Teeth for a Lifetime?

Oral Health in Sacramento, 2022

December 2022

BARBARA AVED ASSOCIATES for
SACRAMENTO COUNTY PUBLIC HEALTH

An Adult-Focused Oral Health Needs Assessment: 2022 Update

Sacramento County Oral Health Program

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EXECUTIVE SUMMARY

"The increased collaboration of the oral health partners has certainly made it a lot easier for school nurses when kids screened with dental disease need referrals." – Key Informant Interviewee

While awareness has grown of the important links between oral health and a person's general health, an historical separation of oral health from the rest of the health care system has put an undue burden of dental disease on the most vulnerable populations who face barriers to accessing dental care. In particular, dental care is often an overlooked aspect of overall health care among older adults. Oral diseases are especially troubling because they are largely preventable by regular home oral care and preventive dental visits. Poor dental health in childhood predicts future dental disease. (Ctrl+Click to view Dr. Olivia Kasirye's comments on report findings here: https://bit.ly/DrKasirye)

This report is an update of the 2018 Sacramento County Oral Health Needs Assessment produced by Barbara Aved Associates. While we examined the same range of community indicators and demographics, the present assessment focused more on adults, including older adults where dental care is often an overlooked aspect of their overall health care, to better understand a population that does not traditionally receive attention.

The report highlights the most emergent findings: the oral health status of children and adults; needs, risks and protective factors; dental services usage; clinical and other resources and gaps in services in Sacramento County; and offers recommendations for improvement. The assessment process was guided by the Sacramento County Oral Health Program (SCOHP) and the Medi-Cal Dental Advisory Committee (MCDAC) and the findings will be used to support strategies to continue improving access and oral health status of Sacramento County children and adults. While the key findings in the highlights below overlap, they are organized into categories only to focus the main points.

Key Findings

Demographic Disparities Relevant to Oral Health

Sacramento is one of the most racially and ethnically diverse counties in the nation, ranking 14th in the U.S. according to the Census Bureau Diversity Index.

The projected 2025 Sacramento County growth rate of 3.3% shows a notable overall shift toward older population groups.

20.8% of children age 0-18 in Sacramento County vs. 14.6% statewide are estimated to live in poverty.

46.0% of Sacramento County adults reported in 2021 being unable to afford enough food (food insecure) compared to 39.0% statewide.

Prevalence of Oral Disease

Children's dental screening results suggest community oral health education and provider training *may* have contributed to lowering the prevalence of dental decay: children with "urgent" dental treatment needs dropped from 6.4% in 2015-18 to 1.5% in 2018-2022.

42.0% of Sacramento adults rated the condition of their teeth as "excellent" or "very good;" only 20.2% of those with low-income gave themselves this rating.

More than one-third of the adult survey respondents said they had experienced sleep problems or missed school or work because of dental pain.

Drug abuse contributes to the risk of dental disease, such as "meth mouth," yet is rarely integrated into discussions about oral health; methamphetamine is one of Sacramento's biggest drug problems.

Oral Health Risk / Protective Factors

In 2016, 14.4% of Sacramento County adults reported they currently smoked; by 2021, only 5.5% said they did so.

14% of Sacramentans have diabetes, and almost 19% have borderline or pre-diabetes—increasing their risk for periodontal disease.

65% of Sacramento County has access to fluoridated drinking water. However, many residents question the safety of tap water and drink bottled water instead—losing the benefit of fluoride.

Access to Services

Five main barriers to care emerged from this study: lack of money (no or limited coverage or ineligibility for Medi-Cal); negative prior dental experiences or worry a procedure *would be* painful; lack of awareness of existing coverage; lack of personal priority/follow-through; lack of knowledge of how/where to access dental services. (Ctrl+Click Barriers to care: https://bit.ly/Barriers2Care)

Community clinics are a critical provider of dental care for Sacramento County's low-income population though capacity for serving adults is uneven; in some cases structural capacity and workforce shortages are contributing to the problem.

Bidirectional use of medical and dental services at community clinics shows less than 30% of medical patients receive dental services within the same FQHC, largely due to auto-assignment to different medical and dental providers at Medi-Cal enrollment.

Of 626 prior authorization requests submitted to Medi-Cal managed care plans for general anesthesia (GA) dental for children and 203 for adults in 2021, 3.1% on average were denied, with no plan an outlier; only 3 of the total denials were for developmentally disabled patients. GA dental treatment *capacity* for Medi-Cal members is still very much a problem, however. (Ctrl+Click on Access to general anesthesia: https://bit.ly/SacCtyGA)

Half of the surveyed adults with private insurance or private-pay reported being able to get a non-emergency dental appointment within 2 weeks; however, only one-third of those with Medi-Cal could say the same.

Most low-income people with Medicare who said they “couldn’t afford to go to the dentist because it’s not covered ” were unaware they *might* qualify for Medi-Cal.

Although most dental offices reported being able to see patients with special needs “if they were cooperative and could sit in the chair,” “cooperative” can be defined various ways, and fewer than half the offices said they offered any type of sedation. (Ctrl+Click on https://bit.ly/SacCtySpecialNeeds)

Lag time (the number of days) differences between treatment authorization requests and dental procedures for adults with Medi-Cal were striking: a 15-day “turnaround” in Access, 54 days in Health Net and 56 in Liberty; adults in FFS had to wait the longest—71.9 days.

The number of private dentists in the GMC plans’ provider directories is not a true total due to provider overlap among the Plans. Health Net and Liberty share many of the same providers; 43% are also shared by Access.

The most commonly denied Treatment Authorization Request for adults with FFS and GMC Medi-Cal—scaling and root planing—is, counterintuitively, the procedure intended to stop further progression of dental disease.

Dental Services Utilization

Dental sealants are significantly under-delivered, especially for Black children. In 2020, 5.4% of 10-14 year-old Black children received them; Asian children had the highest usage, at 9.8%. (Ctrl+Click on school-based dental care: https://bit.ly/SacCtySchoolBased)

The percentage of children age 6-9 who received sealants in FQHC clinics varied greatly in 2021; they ranged from 70.0% at WellSpace to 27.6% at Native American Health Center.

The women with Medi-Cal made half the percentage of dental visits during their pregnancy than women with private insurance did, 31.3% and 61.6%, respectively.

Though utilization has increased, a higher proportion of CA children in FFS, 46.4%, than in Sacramento GMC (28.5% in Access, 40.6% in Health Net, and 44.7% in Liberty) made an annual dental visit in 2021. (Ctrl+Click on Lack of awareness of benefits: https://bit.ly/SacCtyLackAware)

Less than one-quarter of adults with Medi-Cal (GMC range: 17.7% - 23.7%) utilized their annual dental visit benefits in 2021; visits among young adults are lowest, and decline after age 75+.

7.1% of the Sacramento adult population reported their last dental visit as 5+ years ago; the proportion for those living below 200% of poverty was nearly double: 13.6%

3,245 children and adults were seen in a Sacramento emergency department (ED) in 2021 for a dental condition considered preventable; Medi-Cal footed the bill for the majority of these visits.

Statewide, about 60% of the ED visits for a dental condition were considered preventable; but, in Sacramento EDs, 70% were—further highlighting the need for better dental home linkage/use. (Ctrl+Click on Using ER for dental needs: https://bit.ly/SacCtyER)

42.6% of surveyed adults with special needs reported being unable to receive the dental treatment they needed. Lack of providers willing to take someone who may need extra time or behavioral support was cited as the main reason.

Twice yearly dental cleanings and exams are standard unless the population represents higher needs. In 2021, the average number of annual visits at Elica health center was 1.34/patient; at HALO it was 2.67; at One Community Clinic, 3.49; at WellSpace, 2.99; and, at Native American Health Center, 3.04 – indicative of patient dental care needs and organizational capacity.

Community Input

Clinic providers observed that pain, and enough of it for long enough, was "the big prompt" for many patients to seek care. Key Informants said "promoters" were having a source of payment and perceiving a need based on self-determined value. (Ctrl+Click on Pain as a motivator: https://bit.ly/SacCtyPainMotivator)

Focus group participants affirmed they valued good oral health—and acknowledged the benefits—yet fewer than half practiced that belief by making regular dental visits.

"First Tooth/First Birthday" for the first dental visit seems to have taken hold among younger adults with children; this recognition may be contributing to what appears to be a lower prevalence of dental decay in the 2021-22 preschool dental screenings.

"Solve the problem of limited access to general anesthesia dentistry" was the top recommendation of the Key Informants, who are frustrated by lack of enough progress. . (Ctrl+Click on Operating room availability: https://bit.ly/SacCtyOR)

More than 50% of surveyed adults and about 80% of focus group participants who had a physician could not recall their doctor ever inquiring about their oral health. (Ctrl+Click on Lack of Medical Integration: https://bit.ly/SacCtyMedIntegration)

Key Informants noted greater community partner OH engagement, increased collaborative relationships, particularly with GMC dental plans, since the 2018 OH Needs Assessment.

Suggested Improvements

These assessment findings are meant to guide Sacramento County Public Health and the Medi-Cal Dental Advisory Committee and its partners, including Department of Health Services, in reinforcing current oral health efforts and supporting additional strategies for improving oral health in Sacramento County. At a minimum, and not necessarily in order of importance, we recommend that an action plan for implementation strategies be developed and focus on the following:

1. Create additional capacity in Sacramento hospitals and surgery centers for general anesthesia (GA) dental procedures.
2. Invest in a professionally-designed and executed countywide targeted OH educational campaign with messaging aimed at adults.
3. Reduce the use of the emergency department for non-traumatic dental conditions.
4. Increase community health center/clinic capacity for seeing adult patients.
5. Improve disparities and inequities in oral health care.
6. Make an all-out effort to recruit *at least* one more oral surgeon in Sacramento who would see Medi-Cal patients.
7. Work to get more local Alcohol and Drug programs (both public and private) engaged in oral health.
8. Increase sealant delivery and utilization.
9. Improve the reliability of the Kindergarten Oral Health Assessment screening data to benefit understanding of caries prevalence.
10. Implement a referral management and care coordination system to track dental screening referrals for treatment.
11. Revamp the Medi-Cal system to auto assign members to the same FQHC when the organization provides both medical and dental services.
12. Ask DHCS to promote more awareness of the Treatment Authorization Request (TAR) guidelines for scaling and root planing by publishing an All Plan Letter, routinely provide data on periodontal denials by provider type, age group, geographic and residential criteria for more transparency in the assessment of need, and implement additional provider education strategies for submitting proper TAR documentation.
13. Ask DHCS to use the information in this report to do a deeper dive on provider network capacity to determine true adequacy.
14. Increase the proportion of Sacramento County with access to fluoridated drinking water.
15. Continue to increase opportunities for integration of oral health in general health settings, and promotion by medical/primary care providers.
16. Include oral health in more types of needs assessments/surveys, particularly for seniors.
17. Have GMC Plan Dental Directors hold regularly scheduled meetings (virtual or otherwise) among one another and with Sacramento FQHC Dental Directors.

INTRODUCTION

"Reduce the various opportunity costs associated with dental utilization for people with low-income—then you might see more regular use increase."
- Key Informant Interview

Good oral health and control of oral bacteria is more than a nice smile; it protects a person's health and quality of life. Teeth that function properly are essential for optimal nutrition as well as speech and hearing. Research shows the association between oral disease and diabetes,[1] cardiovascular disease,[2] and even adverse birth outcomes.[3] Poor oral health among adults can lead to increased risk for long-term chronic conditions, lost workdays and reduced employability. Children suffering from tooth pain often miss school or are distracted from learning. There is also a greater appreciation for the psychosocial impact of oral health influencing how people appear, speak, chew, work and socialize.[4] Early childhood caries—the most prevalent unmet health care need for children nationwide[5]—is especially troubling because it is preventable. Untreated tooth decay in children can, for instance, affect children's quality of life, causing pain and infections that may lead to problems with learning.[6] Importantly, poor dental health in childhood predicts future dental disease as oral diseases are progressive and cumulative and become more complex over time. Since the consequences of poor oral health can have lifelong effects, pregnancy is a particularly important time to access oral health care.

Local oral health programs best meet the needs of their communities when they are tailored to match current needs and to solve current problems. Resources are best used when targeted to populations currently at risk.[7] While regular dental care is recommended for all older adults, even those with full dentures, oral health is often an overlooked aspect of their overall health care. Because Medicare does not cover routine dental care, it is not a coincidence that many older adults have trouble accessing appropriate dental care.[8] A recent discussion of trends in health care access in state Medicaid programs concluded that "while children have achieved good access across the nation for oral health services, this is not the case for adults, and particularly older adults." Cost was generally always cited as the main reason that seniors avoided going to the dentist.[9]

When cost for health care is a factor, no matter the age group, a commonly skipped health care practice is dental visits, particularly for populations with historical access challenges. The California Health Care Foundation statewide survey of Californians in late 2021 was conducted to understand adults' views on health care policy and experiences with COVID-19 and the health care system. Although the findings are not Sacramento-specific, they are informative and applicable. Close to 40% of the adults said they skipped dental care or checkups in the last 12 months due to cost; only 25% had put off physical health care for that reason. Those with lower incomes (<200 FPL) were about 1.5 times more likely to say they skipped or postponed dental care, with Black and Latinx adults the most likely to put it off.[10]

In addition to cost and dental insurance as one of the social determinants of access, this report addresses the social determinants of health that impact a person's ability to make healthy life choices and social determinants of equity—not in a person's control—that underlie social, political and economic forces.[11]

Purpose of the Report

This report produced by Barbara Aved Associates updates the 2018 Sacramento County Oral Health Needs Assessment to document progress on the indicators important for oral health. It also expands the focus on adults where dental care is often an overlooked aspect of their overall health care, to better understand a population that does not traditionally receive attention. The information—some at a more granular level—will serve multiple audiences in: highlighting the oral health status of children and adults; identifying needs from multiples sources of community input; detailing risks and protective factors; describing dental services usage, resources and gaps within Sacramento County; and offering recommendations for improvement.

