training so that RDAs could perform new duties and to improve other skills (sealants). A credentialing process would require RDAs to pass a practical exam (dental assisting programs would do exams under the supervision of a dentist). An application process with the Board of Dentistry would be included, with a mandatory 24 hours of continuing education and a 2 year renewal.

FDA

Dr. Hoffman gave a brief oral presentation stating that FDA supports the ECC (Early Childhood Caries) prevention program. The context of what the Workgroup is considering, some form of “Public Health Supervision” which would not require a prior exam and authorization by a dentist in order for a dental auxiliary to perform specific duties, is not currently legal. The current policy requiring a prior exam and authorization by a dentist prior to dental treatment has been in effect since 1979. Thus, FDA policy is that the exam and authorization must be done first.

Discussion

The floor was opened for the rest of the Workgroup participants to comment (not to exceed 2-3 minutes).

Cathy Cabanzon of Florida Public Health Institute (FPHI) stated that we need to work as a group to bridge the gaps - that it is time to come together.

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Dr. Catalanotto stated that his personal opinions are the following 2 observations:

1) Several years ago it was discovered in law and economic literature that a restrictive professional dental practice act would result in better health of the public—research shows no relationship.

2) He addresses the map of direct access and asked—if “direct access” is safe in 29 other states—why wouldn’t it be safe in Florida? He stated that the time has come to try this “direct access” model in Florida statewide. He went further to state that his wife trained (as a dental assistant) at Forsythe Dental Center (which is now closed) was carving amalgams—this is also done in the military (as well as simple restorative). If it is done in the military, why isn’t it safe here?

Dr. Fisher questioned where will the reimbursement come from? It needs to be part of the discussion.

Dr. Abel stated that Nova Southeastern University spends a lot of time training students in multidisciplinary approach and that we are making progress---non-dental colleagues are interested—reinventing not necessary.

Glen Davis believes that access to the underserved will improve access which will help save money down the road.

Karen Miller echoes what has been said previously; the Health Foundation of South Florida stands behind hygienists expanding scope of practice and supervision levels.

Dr. Ford echoed expanded duties and supervision levels for assistants and hygienists. Time is being used unwisely with dentists doing jobs that other dental workforce can do; public health can better utilize dental workforce.

Michael Bolin recommended a book that Secretary Benson (who is an avid reader) recommends: “Prescription for change” (by George C. Halvorson-author). The premise of the book is to take the business approach to medical/dental care. Models will have to change—adapt to new conditions. As the market advances and progresses, you tend to bring in more and more ways to deliver services; for example retail clinics for health care staffed with PAs (Physicians’ Assistants) and NPs (nurse practitioners). We need to be looking for ways to advance care and access.

Dr. Morgan gave a brief review of the function of the Board of Dentistry (BOD) whose function is the protection of the public. The BOD is currently spending a large amount of time dealing with discipline. Dr. Morgan feels (personally) that Frank Catalanotto is dead on—it is unconscionable for a state this large that we are so far behind.

Dr. Morgan felt that legislatively providers could come from out of state and work in rural counties; perhaps we could try this in several counties.

Karen Miller asked the question: “Isn’t there enough information out there from the 29 other states?”

Nancy Zinser stated that there are 28 accredited dental assisting programs which have site visits and self studies---auxiliaries can work in so many different directions. A discussion ensued about proprietary programs---some do not have stringent standards. We should only allow

Florida Board of Dentistry approved programs. Safety and protection of the public should be the goal.

Dr. Catalanotto brought up that dental hygienists are not talking about changing their scope of practice---they are talking about supervision.

Dr. Morgan what we would like is a “direct access” model in public health settings for dental hygienists; that this change this may need to be accomplished through legislation vs. BOD rulemaking. He needed to check with the BOD legal council to see if such changes could be done through the Board.

Dr. Manning brought up the aspect of language of public health settings and direct access, that whatever the workgroup decides it needs to be clear, consistent and not create any poor public perceptions.

Glen Davis asked if the health access dental license provided precedence.

Dr. Morgan said at this point there have been 3 applicants for health access license (they have a license in another state).

Dr. Maria Pardo stated that the health access license is not just for county health departments.

The public was invited to make comments and there was no further comment.

