BRIDGING GAPS IN WASHINGTON ORAL HEALTH CARE

EQUITY-FOCUSED, COMMUNITY-DRIVEN RECOMMENDATIONS

JUNE 2025

Prepared by:

Washington Oral Health Equity Task Force

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The **Washington State Oral Health Equity Task Force** was formed to address persistent gaps in oral health care, particularly for underserved communities. Supported by a $100,000 state grant (Fiscal Year 2025), the Task Force united experts from dentistry, public health, tribal clinics, and community organizations to review the 2023 Oral Health Equity Assessment and develop actionable recommendations for the state lawmakers.

Oral health disparities in Washington most severely affect lower-income families, communities of color, non-English speakers, and rural residents. These groups face steep barriers to dental care: high costs, limited or no insurance, too few providers, transportation problems, and lingering mistrust or fear rooted in past experiences. Many also lack access to fluoridated water, increasing their risk of preventable dental problems.

After surveying more than 100 community health and service providers, the Task Force found the biggest challenges are financial barriers, lack of insurance and/or insurance limitations, and a shortage of providers in rural areas. Providers called for higher Medicaid reimbursement rates, a stronger, more diverse dental workforce, and expanded community outreach to build trust and improve access.

The Task Force's recommendations are organized into three core pillars, all grounded in trust and authentic community partnership:

- Partner and engage communities to build trust and improve equity
- Remove barriers and expand access
- Reform systems and strengthen policy

Meaningful progress in oral health equity starts with investing in genuine relationships and building trust – listening to community voices, showing up where people are, and consistently following through on commitments. These efforts must also be matched by legislative action and adequate funding to make a real difference. The Task Force underscores a critical disconnect between the state's commitment to oral health equity and the resources currently allocated, especially for Medicaid and safety net programs. Achieving lasting change requires sustained investment, strong partnerships, and collective resolve. Only through ongoing collaboration and meaningful support can Washington ensure that every resident has access to affordable, high-quality dental care.

BACKGROUND

The Washington State Department of Health (DOH), in partnership with the University of Washington School of Dentistry, conducted the 2023 Oral Health Equity Assessment (OHEA).

The OHEA identified significant disparities in access to oral health care and fluoridated water across Washington communities and includes these recommendations:

1. The state must focus efforts to improve tap water fluoridation in counties with low fluoridation levels and oral health disparities.
2. The state's public health efforts should focus on communicating that tap water is safe.
3. Community-based education efforts should focus on the value of water fluoridation.
4. Additional research is needed to understand the views on tap water and fluoridation among communities disproportionately impacted by oral health disparities to help develop refined oral health equity strategies.

This report led the legislature to allocate a $100,000 grant to the **Center for Dialog & Resolution** (CDR) for the following purposes:

- **Convene** a task force, facilitated by the Center for Dialog & Resolution.
- **Review** the findings from the 2023 Oral Health Equity Assessment Report.
- **Identify** Washington communities experiencing the greatest oral health disparities.
- **Develop** recommendations for partnering with communities to address oral health disparities and providing accurate information about programs like community water fluoridation.
- **Submit** a report to the legislature by June 30, 2025.

WASHINGTON STATE ORAL HEALTH EQUITY TASK FORCE

The membership of the **Washington State Oral Health Equity Task Force** was curated from a variety of organizations, prioritizing subject matter expertise in community health, oral health, drinking water, and other related fields.

Washington State Oral Health Equity Task Force Membership
(*See Appendix A for more details on Task Force membership.)*

- **Derrick Dennis,** WA Department of Health, Office of Drinking Water
- **Luzmila Freese MA SID, MA COEX,** Latino Community Fund
- **Andrew Guillen MS**, Seattle Indian Health Board
- **Jesus Hernandez**, Family Health Centers
- **Rachael Hogan DDS,** Swinomish Dental
- **Mariah Kunz MPPA,** Arcora Foundation
- **Anni-Michele Jean-Pierre JD**, Children's Alliance
- **Lauren Johnson MPA,** Washington State Dental Association
- **Alison Mondi MPA,** Arcora Foundation
- **Lynnette Ondeck MEd, BSN, RN, NCSN,** Washington State School of Nurses
- **Foti Panagakos DMD PhD**, Pacific Northwest University of Health Sciences
- **Amanda Saxton MSW, MPA,** Washington Association for Community Health
- **André Ritter DDS, MS, MBA, PhD**, University of Washington, School of Dentistry
- **Santiago Valdez,** Washington State Dental Hygienists' Association
- **Sarah Vander Beek, DMD,** Washington State Healthcare Authority

Center for Dialog & Resolution Staff

- **Maralise Hood Quan**, Director, Facilitator
- **Heather Bidwell**, Communications, Co-Facilitator, Report Writer
- **Parker Hallof**, Business Development Project Coordinator

Recruitment challenges - *Recruiting oral and public health professionals for the 2024/2025 task force was challenging due to many factors. Many potential members were already overextended with multiple commitments and heavy workloads. Combined with an evolving public health landscape and shifting federal priorities, this strained capacity. Despite these hurdles, Task Force meetings were well-attended, proving members' strong commitment to oral health equity.*

Communities Experiencing Oral Health Disparities

The Task Force was asked to identify Washington communities facing the greatest oral health inequities, a crucial first step toward oral health equity.

The CDC Oral Health Report (2019), Washington's Smile Survey (2016) and the 2023 Oral Health Equity Assessment all reveal that oral health disparities are most severe in low-income households, Black, Indigenous and People of Color communities, non-English speakers, and rural residents.

To prioritize funding and decisions, the state of Washington should consider:

- **Social determinants of health:** Poverty, education, language, age
- **Geography:** Urban vs. rural, population density, transportation access/infrastructure, community water fluoridation, dental provider access
- **Health system factors**: Medicaid use, Smile Survey data, school absences due to oral health, ER visits for dental problems
- **Community engagement:** Needs assessments, partnerships with local organizations

While individual barriers may be manageable on their own, many residents face multiple, overlapping barriers that, when combined, make it difficult to obtain even basic oral health services. The Task Force recommends the state leverage integrated data dashboards to identify communities where these challenges converge and prioritize resources and interventions accordingly.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) such as poverty, education, language, and age are key drivers of oral health disparities. These factors shape the environments where people live, work, and age, directly affecting their access to care. SDOH rarely act in isolation; they intersect and compound, creating complex barriers that make it difficult for many individuals and communities to access dental care.

- **Poverty and income:** Lower-income households face greater oral health challenges due to limited access to preventive care, healthy foods, and dental insurance. Financial barriers, stigma, and concerns about culturally insensitive treatment, especially for those with state-funded insurance, often deter people from seeking care.
- **Education level:** Individuals with lower educational attainment generally have less oral health knowledge, lower health literacy, and fewer opportunities to access health-promoting resources.

- **Language:** Non-English speakers may experience difficulties navigating the healthcare system, understanding health information, and communicating with providers, all of which can limit access to quality dental care.
- **Age:** Both children and older adults are at increased risk of oral health issues. Children may lack access to preventive care, while older adults often face barriers related to mobility, fixed incomes, and increased medical needs.

GEOGRAPHY

Washington's diverse geography poses major barriers to oral health, especially for rural and underserved communities. Gaps in provider availability, limited public transportation, and inconsistent access to fluoridated water are compounded by factors like poverty and unemployment, particularly in remote areas. While these obstacles are not unique to Washington, there should be an active effort to find solutions that have proven effective in other areas to address these persistent problems.

- **Urban vs. rural disparities:** Urban centers have more dental professionals and specialized services, while rural areas face provider shortages, longer travel distances, and fewer preventive care options.
- **Low population densities:** Many eastern counties are "dental deserts," where low populations make dental practices unsustainable and force residents to travel far for care.
- **Transportation barriers:** Inadequate public transportation in rural and some suburban areas limits access for low-income families, seniors, people with disabilities, and those without vehicles, leading to missed or delayed care.
- **Community water fluoridation:** Only 56% of Washingtonians are on community water systems with optimal fluoridation, below the national average of 72%. This increases the rates of tooth decay and gum disease in those unfluoridated areas.
- **Cultural responsiveness:** Rural and underserved communities often lack access to culturally responsive dental professionals, which can discourage care-seeking and undermine trust in the healthcare system.

HEALTH SYSTEM FACTORS

Health system usage metrics often reveal where barriers to dental care are most acute. By using these metrics, Washington can strategically target resources for communities most in need.

- **Medicaid utilization:** In 2021, only 23% of Medicaid-eligible residents accessed dental services, despite having coverage. Many Washington counties are federally designated Dental Health Professional Shortage Areas, highlighting

widespread access issues. *(Washington State Department of Health, 2023; Washington State Health Care Authority, 2023)*

- **School absenteeism:** Oral health problems are a leading cause of school absences, signaling unmet dental needs and the broader impact on children's education and well-being. *(Journal of the American Dental Association, 2023)*
- **Emergency room visits:** High rates of ER visits for dental issues reflect severe access barriers and inefficient use of healthcare resources. Lack of routine care leads to costly, acute interventions, often treated with only pain relief/antibiotics.
- **Smile Survey data:** The Washington State Smile Survey tracks children's oral health, including tooth decay, treatment needs, and sealant coverage. The data also highlights disparities by income, race, ethnicity, and language.

COMMUNITY ENGAGEMENT

Direct engagement with community members offers critical insights into cultural, linguistic and trust-related barriers that quantitative data alone cannot capture. The 2023 Oral Health Equity Assessment underscores the value of this approach for designing effective interventions.

- **Community needs assessments:** Evaluating local needs ensures interventions address specific challenges, such as provider shortages, transportation barriers, or lack of preventive care awareness, rather than relying on assumptions.
- **Partnering with local organizations:** Collaborating with trusted community health centers, schools, and advocacy groups expands program reach, builds trust, and increases participation. These partners offer local credibility and help tailor solutions to community priorities.

Oral health disparities in Washington are shaped by the intersection of social, geographic, health system, and community factors. Data consistently shows that low-income households, Black, Indigenous, People of Color communities, non-English speakers and rural residents face the greatest barriers to care. These challenges are compounded by provider shortages, limited transportation, inadequate water fluoridation, and low Medicaid utilization. To close the gaps, Washington must prioritize resource allocation using integrated data dashboards that highlight where multiple barriers converge.