In addition to the 2018 Oral Health Needs Assessment, available information from previous Sacramento County oral health-related studies, conducted over the last decade and primarily focused on the Medi-Cal population, benefitted the present analysis. These studies identified significant access issues, utilization barriers and gaps in services, and brought together a diversity of consumers, policymakers, community leaders, local stakeholders and providers to create and support the current leadership and advocacy to promote oral health in Sacramento County.[12] This report builds on that information and closely aligns with the goals and objectives of the State Oral Health Program.

Note to Readers

➡ Readers will note that some topics are discussed in multiple places in the report. For example, pregnancy, sealants and special needs are addressed in both the "Access" and "Utilization" sections because of their relevance to those sections. For a glossary of commonly-used acronyms and terms in this report, see Attachment 11 in the Appendices (page 149).

BACKGROUND

Medi-Cal Dental Advisory Committee (MCDAC)

On December 11, 2012, the Sacramento County Board of Supervisors approved the creation of a Sacramento County Medi-Cal Dental Advisory Committee (MCDAC) to address issues related to Medi-Cal dental for children ages 0-20 and pregnant women, authorized by Assembly Bill 1467.[13] On January 26, 2016, the Board updated the MCDAC-authorizing resolution to expand its focus to include adult Medi-Cal dental beneficiaries (Resolution #2016-0566).[14] The purpose of MCDAC is to provide oversight and guidance to improve Medi-Cal Dental utilization rates, the delivery of dental care services, including prevention and education services. MCDAC members include local non-profit organizations, representatives from First 5 Sacramento, the local dental society, the GMC dental plans and other interested individuals. Meetings are held in February, April,

June, August, October and December.[15] Sacramento County Public Health Oral Health Program provides staff support for MCDAC. One of the ways in which MCDAC monitors dental utilization rates and the number of individuals enrolled in the Medi-Cal Dental Program—both the mandatory GMC dental program, in which the majority of Sacramento County Medi-Cal Dental clients are served—and the FFS dental delivery system is to support studies such as this report.

Sacramento County Public Health Oral Health Program (SCOHP)

The Sacramento County Oral Health program contracts with the California Department of Public Health – Office of Oral Health through revenue generated by the California Healthcare Research and Prevention Tobacco Act of 2016/Proposition 56. The goals of Proposition 56 include expanding the capacity of local health jurisdictions to coordinate public health activities that support oral health education, disease prevention (including oral diseases caused by tobacco use), surveillance, and linkages to dental care services. The Sacramento County Oral Health program plans, implements, and evaluates projects to support the goals of *California Oral Health Plan 2018 – 2028*. Projects include surveillance of school-based/linked oral health preventive programs, promoting compliance with the Kindergarten Oral Health Assessment mandate, providing tobacco-cessation and sugar-sweetened beverage resources to dental professionals, and improving overall oral health literacy.

Effect of COVID-19

One of the most significant recent oral health challenges has been the COVID-19 pandemic. In addition to its overall impact on society, COVID-19 had an unprecedented and drastic impact on dental care, affecting delivery of care, financial sustainability, and even dental professionals' attitudes toward their profession, with anticipated long-term effects on dentistry.[16] While a full assessment of the pandemic's effect on the dental sector is beyond the scope of this study, it is of interest to note its effect on individuals' oral health: according to a 2021 American Dental Association survey, dentists reported increased rates of stress-related issues such as teeth grinding (up 76%), cracked teeth (up 69%) and chipped teeth (up 68%) during the pandemic. In addition, dentists said they were seeing increases in cavities and gum disease, likely as a result of changes to people's hygiene and eating habits during the crisis.[17]

Dental Care Market Factors

Any plans to improve oral health and dental capacity in Sacramento County have to take into account certain basic market factors that affect oral health services. The main "forces" of the market are supply and demand. These factors are *especially* important for services, like oral health, that have behavioral and psychological aspects that are not always appreciated or understood.

The demand side of the equation involves the user, or the consumer which includes patient demographics, perceived need for dental care, ability to obtain care, and experiences receiving dental care. The supply side includes dentists and other dental health professionals, dentist demographics, other dental practice organizations and their locations, office and treatment hours, and surgery facilities. These market dynamics have been especially sensitive to the effects of the

COVID-19 pandemic. For example, office closures and restrictive practices (e.g., fewer elective procedures) lowered supply, some of which was not recovered. Avoided dental visits by consumers to reduce the risk of COVID-19 infection caused a decline in the demand for dental care[18] that may not have fully recovered.

These collective market factors highlight the necessity of promoting and educating the public about the importance of oral health—especially prevention—for effective demand. They speak to the importance of recognizing the value proposition, i.e., why should someone want to seek dental care for themselves or their family. Reasons differ.

THE VALUE PROPOSITION

Individuals choose to receive dental services because they believe they have a need for those services to maintain their oral health[19]– or they have discomfort or dysfunction. The basic premise is that the demand for oral health stems from an individual's need for dental services and realization of that need. And, the value they place on it relative to other needs. Both need and awareness of need are required for a person to act. For some people—like many who seek treatment from dental providers in Sacramento County—oral disease and the resulting need for treatment are the starting point for the demand for dental services. Under this concept of demand, if a person is unaware of a need for care—or is not questioned about oral health by their primary care provider at preventive medical appointments—chances are less that they will seek care. These individuals can benefit from health education and promotion. However, if that individual continues to ignore professional care, the progression of any disease or condition will probably bring the person to understand that a need exists. It may require an episode of acute pain, teeth getting loose, or some other consequence, but the need will express itself sooner or later.[20]

Other community members have more awareness about the risks for oral disease. They make regular visits to dentists to obtain information about the current condition of their oral health. Dentists provide that update with diagnostic services, and patients receive preventive services to keep disease from occurring. When disease is detected, they receive treatment to treat oral disease, relieve pain or discomfort, restore function, or correct malocclusion. They understand the relationship between "good teeth" and employment; they understand regular dental care reduces the potential for missed school or work days. Under this theory of demand, awareness of the value of regular dental care will have a strong impact on the demand for dental services.[21] *That is the value proposition being offered.* Consumers—including those with financial constraints and others simply struggling with the demands of everyday life—must share that value, that is, they must view regular dental care as having a clear and compelling "value advantage" for the expenditure of their time, energy and, in some cases, money.

Value Proposition Challenges for the Medi-Cal Population

The Reality

The influx of the Medi-Cal population in recent years has required a re-set to engage them in the

importance of oral health. Cultural differences open up their own set of challenges and it takes time for the newest residents to buy in.

Organizations responsible for connecting Medi-Cal clients to a dental home have noted that the populations automatically assigned to a dentist vs. those who choose their own dentist will be the least likely to utilize services and represent the highest treatment needs.

The medical integration of oral health into general health has been a "slow idea."

When people understand and *act on* the belief that oral health is related to the quality of life, progress is possible; otherwise it is stagnant.

Dental care will always compete unfavorably when people are overwhelmed in meeting basic life needs like rent and food.

ACKNOWLEDGEMENTS

Funding for this study came from Sacramento County Oral Health Program Prop. 56 funds (California Healthcare, Research and Prevention Tobacco Tax Act of 2016); Sacramento County General Fund, DentaQuest Foundation, Inc., which supports programs designed to improve oral health; and Access, Health Net and LIBERTY Dental Plans which offer dental services to Sacramento Medi-Cal members through the California Medi-Cal Geographic Managed Care (GMC) dental program. The Sacramento District Dental Society graciously provided some of the items that were included in the thank-you gift bags for the many focus group participants we met with in-person.

We also wish to express special appreciation to the organizational representatives who took the time and interest in helping us identify and facilitate focus group opportunities with the populations they serve and their vast network of partner agencies. Their knowledge of the community and understanding of the information we were seeking helped inform the assessment. Thank you too to the experts and other insightful key informants whose input in certain ways influenced the direction our data collection took.

The California Department of Health Care Services Medi-Cal Dental Program staff was open and responsive to our multiple questions and requests for information, and facilitated access to various sources of data. Their help and participation in the study is particularly appreciated.

The consultant team included Barbara M. Aved, RN, PhD, MBA, principal investigator; Taline Kuyumdjian, MS; Dian Scheideman, RDH; and Jared Funakoshi, BS. Margaret Brazones, DDS, provided valuable review and consultation.

Disclaimer

This report was produced independently by Barbara Aved Associates at the request of the Medi-Cal Dental Advisory Committee and Sacramento County, and does not necessarily represent the views of individual Committee members or organizations represented, or the views of the study funders.

PROCESS

"At the end of the day—and it's unfortunate—patients have to fit into our schedule and not us into theirs." - Dental clinic representative

This oral health assessment involved gathering, analyzing and interpreting statistical and community data to identify community needs and provide the basis for developing action plans that can be responsive to the identified needs. The study is a point-in-time picture of oral health status, demographic and other indicators of community health and well-being, and access and utilization patterns in Sacramento County. Unavoidably, some data will be out of date as soon as we report it (if not before). Both quantitative (statistical data) and qualitative (surveys and interviews) methods were used to collect the information for the assessment. Where comparisons are made by income groups, "people with lower incomes" refers to those with household incomes below 200% of the federal poverty level (e.g., $36,900 annually for a family of four in 2022).

Data Sources and Collection Methods

Secondary Data

- The California Department of Health Care Access and Information (HCAI)—formerly called the Office of Statewide Health Planning and Development (OSHPD)—provided data on emergency department visits for dental conditions using discharge data when an oral condition was the primary diagnosis. [22] The oral conditions were identified using the ICD-10 diagnosis codes for non-traumatic dental conditions. Because these dental conditions are largely considered to be *preventable*, they are regarded as potentially avoidable, reflecting conditions that would "likely or possibly benefit from better prevention or primary care."[23] The Association of State and Territorial Dental Directors provided the ICD-10 dental codes HCAI used to pull the data for this report.

- Population-based data from UCLA's California Health Interview Survey (CHIS)—the largest state health survey in the U.S.—were accessed to examine oral health status, behaviors, and dental service utilization among the general Sacramento County population.

- Encounters, patient characteristics and other data that dental clinics are required to report to the state and federal government were accessed from the HCAI primary care clinic reports and HRSA's Uniform Data System (UDS), respectively.

- Existing data on Medi-Cal dental utilization were retrieved from the California Department of Health Care Services Medi-Cal Dental program through the California Health and Human Services Open Data Portal. There were data gaps due to small sample sizes (suppressed data) and sometimes data inconsistencies because of the timing or way some data are reported. For other Medi-Cal data, because DHCS staff does not prioritize "ad hoc" data requests (i.e., data

not already on its website) requesters must use the Public Records Act to obtain it and requesters must pay for it; a limited amount of funds to purchase data was provided for in this contract.

Primary Data – Community Input

Primary data are a rich and unique source of information that allows researchers to learn more about community needs, knowledge, attitudes, values, experiences and behaviors. It also provides opportunities to draw on the insights and experiences of others—providers, health planners and educators, advocates—in making recommendations for improvement.

Interviews

- **Key Informants.** Thirty-two key informants participated in structured telephone interviews as part of the assessment process. They included dental plan representatives, local leaders, policy makers, dental experts, providers, community-based organization representatives and advocates. Their views and knowledge—and in some cases data they shared—reflected a wide range of experience and served as a key asset to inform the study. Follow-up emails and phone calls helped us learn more about service issues, capacity and perspectives on need. (Attachment 1 contains a list of these individuals.)

- **Sacramento Dentists.** To verify the information on the state's Medi-Cal Dental Provider Directory (local dentists currently accepting Medi-Cal patients, we called all 83 of the Sacramento County dental offices listed on the state's dental provider website; 69 dental practices were listed as accepting Medi-Cal patients, and 13 as *not* accepting Medi-Cal "at this time." We were able to speak with someone from 81 (97.6%) of the practices. In most cases we spoke with office managers; in some cases, it was a dental provider or owner. The purpose of the interview was to verify the website information and ask about service capacity and any restrictions regarding Medi-Cal patients. We also wanted to identify those who provided sedation dentistry and served patients with disabilities and other special needs.

Surveys

- **Community Oral Health Survey.** A multi-language online survey formatted in SurveyMonkey solicited community member's knowledge and opinions on the value of oral health, and asked about their needs and experiences in accessing services (Appendix 5). The survey was translated by IRCO (Immigrant & Refugee Community Organization), and available in English, Spanish, Pashto, Vietnamese, Farsi, Ukraine and Russian. No identifiable respondent information was collected. MCDAC, SCOHP, Sacramento County Public Health and many Sacramento community-based organizations promoted the survey through their various social media platforms. The link to the survey opened on June 23, 2022 and closed on August 20, 2022. The survey data were captured in Excel spreadsheets, cleaned, coded and analyzed.

