



Washington
DENTAL ACCESS
Campaign

Tera Bianchi, MSW
Oral Health Access Project Manager
Children's Alliance
718 Sixth Ave S, Seattle, WA 98104
Staffer of the Washington Dental Access Campaign

My name is Tera Bianchi and I am the Oral Health Access Project Manager for the Children's Alliance.

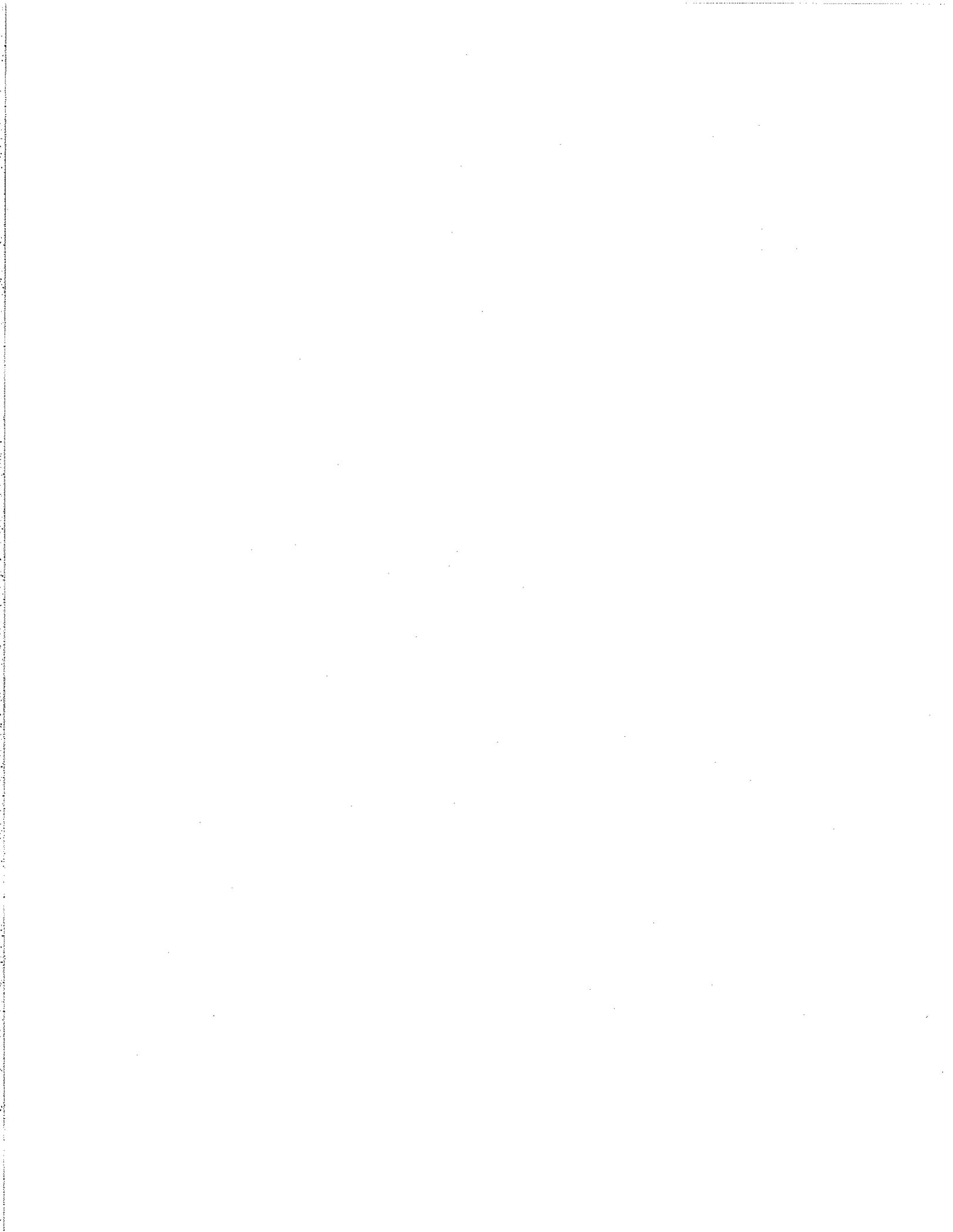
Children's Alliance is a statewide advocacy organization based in Seattle, Washington. We have a 30 year history of working with community partners to ensure laws, policies, and programs work for children and their families. Our experience shows that effective policies and programs are informed by cross-sector, diverse groups of stakeholders, including populations directly affected by public policies.