Oral Health Equity Community & Service Provider Survey

To inform state strategies for addressing oral health disparities, the Task Force developed a confidential online survey for community and service providers. The survey aimed to identify key barriers, service gaps, trusted messengers, and systemic challenges within dental programs.

SURVEY PARTICIPANT SELECTION

While surveying individuals directly affected by inequities was considered, the Task Force ultimately focused on oral health and community service providers due to:

- **Limited time and resources:** The temporary nature and budget constraints of the Task Force made deep community engagement and long-term, trust-based relationships unfeasible.
- **Contextual and political challenges:** Historical distrust and the current political climate hinder building meaningful partnerships with marginalized communities, especially within the framework of the Task Force's limited timeline and budget.
- **Anonymity concerns:** Ensuring true anonymity for community members was not possible with available resources.
- **Ethical considerations:** Engaging already burdened communities without a plan for sustained impact risked causing unintended harm.

Surveying community and service providers allowed the Task Force to gather actionable insights while respecting community boundaries and resource limitations.

SURVEY DESIGN AND IMPLEMENTATION

The **Oral Health Equity Community Health and Service Provider Survey** *(see Appendix B)* was distributed to community health providers and staff at organizations serving the public. Designed in a conversational style, the survey gathered qualitative insights and actionable recommendations, rather than quantitative data.

Value and limitations

Provider perspectives are helpful in identifying barriers and systemic challenges, but do not fully capture the diversity or needs of the communities themselves. Survey insights can inform outreach and system improvements but are not a substitute for direct community engagement.

The importance of authentic engagement

Meaningful progress toward oral health equity requires that community members have

opportunities to share their experiences and influence decisions. Sustained engagement is more attainable when feedback leads to visible, meaningful change.

Provider selection
The Task Force surveyed a diverse range of Washington providers, prioritizing those delivering frontline dental services and serving both urban and rural populations.

Examples of community health and service providers that completed the survey:

- **Nursing and school health services:** School nurses, district nurses, nurse managers, and registered nurses.
- **Dental professionals:** Dentists, dental directors, dental hygienists, dental assistants, dental therapists, dental clinic managers, people working in dental clinics, health centers and tribal health organizations.
- **Health program management and coordination:** Program managers, coordinators, dental operations and community health programs.
- **Executive leadership:** CEOs and executive directors leading health centers, community organizations and clinics.
- **Community and public health workers:** Community health workers, health educators, case managers, program specialists with public health departments, and community-based organizations.
- **Administrative and support roles:** Office managers, operations managers, and clinic administrators.
- **Advocacy and policy:** People working on policy, advocacy and funding development for health equity and access.
- **Education and training:** Faculty members, external learning specialists, coordinators involved in training and education.
- **Mental health and social services:** Mental health counselors, case coordination, and youth development.

Examples of organizations that responded to the survey: Tribal dental clinics, Federally Qualified Health Centers (FQHCs), Migrant Education Health Program, Access to Baby & Child Dentistry (ABCD) providers

A total of 108 community health and service providers completed the survey. To ensure confidentiality, all results are reported in aggregate, with no identifying details included. This approach protects privacy, aligns with ethical research standards and builds trust – encouraging honest feedback and ongoing participation.

RECOMMENDATIONS TO IMPROVE ORAL HEALTH EQUITY

The Washington Oral Health Equity Task Force was asked to provide recommendations to address oral health disparities. Drawing on extensive industry experience and survey input, the Task Force developed 11 actionable recommendations, organized into three core pillars.

TASK FORCE RECOMMENDATIONS

Partner and engage communities to build trust and improve equity

1. Establish a permanent Oral Health Equity Council with representation from communities experiencing oral health inequities.
2. Educate, empower and mobilize communities to champion safe water, fluoridation and oral health equity
3. Bridge gaps in care by co-locating dental services and fostering community-based partnerships.

Remove barriers and expand access

1. Restore and redesign Apple Health (Medicaid) dental benefits to strengthen provider networks, improve access, and align coverage with modern oral health therapies.
2. Expand and sustainably fund mobile dental units in rural and underserved areas.
3. Expand and diversify the dental workforce to meet community needs

Reform systems and strengthen policy

1. Expand access to preventive dental care and advance outcome-based models
2. Explore implementing school-based oral health screenings
3. Reinstate the Washington Department of Health State Dental Director
4. Develop and fund infrastructure grants to support community water fluoridation and safe drinking water
5. Establish a full-time state fluoridation technical assistance position

Partner and engage communities to build trust & improve equity

Equity cannot be achieved without authentic, ongoing partnerships with the communities most affected by disparities. Trust and relationship building are foundational to all reform. When communities are empowered as active partners, it leads to sustainable solutions and stronger systems that support the specific needs of the community. Long-term trusted partnerships leverage limited budgets and create greater ability for collaboration across funders, providers, policymakers, and community organizations, ultimately improving oral health equity and oral health outcomes for all.

RECOMMENDATIONS TO PARTNER AND ENGAGE COMMUNITIES TO BUILD TRUST AND IMPROVE EQUITY

1. **Establish a permanent Oral Health Equity Council with representation from communities experiencing oral health inequities.**
2. **Educate, empower and mobilize communities to champion safe water, fluoridation and oral health equity**
3. **Bridge gaps in care by co-locating dental services and fostering community-based partnerships**

1.) Establish a permanent Oral Health Equity Council with representation from communities experiencing oral health inequities.

OBJECTIVE: *Create a permanent Oral Health Equity Council with representation from populations experiencing oral health disparities. This Council will drive statewide oral health planning, policy, and implementation, ensuring ongoing engagement with impacted communities, providers, and policymakers.*

KEY ACTION(S):

- **Establish a permanent Oral Health Equity Council –** Enact legislation to establish the Council, including members with lived experience from underserved communities, oral health professionals, Tribal representatives, advocacy groups, educational institutions, payers, and community-based organizations. This Council develops and oversees a statewide Oral Health Equity Strategic Plan.

BENEFIT(S): A permanent Council ensures sustained, community-informed leadership and continuity across legislative cycles. It bridges the gap between decision-makers and those most affected, fostering trust, accountability, and measurable progress. Survey responses show a strong interest among providers and advocates for a collaborative platform to drive coordinated action. This approach aligns with best practices in public health and mirrors successful models like the Washington Traumatic Brain Injury Strategic Partnership Advisory Council.

2.) Educate, empower and mobilize communities to champion safe water, fluoridation and oral health equity

OBJECTIVE: *Advance oral health equity by building community knowledge, trust, and leadership to support safe water practices, evidence-based community water fluoridation, and equitable health outcomes. Address misinformation, reduce disparities, and ensure preventive measures benefit all Washington residents.*

KEY ACTION(S):

- **Increase state outreach funding –** Expand state investment in oral health initiatives to support the development and delivery of targeted, culturally relevant education campaigns about oral health equity, community water fluoridation, and drinking water safety.

- **Develop and implement a comprehensive public outreach plan –** Create and disseminate clear, evidence-based materials on oral health, community water fluoridation, and water safety tailored to diverse communities.

- **Partner with local leaders and organizations –** Collaborate with schools, Tribal communities, and trusted local organizations to engage residents, promote transparent communication, and share updated water quality and oral health data.

- **Mobilize subject matter experts and trusted messengers** – Engage local healthcare providers, oral health professionals, and community organizations to deliver accurate information, provide education, and advocate for community water fluoridation, especially in areas where misinformation and distrust exist.

BENEFIT(S): Increasing state outreach funding and supporting coordinated, community-led education efforts build trust, address misconceptions, and fosters public

acceptance of community water fluoridation and safe water practices. Leveraging trusted messengers and expert networks ensures outreach is impactful, culturally relevant, and responsive to local concerns, reducing disparities and improving oral health outcomes statewide.

3.) Bridge gaps in care by co-locating dental services and fostering community-based partnerships

OBJECTIVE: *Advance oral health equity by bridging gaps in care and building sustainable partnerships through community-driven outreach, co-location of dental services, and integration with trusted community programs.*

KEY ACTION(S)

- **Partner with trusted organizations** – Collaborate with schools, tribal clinics, community health centers, and local organizations to host health fairs, dental screenings, educational workshops, benefit fairs, and pop-up clinics – maximizing reach and building trust with underserved populations.

- **Co-locate dental services** – Integrate dental care into community-based settings such as food banks, schools, and primary care clinics to provide comprehensive, one-stop health services and reduce barriers to access.

- **Invest in school-based and integrated programs** – Support school-based dental clinics and medical-dental integration within health centers to ensure children and families receive preventive and routine care where they already access services.

- **Support medical-dental integration** – Promote interoperable health records, provider education, and patient awareness to strengthen the link between oral and overall health.

BENEFIT(S): Community-based outreach and co-location models are effective in engaging hard-to-reach populations, improving access, reducing disparities, and fostering trust. Integrating dental care into familiar settings increases preventive visits, enhances health outcomes, and addresses multiple needs efficiently, especially for those facing geographic, financial and social barriers.

Remove barriers & expand access

Persistent oral health disparities reveal that expanding access is not enough. Dental systems often fail to serve many, especially those covered by Medicaid and in underserved/unserved rural communities. Structural barriers such as low provider participation, inadequate reimbursement rates, geographic isolation, and limited coverage for preventive care mean that even when services are technically available, they are still out of reach for many. For some, the system itself is the barrier.

RECOMMENDATIONS TO REMOVE BARRIERS & EXPAND ACCESS

1. **Restore and redesign Apple Health (Medicaid) dental benefits to strengthen provider networks, improve access, and align coverage with modern oral health therapies.**

2. **Expand and sustainably fund mobile dental units in rural and underserved areas**

3. **Expand and diversify the dental workforce to meet community needs**

1.) Restore and redesign Apple Health (Medicaid) dental benefits to strengthen provider networks, improve access, and align coverage with modern oral health therapies.

OBJECTIVE: *Advance oral health equity by increasing access to dental care for Apple Health (Medicaid) enrollees, with a focus on strengthening provider participation, expanding preventive and comprehensive benefits, and addressing geographic barriers.*

KEY ACTION(S)

- **Restore dental funding –** Reinstate adult and child Apple Health dental benefit funding cut during the 2025 legislative session to maintain and expand provider participation.

- **Increase reimbursement rates –** Adjust Medicaid dental reimbursement rates to reflect the true cost of care, support provider sustainability, and incentivize more practices to serve Apple Health patients.

- **Expand adult dental coverage –** Include comprehensive, evidence-based preventive and diagnostic services in adult Medicaid dental benefits to reduce disparities and support overall health.