### **Small Group Exercise**

The workgroup was divided into 3 small groups and the guests were invited to form a small group of their own. Dee Jeffers tasked the small groups with developing a proposal concerning scope of practice and supervision levels for dental hygienists in round 1 and dental assistants in round 2. Worksheets for proposed supervision levels were handed out and participants of small groups were asked that its proposals define the setting, duties, supervision levels, and what would be necessary to implement their proposal. Each group was to elect a leader who would then present its results to the larger group.

#### ***Round 1 Small Groups – Dental Hygienists***

The results of the small group (regarding dental hygienists) were as follows:

1<sup>st</sup> group-

- \*Expand supervision to public health supervision to include: prophylaxis, sealants and varnish
- \*Deliver through DOH; rural community as vehicle
- \*Title I (free and reduced lunch) guidelines—data to be recorded
- \*Regions to be determined
- \* RDH to do referral through resource guide

2<sup>nd</sup> group-

- \*Direct access with collaboration with a dentist who must review records within 30 days
- \*A protocol must be in place for referral to a dental home and for urgent dental care needs
- \*Setting clarifications/changes
- \*Allied dental programs accredited by CODA
- \*School based settings
- \*Senior centers

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\*“programs”

\*Other experience/qualifications: as a requirement 3,000 hours of clinical experience with an appropriate population (children vs adults)

3<sup>rd</sup> group-

\*Current definition of “health access setting” may exclude many people needing services- schools, long term care, facilities, community clinic and/or prison, refer to Minnesota example (legislative) – does the term “programs” in the “health access settings” definitions include school-based programs of CHDs for example or must programs occur in CHD facilities to qualify – may need clarification although the group thought the term program allowed for school-based programs to be included. Need to include in the definition, besides dental schools other allied dental schools and programs too – may need legislative change here.

\*Lift general supervision level-In these setting-RDH first point of care-no prior exam by DDS

\*Advocate for reimbursement initiatives such as Medicaid

\*Referral of patient to health access setting (to be determined)

4<sup>th</sup> group-

\*Propose legislation to establish public health supervision as the dental hygienist is the starting point of care and the registered dental hygienist is a graduate of an accredited dental hygienist program

\*Prior authorization of a dentist is not required

\*eliminate prior dental exam by the dentist

\*provide preventive services to the patient without the presence of a dentist unless urgent care is needed, which requires an immediate referral (similar to the South Carolina model)

\*Allow the RDH to be a Medicaid provider

\*Require a referral to dentist to establish a dental home

***Round 1 Discussion Period.***

Each small group presented its proposal to the workgroup as a whole. The Workgroup participants had the opportunity to comment and ask questions of each small group’s proposal. The workgroup discussed the pros and cons of each proposal separately and as a whole.

Nancy Zinser felt that we should not limit the number of hours of RDH to a certain population. Dr. Pardo stated that she has worked with hygienists who have a lot of experience but did not have expertise to place sealants---were they the exception? If you haven’t worked with a child there are behavior management issues.

Nancy Zinser pointed out that accreditation standards demand that they work with young children. Continuing education could be provided for that area of expertise.

Holly Kahler asked how does one document 3,000 hours?

Dr. Abel commented that we would never require this of dentists. RDHs have to get CE credits just like dentists do.

Dr. Hoffman offered that California has experience level and 500 hours of education.

Dr. Manning asked if we want to look at experience, education for 2 different populations: school setting and senior population.

Cathy Cabanzon stated in a public health setting one needs to become familiar with paper work, protocol and product.

Dr. Catalanotto stated that whatever the public health setting, they need to certify their competency.

Dr. Hoffman stated that finding a means for direct access is key. Is it no supervision? Or collaborating with a dentist?

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Dr. Morgan felt that changing the supervision to allow direct access through legislation or board rules is advisable.

Cathy Cabanzon felt we should define public health access settings and eliminate prior authorization by a dentist.

Dr. Catalanotto summed it up by saying that he felt we broadly agree with the definition of Health Access setting---but does it cover a school setting?

Dr. Morgan stated that one group agreed and went with the school based program.

Dee Jeffers interjected that we should make sure the term is inclusive instead of limiting.

Someone wanted clarification on “programs”---school based sealant program? Is it covered; setting is not specific.

Dr. Abel asked the question regarding long term care facilities provided with public dollars---can we send students in?