Children's Alliance convenes the Washington Dental Access Campaign which includes over 40 groups, including health care associations, community advocacy groups, dental practitioners, educational institutions and Tribal governments. The campaign is working to bring Washington State new, evidence-based dental health care practitioners based on the Alaska and Minnesota dental therapist models. A list of members and additional information about the campaign is available at www.wadentalaccess.com. Washington is one of many states across the country looking at emerging oral health workforce models as a key strategy to increase access to oral health care for underserved communities.

Thank you for your work to improve access to oral health care and for inviting feedback from communities on the Washington State Board of Health Recommended Strategies to Improve the Oral Health of Washington Residents. We are requesting that the Board add language to the Workforce section of the Recommended Strategies to include the exploration of evidenced-based workforce models that will expand access to care.

There is diverse and growing support for exploring evidence-based workforce models to expand access to oral health care. With the vision of creating a more comprehensive delivery system, the Institute on Medicine (IOM) issued a report; "Improving Access to Oral Health Care for Vulnerable and Underserved Populations".¹ Among the recommendations of the report was that State legislatures should amend existing state laws, including practice acts, to maximize access to oral health care. The 2009 *Washington State Oral Health Workforce Report* from the University of Washington similarly recommended exploring the introducing of new types of providers such as dental therapists and other emerging workforce models.

Equity in access and oral health outcomes for underserved populations should be a paramount focus for all intervention strategies, including workforce. Kids from low-income families in Washington



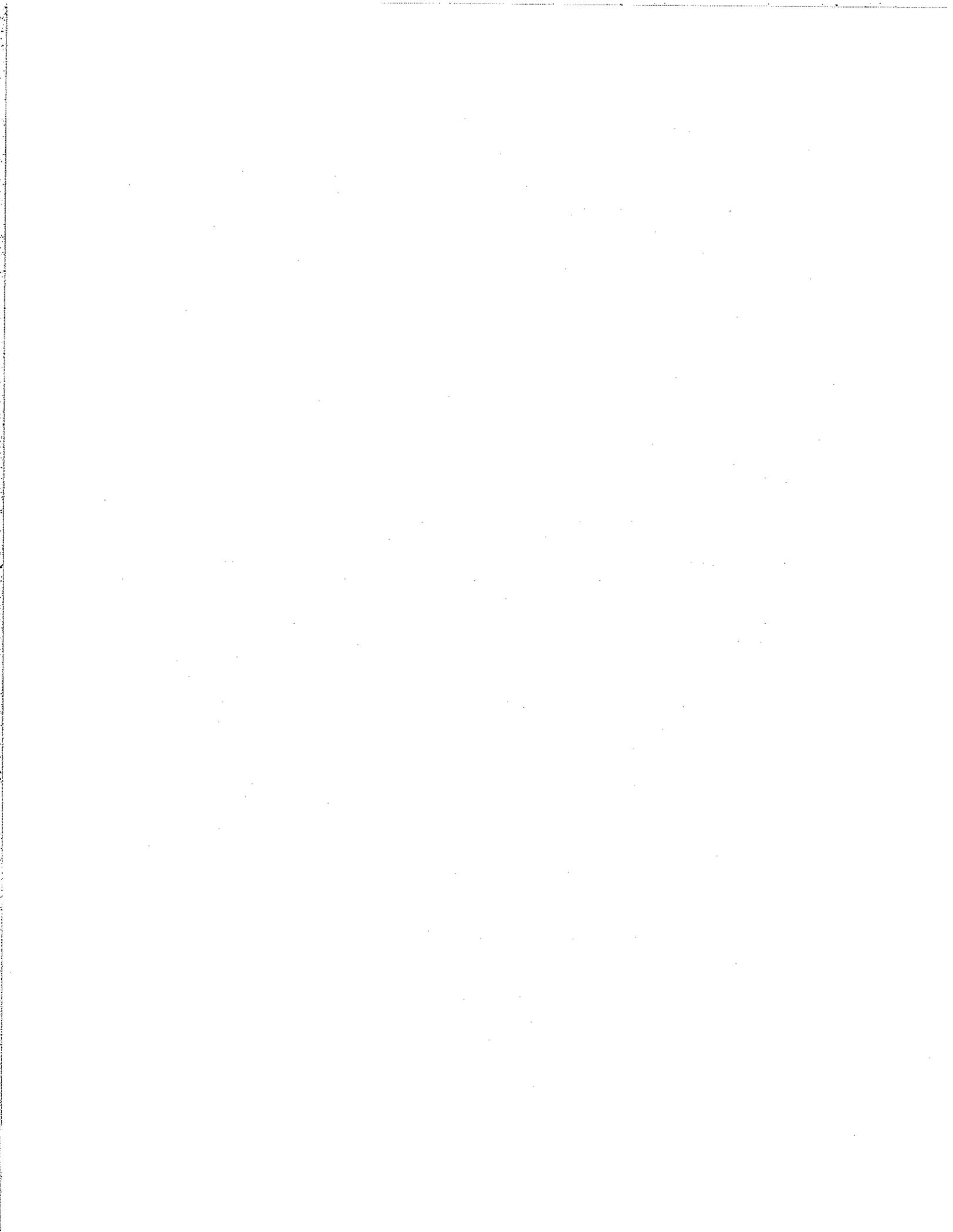
are 44 percent more likely to have untreated cavities and kids of color are 18 percent more likely to have untreated cavities by the third grade. Children of color have twice as likely to have untreated decay (difficulty in accessing dental care) as White Non-Hispanic children.² And children in Washington fare far better than adults. A study by the Washington State Hospital Association found that dental related issues are the number one reason uninsured people visit the emergency room and a leading reason for ER visits by people on Medicaid. These dental emergencies accounted for 54,000 ER visits in Washington, and over \$35 million in expenditures between January 2008 and June 2009.³