- **Redesign children's dental benefits –** Align children's dental coverage with the ABCD program and current best practices to ensure effective preventive and restorative care.

- **Subsidize transportation –** Provide transportation support or vouchers for dental appointments in rural and underserved communities to address geographic barriers and improve appointment attendance.

BENEFIT(S): Restoring and redesigning Apple Health dental benefits expands provider participation, increases access to care, and reduces oral health disparities. Higher reimbursement and comprehensive coverage support early intervention and better long-term outcomes. Addressing transportation and geographic barriers, especially in rural areas, improves accessibility. Aligning benefits with modern, evidence-based practices sustains providers and delivers better outcomes for Washington residents.

2.) Expand and sustainably fund mobile dental units in rural and underserved areas

OBJECTIVE: *Advance oral health equity by increasing access to preventive and routine dental care through mobile dental units, particularly in rural and hard-to-reach communities, while ensuring sustainable funding and strong community partnerships.*

KEY ACTION(S)

- **Expand mobile dental units –** Increase the deployment of mobile dental units in rural and underserved communities, ensuring Medicaid reimbursement fully covers operational costs to support sustainability.

- **Enhance technical assistance and partnerships** – Provide technical support to mobile dental units for stronger connections with local organizations and implement a referral system that ensures reliable, consistent follow-up care.

BENEFIT(S): Expanding mobile dental units reduces transportation and access barriers, increases the availability of preventive care, and fosters early detection and treatment, leading to fewer emergency visits and lower overall costs. Adequate

Medicaid reimbursement supports long-term sustainability of these services. Community partnerships and referral systems enhance continuity of care, build trust, and improve oral health outcomes for rural and underserved populations across Washington.

3.) Expand and diversify the dental workforce to meet community needs

OBJECTIVE: *Advance oral health equity in Washington by addressing persistent workforce shortages and disparities, especially in rural and underserved areas, through targeted expansion of workforce capacity, increased diversity, and strong clinical training pipelines. Ensure all communities have access to culturally competent, preventive, and routine dental care.*

KEY ACTION(S):

- **Increase training and incentives for midlevel providers –** Invest in training for dental hygienists, therapists, and assistants, and expand rural recruitment incentives such as loan repayment, tuition reimbursement, and housing support. Explore alternative workforce models such as Indian Health Service Expanded Functional Dental Assistant to strengthen career pathways and broaden preventive care access.

- **Expand dental education access through scholarships and loan repayment –** Provide scholarships and loan repayment to dental students and new graduates, prioritizing those serving high-need or rural populations, based on patient demographics rather than the practice setting alone.

- **Strengthen provider-educator partnerships –** Foster partnerships between dental providers and educational institutions to enhance clinical training, increase student exposure to diverse patient populations, and improve recruitment and retention in community health settings.

BENEFIT(S): Expanding and diversifying the dental workforce reduces persistent vacancies, especially in rural areas, and increases access to preventive and routine care for underserved populations. Financial incentives and training build a workforce that reflects community diversity and fosters trust. Strengthened provider-educator partnerships ensure a robust pipeline of dental professionals committed to serving all Washington residents.

Reform systems & strengthen policy

A strong system supported by effective policy can reduce barriers by expanding coverage and ensuring care is culturally responsive.

RECOMMENDATIONS TO REFORM SYSTEMS & STRENGTHEN POLICY

1. **Expand access to preventive dental care and advance outcome-based models**
2. **Explore implementing school-based oral health screenings**
3. **Reinstate the Washington Department of Health State Dental Director**
4. **Develop and fund infrastructure grants to support community water fluoridation and safe drinking water**
5. **Establish a full-time state fluoridation technical assistance position**

1.) Expand access to preventive dental care and advance outcome-based models

OBJECTIVE: *Promote oral health equity by increasing access to preventive dental services across the lifespan and incentivizing high-quality, patient-centered care through outcome-based insurance models.*

KEY ACTION(S)

- **Remove barriers to preventive care –** Eliminate age restrictions and frequency limitations on preventive dental services such as fluoride applications and sealants, ensuring all patients receive evidence-informed preventive care, regardless of age.

- **Adopt outcome-based insurance models –** Transition from fee-for-service to outcome-based dental insurance models that reward providers for delivering effective preventive care and achieving measurable improvements.

- **Expand coverage for preventive services –** Ensure dental insurance policies include comprehensive preventive benefits, such as regular screenings, fluoride treatments, sealants, and risk assessments for all ages.

BENEFIT(S): Expanding access to preventive care and shifting to outcome-based models reduces costly and complex oral health issues, lowers emergency visits, and improves patient outcomes. Removing coverage limits ensures better access to essential preventive services, while outcome-based reimbursement incentivizes providers to focus on prevention and long-term oral health.

2.) Explore implementing school-based oral health screenings

OBJECTIVE: *Improve oral health equity by requiring school-based oral health screenings alongside vision and hearing checks to detect dental issues early, enabling prompt treatment and reducing serious oral health problems.*

KEY ACTION(S)

- **Integrate oral health screenings into existing school-based vision and hearing checks –** Engage stakeholders to implement annual oral health screenings for elementary students statewide.

- **Establish referral pathways –** Connect students with dental needs to local providers and community resources for timely follow-up care.

- **Monitor and evaluate outcomes** – Collect and analyze data on screening results, referrals, and treatment completion to assess impact and inform continuous improvement.

BENEFIT(S): Adding oral health screenings to school health checks leverages established systems to detect dental issues early, increasing the likelihood of timely treatment and reducing the risk of serious oral health problems. Early intervention supports student attendance, reduces pain-related absences, and promotes better academic performance.

3.) Establish the position of Washington Department of Health State Dental Director

OBJECTIVE: *Improve oral health equity by increasing the capacity of the Washington Department of Health to lead and coordinate oral health programs and initiatives through a full-time State Dental Director.*

KEY ACTION(S)

- **Establish and codify the position of Washington Department of Health State Dental Director –** With sustainable, long-term, establish the position of State Dental Director and provide adequate staff and resources to effectively lead statewide oral health initiatives.

BENEFIT(S): A dedicated State Dental Director provides essential leadership for the development, implementation and evaluation of statewide oral health programs. This role advances oral health equity through policy and program oversight, fosters collaboration and partnerships, enhances public communication and advocacy, and supports workforce development. States with dental directors are more likely to have robust, up-to-date oral health plans. Establishing the position unifies efforts, reduces fragmentation, improves provider distribution, and drives equitable oral health outcomes in Washington.

4.) Develop and fund infrastructure grants to support community water fluoridation and safe drinking water

OBJECTIVE: *Improve oral health equity by ensuring all communities have access to the infrastructure, expertise and resources necessary for effective community water fluoridation and safe drinking water.*

KEY ACTION(S)

- **Establish a community water fluoridation grant program** – Create a grant program to fund infrastructure upgrades, installation, and operator training for public water systems to ensure proper administration and maintenance of community water fluoridation and drinking water safety.

- **Increase funding for the Drinking Water State Revolving Fund (DWSRF)** - Boost funding to support the DWSRF, enabling communities to replace or add fluoridation equipment and improve water treatment infrastructure.

BENEFIT(S): Combined grant and revolving fund investments enable communities, especially those with limited resources, to modernize water treatment facilities, train personnel, and maintain optimal fluoride levels. This improves oral health equity by preventing tooth decay across all populations and strengthens public health infrastructure for safe drinking water. Evidence shows that such investments yield significant public health benefits, cost savings, and economic stimulus, particularly in communities facing oral health disparities.

5.) Establish a full-time state Fluoridation Technical Assistance position

OBJECTIVE: *Enhance oral health equity and water safety by establishing a dedicated, full-time Fluoridation Technical Assistance position to provide expert guidance, oversee water operations, implement best practices, and address community concerns related to community water fluoridation and drinking water safety.*

KEY ACTION(S):

- **Create a permanent position for Fluoridation Technical Assistance –** Establish a full-time position within the Department of Health to provide technical support and training to water system operators statewide and ensure consistent and safe administration of community water fluoridation.

- **Conduct research and implement best practices –** Lead ongoing research and benchmarking of fluoridation best practices from other states to inform continuous program improvements.

- **Collaborate with oral health leadership –** Work closely with the State Dental Director and the Oral Health Equity Council to align technical assistance with broader oral health equity initiatives and strengthen community partnerships.

- **Lead responsive communication and outreach –** Oversee public communication efforts to address community concerns and misinformation about fluoride and drinking water safety through transparent, evidence-based outreach.

BENEFIT(S): Establishing a full-time Fluoridation Technical Assistance position ensures expert, consistent oversight and support for Washington community water fluoridation programs. The role enhances operator training and confidence, promotes best practices, and strengthens public trust through transparent, informed community

engagement. Coordinated efforts with the Dental Director and Oral Health Equity Council streamline public health initiatives, improve program reliability, and contribute to reducing oral health disparities statewide.

LOOKING AHEAD: THE PATH TO EQUITY

Achieving oral health equity in Washington requires not only policy change, but a sustained, community-driven effort to dismantle the complex barriers that exclude many residents from essential dental care. The findings of the 2023 Oral Health Equity Assessment and the survey input from 108 community health and service providers reveal the depth of these challenges and also provide practical, actionable solutions.

The Task Force's recommendations in this report offer a clear roadmap for meaningful progress. Establishing a permanent Oral Health Equity Council, restoring and redesigning Apple Health (Medicaid) dental benefits, expanding mobile and school-based clinics, growing a diverse dental workforce, and integrating dental and medical services are solid steps to address systemic inequities and build a more inclusive oral health system. Equally critical are investments in community water fluoridation, culturally responsive care, and public health education to counter misinformation and promote prevention.

Survey results (Appendix B) underscore the power of community-centered, culturally responsive care and trusted local partnerships. Respondents called for flexible, accessible services, such as evening and weekend hours, mobile clinics, and transportation support, alongside expanded Medicaid coverage, higher reimbursement rates, and streamlined insurance. Prevention and early intervention, workforce diversity, and addressing social determinants such as food access and language barriers were recurring priorities.

The wealth of data and practical suggestions from survey respondents can guide meaningful action and serve as a foundation for listening and partnering with communities most affected by oral health inequities. Frontline experiences offer important insights into what works and where gaps persist. Authentic, ongoing community engagement is essential to ensure that interventions are relevant and sustainable. By centering community voices and co-creating solutions, Washington can restore trust and make oral health care accessible to all, regardless of income, location, race or language.