- **ACRC Service Coordinators.** We created an online survey for the Service Coordinators at Alta California Regional Center who worked with clients with disabilities and other special needs to

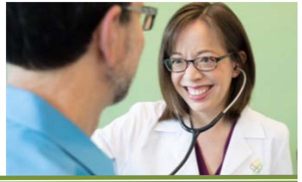
learn about their experiences in helping children and adults to access dental services, including hospital/surgery center dental care. Alta disseminated the online survey to 287 of its staff on June 16, 2022, the majority of whom were Service Coordinators; we closed the survey July 12, 2022. The data were captured in an excel spreadsheet, cleaned, coded and analyzed.

Community Focus Groups

- Various types of organizations in Sacramento County hosted 9 focus group opportunities for us with its clients/members (see Attachment 2). All except one of the discussion groups was able to be held in-person. Because the focus of this study was on adults, the sites and events chosen were intended to draw adult populations who typically gathered or were served there (e.g., parents attending some sort of class, older adults attending an exercise event, people receiving food bank services). Although the participants constituted a convenience sample and no one group was necessarily representative of Sacramento County, there was the expectation that *in the aggregate* the diversity of the groups would reflect the populations of highest interest to the needs assessment. The questions (Attachment 7) were generally open-ended to encourage dialogue, but included some that were intended to learn specific information (e.g., barriers to dental services). Spanish interpreters (generally program staff) provided interpretation when necessary, and written questions in Russian facilitated discussion in one of the groups. The focus groups were conducted by the same facilitator and the data were hand recorded during each meeting, then transferred to written summary formats where the notes were coded, analyzed and summarized.

Literature Review

To give context to and meaning to our findings, interpretations, and recommendations we performed a review of journal articles, studies and relevant reports related to the study purpose.



MEDI-CAL: A BRIEF OVERVIEW

"Dentistry still lives outside of medicine." – Key informant interviewee

Medi-Cal Health Program

Medi-Cal—California's version of the federal Medicaid program—is a major source of health insurance for millions of Californians. Recognizing that there are multiple audiences for this report, a brief overview of its key features, including the Medi-Cal Dental Program described later, is presented below for context. The program provides coverage for primary, specialty, and acute services for one-third of the state's population, and more than half of all children. Medi-Cal is administered by the California Department of Health Care Services (DHCS), one of 12 Departments and 5 Offices overseen by the California Health and Human Services Agency.[24]

Eligibility for Medi-Cal coverage is determined based on an individual's income and resource levels. Medi-Cal beneficiaries who have a share of cost (SOC) refers to individuals with income too high to meet the Medi-Cal income limit requirement. SOC works similar to a monthly insurance deductible in that the monthly SOC must be met before Medi-Cal starts to pay, and members get billed for services until they meet their SOC

Statewide, about 82% of Medi-Cal beneficiaries receive their health (medical) coverage through managed care plans contracted with the state, while the remaining 18% are enrolled through the fee-for-service (FFS) system. Eligible Medi-Cal members (see page 24, Table 5 for exempt groups) choose a managed care plan or one is assigned to them in the absence of a selection. They also must choose a physician or physician group (which can include a community health center clinic).

The managed care plans vary depending on the county a person resides in. Most counties—which are responsible for administering Medi-Cal at the local level—offer commercial plans including Anthem Blue Cross, Kaiser Permanente, Health Net, and Molina, the same ones Sacramento does. Other counties offer public plans administered by the community. If a county only administers one plan, then all Medi-Cal members are enrolled in that plan.[25]

Enrollment

Medi-Cal members are allowed to change their plan or provider monthly. A change takes effect the first of the month following the request. If a member does not choose a provider within 30 days of the initial enrollment, then the managed care plans will auto-assign. Plans have to ensure that a provider is selected within time or distance standards (30 minutes or 10 miles from the member's residence). The algorithm process, described more fully in the endnote to this section, includes those time/distance standards as well as member-to-provider ratios.[26] If a Federally Qualified Health Center (FQHC), for example, is listed in provider networks for both the medical plan and the dental plan, then the member can choose that FQHC under each plan. This is an important issue addressed more fully later in this report. The algorithm criteria are only used when a member does not make their selection within the allotted 30 days.

At mid-July 2022, 621,993 individuals in Sacramento County were enrolled in Medi-Cal (Table 1).[27] Almost 40%, or 242,189, of the members were children age 0-20; 11%, or 67,340, were young children age 0-5. The remaining members, 312,464, are adults. Most of these members (86.9%) were enrolled in the managed care delivery system,[28] with Anthem Blue Cross having the majority of members (Table 1).

On December 30, 2022, DHCS announced its intent to award contracts to the managed care plans that "will operate under [a] new, rigorous Medi-Cal contract" to cover Sacramento for medical care. These are Molina Health Care, Health Net Community Solutions, Inc. and Anthem Blue Cross Partnership Plan;[29] and, Kaiser outside of the contracting selection process. The new contract term is expected to be 1/1/24 – 12/31/28. In this announcement, DHCS also expressed intention to increase oversight of the managed care plans and link payments to them more closely to the value they provide relative to member access and outcomes (metrics to be defined).

Table 1. Sacramento County Medi-Cal Enrollment by Type of Health Care Delivery System, December 2021[1]

Medi-Cal Health Care System[1]	Number of Members[1]	Percent
Fee for Service (FFS) total	81,736	13.1%
Managed Care (M/C) total	540,257	86.9%
FFS + M/C	621,993	100%
Managed Health Care by Plans		
Sutter Senior Care	443	.08%
Out of County Plan	5,271	1.0%
Aetna Better Health of CA	20,431	3.8%
Molina Healthcare	57,398	10.6%
Kaiser	113,721	21.0%
Health Net	130,560	24.2%
Anthem Blue Cross Partnership Plan	212,433	39.3%

Source: https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-tables-by-county-from-2010-to-most-recent-reportable-month
[1]Most-recent reportable month is December 2021.
[2]Most-recent reportable month is July 2022.

Dual Eligibility

Medicare is health insurance for people who are: 65 and older; under age 65 with certain disabilities; any age with end-stage renal disease (requiring dialysis or a kidney transplant); or, any age with ALS (Lou Gehrig's disease).[30] Regular Medicare does not cover most dental care including procedures and supplies like cleanings, fillings, tooth extractions, dentures, or other dental devices. However, many Medicare Advantage plans (with a cost to the member) include some dental benefits, and nearly half of Medicare beneficiaries in California are enrolled in Medicare Advantage. In addition, Medicare Part A (hospital insurance) can pay for certain dental services for individuals who are hospitalized such as emergency or complicated dental procedures[31]

People who qualify for both Medicare and Medi-Cal are called "dual-eligible" or *Medi-Medi* beneficiaries. Depending upon their Medi-Cal status, Medi-Medi beneficiaries may have dental

benefits covered by Medi-Cal.* It was clear from the focus groups we conducted for this study that many older people with Medicare who appeared to be very low-income and said they "couldn't afford to go to the dentist" were unaware they *might* qualify for Medi-Cal as a Medi-Medi beneficiary. It was also clear that some Medicare patients need better education on the difference between Medicare and Medi-Cal, and better education on applying for Medi-Cal to see if they are eligible. Those who are eligible but not enrolled tend to be the ones who need care.

Of the 256,593 Sacramento County residents with Medicare in March 2021, 58,497 (22.8%) were dually eligible for Medicare and Medi-Cal,[32] the same percentage as statewide. Data on differences by race and ethnicity are not available at the county level but statewide enrollment shows the distribution as: 55.2% Hispanic; 40.7% Asian; 33.9% Black, and 14.7% White beneficiaries.[33]

Voluntary vs. Mandatory Enrollment

Some Medi-Cal members in certain aid codes are not enrolled in managed care, such as those with a Share of Cost, and instead received services through the Fee-for Services (FFS) program. However, because some aid codes (the eligibility categories are determined at the time of Medi-Cal application) allow voluntary enrollment, beneficiaries not assigned a mandatory aid code have the *choice* of going into a contracting managed care health plan (and managed dental plan) rather than the FFS system. Categories of beneficiaries with exempt and mandatory enrollment[34] include those shown in Table 2 below. (See also Table 5 on page 24 for dental-specific information.)

Table 2. Medi-Cal Beneficiaries with Exempt and Mandatory Enrollment in Managed Care

Beneficiaries not required to enroll in a managed care but may voluntarily choose to do so	Beneficiaries that have mandatory FFS enrollment and do not transition to managed care
Aid Code Group: ▪ Child and Adult Refugees ▪ Children in the Adoption Assistance Program ▪ Children in the Kinship/Guardianship Assistance Program ▪ Children in Foster Care ▪ County and state inmate programs (juvenile and adult)	**Aid Code Group:** ▪ Restricted scope Medi-Cal ▪ Share of Cost (SOC) including Trafficking and Crime Victims Assistance Program (TCVAP) SOC, excluding Long-Term Care SOC ▪ Presumptive Eligibility ▪ State Medi-Cal parole, county compassionate release and incarcerated individuals ▪ Non-citizen pregnancy-related individuals enrolled in Medi-Cal (not including Medi-Cal Access Program)

Source: DHCS Medi-Cal Dental Program, May 26, 2022.

* While Medi-Medi beneficiaries are eligible for the same Medi-Cal dental benefits as all other full-scope Medi-Cal beneficiaries, Medi-Cal is the payer of last resort according to DHCS. So, any dental benefits also available under Medicare are first paid through the Medicare Advantage plan or Original Medicare, with any coinsurance billed to Medi-Cal.

CalAIM (Health) Overview*

In order to meet the increasingly complex health needs of Medi-Cal beneficiaries, the Department of Health Care Services plans over the next 5 years to integrate delivery systems and align funding, data reporting, quality and infrastructure. The framework for achieving this is California Advancing and Innovating Medi-Cal (CalAIM), a long-term state commitment that went into effect January 2022 to transform Medi-Cal that encompasses broader delivery system, program and payment reform across the program. A high-level summary by DHCS[35] describes the goal as leveraging Medicaid to help address many of the complex challenges facing California's most vulnerable residents, e.g., homelessness, insufficient behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

Because DHCS has increased the number of beneficiaries receiving the majority of their health care through Medi-Cal managed care plans, it expects the plans will be able to offer more complete care coordination and management than is possible through a fee-for-service system, and provide a broader array of services aimed at stabilizing and supporting Medi-Cal members. Accordingly, CalAIM would allow the state to take a population health, more equitable person-centered approach to providing services that prioritizes prevention and puts the focus on improved outcomes. The CalAIM initiative is also expected to ensure that benefits covered by both Medicare and Medi-Cal are coordinated by one health plan to reduce fragmentation and improve care for a population that often has multiple chronic conditions and many care providers.

* CalAIM *Dental* is described in the next section of this report.

MEDI-CAL DENTAL PROGRAM

While the majority of the California Medi-Cal program is administered as a managed care system, the Medi-Cal *Denta*l Program is administered as a fee-for-service (FFS) program, and its policies, including rates, are the foundation of the entire dental care program.

Uniquely in Sacramento County, however, since 1994, Medi-Cal dental is a *mandatory* managed care system delivered through the Geographic Managed Care (GMC) dental program. Except for certain non-mandatory aid codes discussed above, Medi-Cal recipients in Sacramento County must enroll in one of the GMC dental plans for their dental care, choosing a contracting dental plan and dentist, or having one chosen for them in the absence of a decision. The only other county in which Medi-Cal dental managed care exists is Los Angeles County; however, there Medi-Cal dental managed care is a *voluntary* managed care delivery system through a program called Prepaid Health Plans (PHP). The Department of Health Care Services (DHCS) currently contracts with 3 dental managed care plans that serve both Sacramento and Los Angeles Counties: Access Dental Plan (which is now part of Western Dental & Orthodontics), Health Net, and Liberty Dental Plan.

DHCS has recently informed Sacramento Medi-Cal dental managed care members that if their plan does not meet performance standards, starting in May 2023 members may choose to leave their plan and go into the FFS system; those who do, however, must return to dental managed care after 2024 when DHCS issues new contracts with dental plans.[36]

Medi-Cal Dental Benefits

Children (Age 0-20)

While states may choose whether to offer dental benefits to adults, most children age 20 and younger with full Medicaid benefits are entitled to dental services. Children's services mandated through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit requires states to provide a comprehensive dental benefit to Medicaid (Medi-Cal)-enrolled children.[37] In California, Medi-Cal requires managed care plans to make direct referrals of enrolled children to dental providers for comprehensive diagnostic, preventive and treatment services.[38]

Adults (Age 21+)

States have flexibility to determine what dental benefits are provided to adults with Medicaid. There are no minimum requirements for adult dental coverage. A 2019 review of states' coverage for adult Medicaid dental benefits[39] showed:

Type of Adult Coverage	Number of U.S. States
None	4 (7.8%)
Emergency	13 (25.5%)
Limited	15 (29.4%)
Extensive*	19 (37.3%)

Source: Centers for Medicaid & Medicare Services. *Includes California.