Dental auxiliaries, known as dental therapists, have been working safely in the United States for eight years and are a well-established member of the dental team in over 50 countries. A 2012 literature review showed that dental therapists increase access to high quality, cost-effective care.⁴ The American Dental Association's subsequent literature review confirmed populations served by dental teams that included dental therapists were able to extend care to more people than dental teams without dental therapists (ADA, 2013).

While increased access to care is the driving force of the Campaign, there are also compelling economic arguments that are important for states and dental practices that are struggling to meet the needs of low-income families. Last month Community Catalyst released a report that examines three practices in Minnesota and one in Alaska that are employing dental therapists.⁵ This is the first study that examines actual dental practices employing dental therapists in the United States. The analysis shows that dental therapists have increased access to care for 40,000 Alaska Natives and in Minnesota, 78% of the patients being treated by dental therapists are enrolled in Medicaid. The report not only confirms that dental therapists are effectively and safely providing routine and preventive care, it also demonstrates that dental therapists are cost-effective. In fact, dental therapists' salaries in both states account for less than 30% of the revenue they generate. Even factoring in 60% overhead costs and a high number of patients enrolled in Medicaid, the study finds that dental therapists are still generating excess revenue for the practices where they work.

The evidence-based Alaska dental therapist program is one of the most successful and innovative examples of a recruiting, training and employing culturally competent oral health practitioners. Providers are successfully increasing access to people using a shared language and cultural norms. While Washington is not Alaska, we can derive lessons from this program that is safely and successfully recruiting, hiring, training and deploying community based providers, under the off-site supervision of dentists, to the most remote areas of the country.

The University of Washington⁶ works in partnership with Alaska Native Tribal Health Consortium (ANTHC) to train Alaska's dental therapists successfully in 3,100 hours, or approximately 2 years. The evidence overwhelmingly shows that dental therapists trained through this program, and similar programs, are able to provide safe, competent, and appropriate care. Colleges in Washington State have examined the successful education programs in Alaska and Minnesota, developing a dual path to achieve dental therapy training: a path based on the evidence of the Alaska DHAT program with career laddering that allows for an optional pursuit of a baccalaureate degree; and a path for Registered Dental Hygienists.



For the foregoing reasons, we hope that you will support this critical strategy to improve the oral health of Washington residents by adding the following language in the Board's proposed strategies under workforce:

Explore New Ways to Use Allied Health Dental Providers and Alternative Dental Providers to Increase Dental Treatment Capacity and Efficiency: Explore increasing dental hygienists' ability to provide certain services for underserved populations and the feasibility of introducing new types of providers such as dental therapists, community dental health coordinators and/or other new practitioners, would be useful for workforce planning.

This language is adapted from: **Washington State Oral Health Workforce Report** (2009), University of Washington found at: http://www.ws-ohc.org/plan/CHWS_FR130_Skillman.pdf.

Thank you again for making oral health access for underserved populations a priority.