Looking ahead – sustained investment and supportive policies can transform Washington's Oral Health landscape. The Task Force urges state leaders to prioritize long-term funding for Medicaid and safety net programs, invest in workforce development, and ensure timely, appropriate follow-up care. Through genuine, community-driven partnerships, collective resolve and shared vision, Washington can transform oral health equity, making it a reality for all residents.

ACKNOWLEDGEMENTS

We would like to express our sincere appreciation to all those who contributed to the work of the **Washington State Oral Health Equity Task Force** and the development of this report.

Washington State Oral Health Equity Task Force Members:

- **Derrick Dennis,** WA Department of Health, Office of Drinking Water
- **Luzmila Freese MA SID, MA COEX,** Latino Community Fund
- **Andrew Guillen MS**, Seattle Indian Health Board
- **Jesus Hernandez**, Family Health Centers
- **Rachael Hogan DDS,** Swinomish Dental
- **Mariah Kunz MPPA,** Arcora Foundation
- **Anni-Michele Jean-Pierre JD**, Children's Alliance
- **Lauren Johnson MPA,** Washington State Dental Association
- **Alison Mondi MPA,** Arcora Foundation
- **Lynnette Ondeck MEd, BSN, RN, NCSN,** Washington State School of Nurses
- **Foti Panagakos DMD PhD**, Pacific Northwest University of Health Sciences
- **Amanda Saxton MSW, MPA,** Washington Association for Community Health
- **André Ritter DDS, MS, MBA, PhD**, University of Washington, School of Dentistry
- **Santiago Valdez,** Washington State Dental Hygienists' Association
- **Sarah Vander Beek, DMD,** Washington State Healthcare Authority

Center for Dialog & Resolution Staff:

- **Maralise Hood Quan**, Director, Facilitator
- **Heather Bidwell**, Communications, Co-Facilitator, Report Writer
- **Parker Hallof**, Business Development Project Coordinator

The Washington State Oral Health Equity Task Force extends its deepest gratitude to the community health and service providers who generously shared their experiences and insights by completing the Oral Health Equity Community Provider Survey. Your dedication and frontline perspective were instrumental in identifying key barriers and opportunities within Washington's Oral Health Care System. The recommendations in this report are grounded in your real-world experiences and thoughtful reflections. Your voice is essential to advancing oral health equity in Washington.

We would also like to thank:

- **Donald Chi**, DDS, PhD, University of Washington, School of Dentistry
- **Teresa Guillien,** Resource Media
- **Shelley Guinn, MPH, RDH, BSDH, C-DPH** WA State Department of Health

REFERENCES

American Dental Association. (n.d.). *Medicaid*. https://www.ada.org/topic/Medicaid

American Dental Association. (n.d.). *Student loan reform* https://www.ada.org/advocacy/legislative-action-center/student-loan-reform

Arcora Foundation. (2024, August 21). *Access to Dental Care Dashboard.* https://arcorafoundation.org/access-to-dental-care-dashboard/

Arcora Foundation. (2024, August). *Apple Health Dental Program facts and figures FY 2008–FY 2022*. https://arcorafoundation.org/wp-content/uploads/2024/08/FY2022-Medicaid-Facts-and-Figures-Final.pdf

Benavides, E., Krecioch, J. R., Connolly, R. T., Allareddy, T., Buchanan, A., Spelic, D., O'Brien, K. K., Keels, M. A., Mascarenhas, A. K., Duong, M.-L., Aerne-Bowe, M. J., Ziegler, K. M., & Lipman, R. D. (2024). Optimizing radiation safety in dentistry: Clinical recommendations and regulatory considerations. *Journal of the American Dental Association,* 155(4), 280–293.e4. https://doi.org/10.1016/j.adaj.2023.12.002

CareQuest Institute for Oral Health. (2025). *State Oral Health Dashboard.* https://www.carequest.org/state-facts

CareQuest Institute for Oral Health. (n.d.). *Medicaid Adult Dental Coverage Checker.* https://www.carequest.org/Medicaid-Adult-Dental-Coverage-Checker

Chau, M. M., Ahmed, N., Pillai, S., Telzak, R., Fraser, M., & Islam, N. S. (2023). Community-based organizations as trusted messengers in health. *The Hastings Center Report,* 53(Suppl 2), S91–S98. https://doi.org/10.1002/hast.1529

Centers for Disease Control and Prevention. (n.d.). *About community water fluoridation*. https://www.cdc.gov/fluoridation/about/index.html

Flynn, B., Weninger Starkel, R., Zaborowski, M., & Vujicic, M. (2024, November). *Barriers to dental care among adult Medicaid beneficiaries: A comprehensive analysis in eight states* (Health Policy Institute Research Brief). American Dental Association. https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/barriers_Medicaid_participation_utilization.pdf

Gao, S. S., Yon, M. J. Y., Chen, K. J., Duangthip, D., Lo, E. C. M., & Chu, C. H. (2019). Utilization of a mobile dental vehicle for oral healthcare in rural areas. *International*

Journal of Environmental Research and Public Health, 16(7), Article 1234. https://doi.org/10.3390/ijerph16071234

Georgetown University Center for Children and Families. (n.d.). *Washington state profile.* https://kidshealthcarereport.ccf.georgetown.edu/states/washington/

Howe, G., Pucciarello, M., Moran, L., & Houston, R. (2021, February). *Moving toward value-based payment in oral health care.* Center for Health Care Strategies. https://www.chcs.org/media/Moving-Toward-VBP-in-Oral-Health-Care_021021.pdf

Indian Health Service, Division of Oral Health. (2017, August 28). *Evaluating the effectiveness of periodontal expanded function dental assistants.* https://www.ihs.gov/doh/documents/perio/Periodontal%20EFDA%20Study%20Report-IHS%20OCPS%20DOH-August_28_2017.pdf

Itriyeva, K. (2024). Improving health equity and outcomes for children and adolescents: The role of school-based health centers (SBHCs*). Current Problems in Pediatric and Adolescent Health Care*, 54(4), https://doi.org/10.1016/j.cppeds.2024.101582

Jackson, S. L., Vann, W. F., Jr., Kotch, J. B., Pahel, B. T., & Lee, J. Y. (2011). Impact of poor oral health on children's school attendance and performance*. American Journal of Public Health,* 101(10), 1900–1906. https://doi.org/10.2105/AJPH.2010.200915

Kentucky Department for Public Health, Oral Health Program. (2017, September). *Fluoridation surveillance (*Dental Public Health Activity Descriptive Report, Practice Number: 20001). Association of State and Territorial Dental Directors. https://www.astdd.org/bestpractices/DES20001KYfluoridationsurveillance-2017.pdf

Kranz, A. M., Preisser, J. S., Rozier, R. G., & Wang, X. (2018). Estimating the cost savings of preventive dental services delivered to Medicaid-enrolled children in six southeastern states. *Health Services Research*, 53(6), 4057–4079. https://pmc.ncbi.nlm.nih.gov/articles/PMC6153169/

Nasseh, K., Vujicic, M., & Yarbrough, C. (2019). A decade in dental care utilization among adults and children covered by Medicaid. *Health Affairs*, 38(7), 1119–1126. https://doi.org/10.1377/hlthaff.2018.05472

National Association of County and City Health Officials. (2018, January 29). *Strengthening community water fluoridation to prevent cavities.* https://www.naccho.org/blog/articles/strengthening-community-water-fluoridation-to-prevent-cavities

New York School-Based Health Alliance. (n.d.). *Oral health resources.* https://www.nysbha.org/oral-health-resources/

The Pew Charitable Trusts. (2014, June 30). *Expanding the dental team: Increasing access to care in public settings.* https://www.pew.org/en/research-and-analysis/reports/2014/06/30/expanding-the-dental-team

River Network. (2025, April 7). *State action on improving State Revolving Fund programs*. https://www.rivernetwork.org/state-policy-hub/water-funding/srf/

Ruff, R. R., et al. (2023). School-based caries prevention and the impact on acute and chronic student absenteeism. *Journal of the American Dental Association*, 154(8), 753–759. https://doi.org/10.1016/j.adaj.2023.05.007

University of Washington Center for Health Workforce Studies. (2024, August). *Washington's oral health workforce: 2024 update.* https://familymedicine.uw.edu/chws/wp-content/uploads/sites/5/2024/08/CHWS-FR-WOHW-2024-DH.pdf

Washington Health Workforce Sentinel Network. (2024, Spring). *Findings brief: Dentist offices/dental clinics.* https://wa.sentinelnetwork.org/wp-content/uploads/sites/2/2024/07/WASentinelNet_Dental_Brief_2024Spring-1.pdf

Washington State Department of Health. (2023). *Oral Health Equity Assessment.* https://doh.wa.gov/sites/default/files/2023-09/140265-OralHealthEquityAssessment.pdf

Washington State Health Care Authority. (2023). *Apple Health Dental Program Facts and Figures FY 2008–FY 2022*. https://www.hca.wa.gov/assets/program/apple-health-dental-facts-figures-2008-2022.pdf

Water Environment Federation & WateReuse Association. (2016, April 29). *The economic, job creation, and federal tax revenue benefits of increased funding for the State Revolving Fund programs.* https://watereuse.org/wp-content/uploads/2015/01/WEF-WRA-SRF-Economic-Impact-Study-Report-April-29-2016.pdf

Werts, M., Amah, G., & Mertz, E. (2020, September). How evidence-based *is US dental workforce policy for rural communities?* Oral Health Workforce Research Center, Center for Health Workforce Studies, School of Public Health, University at Albany, State University of New York. https://oralhealthworkforce.org/wp-content/uploads/2020/10/OHWRC_Dental_Workforce_Policy_for_Rural_Communities_2020.pdf