In California in the last decade and a half, Medi-Cal adult dental benefits—along with provider reimbursement rates—have fluctuated in response to shortfalls or surpluses in the state budget. A brief history of Medi-Cal adult eligibility/scope of benefits shows:

- In 2009, as a way to save money, most of the Medi-Cal adult non-emergency dental benefits were eliminated.
- In May 2014, pursuant to Assembly Bill 82 (Chapter 23, Statutes of 2013), DHCS partially restored Medi-Cal adult optional dental benefits which included basic preventive, diagnostic, restorative, anterior tooth endodontic treatment, complete dentures and complete denture reline/repair services.
- Full scope adult Medi-Cal Dental services were restored on January 1, 2018. Adult dental benefits that remained in place and did not change as a result of either the 2014 or 2018 restorations included pregnancy-related services; emergency services; services provided to residents of in Intermediate Care Facility/Skilled Nursing Facility; and services provided to consumers of the Department of Developmental Services.
- On May 1, 2022, individuals age 50 + who met all Medi-Cal eligibility criteria, and did not have satisfactory immigration status for federally-funded full-scope Medi-Cal, became newly eligible for state-funded full-scope Medi-Cal under the Older Adult Expansion. DHCS transitioned adults age 50+ who were currently enrolled in restricted scope Medi-Cal to full-scope Medi-Cal. Individuals who currently apply for Medi-Cal (medical and dental benefits) will automatically be determined eligible for full-scope Medi-Cal if they are 50 years of age or older and meet all other Medi-Cal eligibility criteria, regardless of immigration status. [40]

A recent DentaQuest report reinforced the fact that many adults, including those who provided input for this needs assessment, are unsure or incorrectly believe Medicaid (74%) and Medicare (62%) cover dental treatment.[41]

Attachment 3 in the Appendices provides a high level description of the most commonly used Medi-Cal dental benefits, while Attachment 4 provides links to detailed information from the Medi-Cal Dental Provider Handbook (updated May 2022) for providing dental services under this program.

Annual Cap on Benefits

Medi-Cal pays up to $1,800 in a year for covered adult dental services; pregnant beneficiaries may qualify for no yearly limit, however. Dental services may exceed the $1,800 cap if shown to be medically necessary. DHCS clinicians review and determine whether the claim or Treatment Authorization Request (TAR) submitted by the dental provider meets the criteria for "medical necessity." Confusion about the coverage, or receiving an actual denial or the belief of a denial, according to our focus group feedback, were reasons related to cost Medi-Cal participants cited as a barrier to care: some didn't go for the needed treatment or didn't complete their treatment—

possibly showing up at an emergency room—because they didn't have the means to pay for all of the dental work (*"I can't afford the full treatment Medi-Cal doesn't pay for"*).

Medi-Cal Dental Population and Enrollment

As each medical and dental plan has its own system using the algorithm process, the assignment has no medical and dental linkage at the provider level to select the same location, such as for Medi-Cal members enrolled at Sacramento Native American Center where both medical and dental services are offered. If a Medi-Cal member wanted to receive comprehensive health care services at that FQHC, for instance, it would stand to reason that they be assigned to SNAHC as the provider of choice both for medical and dental rather than allowing for the algorithm process described above to determine the assignment.

In CY 2021, 574,714 children and adults in Sacramento County with Medi-Cal were enrolled in either the Dental Managed Care (DMC) or the fee-for-service (FFS) program (Table 3).[42] (Note that this figure differs slightly from the number of enrollees reported in other tables because different datasets sometimes use different reporting parameters.[*])

Table 3. Number of Medi-Cal Members by Type of Dental System, Sacramento County, CY 2021

	Children (Age 0-20)	Adults (Age 21+)	Total
GMC	226,120	284,711	510,831
FFS	56,248	7,635	63,883
Total	282,368	292,346	574,714

Source: Department of Health Care Services Medi-Cal Dental Services Division FFS provided through Public Records Act, August 30, 2022.
Note: GMC data are DMC Performance Measures; members with 90 days continuous eligibility in that plan during the measurement period. ; GMC are beneficiaries continuously enrolled for one (1) year with no gap in coverage.

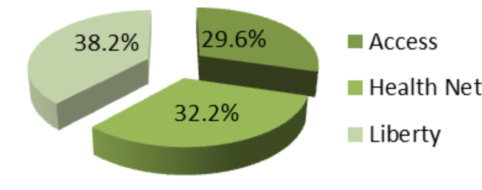
Table 4 and Figure 1 show the DMC enrollment of children and adults by each of the 3 GMC dental plans, and the percentage distribution of members among the plans, respectively, for CY 2021.[43] Figure 2 (the pie chart on the next page) displays the race/ethnic break-out of DMC members.

Table 4. GMC Dental Plan Enrollment, CY 2021

	Age 0-20	Age 21+	Total by Plan
Access*	65,663	84,991	150,654
Health Net	69,958	95,476	165,434
Liberty	90,499	104,244	194,743
Total for Age Group	226,120	284,711	510,831

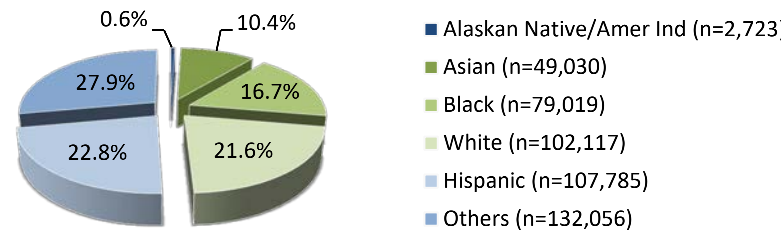
*Access Dental is now part of Western Dental & Orthodontics
Source: Department of Health Care Services. Dental Managed Care Performance Measures

Figure 1. GMC Member Distribution, CY 2021



[*] DHCS datasets by county, age, time period, type of service, and type of delivery system do not always match one another.

Figure 2. GMC Dental Members by Primary Race/Ethnicity Groups, 2022



Exemption from Mandatory DMC Enrollment

In CY 2021, 114,676 (18.4%) of the Sacramento County 621,993 Medi-Cal members were exempt from mandatory enrollment in Dental Managed Care based on Medi-Cal aid codes. Of these members, 16,558 (14.4%) were children 0-20 and 98,118 (85.6%) were adults age 21 and older. Of the total exempt members, 50,703 (44.3%) *voluntarily* chose to enroll in a GMC dental plan while 63,883 (55.7%) remained in the FFS system (Table 5). The majority (88.0%) of the dental population remaining in FFS were children.

Table 5. Sacramento County Medi-Cal Members with Non-Mandatory Aid Codes and Dental Enrollment, CY 2021

Age Group	Aid Codes Exempt from DMC	Chose to Enroll in DMC Dental	Remained in FFS
Children Age 0-20	98,118 (85.6%)	41,870 (82.4%)	56,248 (88.0%)
Adults Age 21+	16,558 (14.4%)	8,923 (17.6%)	7,635 (12.0%)
Total	114,676 (100.0%)	50,793 (100.0%)	63,883 (100.0%)

Source: Department of Health Care Services Medi-Cal Dental Services Division, data run provided through Public Records Act, August 30, 2022.

Medi-Cal Dental Outreach and Support

Outreach to Members

The *Smile, California* campaign, part of Delta Dental's 2022 Medi-Cal Dental Member and Provider Outreach Plan,[44] is a strategy to educate Medi-Cal FFS members about their available dental benefit, with the aim of motivating them to schedule a dental appointment. The campaign has developed several culturally and linguistically relevant downloadable resources, including: flyers, brochures, posters, fotonovelas, infographics, social media assets, presentations and videos. These resources have been distributed by a variety of partners, including state agencies, Local Oral Health Programs and community-based organizations. The key messages to members highlight the following:

- Medi-Cal covers dental services
- Medi-Cal members are eligible for free or low-cost dental services
- Regular dental visits are as important to good health as daily brushing and flossing
- Annual dental visits are free or low-cost with Medi-Cal
- Keeping your teeth healthy is one of the best things you can do for your overall health
- It is safe and recommended to see a dentist for a cleaning and exam during pregnancy
- Medi-Cal members ages 21 and older have full-scope dental coverage

Despite basic information provided about dental benefits during eligibility determination, enrollment support from dental managed care plans—such as materials provided in multiple languages with attractive graphics—and much more visibility by *Smile, California*, some Medi-Cal members in our focus groups and surveys remained unaware they had adult dental benefits or what was included.

Outreach to Dental Providers

The campaign also includes outreach to provider audiences for recruitment and retention purposes and is aimed at: current Medi-Cal dental providers; current providers not actively taking patients and/or referrals; and currently enrolled and recently graduated dental students. The outreach activities target providers with specialized approaches for areas where the number of enrolled dental providers and/or facilities providing dental services to Medi-Cal members is low compared to the Medi-Cal population or sub-population, and the number of billing and rendering providers to member population and sub-population is low compared to the Medi-Cal population or sub-population in the area.[*] To counteract some of the negative perceptions/experiences or misinformation of providers, the key messages highlight the following:

- The enrollment application process has been streamlined (see next paragraph)
- Outreach representatives are available for one-on-one assistance during the application process
- One-on-one assistance from the fee-for-service Delta Dental Support Team is also available for provider enrollment, billing issues, explanation of Medi-Cal Dental benefits
- The provider website application (self-service web portal) allows secure login for providers and their staff to access claim status, Treatment Authorization Request (TARs) status, weekly check amounts and accessing member history
- Interpreter services for Medi-Cal patients are available and free
- Transportation is also available free of charge for members

DHCS also enhanced the portal to simplify and accelerate the Medi-Cal enrollment processes for dental providers. Starting October 31, 2022, providers were able to electronically submit enrollment applications and required documentation to DHCS through a new system called Provider Application and Validation for Enrollment (PAVE).

The 2021 statewide Medi-Cal Provider Survey revealed that among the non-enrolled providers—who had a "neutral or mostly positive perception" of the program—the top two reasons that prevented dental providers from participating in Medi-Cal were again a) low reimbursement rates, and b) difficulty processing TARS and claims. Unfair or not, this "reputation" continues to hamper dental provider recruitment—and retention—efforts.

CalAIM Dental Overview

The major components of CalAIM Dental build on the outcomes of various pilots (including the Dental Transformation Initiative) with an aim to improve access, oral health outcomes, and long-

[*] "Low" is defined as a 1:2,000 member-to-enrolled provider ratio within a specific county.

term cost savings/avoidance. The DHCS goal is to reach a 60% dental utilization rate for Medi-Cal eligible children, and increase preventive service utilization for children and adults (no percentage goal stated). To align with national dental care standards, the new benefits will include:[45]

- Expanded pay-for-performance (P4P) payments that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home.
- Caries Risk Assessment (CRA) Bundle for young children.
- Silver Diamine Fluoride (SDF) for young children and specified high-risk and institutional populations.

NEEDS ASSESSMENT FINDINGS

"When someone personally asks you to do something, it's harder to say no."
– Key informant interviewee on why physicians should promote dental visits

County Demographic Snapshot

Demographic trends help to project potential unmet needs for dental and other healthcare-related services and how to plan strategically. In the 2020 Census, Sacramento County had an estimated population of 1,585,055. Looking at the projected population change between 2020 and 2021 by county and city, Table 6 indicates a slight increase overall, with small growth in most areas.

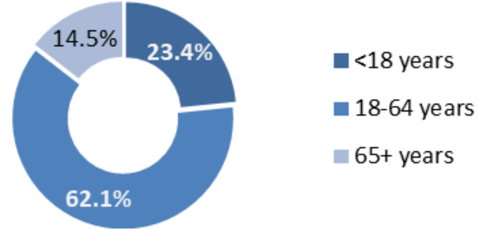
Table 6. Percent Change in Population Between 2020 and 2021 by County and City

County/City	Total Population		Percent Change
	1/1/2020	1/1/2021	
Sacramento	1,553,157	1,561,014	0.5
Citrus Heights	87,788	87,811	0.0
Elk Grove	176,036	178,124	1.2
Folsom	81,106	82,303	1.5
Galt	26,006	26,116	0.4
Isleton	832	832	0.0
Rancho Cordova	78,333	79,662	1.7
Sacramento	513,626	515,673	0.4
Balance of County	589,430	590,493	0.2

Source: California Department of Finance. City/County Population Estimates with Annual Percent Change

Looking at population by age group, children aged 0-18 comprise 23.4% or 370,903 of the county's total population, with 984,319 adults making up 62.1% and 229,833 seniors making up the remaining 14.5% (Figure 3).

Figure 3. Sacramento County Population by Age Group, 2021



As Table 7 indicates, while the projected 5-year population change in 2025 is expected to be an overall growth of 3.3%, some age groups show pronounced differences; for example, an increase of 18.6% for adults 30-34 but a drop of 13.2% for adults 35-39—and notably a projected overall shift toward the older population groups.

Table 7. Sacramento Population by Age Group with Projected Percentage Change

Age Group	2020 (Actual)	2025 (Projected)	% Change
0	19,505	18,940	-2.9
1-4	78,081	76,334	-2.2
5-9	99,328	97,314	-2.0
10-14	103,275	99,949	-3.2
15-19	110,124	112,357	2.0
20-24	122,055	121,512	-0.4
25-29	109,813	113,487	3.3
30-34	92,875	110,183	18.6
35-39	108,553	94,214	-13.2
40-44	102,351	110,077	7.5
45-49	97,599	103,257	5.8
50-54	96,346	96,401	0.1
55-59	97,993	92,912	-5.2
60-64	91,868	92,099	0.3
65-69	77,680	86,057	10.8
70-74	62,668	71,462	14.0
75-79	39,025	55,243	41.6
80-84	26,092	32,113	23.1
85-89	17,166	19,371	12.8
90-94	8,259	9,375	13.5
Total	1,560,656	1,612,657	3.3

Source: California Department of Finance. Demographic Research Unit. Report P-2C: Population Projections by Sex and 5-year Age Group, California Counties, 2010-2060. Sacramento: California. April 2021.

