WASHINGTON STATE BOARD OF HEALTH

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Health Impact Review Request Form

Date of request: 7 / 31 / 2014

Requester: Representative Eileen Cody

Note: Health impact reviews may only be requested by the Governor or a legislator.

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What is the subject of the Health Impact Review?

☒ **Bill** Number: 2321 Title: Concerning Mid-level Dental Professionals

☐ **Bill Draft** Draft Number:

☐ **Decision Package**

☐ **Budget Proposal**

☐ **Other:** ____

If possible, please attach a copy of the relevant portion/aspect of what you are requesting to be reviewed.

Should the Health Impact Review analyze the entire proposal or only a portion?

☒ **Entire** ☐ **Portion**

If only a portion, please describe what portion(s) the review should analyze.

Requested completion date: 10 / 30 / 2014

If requesting less than a ten-day turnaround during session or less than a 60-day turnaround during the interim, please explain the reasons for the request (for example, needing a review completed in time for a committee hearing).

Please consider completing the optional section on the back of this form, which will give the Board a sense of why this review has been requested.

Washington State Board of Health
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*~ **Optional** ~*
Please consider completing this optional section, which will give the Board a sense of why this review has been requested.

***NOTE:** When conducting a health impact review, the Washington State Board of Health will consider various ways that a proposal might exacerbate or ameliorate health disparities. Completing this section will give the Board a head start by helping it understand the reasons why a review is being requested.*

Briefly describe how you think the proposal might impact health disparities and whether you believe the impact will be in a positive or negative direction.

At its core, the purpose of this proposal is to reduce health disparities by increasing access to oral health care through the establishment of a new category of oral health providers to work with dentists as part of the dental team called mid-level providers. We believe this model offers a sustainable solution to our state's oral health crisis by making care more affordable, location-efficient, and sustainable. As the socio-ecological model and public health research demonstrate, community-level factors such as access to education and living-wage employment also impact health equity. This bill operates at the community level, as well as the individual and family-levels by establishing an accessible education track to becoming a dental therapist. Establishing mid-level providers is an evidence-based model that is currently working in several states to increase access to oral health care and reduce disparities as the case studies mentioned below demonstrate.

Individual and Family Impact: This proposal stands to reduce existing inequities in oral health by increasing access to affordable care, making care more, geographically, and culturally accessible for children and families. In addition to treating oral health problems, the mid-level provider model supports routine and preventive dental care by making available regular lower cost, community-based routine preventive and restorative care. Additionally, the proposal supports sustainability because it increases the likelihood that providers will be from the community and in turn provide services that are consistent and culturally responsive and relevant. When patients receive regular, culturally competent services they are more likely to build relationships and sustain their care with that provider.

Community Impact: This proposal includes an education model through a technical degree program, which students can pursue without having to obtain a bachelor's degree. We believe that the education model is important because it makes the profession more accessible to communities that face barriers to attaining a 4-year education (due to cost and other factors). This education model has been used successfully in Alaska for the last 10 years and around the world for the last 90 years. We also believe that this will increase patient access to culturally competent care and will not only foster trusting, sustainable relationships between provider and patient, but also encourage future generations to pursue this profession (because when your health care provider looks like you, you are more likely to believe that their career is within your reach). As a result, we anticipate that the proposal will positively impact health disparities at the community level by increasing economic growth, access to education, and community trust in service providers.

Case Studies: We have seen great health and economic impacts in rural communities, such as those in Alaska, where mid-level providers have been utilized for 10 years. This year, report from Alaska showed that the first 17 dental therapists generated $9.7 million in economic activity for the rural communities served by this provider. This will have a great impact on not just health disparities but also the social determinants of health in those rural communities. As we have seen in Alaska, this provider creates jobs, educational opportunities, and improves oral health and overall health in communities that previously had barriers to jobs, education, and oral health services.

This provider has been utilized in Minnesota since 2009. Communities are seeing an increase in providers that take Medicaid and access to oral health services. Additionally, patients report reduced travel times and wait times to see their providers; these findings are particularly pronounced in rural communities. Clinics report (from multiple seetings including private practice and clinic based care) increased patient satisfaction, cost-saving, higher productivity and enhanced capacity to treat underserved and public programs patients. These existing case studies offer us an opportunity to glean the potential long term impacts of this proposal.

Are there specific organizations or community groups you would like the Board to contact as part of this review if time allows?

We recommend the board utilizes the existing data and information from Alaska and Minnesota in their review. If time

allows, you should consider speaking with mid-level providers and patients from diverse communities in these states. Included are studies done by Minnesota and Alaska on their mid-level provider programs. The educational institutions that provide the technical education for this model may offer helpful information including Ona U. Canfield, RDH, Ed Director, Dental Hygiene Program, Seattle Central Community College and Ruth Ballweg, MPA, PA-C, Professor; Senior Advisor for Advocacy, Health Policy & Global Development, University of Washington MEDEX and DENTEX program. This University of Washington program currently educates the Dental Health Aide Therapists in Alaska. Talking to supportive local and national dentists will be very valuable. We have attached contact information for Dr. Lyle McClellan DDS, Director of Doctor Development for Willamette Dental Group, Dr. Rachael Hogan DDC, Dental for the Swinomish Indian Tribal Community, Dr. Mary Williard DDS, Director of the Dental Health Aide Therapist Program for the Alaska Native Tribal Health Consortium in Anchorage, Dr. Frank Catalanotto, D.M.D., Department Chair, University of Florida School of Dentistry, Department of Community Dentistry and Behavioral Health Additionally, in Washington State, we recommend you contact communities most impacted by existing barriers to oral health care, including tribes that have been working to establish mid-level provider models. The Swinomish tribe as well as the Northwest Portland Area Indian Health Board is very knowledgeable about this provider and the bill. Lastly, for more in depth information regarding this issue, you may contact the Washington Dental Access Campaign.