APPENDICES

A. Task Force Members

Proviso Specified Representatives	Organization	Name/Contact
(i) Three representatives from different organizations that represent individuals or underserved communities, including but not limited to children, seniors, African Americans, Latino Americans, Native Americans, Pacific Islander Americans, and low income and rural communities;	Seattle Indian Health Board (SIHB)	**Andrew Guillen** SIHB Chief Public Affairs Officer
	Latino Community Fund (LCF)	**Luzmila Freese** LCF Director of Community Programs
	Children's Alliance	**Anni-Michele Jean-Pierre** Senior Policy Director
(ii) One representative from the department of health;	Department of Health - Office of Drinking Water (ODW)	**Derrick Dennis** ODW Water Quality and Data Management
(iii) One representative from the University of Washington school of dentistry;	UW School of Dentistry (UWSoD)	**Andre Ritter** Dean of UW School of Dentistry
(iv) One representative from the Washington state dental association;	WA State Dental Association (WSDA)	**Lauren Johnson** WSDA Govt Affairs Manager
(v) One representative from the Washington state dental hygienists' association;	Washington state Dental Hygienists' Association (WDHA)	**Santiago Valdez** President of WDHA
(vi) One representative from the Washington state chapter of the American Academy of Pediatrics;	WA State Chapter of the American Academy of Pediatrics (WCAAP)	Vacant
(vii) One representative from a Washington tribe or tribal dental clinic;	Swinomish Dental Clinic	**Rachael Hogan** Swinomish Dental Director
(viii) One representative from a federally qualified health center or the Washington association for community health;	WA Association for Community Health (WACH)	**Amanda Saxton** Senior Policy Analyst
(ix) One representative from the Washington State Oral Health Coalition;	WA State Oral Health Coalition	**Sarah Vander Beek** HCA Dental Director

(x) One representative from a state-based oral health foundation;	Arcora Foundation	**Alison Mondi** Arcora Policy Director
		Mariah Kunz Arcora Policy Advocate & Analyst
(xi) One representative from a class A water system with at least 50,000 connections;		Vacant
(xii) One representative from a health care service contractor; and		Vacant
(xiii) One representative from an accountable community of health in eastern Washington and one representative from an accountable community of health in western Washington.	An accountable community of health in eastern WA	Vacant
	An accountable community of health in western WA	Vacant
Additional Stakeholders	PNWU School of Dental Medicine	**Foti Panagakos** Dean of PNWU School of Dental Medicine
	WA State School Nurses	**Lynette Ondeck** School Nurse Corps Administrator, NW Educational Service District
	Family Health Centers	**Jesus Hernandez** CEO of Family Health Centers
Proviso Language: In addition, members of the task force may include members from the legislature as follows:	The president of the senate may appoint one member from each of the two largest caucuses of the senate	Vacant
	The speaker of the house of representatives may appoint one member from each of the two largest caucuses of the house of representatives.	Vacant

B. Survey Questions & Findings

SURVEY QUESTIONS

Survey questions and a summary of the responses received. When needed, responses have been adapted for clarity and confidentiality.

Q1.) Provider name, job title

Q2.) What communities does your organization serve? We value you being as descriptive as you feel comfortable. If you prefer not to answer, please state that.

Q3.) Many factors can influence a person's ability to get accessible, affordable and equitable oral health care. From your perspective, what do you think are the most common factors influencing your community's access to oral health care?

Select the top three of these choices:

- Financial Barrier (cost/income)
- Insurance (lack of or acceptance of)
- Living in rural areas without providers
- Cultural barriers
- Language barriers
- Transportation gaps
- Limited access to healthy foods
- Other _____

Q4.) In your opinion, what can be done to make it easier for people in Washington to access affordable oral health care? [Open-text answer format]

Q5.) From your perspective, who do your community members TRUST to provide health-related information (oral or otherwise)?

Check all that apply.

- Dental office or clinic
- Family members
- Community health centers
- Schools
- Faith-based organizations
- Local government
- Employers
- Don't know
- Other_____

Q6.) For the organizations listed in question 5, who do you think are the trusted messengers (types of employees or positions) at these organizations? [Open-text answer format]

Q7.) In your opinion, what are the best ways to communicate about oral health to the communities you serve?

Check all that apply.

- Social media
- Community events
- Flyers or brochures
- Text messages
- Email
- Local newspapers
- Neighbor-to-neighbor
- Community gathering places (barber, restaurants, libraries, etc.
- Radio ads
- Other _____

Q8.) In your opinion, what oral health community programs and/or partnerships are SUCCESSFULLY providing oral health care services to communities experiencing health disparities? Please include the program(s) outcomes that you believe make it successful. [Open-text answer format]

Q9.) What are you currently doing to work against discrimination or bias as a community provider or community service worker? How are you working to engage in cultural humility? [Open-text answer format]

Q10.) During discussions about community water fluoridation, what are you hearing from the communities you serve? [Open-text answer format]

Q11.) In your opinion, what system or policy changes would have the biggest impact on improving oral health for the communities you serve? [Open-text answer format]

Q12.) The state of Washington is looking to partner with communities experiencing oral health disparities. Would you like to OPT-IN as a recommended community provider for future oral health equity conversations and updates from the state?

Q13.) If you answered "yes" to question 12 - THANK YOU! Please include your email address

SURVEY FINDINGS

Q1.) Provider name, job title

This question was optional and due to confidentiality, specific provider names and job titles will not be included in survey response data.

Q2.) What communities does your organization serve? We value you being as descriptive as you feel comfortable. If you prefer not to answer, please state that.

Both urban and rural communities

- Providers indicated they serve communities in both urban and rural areas including counties Chelan, Clallam, Clark, Cowlitz, Douglas, Grant, Grays Harbor, Island, King, Kittitas, Okanogan, Pacific, Pierce, Skagit, Snohomish, Spokane, Thurston, Wahkiakum, Walla Walla, Whatcom, Yakima, and others.

Communities and populations served by respondents

- **Children and youth –** Many respondents mentioned serving school-age children, including those in Title 1 schools, Head Start, Early Childhood Education and Assistance Program, and early childhood programs (ages 0-21).
- **Low-income and underserved populations –** There was a strong emphasis on serving low-income families, those with limited access to healthcare, and people who are uninsured or underinsured.
- **Racial and ethnic minorities –** Many respondents serve large populations of Hispanic/Latino, Black, Indigenous, Asian, Pacific Islander and other communities of color. Multiple respondents serve immigrant, refugee and non-English speaking families.
- **Specific populations –** Respondents serve veterans (and families), individuals experiencing homelessness, people with disabilities (developmental, physical, cognitive, etc.), seniors and older adults, individuals with behavioral health or complex medical needs, survivors of human trafficking, agricultural workers and migrant families, individuals re-entering society after incarceration, LGBTQ+ individuals, pregnant patients and people with addiction recovery needs.
- **Tribal and indigenous communities –** Respondents serve federally recognized tribes, often extending care to tribal members from across the region.

Other factors mentioned by respondents

- **Safety net providers –** Respondents referenced their services as being part of safety net clinics, offering care regardless of ability to pay and focusing on those with the greatest barriers to accessing oral health care.
- **Cultural humility and linguistic access –** Respondents emphasized interpretation services, in-language health education and culturally relevant care to reduce barriers to diverse populations.
- **Comprehensive services** – Services mentioned include dental, medical, and behavioral health care for all ages, often with a focus on early childhood and family health.

Q3.) Many factors can influence a person's ability to get accessible, affordable and equitable oral health care. From your perspective, what do you think are the most common factors influencing your community's access to oral health care? Select the top three of these choices:

- **Financial Barrier (cost/income)**
- **Insurance (lack of or acceptance of)**
- **Living in rural areas without providers**
- **Cultural barriers**
- **Language barriers**
- **Transportation gaps**
- **Limited access to healthy foods**
- **Other _____**

Respondents selected these factors, listed in order of most selected to least with the number of times each was selected.

- **Financial Barriers (Cost/Income) - 79 responses**
- **Insurance (Lack of or Acceptance) - 66**
- **Transportation gaps – 46**
- **Living in rural areas without providers – 45**
- **Limited access to healthy foods – 26**
- **Other – 25**
- **Language Barriers - 21**
- **Cultural Barriers – 16**

"Other" mentions include:

- **Scheduling conflicts –** Work, school and childcare obligations make it hard for families to attend appointments, especially if clinics aren't open on evenings or weekends.
- **Lack of accessible information –** When oral health information isn't provided in accessible formats or languages, or communication with providers is unclear, families may not understand the value of preventive dental care or how to access services.
- **Fear of trauma –** Negative past experiences, dental anxiety, and historical trauma discourage people from seeking care.
- **Staff and administrative barriers –** Provider shortages and complex requirements (like proof of residency or tribal enrollment) further limits access.

Survey responses highlight widespread, interconnected barriers to affordable, equitable oral health care. Systemic issues include insurance challenges, limited appointment availability (due to staff shortages or location), and clinics not offering evening hours. Socioeconomic factors, like transportation difficulties, inflexible work schedules, lack of paid time off, and the rising cost of living, play a major role. Respondents also noted distrust from past experiences and a lack of accessible oral health information, especially among Medicaid and uninsured populations.

Q4.) In your opinion, what can be done to make it easier for people in Washington to access affordable oral health care? [Open-text answer format]

Respondents provided detailed, complex answers that often underscored the need for comprehensive community-driven solutions around these central themes:

Expand access and reduce barriers

- **Mobile/school-based clinics:** Increase mobile dentistry and school-based programs to help families with transportation and scheduling challenges.
- **Extended and flexible scheduling:** Offer more evening/weekend appointments to accommodate work and school.
- **Transportation solutions:** Provide vouchers, ride shares, and improve public transit, especially in rural areas.

Insurance and financial support

- **Higher reimbursement rates:** Raise Medicaid rates to encourage more providers to accept public insurance.

- **Streamline insurance:** Simplify administrative processes and patient enrollment.
- **Flexible payment:** Offer sliding scale fees and payment plans for low-income families.

Workforce and provider availability

- **Recruitment/retention:** Recruit more providers in rural/underserved areas through local incentives and expanded training.
- **Mid-level providers:** Expand roles for dental therapists, hygienists and assistants to increase workforce capacity

Cultural humility and linguistic access

- **Language access:** Provide interpretation, multilingual materials, and cultural competency training.
- **Community outreach and education:** Increase outreach to immigrant, refugee, and underserved communities to boost health literacy and service connections.

Prevention and early intervention

- **School-based prevention:** Emphasize sealants, fluoride and oral health education in schools.
- **Early education:** Start oral health education and prevention early for better long-term outcomes.

Systemic and policy changes

- **Universal coverage:** Advocate for universal dental coverage and expanded Medicaid benefits.
- **Integrate oral/medical health:** Promote collaboration and integration between medical and dental care.
- **System navigation:** Provide care coordinators or navigators to help patients understand access oral health services.