Data from the California Department of Agency[46] provide a snapshot of some of the key demographic characteristics of Sacramentans age 60+ that are used in planning health and other community-based services (Table 8).

Table 8. Key Characteristics of Adults Age 60 and Older, Sacramento County 2020

Characteristic	Number	Percent
Lives alone	65,130	14.4%
Low-income	41,775	9.2%
Race/ethnic minority (non-White)	123,713	27.3%
Non-English speaking	12,780	2.8%
Non-minority	202,788	44.8%
Rural	6,251	1.4%

Source: California Department of Aging.

Sacramento is one of the most racially and ethnically diverse counties in the nation. Using a Diversity Index,[*] the Census Bureau[47] in 2020 determined which counties with populations "significantly

[*] The Diversity Index tells the chance that two people chosen at random will be from different racial and ethnic groups. In Sacramento County, the chance is 73.3%. Sacramento is third highest in diversity in California after Solano and Alameda Counties, at 75.6% and 75.1%, respectively.

larger than 5,000" were the most diverse. Sacramento County ranked 14 in the U.S., followed by Contra Costa County at number 15. Figure 4 displays the race and ethnic diversity of Sacramento County at the 2020 Census.

Figure 4. Sacramento County Population by Race/Ethnic Group, 2020

Source: https://censusreporter.org/profiles

Findings from the Decennial Census[48] reflect the population change in Sacramento County's racial and ethnic diversity since 2010.[*] Because of the focus on adults in this assessment, the right-hand columns of the table break out the percentage change for only the population age 18 and older. As Table 9 indicates, the proportion of white adults decreased between 2010 and 2020 while all other groups increased—"two or more races" significantly so.

Table 9. Number of Sacramento Residents by Race/Ethnicity, 2010 and 2020

		2010		2020		% Change All Ages		% Change Age 18+ only	
		#	%	#	%				
Race	**Total**	**1,418,783**		**1,585,055**		**11.7%**	↑	15.3%	↑
	White	815,148	57.7%	715,722	45.2%	-12.2%	↓	-8.7%	↓
	Black	147,055	10.4%	152,795	9.6%	3.9%	↑	10.4%	↑
	American Indian	14,307	1.0%	18,637	1.2%	30.3%	↑	36.3%	↑
	Asian	203,212	14.3%	281,733	17.8%	38.6%	↑	42.0%	↑
	Pacific Islander	13,856	1.0%	18,914	1.2%	36.5%	↑	42.1%	↑
	Other	131,687	9.3%	185,565	11.7%	40.9%	↑	54.1%	↑
	Two or more	93,511	6.6%	211,669	13.4%	126.4%	↑	179.6%	↑
Ethnicity	Hispanic	306,192	21.6%	374,434	23.6%	22.3%	↑	31.9%	↑

Source: 2020 Decennial Census

Refugee Populations

Refugee and asylum-seeker populations have shown higher burden of oral diseases and lower access to dental services.[49] They frequently arrive with limited oral health knowledge, making oral health disparities a concern for these populations. Sacramento is one of the 8 designated refugee-

impacted counties in California, with an extensive history of embracing refugee groups. According to Amnesty International Sacramento, the county has welcomed more than 20,000 refugees during the last 15 years, largely from Afghanistan, Iraq and the former Soviet Union. In 2019, approximately 9,700 Afghans were estimated to be residing in Sacramento County, for example. And, with an already high concentration of Ukrainian immigrants in Sacramento (18,000 according to the Migration Policy Institute[50]), a greater number of refugees from that country could be expected following the Russian attacks on Ukraine.

Previously imposed ceilings and more recent revisions on the resettlement program, along with some remaining COVID-19-related logistic challenges, have made it difficult to anticipate the potential program and fiscal impact for Sacramento County organizations that serve refugee populations. Based on the poor oral health of these populations, it can be expected that many newly-arriving individuals—who will qualify for public programs—could present with diverse needs, including issues like oral disease with significant treatment needs.

Selected Community Health Indicators

"We're so busy getting out the door in the morning we honestly forget to have them [children] brush; I guess we're too tired a lot at night, too."
- Focus Group participant

Certain socioeconomic factors—education level, dietary habits, income and poverty—have been shown to affect overall health as well as oral health status and outcomes. The burden of oral disease falls heaviest on vulnerable population groups. For example, adults with low-income are less likely to receive timely dental care like regular checkups and are more likely to visit the dentist for specific problems than those with higher incomes—a fact that holds true even for low-income residents who have dental insurance. [51] A review of some of these indicators in Sacramento County helps to fine tune approaches to delivering oral health services.

Population in Poverty

Socioeconomic status has a significant impact on access to preventive as well as treatment services. While different predictors can play a role, overall, individuals in lower socioeconomic groups have less awareness and access to oral health care and are at a higher risk for dental disease. "Persons living in poverty," as federally defined is a common measure of economic insufficiency in health services planning. While many Sacramento County residents fall under higher-household income brackets, a notable share of households and individuals are struggling. About 12.5% of the population in the county is estimated to live in poverty, as indicated in Table 10, while children the proportion is close to 21%, both figures higher than the statewide average.

Table 10. Percent of the Population Living in Poverty, 2020

	Total Population[1]	Children Ages 0-17[2]
Sacramento County	12.5%	20.8%
California	11.5%	14.6%

Source: [1] U.S. Census Bureau. Small Area Income and Poverty Estimates. [2] U.S. Census Bureau, ACS Summary Files (December 2019) as reported in kidsdata.org.

Food Security

Having access to enough food for a healthy life is commonly used as one marker for poverty. Asked in the 2021 California Health Interview Survey (CHIS) of adults whose annual household income was less than 200% of the Federal Poverty Level whether they were able to afford enough food (food secure), 46.0% in Sacramento County (up from 35.0% in 2020) said "no," identifying them as food insecure.[52] CalFresh, which provides nutrition assistance to low-income Californians, plays an important role in alleviating poverty. In March 2022, 233,415 (about 15%) Sacramento County children and adults were receiving CalFresh benefits (Table 11) compared to 11% statewide.[53] This

indicator is relevant to oral health because it assesses vulnerable populations that are more likely to have multiple access, health status and social support needs.

Table 11. Number of Sacramento County Individuals and Households Receiving CalFresh

Point-in-Time 2021	
Children under age 18	80,749
Persons age 18-59	97,821
Persons age 60 and over	35,138
Persons with English as a Second Language	47,466
March 2022	
Persons	233,415
Households	125,249

Source: CA Department of Social Services. CalFresh Data Dashboard.

Employment

Besides the advantage of having employer-based health insurance in many cases—sometimes with dental insurance—healthier people are more likely to gain and retain employment, making for greater family stability.[54] Unemployment rates available at the sub-county level lists areas in Sacramento County in decreasing order of amount (Table 12). The county average, 3.8%, was slightly more favorable than the state average at 4.1%, and clearly more favorable than May 2021, 7.1%, as the county has now regained more jobs lost during March and April of 2020 due to COVID-19.

Table 12. Monthly Unemployment Rate for Cities and Census Designated Places, August 2022

Sacramento County Average (3.8%)	
Area Name	**Unemployment Rate**
Florin CDP	6.3%
Galt city	5.5%
Arden Arcade CDP	4.6%
Foothill Farms CDP	4.5%
Sacramento city	3.7%
Citrus Heights city	3.5%
Rancho Cordova City	3.4%
Carmichael CDP	3.3%
Gold River CDP	3.2%
Rosemont CDP	3.2%
Walnut Grove CDP	3.1%
Elk Grove CDP	3.0%
Vineyard CDP	2.9%
Orangevale CDP	2.9%
Rio Linda CDP	2.9%
North Highlands CDP	2.6%
Wilton CDP	2.6%
Fair Oaks CDP	2.4%
Folsom city	2.3%
La Riviera CDP	2.1%
Isleton city	2.0%
Rancho Murieta CDP	1.5%

Source: Employment Development Department. Labor Market Information Division. In decreasing order of magnitude.

Educational Attainment

Low educational level is a predictive factor for a low level of oral health knowledge—understanding and knowing how to manage oral conditions, adopting preventive health practices, and so forth.[55] Research has also shown that among adults educational level influences oral conditions (number of teeth, caries experience).[56] The U.S. Census Bureau estimated that while 83.3% of adults age 25 and older statewide have obtained at least a high school diploma (or equivalent) in 2020, 87.9% of Sacramento County residents have done so. About 31.4% of county residents have earned a bachelor's degree or higher compared to 34.7% in California. [57]

English Language Learners

Families where English skills may be limited may also have a low level of oral health literacy, which can interfere with their ability to process and understand oral health information, or possibly influence oral health status. In Sacramento County, 2020 U.S. Census data show 32.4% of households speaks other than English at home by family members age 5 and older.[58] In thinking about language proficiency and the question of health literacy, it is instructive to also look at children and adolescents considered English Learners. Of Sacramento County's K-12 public school enrollment in 2020-21, 42,410 (17.5%) of students were reported to be English-Language Learners.[59]

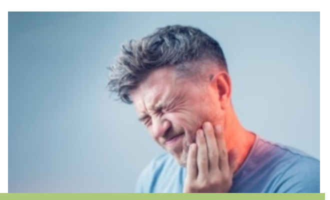
Family Composition

In designing and implementing targeted outreach and education campaigns an understanding about families and family composition can be useful. (While "family" can mean many things, it is officially defined by the U.S. Census as a householder and one or more other people related to the householder by birth, marriage, or adoption.) Various characteristics concerning Sacramento families are displayed in Table 13.

Table 13. Family Composition, Sacramento County*

	Sacramento County	California	Year
Households with children 0-17[60]	33.2%	33.4%	2018
Husband and wife families as a percent of all families[61]	65.0%	72.0%	2020
Percent of households with own children of the householder who are:[62] a) married couple b) female head c) male head	a) 20.6% b) 17.1% c) 21.3%	a) 21.2% b) 15.8% c) 22.0%	2020
Percent of children ages 0-5 living with grandparent householder with no parent present in the home[63]	16.0%	16.2%	2020

*See Endnotes for data sources.



Extent of Oral Disease

"They said not enough of my teeth were doomed so the state wouldn't approve them doing that deep kind of cleaning."
- Focus Group participant referring to root planing and scaling

Oral diseases are among the most prevalent diseases and have serious health and economic burdens, greatly reducing quality of life for those affected. The most prevalent and consequential oral diseases are dental caries (tooth decay), periodontal disease, tooth loss, and cancers of the lips and oral cavity. Children living in poverty, socially marginalized groups, and older people are the most affected by oral diseases.

Prevalence of Oral Disease Among Children

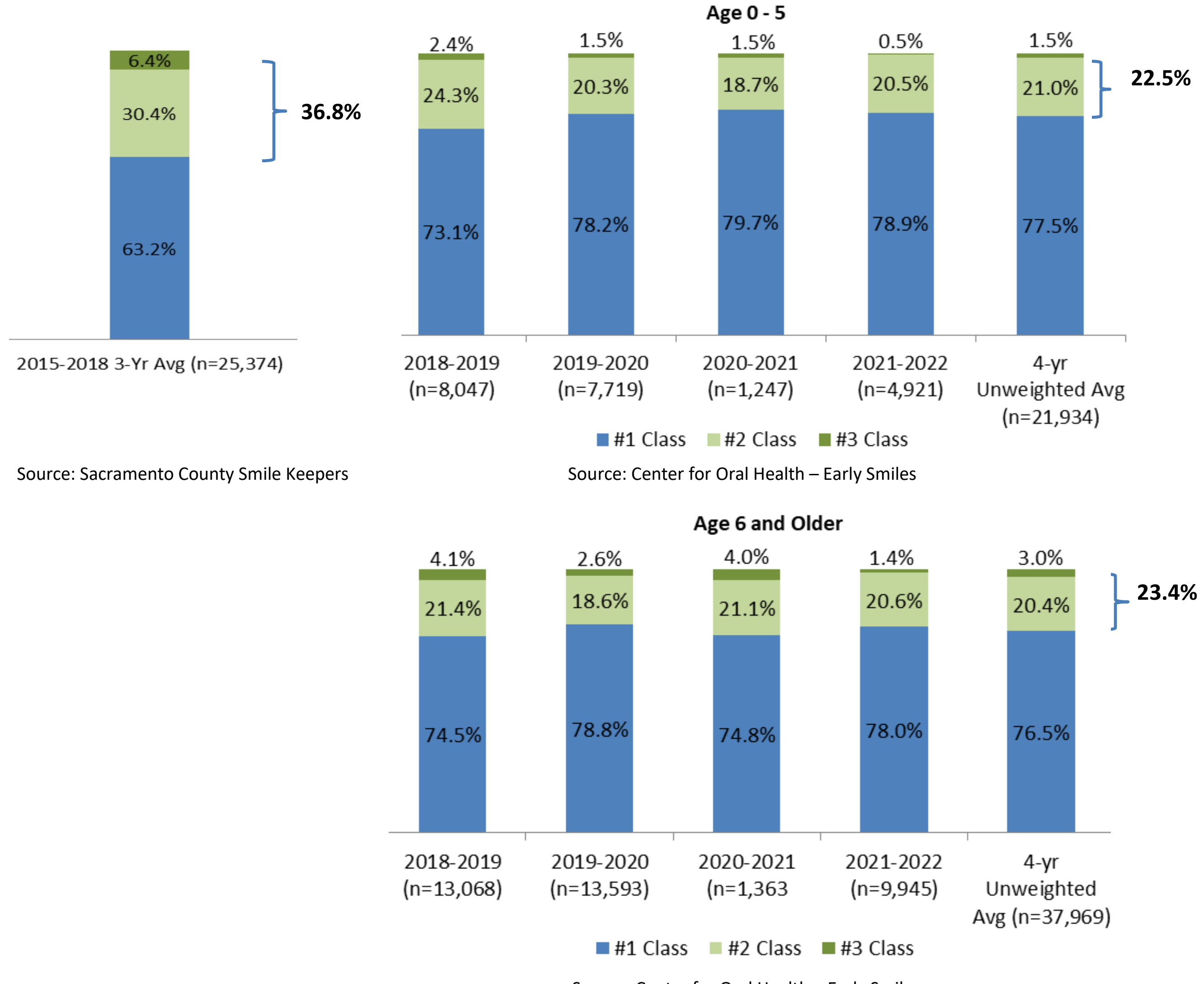
The consequences of poor oral health are particularly critical for children and can have a huge impact on a child's social-emotional health, systemic health, as well as affect a child's performance in school. Dental disease, the most common chronic childhood disease, contributes to school absenteeism, difficulty learning, and diminished nutritional status, self-esteem and overall well-being and development. Prevalence of untreated decay in primary or permanent teeth among children from lower-income households is more than twice that among children from higher-income households.[64]