Thank you,

Tera Bianchi

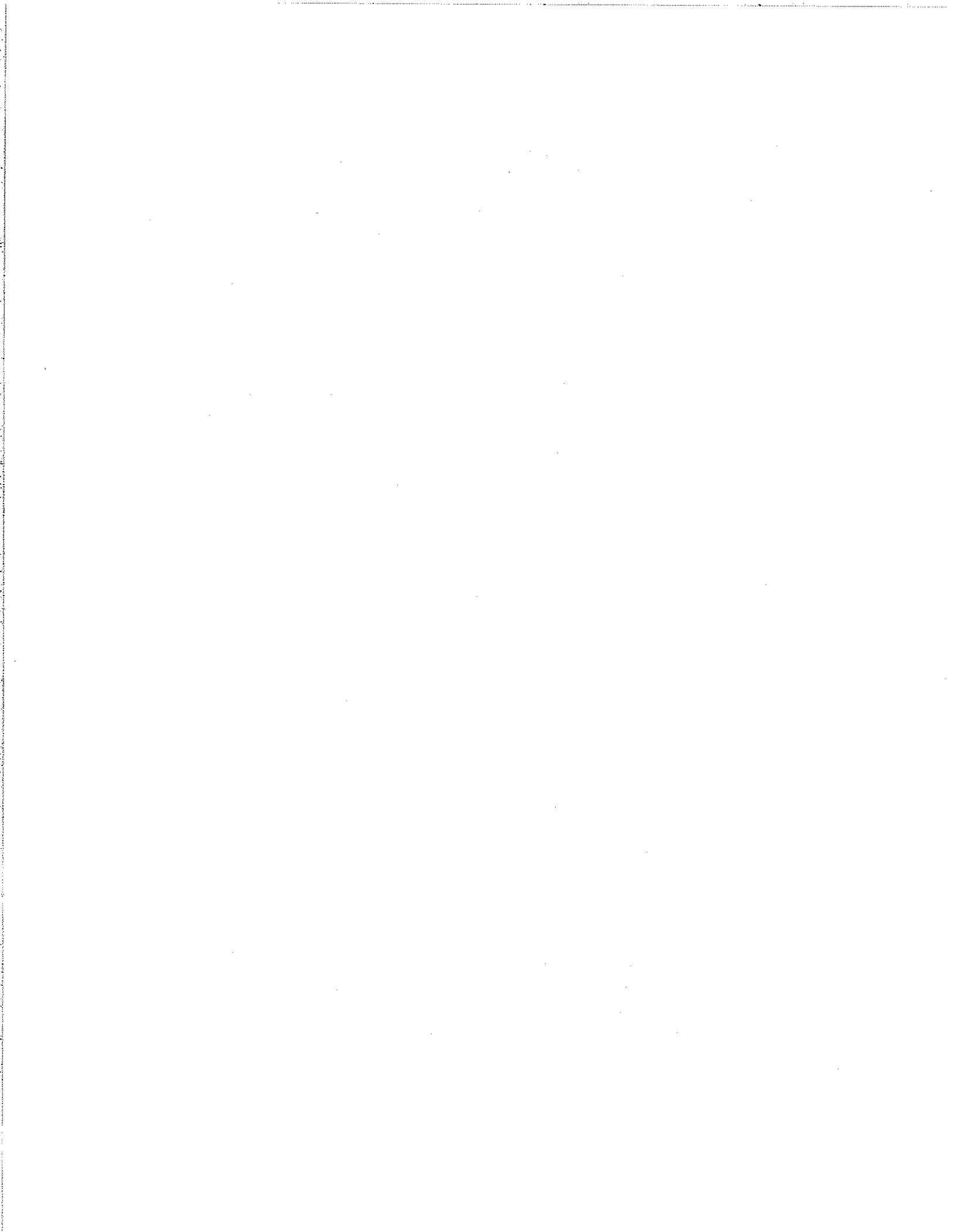
(1) Institute of Medicine Report. (2011). <http://www.iom.edu/~/media/Files/Report%20Files/2011/Improving-Access-to-Oral-Health-Care-for-Vulnerable-and-Underserved-Populations/oralhealthaccess2011reportbrief.pdf>
(2) Washington State Smile Survey. (2010). https://www.doh.wa.gov/Portals/1/Documents/Pubs/160-099_SmileSurvey2010.pdf
(3) Washington State Hospital Association. (2011). <http://www.wsha.org/0310.cfm>
(4) Dr. David Nash. (2012). <http://depts.washington.edu/dentexak/wordpress/wp-content/uploads/2012/10/Global-Literature.pdf>
(5) Dr. Frances M. Kim. (2013). <http://www.communitycatalyst.org/doc-store/publications/economic-viability-dental-therapists.pdf>
(6) University of Washington, DENTEX, Alaska Dental Therapist Training Program: <http://depts.washington.edu/dentexak/>