Q4 Quotes from Respondents

"Expand/Increase access to mobile dentistry; this removes the barrier of parents/guardians needing to take time off work or having to provide transportation to and from. Although these programs are costly to run, they are still less costly than brick and mortar buildings."

"Mobile oral clinics that come to them in order to bridge the transportation gap."

“We are bottle necked as far as number of dental providers and capacity to see the patients. Need to have more providers and more chairs.”

“More providers who accept Medicaid. Providers who have longer hours or hours 'after-work' or on weekends.”

“The Columbia River Gorge needs access to dental care. It takes 4+ weeks to get an ‘urgent’ appointment, even if students go all the way to Vancouver, WA. It takes about 9+ months to schedule routine cleanings/checkups, so kids are not getting the recommended care every 6 months.”

“Improve public transportation to Community Health Centers that have dental offices, hospitals/clinics and private dental offices. More health providers educated and committed with oral health in rural areas using the SmileMobile.”

“Right where we live there is a FQHC so affordability of care and access to care are not the issues in theory. The barrier to care in this community is in part that my clients work in the fields. To take their children or themselves to the dentist, they have to take a day off of work. It isn't the health care that is expensive. It is the scheduling nightmare.”

“To improve access to dental care, it is essential to allocate additional funding to expand Medicaid services. This would enable a broader range of services to be covered, ensuring more individuals have access to the care they need. Additionally, expanding the network of providers who can treat Medicaid patients will increase accessibility and reduce wait times. To address the ongoing staff shortage, we should invest in programs that train and certify Dental Assistants and Hygienists, providing essential support to dentists while also building a robust pipeline of qualified professionals to meet the growing demand for care.”

“Oral insurance often doesn’t cover ‘enough’ to feel justified. Getting 1-2 cleanings a year for an affordable price isn't enough when most folks also need dental caps, and most offices that accept state dental insurance are only authorized to do one filling a month (speaking from personal experiences), so there's an additional time requirement there. I also found that the dentist offices that did take my insurance weren't on a reliable bus line, so I would have to schedule an extra 1-1.5 hour for each way there. It's also confusing to have the dentist explain that as a client I need an x-ray, but my insurance doesn't cover it - making it feel like dental insurance isn't worth it. I think if the insurance covered more, more places with more transportation access, and the dentists were trained on how to better serve hesitant/nervous clients.”

“I find that parents/guardians are more inclined to take advantage of opportunities when we make it SUPER easy for them. A lot of our students who have needs, have parents

who work full-time, have younger siblings, or parents struggling and can't take time off to get them seen or even know where to start looking for resources. If we tell them, we have a dental day coming, please sign up, this will not take any of your time. . . then we get better results."

"Make insurance easier to access for Washingtonians, lower income thresholds keeping families from getting the care they need just because they make 'slightly over.' (I've been there and it feels hopeless, my brother also pulled his own teeth before from lack of access to dental care). We should set up mobile units that can travel to rural areas so that the people in those areas can access dental care."

"Improving access to affordable oral health care requires promoting legislation that supports healthcare access to people across the continuum, promoting the importance of dental health as part of the overall health of a person, and reducing barriers to care."

"All children need to be covered under Washington Medicaid. We have a binder full of patients that have private insurance but still even with that their parents cannot afford the cost in today's world; it just isn't realistic. not only that the age restrictions for the teenagers need to be removed, they need the same coverage as the younger kids."

"Language support through translators or multilingual flyers, more advertisements for places that offer real time translation, healthcare providers who care and won't judge patients for what they do, or don't, or will respect their inquiries."

"So far, my district is not participating in our FQHC Dental van. Allowing students to be assessed with these services would help our families who cannot find a provider that accepts their Medicaid and those that have no transportation."

"There isn't a short-term solution as the underlying problem is related to a lack of providers (hygiene and dentists) available to work in underserved areas and limited infrastructure (CHC's and practices that see Medicaid patients) to allow access. The current cost of dental education is driving new dentists into DCO's or private practices, which is diluting the available oral health care providers in other areas of need. The current fee for service model also disincentives private practices to see Medicaid patients further decreasing access. Long term, dentistry needs to move to an outcome-based model as our medical colleagues have embraced with population level plans that reimburse systems for case management."

"Provide incentive that draws in providers to rural communities. Have midlevel providers that are trained in their communities to provide services in their community."

Q5.) From your perspective, who do your community members TRUST to provide health-related information (oral or otherwise)? Check all that apply.

- **Dental office or clinic**
- **Family members**
- **Community health centers**
- **Schools**
- **Faith-based organizations**
- **Local government**
- **Employers**
- **Don’t know**
- **Other_____**

Respondents selected these answers, listed in order of most selected to least with the number of times each was selected.

- **Dental office or clinic – 84 responses**
- **Family members – 71**
- **Community health centers – 66**
- **Schools – 58**
- **Faith-based organizations – 32**
- **Other - 23**
- **Employers - 13**
- **Local government – 10**
- **Don’t know – 9**

"Other" mentions include:
Survey respondents mentioned clients trust health information from personal and community-based relationships, friends, family and social groups (both in-person and online). Community leaders, tribal elders, pediatricians, primary care providers, and school liaisons are also trusted sources. Respondents noted that Facebook and online communities are commonly used for health information, which can spread misinformation. Another respondent emphasized that trusted information channels depend on the community, underscoring the need for culturally relevant communication.

Q6.) For the organizations listed in question 5, who do you think are the trusted messengers (types of employees or positions) at these organizations? [Open-text answer format]

Respondents emphasized that trust is built through consistent, respectful, and culturally responsive interactions. Community members who speak the language and share lived experiences are most trusted.

- **Healthcare providers:** Dentists, medical providers, nurses, pediatricians, nurse practitioners, and allied health professionals are highly trusted. Dental hygienists and dental assistants are especially trusted in oral health settings due to their patient time and education focus.
- **Frontline and support staff:** Front desk, receptionists, and office staff build trust as first contacts. Community health workers, case managers and outreach coordinators are trusted for their communities' ties and ability to bridge cultural/linguistic gaps.
- **School-based roles:** Teachers, school nurses, counselors, principals, and family support specialists are trusted in schools. School health staff and liaisons are reliable for families.
- **Community and cultural liaisons:** Those who speak the language or share the culture, including tribal/community elders, faith leaders, and respected leaders, are influential. Peers and neighbors are sometimes trusted more than professionals, especially in tight-knit or immigrant communities.
- **Leadership and administration:** Leaders, mentors, and management are trusted for authority and consistency. Human resources and supervisors may be trusted in workplace settings.

Q6 Quotes from Respondents

"Employees who can connect and speak the language of the patient."

"Ones who speak the family's native language are always the most trusted. And people who serve in liaison type roles who are able to build more rapport with families than providers would be able to."

"In my experience, dental providers and coordinators in the school-based clinic setting are very trusted because many families trust the school where their student attends and look to the school for resources. I also think community health centers that have translators on site to overcome language, and cultural barriers are huge to build trust and allow people to ask questions and receive care in a way that is translatable."

"I think there is a lot of controversy with families and the medical profession right now. As the school nurse I have been able to partner with a clinic and help to provide care but only because I have a relationship with many of our families."

"All staff at a dental clinic who are friendly and approachable. I think the trusted messengers begin at the front desk and continue into the exam room. If any of those people are not friendly and helpful, that can impact whether or not a person will return."

"Religious leaders are trusted in the communities we serve. Schools also provide significant information and serve as a constant point of contact for families with children. A lot of patients also rely on CHCs for access to multiple services, education, outreach, etc."

"Often a healthcare provider is trusted; however, this is not universal given past traumatic medical practices and racism/discrimination. Also, trust is declining in public health. Often a member of the care team that is relatable to the patient and is able to build trust will be relied upon. The relationship over time and trust is the most important and so who can build that- patients must tell us this."

Q7.) In your opinion, what are the best ways to communicate about oral health to the communities you serve? Check all that apply.

- **Social media**
- **Community events**
- **Flyers or brochures**
- **Text messages**
- **Email**
- **Local newspapers**
- **Neighbor-to-neighbor**
- **Community gathering places (barber, restaurants, libraries, etc.**
- **Radio ads**
- **Other _____**

Respondents selected these answers, listed in order of most selected to least with the number of times each was selected.

- **Community events – 88 responses**
- **Social media – 84**
- **Community gathering places (barber, restaurants, libraries, etc.) - 67**
- **Neighbor-to-Neighbor – 46**

- **Flyers or brochures – 45**
- **Text messages – 42**
- **Local newspapers – 22**
- **Email – 21**
- **Radio ads – 17**
- **Other - 17**

"Other" mentions include:
School-based newsletters, What'sApp, Google and ParentSquare, in-class presentations, one-one-contact with staff, community reader boards and local media. Respondents emphasized personal, trusted, and accessible channels.

Q8.) In your opinion, what oral health community programs and/or partnerships are SUCCESSFULLY providing oral health care services to communities experiencing health disparities? Please include the program(s) outcomes that you believe make it successful. [Open-text answer format]

Success stories show that effective programs bring care directly to communities, focus on prevention and early services, and rely on trusted local partnerships to overcome barriers like insurance, transportation, education, and trust. Programs that integrate services, simplify access, and maintain a consistent community presence are most successful.

Successful programs and partnerships identified:

- **Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs):** Vital for underserved groups, offering affordable, integrated dental/medical care. Examples mentioned include: SeaMar, Neighborcare Health, HealthPoint, UnityCare NW, and One Community Health.
- **School-based programs:** SmileMobile, DentALL, Big Smiles, Tooth Fairy school sealant/screening initiatives are highly effective in rural/low-income areas, especially with Head Start, Migrant Head Start, and school nurses.
- **Mobile, portable and community-based clinics:** SmileMobile, Medical Teams international, and DentALL bring care to rural, tribal and underserved areas, reducing transportation barriers.
- **Access to baby and child dentistry (ABCD):** Increases care for Medicaid-enrolled kids, especially with Head Start, Migrant Head Start and WIC. Focus on early intervention, education, and family relationships.
- **Tribal and community-specific programs:** Culturally responsive, innovative approaches.

- **Community partnerships:** Collaboration between schools, health centers, nonprofits, universities (e.g., UW School of Dentistry, Seattle Central College), and local government.