Since 2018, The Center for Oral Health (COH) Early Smiles program has conducted dental screenings for children age 0-20 in most of the high need preschools, Head Start Centers and other schools in Sacramento County. The COH also provides children with fluoride varnish applications, oral health education and tooth brushing kits. In 2021-22, screening and other oral health services were provided at 145 preschools and 91 other schools to 4,921 children age 0-5 (33.1%) and 9,945 children age 6 and above (66.9%).

The most recent 4-year children's dental screening results suggest community oral health education and provider training efforts *may* have made a difference in lowering the prevalence of dental decay. (This is consistent with what we heard anecdotally in the key informant interviews; though to be fair, the findings could be based on confounding factors such as the populations screened, the dental programs and calibration issues.) Yet, the difference between the 4-year FY 2018-2022 average compared to the previous 3-year 2015-2018 average (the latter conducted in nearly the same schools but by the County Smile Keepers program) is striking. In the distant period, an average 36.8% of the children were assessed to have some level of dental concern, 6.4% considered urgent; in the recent period, the average proportion dropped to 22.5%, with only 1.5% considered urgent (Figure 5). There was a little less variation in the year-to-year reduction of dental decay or caries experience in children age 6 and older than among the younger children, though there was improvement between 2018 and 2022. The 4-year averages for both age

groups, 22.5% and 23.4%, respectively, appear to be somewhat consistent with U.S. data for children from low-income families. [65]

Figure 5. Results of Sacramento Dental Screenings, Ages 0-5 and 6 and Older, FY 2015-2022

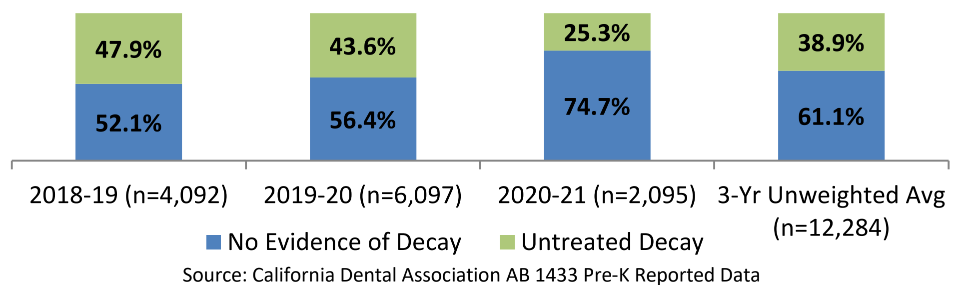


Class 1: No obvious problem found; teeth and gums appear healthy. Visit dentist every 6-12 months for regular check-ups.
Class 2: Early dental care recommended (caries without pain or infection or child would benefit from sealants or further evaluation).
Class 3: Urgent care needed (pain, infection, swelling or soft tissue lesions).

The kindergarten dental checkup law (AB 1433) helps identify children with unmet oral health needs. Participating schools distribute oral health education materials and the assessment consent/waiver form to parents who are registering their child in public school for the first time, in either kindergarten or first grade (see Attachment 11). Schools collect forms by May 31 of each school year and report collected data by July 1 of that calendar year through SCOHR (the System for California Oral Health Reporting). These dental assessments are another important source of surveillance data for providing a picture of dental disease among children.

Based on the most recent 3-year average (2018-2021), screening results for the reporting school districts in Sacramento County (11, 6 and 13 schools, respectively, for the data displayed in Figure 6) show that 38.9% of the children had evidence of untreated dental decay.[66] Note that the assessment data may inadvertently be double counted with those being done in preschools or transitional kindergartens screened by the Center for Oral Health Early Smiles and, in some cases, the children's private dentists; hence, there is an unavoidable overlap of the findings between Figures 5 above and 6 below, which makes understanding of true caries prevalence a challenge.

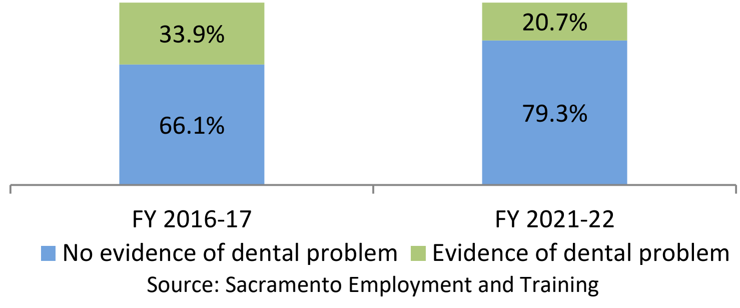
Figure 6. Results of the Kindergarten Oral Health Assessments, Reporting School Districts in Sacramento County



Source: California Dental Association AB 1433 Pre-K Reported Data

In addition to the Early Smiles screenings at Head Start centers as described above, Sacramento Employment and Training Agency (SETA), which operates 39 Head Start centers in Sacramento County, also collects dental reports done for children in their care. These reports come from dentists when the child has a comprehensive exam – with radiographs if necessary, not just a screening. Thus, the reported results in Figure 7 below should be non-duplicative and can supplement the Sacramento screening results above. While in 2016-17 one-third of the Head Start children (33.9%) showed "visible evidence of decay," in the 2021-22 exams only 20.7% were found with evidence—about a 40% improvement difference.

Figure 7. Results of SETA Head Start Oral Health Screenings, FY 2016-17 and FY 2021-22



Source: Sacramento Employment and Training

Statewide findings from the California Third Grade Smile Survey (CSS),[67] from a representative sample of 3rd graders in California, provide useful surveillance data that can be used for improving local caries experience and untreated tooth decay among children in Sacramento County. Although overall Sacramento compares more favorably than the state as a whole, close to half (46.2%) of the students had some level of caries experience (Table 14). Children from some racial or ethnic minority groups are disproportionately at higher risk for childhood caries compared to

other racial/ethnic groups and the general population, as the differences below makes clear. Among American Indian and Alaska Native (AI/AN) children, for example—which are not broken out in the CSS data—these problems begin early. By the age of two, approximately 39% of AI/AN children have experienced dental caries and by the age of five, 76% are affected by caries.[68] Having low-income and being an English learner are also associated with higher rates of caries experience and untreated tooth decay.

Table 14. Percentage of California Third Grade Students with Caries Experience and Untreated Tooth Decay, Selected Factors, 2018-2019

Factors	Caries Experience[1]	Untreated Decay[2]
Area		
Sacramento 4-county region	46.2%	17.2%
California	60.6%	21.9%
Race/Ethnicity		
Black	59.1%	25.8%
Asian/Pacific Islander	50.2%	17.4%
Hispanic	72.2%	24.8%
White	40.0%	13.7%
Socioeconomic Status		
SE disadvantaged	72.8%	26.0%
Not SE disadvantaged	40.5%	13.2%
Language Proficient		
English Learner	76.0%	26.8%
English proficient	54.7%	19.0%

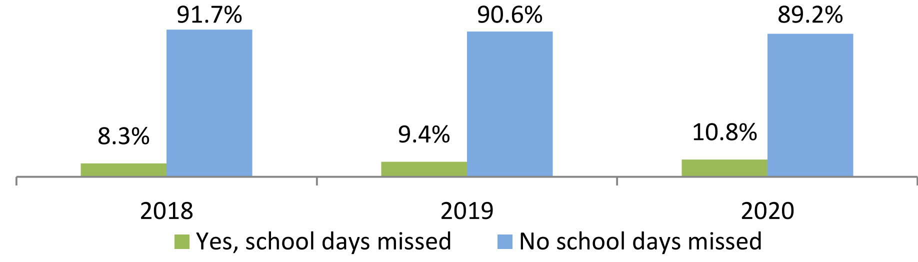
Source: CA Third Grade Smile Survey (CA Department of Public Health OH Program)

[1]**Dental Caries Experience =** Caries experience means that a child has had tooth decay at some point in time. Caries experience covers both past treatment (e.g., fillings, crowns) and untreated decay at the present time (e.g., untreated cavities).

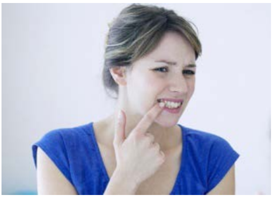
[2]**Untreated Tooth Decay =** Untreated decay is tooth decay (e.g., one or more cavities) that has not received treatment.

Children with poorer oral health status are more likely to experience dental pain and perform poorly in school.[69] Dental disease also contributes to school absenteeism.[70] Although the CHIS results for this indicator for Sacramento County were too small to report, looking at California data shows the proportion of missed school days due to a dental problem slightly rose each year from 2018 to 2020 (Figure 8). (The 2021 data are not representative as many children were not attending in-person school due to COVID.)

Figure 8. Percent of California Students Age 5-17 Reporting Missed School Days Due to a Dental Problem



Source: CHIS. Does not count the time missed for cleaning or a check-up. Only includes teens who attend school.

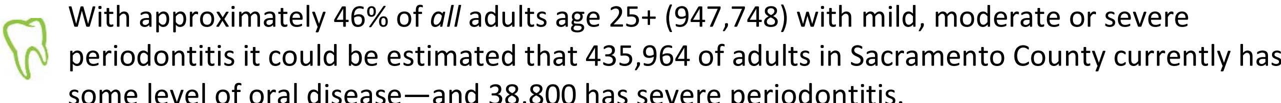


Prevalence of Oral Disease among Adults

Dental disease is a chronic problem among many adults, with those from low-income groups disproportionately affected. As evidence of the seriousness of adult dental disease, the CDC has included dental visit within the past year, and for adults 65+ complete tooth loss and lost 6 or more teeth as chronic disease indicators.[71]

Prevalence estimates show that about 46% of all American adults aged 30 and older have mild, moderate or severe periodontitis; of these, 8.9% have severe periodontitis, the more advanced form of periodontal disease.[72] In adults 65 and older, prevalence rates increase to 70.1%. Prevalence is highest in Hispanics (63.5%) and Non-Hispanic blacks (59.1%), and least among non-Hispanic whites (40.8%). Research also shows 40% of poor adults age 20 years and older in the U.S. were estimated to have at least one untreated decayed tooth in 2012; [73] among 45-64 year-olds, the percentage with untreated dental caries was 48.6%.[74] An update to these CDC surveillance findings found the overall prevalence of caries decreased only slightly during 2011-2016, but no difference was detected in untreated decay. Disparities by race or ethnicity, poverty, education, and smoking status persisted between the two survey periods. Among older adults 65+, there was a small increase in the prevalence of caries, but no change in the prevalence of untreated decay. Among the older adults who were Black, Hispanic, poor, near-poor, or current smokers, the prevalence of untreated decay was about 2 to 3 times that of those who were non-Hispanic white, not-poor, or never smoked.[75]

Because precise oral disease prevalence among Sacramento County adults is lacking, national estimates applied locally from this collective research suggest the following could be the case for adults in Sacramento:



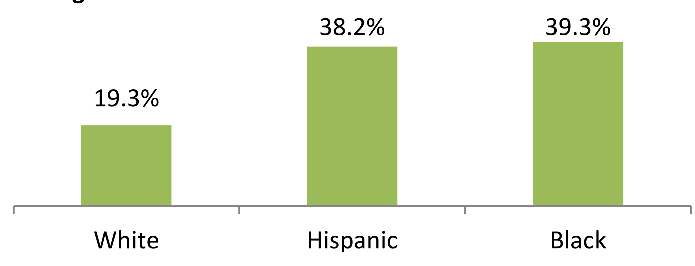
- With approximately 46% of *all* adults age 25+ (947,748) with mild, moderate or severe periodontitis it could be estimated that 435,964 of adults in Sacramento County currently has some level of oral disease—and 38,800 has severe periodontitis.
- Approximately 70% of *all* adults age 65+ (176,608) with mild, moderate or severe periodontitis means an estimated 123,802 of seniors in Sacramento County are likely to have some level of oral disease.
- 16.3% of the population living below the federal poverty level in Sacramento County means an estimated 78,769 poor adults have some level of oral disease, and approximately 7,010 have severe periodontitis.
- 67,234 low-income adults in Sacramento County (40% of the 171,238 poor age 20 years and older) likely have at least one untreated decayed tooth.