Additional Research on "Mid-level" Dental Practitioners

In 2012, an extensive review of the 1,100 documents from over 50 countries found that mid-level dental providers (MLP) provide safe, effective dental care. None of the 1,100 documents found any evidence of compromises to safety or quality of care. The following is a list of the major research organized by areas of proven outcomes:

They provide dental care as safely and effectively as dentists

- Abramowitz J, Berg LE. "A four-year study of the utilization of dental assistants with expanded functions." *Journal of the American Dental Association*. 1973; 87:623-635.
- Abrose ER, Hord AB, Simpson WJ. *A Quality Evaluation of Specific Dental Services Provided by the Saskatchewan Dental Plan*. (Regina, Canada: Province of Saskatchewan Department of Health, 1976).
- Bolin KA. Assessment of treatment provided by dental health aide therapists in Alaska: a pilot study." *Journal of the American Dental Association*. 2008; 139:1530-1535.
- Brearley LJ, Rosenblum FN. "Two-year evaluation of auxiliaries trained in expanded duties." *Journal of the American Dental Association*. 1972; 84:600-610.
- Fiset, L. *A Report on Quality Assessment of Primary Care Provided by Dental Therapists to Alaska Natives* (Seattle, WA: University of Washington School of Dentistry, 2005).
- Hammons PE, Jamison HC, Wilson LL. "Quality of service provided by dental therapists in an



experimental program at the University of Alabama.” *Journal of the American Dental Association*. 1971; 82:1060-1066

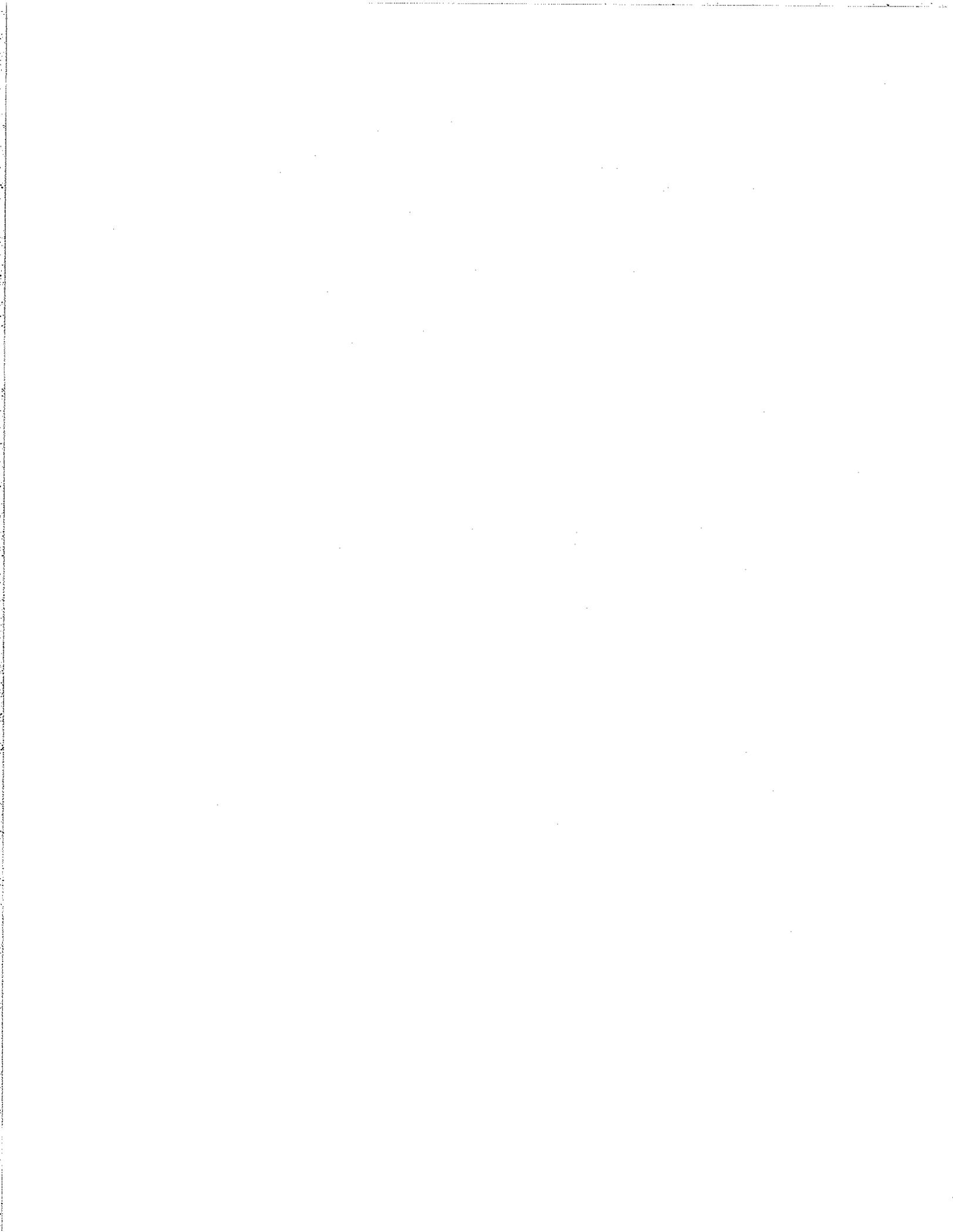
- Lobene R, Kerr A. *The Forsyth Experiment: An Alternative System for Dental Care* (Cambridge, MA: Harvard University Press, 1979).
- Lotzkar S, Johnson DW, Thompson, MB. “Experimental program in expanded functions for dental assistants: Phase 3 experiment with dental teams.” *Journal of the American Dental Association*. 1971; 82:1067-1081.
- Nash DA, Friedman JW, Kardos TB, Kardos RL, Schwarz E, Satur J, Berg DG, Nasruddin J, Davenport EG, Nagel RJ. “Dental therapists: a global perspective.” *International Dental Journal*. 2008; 58:61-70.
- Wetterhall, S., Bader, JD., Burrus, BB., Lee, JY., Shugars, DA. “Evaluation of the Dental Health Aide Therapist Workforce Model in Alaska.” RTI International. 2010. RTI Project Number 0211727.000.001.