Dr. Morgan said he would check with the board office---if it is not a board rule then we will need a legislative change.

Dr. Catalanotto suggested that we add language to reflect this as currently it says only schools of dentistry—needed to include allied dental programs too.

Nancy Zinser asked is this for practitioners to be able to go into schools and reimbursement occur.

Dr. Manning cautioned using students; be sure educational programs are not violating the law.

Dr. Morgan felt the best course of action was to change the language to include allied health services.

Dr. Catalanotto stated this may be a potential point of disagreement; would we rather see a pilot program or just go ahead.

Dr. Hoffman felt it depends if it has to be done legislatively there could be a problem.

Dr. Morgan said that we could say pilot and then go for legislation.

Dee Jeffers reiterated—if the board is OK—then statewide—if it is not OK then legislative.

Tami Miller, executive director of FDHA stated that FDHA had a legal review and was told it was outside of the BOD purview to approve.

Karen Miller interjected that the value of a pilot is that it is evaluated and then we can go to the legislature; however, where will the funding come from for a pilot?

Dr. Morgan also stated that if this were to go statewide, then more money may be needed.

Dr. Catalanotto stated that if it can be done by board rule-OK, do statewide; if we have to go legislatively—are you saying that FDA will not support it? Why?

Dr. Morgan said the good thing about trying to get it accomplished through the board is that you can't lobby the board. It will be easier getting it done through the board than legislative action. (The board is approved by the governor.)

Nancy Zinser stated that there is a consensus to make a recommendation—we are not here at the whims of FDA—this is a collaborative effort to say this is what needs to happen.

Pilot program only hits one segment; then we'll be another 2, 3 or 4 years before we get something done. It is up to this group to educate regarding this matter.

Dr. Morgan made the statement that the FDA has soundly defeated proposals in the past and that “Vision without resources is just an illusion”. People's lives are at stake.

Dr. Hoffman said to go ahead and do what you think is right---don't worry about us.

Dee Jeffers suggested that we can talk about phase-in plans other than a pilot project.

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Dr. Catalanotto said if we are going to go ahead with it legislatively, then just do it. The institute has a resource guide; the FDA has a resource guide of where to get care.

Dr. Manning asked if we want to include radiographs?

Dr. Hoffman asked whose responsibility it would be to take care of radiographs?

Dr. Morgan says: "You bill it—you own it."

Dr. Ford spoke about volunteer dentists going with nurses who do other screenings. Volunteers are a wonderful tool; but, that devalues services provided.

Dr. Catalanotto says he could live with the idea person needs to be credentialed by whatever they use to determine that licensure instead of putting on extra hours—this is about health care settings.

Nancy Zinser stated that not every child/patient will need a referral; referral will only be on an as needed basis.

Dr. Pardo says of the school sealant program that if there is no urgent care; doesn't that mean they will never have a dental home?

Dr. Catalanotto says that pediatrician by rules (step #5) must make an attempt to refer to dental home by saying "You need to take the child to a dentist". However, there is no obligation that it has to occur.

Dr. Pardo says that if she sees a child needs to see a dentist but can't get them in what is to be done?

Dr. Ford states that if a parent is told that the child has needs then it is up to the parent

Nancy Zinser states that we can go in and deal with prevention and education so that we are having less of these critical cases as this unfolds. The pipeline will become unclogged.

Dr. Hoffman stated that after seeing a child multiple times in a screening, if they have repeatedly been told no problem---when do they go to see the dentist?

Dr. Ford said "no needs" means there is no immediate decay---but, yes---they need to see a dentist. It's all about being proactive instead of reactive.

Dr. Pardo gave an example of a hygienist that seals over decay.

Dr. Catalanotto asked what is the difference between that---it's the organization that is responsible.

Dr. Pardo stated that is why she wants a certain number of hours---to have a competency.

Dr. Morgan stated that that is an ethics problem if a hygienist seals over decay---they could have 20,000 and still do that.

### **Consensus**

Dee Jeffers asked if there were any points of consensus and if the workgroup could decide upon a consensus proposal. The following is the consensus of the Workgroup:

- There is no need to change scope of practice as dental hygienists already are trained and able to perform the necessary duties.
- The Workgroup agreed that changing supervision levels and establishing a form of "direct access" could improve access to care for disadvantaged populations
- Change in Supervision level should include:
  - No prior examination or authorization by a dentist for a dental hygienist to perform existing scope of practice duties.