Looking at research on disparities in oral health care between low-income and high-income adults, the following key dental health indicators have additional relevance for Sacramento County adults:[76]

- Adults living at or below the federal poverty level are less than half as likely to have seen a dentist in the past year as adults earning more than four times the poverty level.
- Adults with Medicaid coverage make fewer visits to dentists than their higher-income counterparts.
- The most vulnerable low-income populations are people who are homeless.

Untreated tooth decay among adults leads to a high degree of tooth loss. Statewide surveillance data from the CDC Behavioral Risk Factor Surveillance System (BRFSS)[77] telephone surveys, which also have implications for Sacramento County adults, indicate that 6% of California adults age 65-74 and 16% of those age 75+ have lost 6 or more of their teeth as a result of oral disease (data not shown). The differences by race/ethnicity (Figure 9) are striking.

Figure 9. California Adults Aged 65+ Who Have Lost Six or More Teeth Due to Tooth Decay or Gum Disease

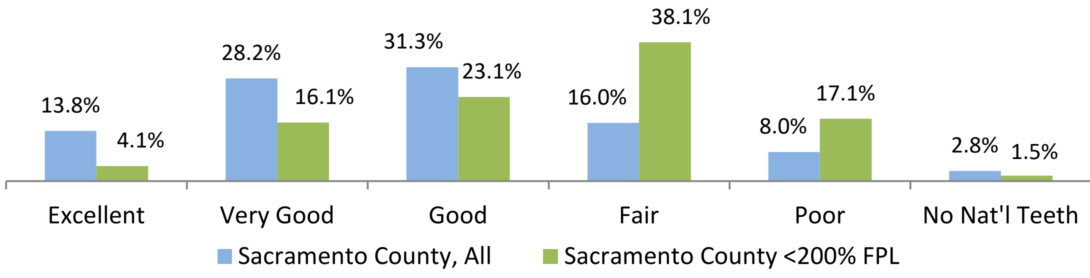


Source: 2020 Behavioral Risk Factor Surveillance System

The incidence of poor periodontal health among nursing home residents—intensified by natural aging and chronic health conditions—is even more compelling. Among 2,372 older adults in California recently screened at 36 skilled nursing facilities, 65% needed treatment for tooth decay and/or periodontal (gum) treatment—1 in 3 of whom needed it immediately or within 2 to 4 weeks.[78]

In Sacramento County, although 42.0% of all adults reported the condition of their teeth in 2021 as "excellent" or "very good," less than half that proportion, 20.2%, of individuals who were low-income reported the same favorable conditions (Figure 10). The differences between these two groups are striking.

Figure 10. Sacramento County Adults' Self-Reported Condition of Teeth



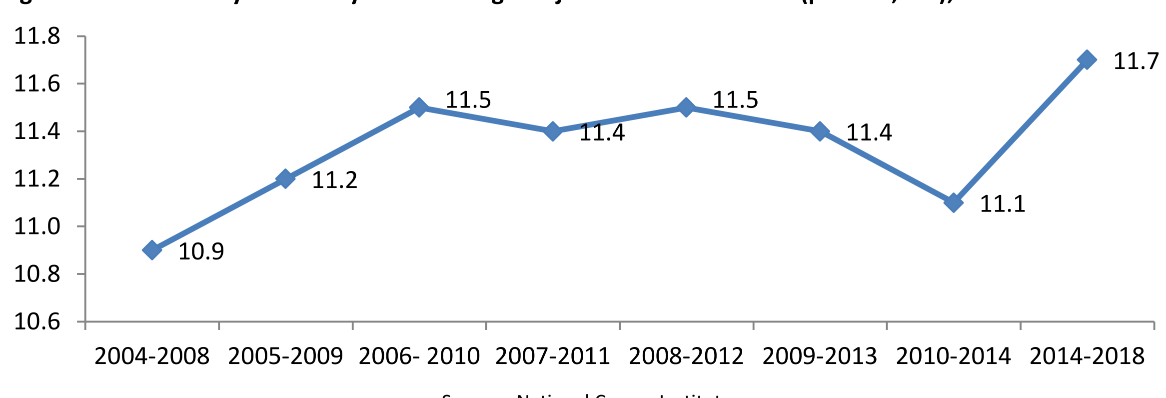
Source: 2021 California Health Information Survey
Note: some data statistically unstable due to small sample size

In addition to preventing decay, access to regular dental care is important because dental professionals may be the first to spot signs of oral and throat cancer, which represented about 2.8% of all new cancer cases in the U.S. in 2022. The rate for men is about 2.5 times the rate for women.[79]

Oral cancers form in tissues of the mouth or the oropharynx (the part of the throat at the back of the mouth). The known risk factors for developing oral cancer—which is largely preventable—are tobacco use (including smokeless tobacco and chewing snuff) and heavy alcohol consumption. According to the American Cancer Society, individuals who both smoke and drink excessively are 30 times more likely to develop oral cancers than those who do not smoke or drink. There is also a significant relationship between human papillomavirus (HPV) and oral cancer. HPV is thought to cause 70% of oropharyngeal cancers in the United States. About 10% of men and 3.6% of women have oral HPV, and oral HPV infection is more common with older age.[80]

While the age-adjusted incidence rate for oral cavity and pharynx cancer in Sacramento County rose to about 11.5 (in cases per 100,000 population) from 2004-08 to 2008-12, it dropped to 11.1 in 2010-14, but rose to 11.7 in 2014-18, the latest period for which data are available (Figure 11).[81] The rate was highest among the White population (12.7); among age groups, 65+ had the highest rate (43.4); the incidence rate among men (18.5) was more than three times that of women (5.9).

Figure 11. Oral Cavity and Pharynx Cancer Age-Adjusted Incidence Rate (per 100,000), Sacramento County



Source: National Cancer Institute.

RISK AND PROTECTIVE FACTORS

"If every time I take him [son] they say I'm doing a good job and he has no problems why should I go back just hear the same thing again?"
– Focus Group Participant

Risk Factors

Oral diseases and other chronic diseases share many common risk factors, such as having diabetes as well as poor dietary habits, including consumption of soda and other sugar-sweetened beverages and tobacco use.

Tobacco Products

The adverse effects of tobacco use on oral health are well established. There is a strong link between smoking and oral cancers, periodontal disease, tooth loss and treatment outcomes. Smokers, for example, are about twice as likely to lose their teeth as non-smokers.

According to the 2021 California Health Interview Survey (CHIS), 5.5% of Sacramento County adults, more favorable than the 6.3% state average, report they currently smoke tobacco; 20.1% formerly smoked and 74.4% said they never smoked (Figure 12). Of adults who have ever smoked, 14.4% current smokers said they did this "every day."

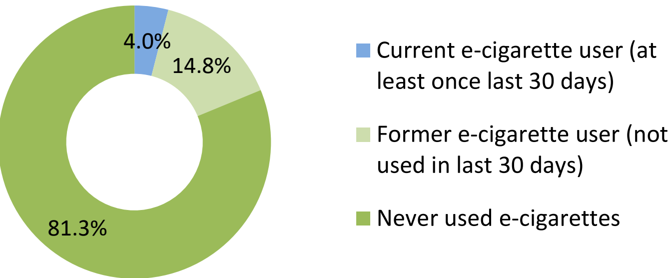
Figure 12. Smoking Status of Sacramento County Adults

Smoking status	Percent
Current	5.5%
Former	20.1%
Never (or <100 cigarettes ever)	74.4%

Source: 2021 California Health Interview Survey

Among current Sacramento tobacco smokers, the CHIS data by gender show that historically about twice the proportion of men than women smoke. However, while the positive finding is that the overall prevalence of smoking reduced since the 2016 CHIS, in 2021 a greater percentage of adult women, 6.2% (down from 10.6%) than adult men, 4.7% (down from 18.8%), currently smoke. With regard to e-cigarettes (vapes) (Figure 13 on the next page) Sacramento user status generally mirrors the statewide average.

Figure 13. E-Cigarette Use in the Last 30 Days by Sacramento County Adults



Source: 2021 California Health Interview Survey

The sample size of teenagers responding to CHIS about tobacco use was considered "statistically unreliable" and too small to report. However, data from the 2019-20 California Student Tobacco Survey are available. [82] The main results for Sacramento 8th, 10th, and 12th graders who were surveyed are displayed in Table 15. Of use status, 28.2% of the students said they had used a tobacco product at some point and 10.1% reported being a current user. It appears vaping was the most common tobacco product use.

Table. 15. Tobacco Use Experience of Sacramento Students, Grades 8, 10 and 12 (n=5,520)

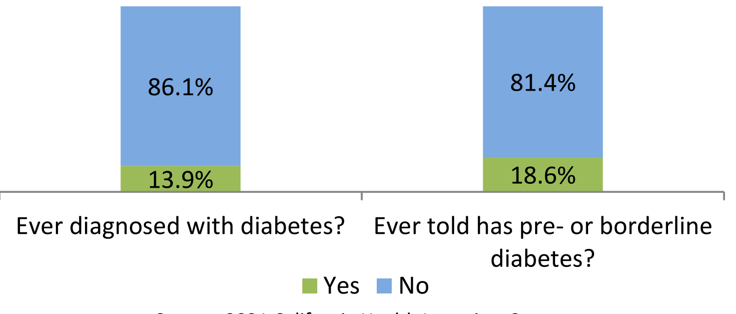
Prevalence of Tobacco Use	
Ever used	28.2%
Current user	10.1%
Prevalence of Current Tobacco Product Use	
Vapes	8.2%
Cigarettes	1.4%
Little cigars or cigarillos	3.2%
Big cigars	0.6%
Hookah	0.7%
Smokeless	0.7%

Source: 2019-20 California Student Tobacco Survey.

Adults with Diabetes

Because oral health and general health are integral to each other, oral signs and symptoms may provide the first clues to the presence of other diseases such as diabetes. Diabetics are more susceptible to the development of oral infections and periodontal disease. They are also less likely to visit the dentist than people with pre-diabetes or without diabetes; about 61% compared to 66.5% among people without diabetes who make annual dental visits.[83] Treating gum disease can help improve blood sugar control in patients living with diabetes, decreasing the progression of the disease. Other than during pregnancy, 14.5% (up from 9.7% in 2016) of Sacramento adults reported in 2021 ever being diagnosed with diabetes, and 16.6% (essentially the same as in 2016) were told by a doctor they had pre- or borderline diabetes (Figure 14 on the next page). Of the respondents who had been told by a doctor that they had diabetes, 14.7% had Type I diabetes and 83.0% Type II (and 2.3% unknown).

Figure 14. Diabetes Experience, Sacramento County Adults



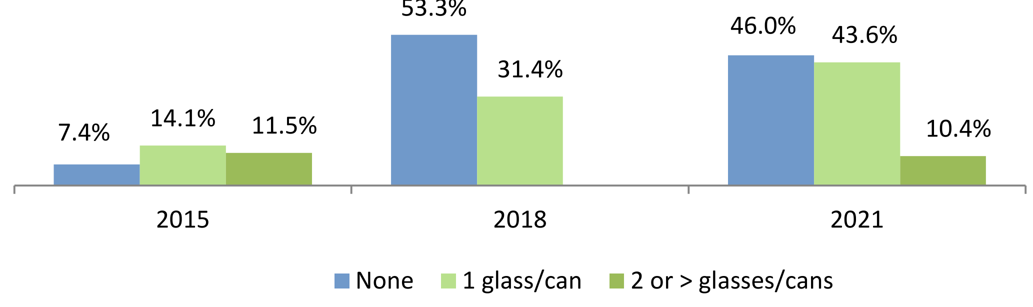
Source: 2021 California Health Interview Survey

Soda and Other Sugary Beverages

Tooth decay is caused by bacteria in the mouth using sugar from foods and drinks to produce acids that dissolve and damage the teeth. Sugar sweetened beverages have high levels of sugar and drinking these can significantly contribute to tooth decay. (Note that diet or sugar-free soda contains its own "acids" which also can damage teeth.) Soft drink consumption, where the U.S. is ranks second highest, also contributes to overweight, obesity, and diabetes.[84]

What evidence we have of this risk factor among children in Sacramento County comes from the CHIS data. Parents of Sacramento teens and children age 2 and above were asked by CHIS, "Yesterday, how many glasses or cans of sweetened fruit drinks, sports, or energy drinks, did you {your child} drink?" To look for changes that might reflect adoption of healthier habits, we examined multiple years. Figure 15 indicates a *possible decrease* in consumption of these sugary beverages over the 6-year period. For example, in 2015, 7.4% of the kids were reported to not have consumed any of these drinks the day before; in 2021, the proportion who reported this rose to 46.6%. At the same time, 14.1% of kids in 2015 compared to 43.6% in 2021 had consumed 1 glass or can or these drinks the day before. Comparisons with statewide trend data were not particularly useful as differences varied year to year without a particular pattern. Sacramento adults were not asked this question after 2017.