Where they work as part of the team there is a decline in permanent tooth loss.

- Mertz E, Anderson G, Grumbach K, O’Neil E. “Evaluation Strategies to Recruit Oral Health Care Providers to Underserved Areas of California.” (San Francisco, CA: Center for California Health Workforce Studies, 2004).
- Miller CE. “Access to care for people with special needs: Role of alternative providers and practice settings.” *Journal of the California Dental Association*. 2005; 33, no.9:715-721.
- Nash DA, Friedman JW, Kardos TB, Kardos RL, Schwarz E, Satur J, Berg DG, Nasruddin J, Davenport EG, Nagel RJ. “Dental therapists: a global perspective.” *International Dental Journal*. 2008; 58:61-70.
- Nash DA, Nagel RJ. “Confronting oral health disparities among American Indian/Alaska Native children: The pediatric oral health therapist.” *American Journal of Public Health*. 2005; 95, no.8: 1325-1329.

The can reduce costs and increase net income for a dentist’s practice.

- Abramowitz J, Berg LE. “A four-year study of the utilization of dental assistants with expanded functions.” *Journal of the American Dental Association*. 1973; 87:623-635.
- American Dental Association “An Economic Study of Expanded Function Dental Auxiliaries in Colorado.” (2009).
- Lobene R, Kerr A. *The Forsyth Experiment: An Alternative System for Dental Care* (Cambridge, MA: Harvard University Press, 1979).
- Pew Center on the States. “It Takes a Team: How New Dental Providers Can Benefit Patients and Practices,” http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/State_policy/Report_It_Takes_a_Team_final.pdf (December, 2010).
- Pew Center on the States. “Expanding the Dental Safety Net: A First Look at How Dental Therapists Can Help”. http://www.pewstates.org/uploadedFiles/PCS_Assets/2012/Pew_Expanding_the_Dental_Safety_Net.pdf. (July, 2012).





Campaign for Dental Health

The Clear Weight of the Evidence: A Summary of Research Supporting Water Fluoridation

Decades of research confirm the benefits of water fluoridation. Some people may question the value of fluoridating water at a time when fluoride toothpaste is widely used and children can get fluoride treatments from dentists. The following peer-reviewed studies and reports answer this question because many of them were conducted within the past 20 years—when both fluoride toothpaste and fluoride treatments were widely available. This research demonstrates the crucial, added protection against tooth decay that fluoridated water provides:

It reduces the rate of tooth decay among children

- The U.S. Task Force on Community Preventive Services—a blue-ribbon panel of experts—examined 21 studies and concluded in its 2000 report that fluoridated water reduces tooth decay by a median rate of 29% among children of ages 4 to 17.¹
- A study of **Alaska** children (2011), conducted by the Centers for Disease Control and Prevention, showed that children living in non-fluoridated areas had a 32% higher rate of decayed, missing or filled teeth than kids in fluoridated communities.²
- A study of **Illinois** and **Nebraska** children (1998) found that the tooth decay rate among children in the fluoridated town was 45% lower than the rate among kids in the in the two non-fluoridated towns. This benefit occurred even though the vast majority of children in each of these communities were using fluoridated toothpaste.³
- A **Nevada** study (2010) examined teenagers' oral health and found that living in a community *without* fluoridated water was one of the top three risk factors associated with high rates of decay and other dental problems.⁴
- A study of more than 17,000 **Australian children** (2003) found that fluoridated water's "preventive effect was maximized by continuous exposure both before and after eruption (i.e., when teeth first appear in the mouth)." This finding refutes the claim made by fluoridation opponents that topical application of fluoride is the only effective way to use fluoride.⁵



It protects adults' dental health

- Nine studies were analyzed (2007) in the *Journal of Dental Research* to estimate water fluoridation's impact on adult teeth, and this report concluded that fluoridation reduced decay by 27%. The co-authors noted the study's significance for seniors because Medicare does not cover routine dental services and this lack of coverage "increases the need for effective prevention" of decay among older adults.⁶



It reduces disparities in dental health

- A 2002 study concluded that water fluoridation is “the most effective and practical method” for reducing the gap in decay rates between low-income and upper-income Americans. The study concluded, “There is no practical alternative to water fluoridation for reducing these disparities in the United States.”⁷
- A study in the *American Journal of Public Health* (2010) determined that the fluoridated water consumed as a young child makes the loss of teeth (due to decay) less likely 40 or 50 years later when that child is a middle-aged adult. The co-authors wrote that this study suggests that the benefits of fluoridation “may be larger than previously believed and that [fluoridation] has a lasting improvement in racial/ethnic and economic disparities in oral health.”⁸
- Australia’s National Health and Medical Research Council (2007) reviewed 77 studies and concluded that fluoridation “remains the most effective and socially equitable means of achieving community-wide exposure” to the decay-prevention effects of fluoride.⁹



It saves communities money

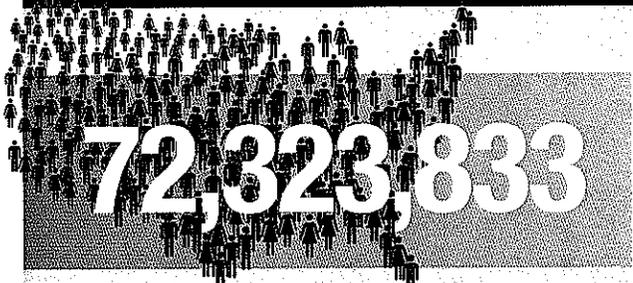
- A **New York** study (2010) revealed that low-income children in less fluoridated counties needed more dental treatments than those living in counties where fluoridated water was common. The annual treatment costs per Medicaid recipient were \$23.65 higher for those living in less fluoridated counties.¹⁰ A **Texas** study (2000) found that fluoridation saved the state Medicaid program an average of \$24 per child, per year.¹¹ Fluoridated water saved **Colorado** nearly \$149 million in 2003 by avoiding unnecessary treatment costs.¹²

Sources:

- ¹ “Preventing Dental Caries: Community Water Fluoridation,” U.S. Task Force on Community Preventive Services, (2000), <http://www.thecommunityguide.org/oral/fluoridation.html>.
- ² “Dental Caries in Rural Alaska Native Children – Alaska, 2008,” *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention, (September 23, 2011) Vol. 60, No. 37, 1275-1278, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6037a2.htm?s_cid=mm6037a2_x.
- ³ R.H. Selwitz et al., “Dental caries and dental fluorosis among schoolchildren who were lifelong residents of communities having either low or optimal levels of fluoride in drinking water,” *Journal of Public Health Dentistry*, (Winter 1998) Vol. 58, No. 1, 28-35, <http://www.ncbi.nlm.nih.gov/pubmed/9608443>.
- ⁴ M. Ditmyer, G. Dounis, C. Mobley and E. Schwarz, “A case-control study of determinants for high and low dental caries prevalence in Nevada youth,” *BMC Oral Health*, (2010), Vol. 10, No. 24.
- ⁵ K.A. Singh et al., “Relative Effects of Pre- and Posteruption Water Fluoride on Caries Experience of Permanent First Molars,” *Journal of Public Health Dentistry*, Vol. 63, No. 1, Winter 2003, <http://www.ncbi.nlm.nih.gov/pubmed/15541159>.
- ⁶ S.O. Griffin, E. Regnier, P.M. Griffin and V. Huntley, “Effectiveness of Fluoride in Preventing Caries in Adults,” *The Journal of Dental Research*, (2007), Vol. 86, No. 5, 410-415, <http://www.ncbi.nlm.nih.gov/pubmed/17452559>.
- ⁷ B.A. Burt, “Fluoridation and Social Equity,” *Journal of Public Health Dentistry*, (2002), Vol. 62, Issue 4, 195-255, <http://onlinelibrary.wiley.com/doi/10.1111/j.1752-7325.2002.tb03445.x/abstract>.
- ⁸ M. Neidell, K. Herzog and S. Glied, “The Association Between Community Water Fluoridation and Adult Tooth Loss,” *American Journal of Public Health*, August 19, 2010, <http://www.ncbi.nlm.nih.gov/pubmed/20724674>.
- ⁹ “NHMRC Public Statement: The Efficacy and Safety of Fluoridation 2007,” National Health and Medical Research Council of Australia.
- ¹⁰ J.V. Kumar, O. Adekugbe and T.A. Melnik, “Geographic Variation in Medicaid Claims for Dental Procedures in New York State: Role of Fluoridation Under Contemporary Conditions,” *Public Health Reports*, (September-October 2010) Vol. 125, No. 5, 647-54.
- ¹¹ “Water Fluoridation Costs in Texas: Texas Health Steps,” Texas Department of Health, May 2000.
- ¹² J.M. O’Connell et al., “Costs and savings associated with community water fluoridation programs in Colorado,” *Preventing Chronic Disease* (November 2005), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1459459/>.

Community Water Fluoridation by the Numbers

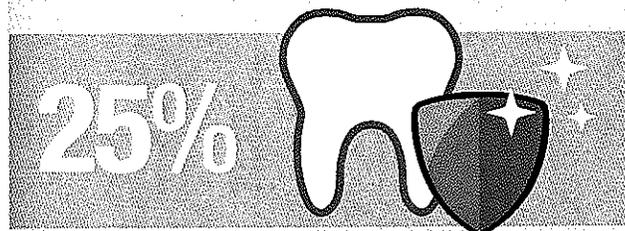
Millions of Americans do not have access to fluoridated water in their communities, leading to higher rates of tooth decay and greater costs to taxpayers. Fluoridation can reduce states' expenditures for emergency room care, Medicaid, and other public health services.



Number of Americans served by public water systems that do not provide fluoridated drinking water¹



Number of Americans treated at hospital emergency rooms in 2009 for preventable dental problems²



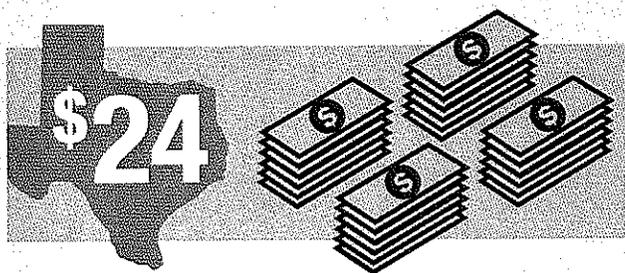
Estimated rate by which community water fluoridation reduces tooth decay throughout a person's lifetime³



Amount of money communities save for every dollar invested in water fluoridation⁴



Lifetime cost of treating one decayed molar⁵



Amount of money saved annually per child by the Texas Medicaid program as a direct result of water fluoridation⁶

¹ These data are as of Dec. 31, 2010, and are the most recent fluoridation census conducted by the Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, "2010 Water Fluoridation Statistics," accessed March 20, 2013, <http://www.cdc.gov/fluoridation/statistics/2010stats.htm>.

² The Pew Charitable Trusts, *A Costly Dental Destination: Hospital Care Means States Pay Dearly, 2012*, accessed April 4, 2013, <http://www.pewstates.org/research/reports/a-costly-dental-destination-85699379755>.

³ Centers for Disease Control and Prevention, "Fluoridation Basics," accessed March 11, 2013, <http://www.cdc.gov/fluoridation/benefits/background.htm>.

⁴ Centers for Disease Control and Prevention, "Cost Savings of Community Water Fluoridation," accessed March 20, 2013, http://www.cdc.gov/fluoridation/fact_sheets/cost.htm.

⁵ Cost is from Delta Dental of California's data of commercially insured patients (January-June 2012).

⁶ Texas Department of Health, "Water Fluoridation Costs in Texas: Texas Health Steps," May 2000, accessed March 11, 2013, <http://www.dshs.state.tx.us/dental/pdf/fluoridation.pdf>.