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- Health access settings only
- Referral to a dental home
- Dental hygienist in collaboration with a dentist in a health access setting.
- Experience requirement?
- Need to check to see how changes can be made
  - Ideally, Board of Dentistry can change supervision levels of duties with limitation to health access settings in the Florida Administrative Code – Board can probably make such changes if it does not need to establish a “new” supervision level (e.g. public health supervision). But:
    - Can Board restrict supervision changes to “health access settings”?
    - Can Board establish requirement for “collaborative” arrangements?
  - If change in Supervision levels creates a “new” supervision level (e.g. public health supervision), such change would probably have to occur through statutory change by the Legislature
- Need to change and possibly clarify the statutory definition for “health access settings”
  - Add allied dental schools and programs – not just dental schools to definition
  - Do we need to clarify the term “programs” in the “health access settings” definition – does this term allow listed providers (such as DOH) to have dental hygienists go into schools or other non-DOH facilities and practice under this type of supervision as long as this is a “program” of the listed provider (e.g. DOH school-based dental sealant program)?
- Changes should be made statewide if at all possible (e.g. if Board can make changes) vs. piloting programs (which may be an avenue that needs to be pursued if changes have to occur through the Legislature)
- Should not duplicate existing resources
- Is there a need to confirm/credential collaborative arrangements?
- Referral to a dental home is a goal of any dental visit and is needed as a standard in allowing dental hygienist to practice under such supervision as established above

The public was invited to make comments and there was no further comment.

**Round 2 Small Groups – Dental Assistants**

Small groups were reassembled to discuss dental assistants - specifically, the establishment of a restorative dental assistant as offered by Dr. Kahler in her presentation.

Ideas that were proposed from small groups:

Group A

- allow dental assistants to take radiographs without a prescription in public health settings
- allow dental assistants to place and carve amalgams in a public health access setting
- allow coronal polishing
- change supervision for sealants to general supervision
- devise CODA educational standards and apply

Group B

- change supervision from direct to general for the following:
  - Radiographs and polishing clinical crowns
  - Fluoride and fluoride varnish
  - Dental sealants
- scope of practice: direct supervision: place and finish composites; place and carve restorations
  - Contour and cement stainless steel crowns

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- education: graduate ADA CODA DA program  
96 contact hours; add education in ADA CODA DA program
- credentialing received upon testing; 24 continuing education units every 2 years

Group C

- Asked the question if the changes were meant for private practice or health access settings and if the standards would be for all dental assistants or only graduates of accredited programs.
- Felt that the following duties should be under general supervision:
  - Medical history
  - Vital signs
  - Radiographs
  - Oral hygiene
  - Topical fluoride
- Felt the following duties should be under indirect supervision:
  - Polishing crowns
  - Sealants
  - Rubber dams
- Felt the following duties should be under direct supervision:
  - Place and finish restorations (with educational requirements) [change scope of practice]

Group D

- Legislation to establish restorative dental assistant
- accredited dental assisting education
- accredited course work (96 contact hours) after graduation
- The following duties under direct supervision:
  - Place and finish composite (slow speed on child then DDS finish with high speed) & Amalgam restorations
  - Contour and cement stainless steel crowns
- credentialing by DOH
  - Written rules and regulations test
  - Practical exam administered at the Dental Assisting program
  - Renew every 2 years
    - 24 continuing education credits
    - CPR certification

**Round 2 Discussion Period.**

Each small group presented its proposal to the workgroup as a whole. The Workgroup participants had the opportunity to comment and ask questions of each small group's proposal. The workgroup discussed the pros and cons of each proposal separately and as a whole.

Dr. Hoffman asked if the proposed restorative assistant is meant for public health settings or private practice

Dr. Kahler said that they would like to see it for both public health and private practice; however, in the past the FDA has been totally opposed to a program involving accreditation.

Dr. Hoffman stated that talking about creating a restorative assistant is another level of licensing of assistants which is a different ball game.

Dr. Morgan believes that would require a statute change.

Holly Kahler felt that FDA would oppose it across the board; without ADA, CODA education that it is not good.