Key themes of successful programs:

- **Community-centered, culturally responsive care:** Meet people where they are (schools, mobile clinics); provide culturally/linguistically appropriate services.
- **Collaboration and partnerships:** Strong partnerships between health centers, schools, nonprofits, and organizations expand reach and improve care.
- **Early intervention and prevention:** Focus on early childhood (ABCD, school sealants); prevention and education are key.
- **Flexibility and accessibility:** Mobile clinics, extended hours, and integrated services remove barriers to underserved populations.
- **Trusted messengers and relationships:** Trusted community members, health workers and advocates are essential to successful outreach and education.
- **Addressing social determinants of health:** Programs tackling transportation, food access, and insurance navigation improve oral health outcomes.

Q8 Quotes from Respondents

"Community Health Center. It has been helpful that CHC has medical and dental. Families have appreciated that they already know where to go and multiple locations."

"Tribal Dental Programs in the region are responding to tribal communities in a positive way to push prevention, new ways to access patients and make appointments easier to get to, shorter or available to meet them outside of the clinic."

"Community Health Clinics: These clinics serve as vital access points for people in underserved areas, providing affordable oral health care services. They often play a crucial role in addressing health disparities by offering preventive care, basic treatments, and referrals to specialists."

"The ABCD program works very well for very young children especially when tied to Head Start and Migrant Head Start programs and a solid group of community providers' offices. As for true definitive programs with proven records then the Head Start programs are far beyond other 'school based' or community-oriented programs because the programs and messaging are all uniform and repeated in every level of their programs in a consistent way.

“The Community outreach programs have been very successful, because it is an opportunity when the various programs have one-to-one contact with people in the community. We have been recruiting hundreds of patients after having these events.”

“School-based program funded through community grant - successful collaboration between the County and Public School.”

“Regular outreach through phone calls, mail, and showing up at community events and bringing oral health providers to the community (mobile clinics).”

“The community health centers are providing the care needed. There are a few private offices accepting children and some adults but don't offer the full spectrum of care for adults on state Medicaid (cherry pick what they will do).”

“DentALL has implemented a mobile model that has successfully increased dental visits in rural and hard-to-reach communities in San Juan and Whatcom Counties. Expansion of these models and care in the community is vital. Partnership with nonprofits and other community-based organizations for mobile or portable clinics.”

“Community Action Agencies, DentALL, tribal clinics. These all meet the community ‘where they are’ rather than forcing community members to navigate challenges to access such as insurance, transportation, etc.”

“District nurses are continually providing referrals to free and sliding scale dental clinics. Pop-up city FREE clinics (like those at sporting arenas) supported by various charitable health organization are also critical.”

“The Afghan Health Initiative who helps connect refugees with medical and dental care and provide lots of education-they are a trusted source for the clients who they assist.”

“For a while, I felt that our work with refugees and their dental screenings was providing a great service to our community, but unfortunately with the administration changes and World Relief funding loss, that partnership has ended and those folks are no longer receiving services as they were. The school-based programs with hygienists offering dental screenings and fluoride treatments have had a great impact in our communities. The partnerships between school staff and the hygienists implementing these programs have made it successful. Data is showing an increase in access to care (children needing fewer referrals) and children are demonstrating a clear understanding of their oral health."

“Community collaborations tend to be the most successful. An example of this is the mobile medical and dental screenings we provide via our mobile units. These programs not only build trust with the community partners, but also the patients screened. These

programs build trust and help deliver consistent screening and referral for additional services process that have a high follow up rate."

Q9.) What are you currently doing to work against discrimination or bias as a community provider or community service worker? How are you working to engage in cultural humility? [Open-text answer format]

Many survey respondents demonstrated a strong commitment to advancing equity, inclusion, and cultural humility in their work as community providers. Key strategies include ongoing staff education, language access, representation in hiring, and personal outreach to overcome barriers. Overall responses aim to ensure that all community members - regardless of background and circumstance - have access to high-quality, culturally responsive care.

Commitment to equity, inclusion and cultural humility

- **Ongoing education and training:** Many respondents highlighted regular staff education in cultural responsiveness, trauma-informed care, motivational interviewing, harm reduction, and anti-bias practices. Organizations invest in training to ensure staff are prepared to serve diverse populations.
- **Language access and communication:** Providing materials (such as consent forms) and services in multiple languages, employing bilingual staff and using interpreters (in-person, virtual and phone-based) are common strategies to remove language barriers and make services more welcoming.
- **Representation and community engagement:** There is a strong emphasis on hiring staff who reflect the communities served and involve community members in program design and feedback.
- **Openness to learning:** Respondents frequently mentioned remaining open to learning from others, self-reflection and being willing to be corrected or challenged on personal bias.

Low-barrier, inclusive service delivery

- **Meet people where they are:** Services offered in schools, mobile clinics and community settings are key to reducing barriers to access.
- **Universal access:** Many programs do not collect co-pays, serve all who seek care and ensure that no one is excluded based on insurance, race, language and other factors.
- **Personal outreach:** Staff reach out directly to families experiencing barriers such as housing insecurity, language differences, or transportation challenges.

Building trust and relationships

- **Respectful and compassionate care:** Treating all clients with dignity, respect, and compassion is a universal priority in respondent's answers. Providers strive to create safe, non-judgmental environments.
- **Listening and advocacy:** Providers prioritize listening to clients' needs, advocating for accommodations, and empowering clients to make decisions about their care.
- **Community partnerships:** Collaborating with local organizations, schools, and faith-based groups helps extend reach and build trust.

Addressing and challenging discrimination and bias

- **Self-reflection and accountability:** Many respondents described ongoing self-reflection on their own biases and the importance of addressing discriminatory behavior when it arises.
- **Policy and practice changes:** Organizations are implementing policies to ensure equitable treatment, including anti-discrimination measures and inclusive hiring practices.

Continuous improvement and community-centered approaches

- **Feedback and adaptation:** Organizations use client feedback, satisfaction surveys, and quality improvement processes to adapt services to community needs.
- **Comprehensive care:** Program often addresses broader needs, such as housing, food, security, and education, recognizing that health is influenced by a variety of factors.
- **Lifelong learning:** Cultural humility is seen as a lifelong journey, with a commitment to ongoing education and improvement.

Q9 Quotes from Respondents

"Our program serves any child who turns in a 'yes' consent form. We do not collect copays from any family EVER. We provide services to children in regions with little to no access to dentistry. We offer consent forms in multiple languages and work with family support specialists and school nurses to reach families with communication barriers to ensure important information regarding their child is relayed."

“In the community health setting, we do a lot of education and communication with each appointment so that the families have agency and are able to connect directly with the provider, ask their questions, express reservations. We had one situation where a child needed an extraction, but the family had reservations based on their cultural story and history and the provider was able to meet them and say 'lets keep an eye on this' and continue to monitor with non-invasive ways like silver diamine fluoride and has kept the child stable. Giving the family decision making power alongside education I think does engage cultural humility in that there is not only one way to do things.”

“... demonstrates our commitment to diversity, equity, and inclusion to promote the health and well-being of our patients, coworkers, and the community we serve. We strive to provide integrated and holistic health care in an environment where age, race, ethnicity, sexual orientation, and gender identity are valued. All staff, go through orientation and ongoing support, receive training in Motivational Interviewing, Trauma Informed Care, Harm Reduction, and Mental Health First Aid. We treat our patients and each other with dignity, respect and compassion, free of harassment, discrimination, or microaggressions.”

“One of the chief impediments to seeking care is language barrier. Our org invests a lot of resources on in person translators, staff translators and automated interpreter devices. The organization engages in training around cultural competence and biases. Our staff training is becoming more robust with the addition of a dedicated trainer and additional resources such as LinkedIn Learn.”

“We have dental providers and staff complete courses on cultural competency, through Relias, Lectures or Certified Diversity Executive (CDE) courses. We also have in-house meetings to talk about specific cases (‘Peer review’) or a review in general terms with providers and staff.”

“We do our best to share all materials in the family's target language. We also have parent engagement committees to invite participation from families.”

“We start by hiring from our clinic and holding our staff diversity to reflect our patients. We have regular and frequent training around bias, equity, antiracism, and cultural considerations. We also commit to providing care in the language preferred, having in person and virtual interpreters available for all visits”

“Growing providers from their own communities so cultural humility is innate. Cultural responsiveness training and awareness through formal courses and informal but regularly scheduled staff discussions. Continual review of patient satisfaction and using positive compliments and constructive criticism to improve. Encouraging staff to be

engaged in the community they serve by supporting out of clinic and/or non-clinic time to attend events."

"I actively work against discrimination and bias through the following strategies: Ongoing Education: I regularly participate in anti-oppression and anti-racism training to stay informed about systemic issues and learn how to be an ally. This includes understanding historical and current social inequities that impact the communities I serve. Inclusive Practices: I ensure that services are accessible and welcoming to people of all backgrounds, including marginalized and underrepresented groups. That means using inclusive language, avoiding assumptions, and advocating for equity within my organization and the larger system. Challenging Bias: I reflect on my own biases and take responsibility for unlearning them. I also gently but firmly address discriminatory behavior when I encounter it in clients, colleagues, or systems, promoting respectful dialogue and accountability. Representation Matters: I support and advocate for leadership and decision-making roles to be inclusive of the communities being served—especially voices that are often silenced or ignored."

"We are part of the LatinX Healthcare Advisory group and meet every other month as well as participate in health fairs and community events in Spanish. We support language translation into Spanish of all outreach, website, and application materials and have Spanish speaking staff present for community dental clinics."

"Trainings for our staff and the community about bias, cultural humility, and trauma-informed care."

"I am interested in hearing my students' and families' stories about their culture. . ."

Q10.) During discussions about community water fluoridation, what are you hearing from the communities you serve? [Open-text answer format]

Survey responses highlight a complex landscape of awareness, attitudes, and misinformation surrounding community water fluoridation. Providers noted that while some communities seem to accept or even advocate for fluoridation, others are skeptical or opposed, often due to misinformation or distrust. Effective public health communication and education are essential to address these challenges and ensure communities can make informed decisions about water fluoridation.

Varied awareness and engagement:

- Many respondents reported that their communities have little to no discussion about water fluoridation. Some stated they have not heard any conversations at

all, while others mentioned only occasional or sporadic discussions, often prompted by news or social media.
- Several respondents noted that the topic is rarely raised by patients or community members, and some have not encountered direct feedback or concerns.

Mixed perceptions and misinformation

- Misinformation is a recurring theme noted by providers who hear concerns about fluoride being “poison” or viewed as a government conspiracy. Social media is frequently cited as a source of misinformation and mistrust.
- Some communities have recently debated or voted on water fluoridation, with outcomes ranging from continued support to removal of fluoride from water systems.
- Providers report that there is a mix of acceptance, skepticism, and outright opposition within communities. Some people appear supportive of water fluoridation, recognizing its public health benefits, while others express concerns about safety, government involvement, or personal autonomy.

Clinical observations

- Providers observe that, in communities with fluoridated water, rates of tooth decay are lower, especially among children. Conversely, in communities without fluoridation, providers see higher rates of early childhood caries (a chronic, progressive disease that causes tooth decay in children under the age of six) and recurrent decay.
- Some providers report increasing hesitancy or refusal of fluoride treatments, often due to misinformation or distrust.

Community-specific attitudes

- In areas where water is fluoridated, many people are either supportive or indifferent, but there are also those who are skeptical or opposed to it.
- In rural and well-water communities, access to fluoridated water is limited, and some families are unaware of the issue or do not have strong opinions.

Need for education and outreach

- Many respondents emphasized the need for more education and outreach to address misconceptions and provide accurate information about the safety and benefits of water fluoridation.
- Trust in public health institutions and scientific consensus is important, but misinformation and distrust can undermine support for water fluoridation.

Q10 Quotes from Respondents

“In general, lots of misinformation about fluoride in the water being a health hazard. Social media seems to have fueled a growing concern about adding fluoride to the water.”

“Mostly lack of understanding of purpose and basic "the risk is in the dose" understanding of how MUCH fluoride would actually cause problems. Much. . . less than put in water.”

“In general, water fluoridation is accepted in our communities. We have had to deal with individual patients requesting not to get any fluoride treatments for them or their children. But these have not been in significant numbers (not "hundreds or thousands").

“In general, most members of the community seem to be in favor or it is not something they have given a lot of thought to previously.”

“Less and less patients are educated on how fluoride works and refuse to let use it on their children. False information is being spread.”

“People seem content with knowing that most of our community water systems are fluoridated. We don't engage on this topic very often with patients, but I have noticed more patients being averse to fluoride in general. I don't hear people saying that they avoid the drinking water as much as they do other fluoride sources.”

“Swinomish's water is fluoridated but drinking tap water is a hard push in and of itself.”

“I seem to be sensing more distrust about water fluoridation, and more fluoride refusal.”

“The majority of our patients support water fluoridation, we occasionally encounter a few who are skeptical about its benefits.”

“I often hear that people can "taste" the fluoridation and that they’re confused on why it’s in the water.”

“Lynden has had a lot of conversations around this and it is a HOT button topic in a unsettling environment politically. We have a dental champion there, but the reality is if they stand up in Lynden community they may lose their business. They are our main Rural provider for low-income families in Whatcom County.”

“People are becoming more skeptical of fluoride and have more hesitant about its use.”

“We have no fluoridated water systems in our community and this seems like a nonstarter with the current federal administration. Instead we are doing a Mouth Matters campaign to integrate oral health and fluoride varnish in primary care setting.”

"In communities where water fluoridation is present, not seeing nearly an issue with decay on all folks young and old. In communities without fluoride, seeing a high caries risk and very young kids coming in with rampant decay. It's become more of putting out fires as best as we can and seeing constant recurrent decay even after all the decay has been addressed."

"People that I serve want water fluoridation because it is the easiest way for themselves and their families to receive fluoride.

Q11.) In your opinion, what system or policy changes would have the biggest impact on improving oral health for the communities you serve? [Open-text answer format]

Survey responses focused on a needed transformation rooted in access, education, dignity and prevention.

Expand access and affordability

- **Increase funding and coverage:** Raise Medicaid reimbursement rates to attract more providers; expand public insurance to cover more procedures and close gaps for adults.
- **Universal access:** Provide no-cost/low-cost dental care for all, especially children, low-income families, and the uninsured.
- **Sliding scale and free clinics:** Establish more clinics with sliding scale or free services to reduce financial barriers.
- **Community-centered care:** Expand mobile clinics, offer evening/weekend hours, and provide transportation support.

Prevention and early intervention

- **School-based programs:** Introduce mandatory oral health screenings, fluoride treatments and sealants in schools.
- **Early education:** Teach oral health from K-12; extend programs like ABCD to older children; create school curricula on hygiene, diet and disease prevention.
- **Community outreach:** Expand multilingual, culturally sensitive education; involve students in campaigns; distribute free oral hygiene supplies in schools and clinics.
- **Navigation assistance:** Fund navigators to help families access care.

Workforce and provider capacity

- **Increase workforce:** Recruit and train more dental providers, especially those who speak multiple languages and represent their communities.
- **Expand mid-level roles:** Allow hygienists and therapists to provide basic care in more settings, especially in rural and underserved areas.
- **Integration of services:** Co-locate dental and medical services for easier access and coordination.

Address social determinants

- **Healthy food access:** Support programs that increase access to healthy foods and reduce sugary drinks/snacks; align public aid with non-cariogenic diets.
- **Transportation and language access:** Provide transportation and interpretation services.

Policy and system reforms

- **Water fluoridation:** Maintain and expand community water fluoridation.
- **Reimbursement and funding:** Increase funding for public dental health programs and raise provider reimbursement rates.
- **Accountability:** Ensure children identified with dental needs in screenings receive follow-up care.

Education and misinformation

- **Public health campaigns:** Fund science-based, multilingual, culturally relevant campaigns; use social media, community programs, and trusted messengers.
- **Parent and family education:** Provide resources to help families understand the importance of regular dental care and good hygiene.

Rebuild Trust and Reduce Stigma

- **Cultural humility:** Fund training on trauma-informed care and non-judgmental environments. Cultural humility involves ongoing self-reflection, recognizing biases, and respecting diverse identities. Training staff and creating supportive environments are crucial, as shame, fear, and past negative experiences often prevent people from seeking care.

Q11 Quotes from Respondents

“Strengthening current programs and increasing their reach to all public schools, possibly make it a requirement to have oral screens like we do for hearing and vision screenings.”

“Having a dental workforce that speaks many languages and comes from many backgrounds - so that all patients can see themselves represented.”

“Have a robust referral system in place where patients in need of dental treatment or a Dental Home are identified and referred to the existing dental clinics, where they can be seen. Or identify regions or areas where mobile dental clinics can be scheduled to serve those clients.”

“Higher reimbursement for Medicaid services so more private practice would take it.”

“Would be nice to have services available at the community health centers so the community can be notified about benefits available and that they are located in the same place as the health clinic.”

“Integration of services between medical and dental communities, prevention incentives for both health centers and patients. More public service education in the community, more about the links to oral disease and systemic disease. Groups like Afghan Health Initiative are very effective and trusted.”

“Short of a massive funding increase of the dental program that will entice all dental clinics to start accepting Medicaid clients, the best thing we can possibly do will be to educate as many families as possible on the topics of oral health. We may need to do a similar campaign as when recycling was introduced - it only became effective when kids in school learned how to do it and they went home and taught their parents how to do it. We may need to have a school curriculum that teaches kids how to truly take care of their teeth by not only good hygiene but also good control of their dietary practices and have them carry that home and change the ‘culture’ of oral health at home.”

“Keeping kids covered by ABCD or another program so they don't drop into nowhere land at 6.”

“As I mentioned before, transitioning away from a procedural-based reimbursement model in dentistry to an outcome-based model. Emphasizing reimbursement on prevention versus repairing damage is the only way to move patients into a state of stabilized oral health.”

“Very simple from out here - 1) Raise basic fees for prevention and minor operative procedures, 2) Extend ABCD to includes kids through elementary school so we have longer to guide them toward lifelong habits for better health and 3) Better support rural transportation providers and help them work with healthcare agencies and providers to coordinate transportation to patients and their families.”

“More dentists who would accept Medicaid and/or would work with families on a sliding scale or ability to pay.”

“Having Apple health cover needed procedures like root canals so patients can save their teeth.”

“More providers accepting public health insurance and/or decreased cost care, and more assistance with helping individuals access public health insurance.”

“Vouchers (paper/email/whatever is easiest to access - including transportation if needed) accepted at multiple locations for dental exams. Outreach from clinics to ensure cancelled or missed appointments are rescheduled. EMPLOYER SUPPORT with pay for employees to be able to access preventive health appointments.”

“Access to dental/oral health outside of business hours. Better coverage for oral health care for youth, oral health information in schools. My fantasy would be access to oral health professionals in school-based clinics for all school districts in Washington.”

“Oral hygiene education in public schools at all age levels, increased services covered by dental insurance of all varieties, incentivizing dentist offices to be open evenings and weekends.”

“Promoting early oral health education and preventive dental care is essential for long-term health. By educating patients about the significant benefits of drinking fluoridated water, we can help prevent tooth decay, strengthen enamel, and improve overall dental hygiene. Early intervention and awareness can set the foundation for healthier smiles and reduce future dental issues.”

“Make quality oral health services more available for everyone and have more providers in our rural area. And have those local providers accept all types of insurance, including state funded.”

“Increasing reimbursement rate for Medicaid for oral health. Focusing on upstream prevention for youth and school-based services to prevent decay.”

“I think providing basic dental care and education for families on the safety and efficacy of procedures would be helpful. Information on dispelling misinformation they find on the internet can also be helpful.”

“Water fluoridation, expanding the network of dentists who take state insurance, elimination of the annual payment cap for people who have private dental insurance.”

“Our numbers are up for desired visits. I see our challenge being capacity to appoint patients due to already maximized scheduling. The backlog I see stems from our ability

for time to see patients. I have also had many patients report to me that routine cleanings are unnecessary and abuse. This is my reasoning for heightened educational awareness."

"Implementing more oral health programs where the community joins. I believe that the community is very strong here and is crucial to the outcome of oral health care."

Q12.) The state of Washington is looking to partner with communities experiencing oral health disparities. Would you like to OPT-IN as a recommended community provider for future oral health equity conversations and updates from the state?

- **Yes – 54%**
- **No – 17%**
- **Maybe – 24%**
- **Other 5%**

Q13.) If you answered "yes" to question 12 - THANK YOU! Please include your email address

---

65 out of 108 survey respondents included their email for question 13.
Having 60% of survey respondents opt-in to a continued conversation with the state about oral health care indicates a strong desire for a collaborative platform that brings together advocates, subject matter experts, providers, community service leaders and others to drive meaningful, coordinated progress.