Dr. Abel questioned why the Medicaid private practitioner could not benefit from the restorative assistant (?)

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Dr. Hoffman stated that there is fear that this may go across the board---use experienced assistants in a more controlled setting (public health).

Dr. Kahler presented that we reduce direct supervision to general for assistants; scope of practice to change; 96 contact hours and ADA CODA DA program be licensed just like a hygienist. Holly went on to say that dental assistants take the same classes as hygienists.

Tami Miller clarified that dental assistants sit in some of the same classes; but do not take all the same course work as hygienists. (Hygienists must attend an accredited program and they take 88 hours of course work---this was in one of the handouts that was given to participants.)

Nancy Zinser stated that certification takes place at the school of dental hygiene. This saves the state and maintains the integrity of the profession. Don't we want to ensure we have a dental team that is well educated and well qualified? Focus on that instead of whether FDA likes it or not.

Dr. Hoffman has problems seeing if this will work economically.

Dr. Catalanotto---CODA requirement---he is in full agreement---sealants---do not support general supervision---accepted indirect supervision

Dr. Pardo---wanted clarification; revisited the 96 contact hours---going back to school for people who are already assistants-not on the job training; only applies to new restorative dental assistants.

Dr. Kahler was asked to give an explanation of the various types of assistants in the state of Florida. She mentioned that the BOD approves proprietary schools who then charge \$6,000 for their assisting program; however, they don't teach them anything and dentists do not want to hire them. There are 28 CODA programs. The Dental Assisting National Board exam is about 300-400 questions. The restorative assistant would take a written exam on Florida Laws and a practical exam. 3 months of in office experience for radiographs. Apply for radiography certificate. Expanded functions certification course-may perform procedures in office; however, there is no verification of this.

Dr. Manning asked if there was anything proposed to try to eliminate other forms of dental assistants and how does this (increase access (?))

Dr. Kahler said that they were not looking to eliminate other forms of dental assistants; this would just be a different avenue for assistants to take. 5 assistants could come in after the dentist examines to perform work, so it would increase access to care.

Dr. Hoffman asked if a restorative assistant benefits a program like Inge's (?)

Dr. Catalanotto responded that the military does it that way.

Nancy Zinser felt that it can increase production in a public health setting.

Dr. Abel---restorative assistant and hygienists---scope collide?

Amy Cober asked if the number of operatories will need to be increased(?)

Dr. Morgan felt we should move for hygienists in public health settings; hygienist in school with portable equipment; 96 hours in CODA approved program after graduating from a CODA approved dental assisting program with 24 continuing education hours every 2 years.

Dr. Morgan stated that it may take legislative changes, changing the scope of practice and creating a new license. Do we create the position globally? Or do we just have it in public health?

Nancy Zinser stated that a nail tech has more requirements of which they have to uphold than a dental assistant. These changes would make it a more attractive profession with standards.

Dr. Ford felt that it would be an incentive for restorative assistants as public health pays pittance!

Dr. Kahler put forth the question would this group support putting this forward globally.

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Dr. Pardo felt that we should push for public health setting first.

Dr. Hoffman felt we stay with public health setting; if it is passed for globally, assistants will go past public health and go right to private practice.

Dr. Catalanotto thinks it is an economically feasible model. Approve it and let the market place prove or disprove.

Dr. Morgan stated that some people will enter public health because it is an esteem builder---not necessarily for the money.

Tami Miller stated that a restorative assistant could increase production 10-15%

It was asked if there is any public comment(?)

Bob McDonald was on the call; said he had no comment.

### **Consensus**

Dee Jeffers asked if there were any points of consensus and if the workgroup could decide upon a consensus proposal. The following is the consensus of the Workgroup:

- The proposal is to establish a new form of dental assistant in Florida – a “Restorative Dental Assistant”
- Proposal is limited to Health Access Settings as defined in Florida statute
- To become a restorative dental assistant, an assistant must have received their dental assisting education and training from a Commission on Dental Accreditation (CODA) approved program
- To become a restorative dental assistant, an assistant must complete 96 additional contact hours of training at a CODA approved program
- To become a restorative dental assistant, an assistant must pass a credentialing exam – pass Florida rules and regulations exam and a practical exam
- Restorative dental assistants must complete 24 hours of Continuing Education (CE) every 2 years
- Applicants for restorative dental assistant credentialing must apply to and register with (including paying a fee) the Board of Dentistry for certification or licensure
- Such a restorative dental assistant will be able to perform the following duties under the listed supervision levels:
  - General Supervision
    - Review and record medical history.
    - Take and record vital signs.
    - Perform preliminary charting and visual assessment of existing oral conditions.
    - Position and expose radiographic film and sensors.
    - Instruct and supervise patients in oral hygiene care.
    - Apply topical fluorides including fluoride varnish.
    - Place dental sealants.
    - Polish clinical crowns of teeth.
    - Place and remove rubber dam.
  - Direct Supervision
    - Place and polish composite restorations - WITHOUT THE USE OF A HIGHSPEED HANDPIECE
    - Place and carve amalgam restorations - WITHOUT THE USE OF A HIGHSPEED HANDPIECE
    - Contour and cement stainless steel crowns.

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- Changes should be made statewide if at all possible (e.g. if Board can make changes) vs. piloting programs (which may be an avenue that needs to be pursued if changes have to occur through the Legislature)
- Need to check with legal council (Board) to see if the Board can make such proposed changes or if these changes will need to be legislated by statutory change?
  - Since proposing a new restorative dental assistant creates a “new” dental provider, such change would probably have to occur through statutory change through the Legislature

The public was invited to make comments and there was no further comment.

### **Moving Strategies Forward and Champions**

Karen Miller asked: what is the next step?

There was discussion among the Workgroup about what would happen next regarding the proposals and how best to move these proposals forward. Dr. Manning mentioned that all consensus strategies and proposals of the workgroup would be written into the Strategic Plan. This strategic plan would be distributed to HRSA, Florida policymakers including the Governor’s office, and would be available to the public. As DOH cannot advocate or lobby, specific strategies and proposals that require policy change would have to be moved along by a champion (from the Workgroup?) or come as a request out of the Governor’s office or DOH’s office of the Deputy Secretary which handles policy requests for the DOH.

Dr. Fisher asked if this shouldn’t come through the governor’s office.

Nancy Zinser felt that the Surgeon General should be solicited to move the recommendations forward.

Dee Jeffers mentioned that as an advocate for groups we should get a legislator to champion and sponsor a bill.

Dr. Catalanotto recommended that we get a lobbyist to draw a bill and get coalitions behind it.

Dr. Manning: part of strategic plan is identifying steps. A report will go to HRSA and DOH and up the chain in DOH. Individual organizations need to get together and propose legislation if needed and support..

Amy Cober inquired if dental hygiene needs legislative action.

Dee Jeffers recommended we get children’s service council on board

Nancy Zinser asked does one initiative support the other - do we really need to separate?

Dr. Pardo felt the issues need to be separated as together it may seem overwhelming.

Dr. Hoffman believes if there is an unforeseen flaw in one, it will bring the other down.

Dr. Catalanotto -going through with legislation (that includes FDA support) is a long, tedious, methodical process. Lobbyists need to be getting together NOW to move things along.

Dr. Morgan mentioned that FNDC meets in June and inquired if FDA could approve a matrix that supported the proposals?

Dr. Hoffman stated that it would take too long---the earliest to get house approval would be January 2010 for a full bill.

Dr. Catalanotto said that’s OK—it gives us a tangible target.

Tami Miller said that FDHA met with FDA at Advocacy Day and FDA looked at some of FDHA language. FDHA has been working openly with FDA for the past couple of years.

### **Schedule**

Dr. Manning went over the schedule for future meetings.

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The grant ends August 31, 2009. We have funding for 2 face-to-face meetings. Dates of June 5 or 26, 2009 in Tampa and August 7<sup>th</sup> in Gainesville of 2009 were offered. Dr. Hoffman as well as Dr. Catalanotto stated that they would not be available for June 5<sup>th</sup>.

**Topics and Guest Participants**

For the next conference do we want to stay centered on 1 topic or have 3 or 4 topics?

The majority felt it is better to limit topics.

Guest speakers were discussed. We had talked about Shelly Gehshan and someone mentioned Tammy Bird (South Carolina).

The meeting was adjourned at 3:47 PM

The public was invited to make any final comments. As there were none, the meeting was adjourned at 3:47 PM