Figure 15. Sugary Drink (Other than Soda) Consumed "Yesterday" by Sacramento County Children and Teens



Source: Selected Years, California Health Interview Survey
Some data not reported in some years; some data "statistically unstable" due to sample size.

Methamphetamine

In addition to tobacco use and consumption of soda and other sugar-sweetened drinks, behaviors such as drug abuse contribute to the risk of dental disease yet are rarely integrated into discussions about oral health.

The direct effects of meth use, as well as accompanying risk factors, significantly increase oral health risk. “Meth mouth” is characterized by severe tooth decay and gum disease, which often causes teeth to break or fall out. For instance, an examination of the mouths of 571 methamphetamine users showed 96% had cavities; 58% had untreated tooth decay; and 31% had six or more missing teeth,[85] findings that are likely applicable to Sacramento meth users as well. Meth users who were 30 years of age or older, women or cigarette smokers were more likely to have tooth decay and gum disease. Treatment often means removing teeth as they are often not salvageable. The extensive tooth decay is caused by a combination of drug-induced psychological and physiological changes resulting in dry mouth and long periods of poor oral hygiene.

To put the problem in perspective, methamphetamine is one of Sacramento’s biggest drug problems. It accounted for nearly one-third of the drug treatment services provided by Sacramento County Alcohol and Drug Services in 2018.[86] Meth was the drug of choice among more than two-thirds of the County Probation Department’s 2019 intakes.[87] Even if the person is lucky enough to quit, their oral health, overall health and socioeconomic consequences are life changing.

Protective Factors

Community Water Fluoridation

In addition to good oral hygiene habits at home and regular dental visits, access to fluoridated water is an important protective factor for oral health. Community water fluoridation is the safest, most effective and most economical protective public health intervention to promote oral health and prevent tooth decay.[88] Almost all water contains some naturally occurring fluoride, but usually at levels too low to prevent tooth decay. Water systems are considered naturally fluoridated when the natural level of fluoride is greater than 0.7 parts per million (ppm). The U.S. Department of Health and Human Services Agency recommends that water systems practicing fluoridation adjust their fluoride content to 0.7 mg/L (parts per million).[89] This optimal target goal is aimed at providing the benefits of fluoridation while minimizing the chance that children develop dental fluorosis, a typically mild condition that causes a discoloration of teeth. About 63% of the California population is receiving fluoridated water.[90]

As a result of efforts by First 5 Sacramento* and the City of Sacramento, more than 885,470 (65%) of Sacramento County residents currently has access to fluoridated drinking water. According to the most recently available state data (2016), the water systems in Sacramento County, shown in Table 16 with fluoride levels, provide a mixture of fluoridated and non-fluoridated water.[91] The water suppliers under contract have committed to maintaining fluoridation for a period of 20 years. In April 2018, an additional system, Golden State Water, began fluoridating the Arden area --the last planned fluoridation capital project of the First 5 Commission's oral health efforts.[92]

Table 16. Fluoridated Public Water Systems and Mg/L (parts per million), Sacramento County, 2016

Fully Fluoridated Water Systems (all water is fluoridated)	Mg/L	Water Systems Providing a Mixture of Fluoridated and Non-Fluoridated Water	Mg/L
Sacramento County WA (Mather-Sunrise)	0.76	Sacramento County WA (Laguna/Vineyard)	0.72
Sacramento County WA (Arden Park Vista)	0.77		
Sacramento Suburban Water District -	0.80		
Cal-American Water Co. (Suburban)	0.79		
Cal-American Water Co. (Parkway)	0.77		
City of Sacramento	0.69		
Cal-American Water Co. (Arden)	0.76		

Source: https://www.waterboards.ca.gov/drinking_water/certlic/drinkingwater/Fluoridation.html

Nearly 500 residents completed a Sacramento County Oral Health "drinking water survey" in March 2020 to assess community beliefs and behavior related to drinking tap water. The main findings from the analysis[93] with implications for program strategies found:

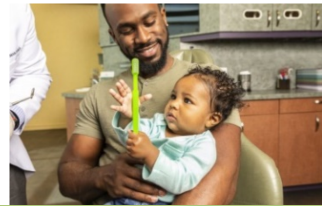
- People tended to get their information about fluoride from dental providers vs. family and friends.
- Fewer than half (42%) agreed that their tap water at home should include fluoride, yet three-quarters of these respondents understood the benefit of fluoride in helping to prevent cavities.

- Those who disagreed that their home tap water should include fluoride gave as reasons, "I get enough fluoride from toothpaste" (47%); "I don't think it's good for my health" (34%); and, "I read or heard negative information about drinking water with fluoride" (45%); an additional 28% gave other reasons.

- Individuals who answered the question about "the unfiltered tap water at your home" were nearly equally split between those who thought it was "safe" (43%) and those who thought it was "not safe" (40%).

- "How water tastes" was a major influence for the type of water people chose to drink outside of their home, with most of these individuals choosing plastic bottled water.

Sacramento County Oral Health program hopes to use these survey findings to develop a "soft" social media campaign to promote the benefits of drinking fluoridated water in a way that would not trigger anti-fluoridation sentiment. Because it concluded more education was needed before a fluoride referendum in the community could be successful, the program plans to continue to focus its community water fluoridation efforts on outreach and education, and beginning in July 2022, add surveillance activities.[94]



ACCESS TO SERVICES

"Last time I saw a dentist? Man, I'm just thinking about how I'm going to pay rent." - Focus Group Participant

Although there is an unmistaken relationship between "*access* to services" and "*utilization* of services," we separate them in this report because of their distinct emphases. "Access" looks at equity—that is, do all who are eligible to receive services and who would benefit from receiving them have an equal opportunity to use them, and if not what are the reasons or challenges? "Utilization," on the other hand, deals with whom and how many used the services, where did they use them, what difference did they make, and what was their experience.

Access Barriers and Predictors of Dental Use

Research indicates the most common barriers—both the delivery system and personal—to accessing oral health care are, in order of importance, financial hardship (lack of insurance), anxiety about going to the dentist, lack of recognition of the importance of oral health (especially for children 0-3), provider geographic location/hours of operation (or not knowing who your provider is), poor oral health literacy, and language, education or cultural barriers. Sacramentans who provided input to this study (see the Community Input section) gave these same reasons for under-utilization or avoidance of dental care. Physical accessibility of dental facilities can also be a barrier for individuals with special needs. In studies of older people, self-reported barriers to dental care general falls into five main categories: cost, fear, availability, accessibility and characteristics of the dentist. Lack of perception of a need for dental care is a common "passive barrier" among denture wearers in particular.[95]

In one study of employer-based coverage, oral health beliefs, travel time cost, income and having a usual source of dental care were significant predictors of at least one dental visit during the previous 12 months. The same research also showed that race was a significant predictor of a preventive dental visit. Blacks were less likely than non-Blacks to visit the dentist for preventive services in the previous 12 months.[96]

Findings from a 2019 cross-sectional consumer survey of adults 18 years and older by the Oral Health Workforce Research Center[97] are similar to our Community Oral Health Survey and focus group findings described later in this report, and are informative about obstacles and in thinking about specific populations and approaches that are needed to respond to barriers. The analysis of 6,951 responses showed:

- The most commonly identified barrier to seeing a dental provider as often as needed was being unable to afford needed dental care (22.2%), followed by difficulty finding a dentist who accepted their dental plan (7.0%), anxiety about going to the dentist (6.7%), and an inability to find time to see a dentist (6.3%).

- Adults who were male, non-elderly, Hispanic, African American, had not graduated from college, and had a lower income were more likely to report *not* getting needed dental care in the past year.
- The most commonly identified *facilitator* of dental care was dental insurance (22.0%), followed by the availability of more dentists who accept the respondent's insurance (16.1%), more reminders to visit the dentist (14.7%), and more convenient hours (11.5%).
- Respondents with lower oral health literacy, negative or neutral attitudes toward oral health, and those who brushed their teeth less than once a day were more likely to report not receiving needed dental care than other groups.
- Adults with self-reported poor or fair oral health were more likely to indicate a failure to obtain needed dental care in the past year than those reporting good or very good oral health.

Access to Insurance

The demand for dental care is closely linked with having dental insurance coverage (which, in turn, is closely linked to employment). Cost remains a major barrier to receipt of dental services across the life span and is the most common reason among working-age adults for not seeking dental care.[98]

About 77% of all adults from representative households in Sacramento County reported currently having "any type of insurance that pays for part or all of my dental care" in the 2021 California Health Interview Survey (CHIS). Fewer adults, however, 63.2%, living under the 200% Federal Poverty Level had coverage (Figure 16).

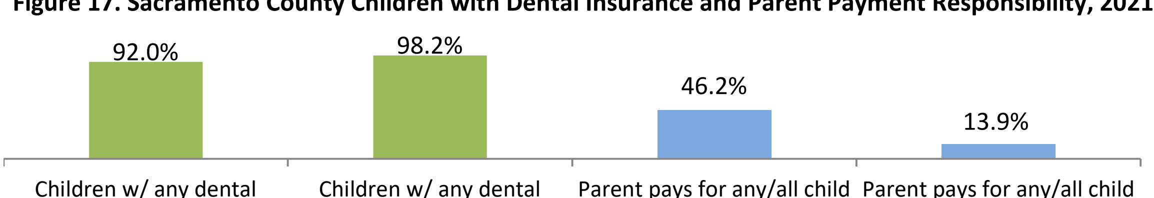
Figure 16. Sacramento County Adults with Dental Insurance, 2021

78.8%
69.3%
All adults
Adults <200% FPL

Source: 2021 CHIS

Parents of the 92.0 % of children with any type of dental insurance (Figure 17) also were asked by CHIS if they paid "any or all of the premium or cost" of that dental insurance plan; just under one-half (46.2%) said that they did. In the case of lower income families whose children had dental insurance, 13.9% paid any or all of the cost.

Figure 17. Sacramento County Children with Dental Insurance and Parent Payment Responsibility, 2021



Source: 2021 CHIS

Medi-Cal Insurance

Medi-Cal is a significant purchaser of health insurance for low-income individuals in Sacramento County, covering about 38% of the population. Table 17 displays age group and race/ethnicity information for the 608,411 individuals enrolled in December 2021.

Table 17. Sacramento County Medi-Cal Enrollment by Age and Race/Ethnicity, December 2021

	Age 0-18	Age 19-44	Age 45-64	Age 65+	Total
American Indian/AN	1,142	1,373	891	240	3,646
Asian	22,038	24,503	17,698	14,389	78,628
Black	33,292	29,398	14,018	4,609	81,317
White	38,953	46,427	28,383	12,648	126,411
Hispanic	61,912	46,533	18,815	6,054	133,314
Not Reported	62,821	77,636	31,694	12,944	185,095
Total	220,158	225,870	111,499	50,884	608,411

Source: https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-tables-by-county

Covered California

Covered California offers children and adults health insurance under the Patient Protection and Affordable Care Act. Because the program is state-subsidized, it provides discounted premiums to those who qualify for it. It is not the same as Medi-Cal; however, contracting health plans available through Medi-Cal and Covered California both offer a similar set of benefits, and one can apply for both programs at the same time through a single application.

According to Covered California income guidelines for 2022, if an individual makes less than $47,520 per year or if a family of 4 earns wages less than $97,200 per year, they qualify for government assistance. Adults living at 0% – 138% of The Federal Poverty Level qualify for Medi-Cal; at > 138% – 400% of FPL they qualify for a subsidy under a Covered California plan.[99]

Dental coverage for children is included with their health plans. All preventative and diagnostic services are offered at no cost, though parents pay part of the cost for other services like fillings, root canals and crowns. Because dental coverage for adults is not considered an essential health benefit, it is offered separately from health insurance plans; no financial assistance is available to purchase these dental plans. Adults in dental PPO plans have a 6-month waiting period for major services (which can be waived if the member provides proof of prior dental coverage). For members who purchase dental benefits through the dental managed care plans, there is no deductible and no annual limit on what the plan will pay for care. The costs for fillings, root canals, crowns and other major treatments and services are shared by the consumer and the plan. Costs for dental work performed by dental providers outside the plan's network are not covered.[100]

Access for Special Populations

Foster Youth

Children and youth in foster care are considered to have special health care needs, including oral health care. Youth with a history of foster care report more oral health problems than their peers, and are markedly less likely than their non-foster peers to report receiving oral care.[101] Despite mandatory state dental coverage (all children placed in foster care in California become eligible for Medi-Cal insurance), children in foster care face significant barriers to accessing oral health care. One of the largest obstacles is finding a dental provider who takes Medi-Cal. The County's Health Care Program for Children in Foster Care is responsible for assuring foster children's health by helping foster parents obtain timely comprehensive dental examinations and facilitating referrals when specialty care is needed. In 2019 (pre-COVID), 54.3% of children age 1-17 in foster care in Sacramento County (vs. 66.6% statewide) were reported to have had a timely dental exam.[102]

Children age 1-7 in foster care with timely dental visit	Sacramento County: 54.3%	California: 66.6%

Pregnant People

Good oral health and control of oral disease is especially important during pregnancy as it has the potential to reduce the transmission of oral bacteria from parents to their children. Good oral health also reduces the risk of pre-term labor and low birthweight outcomes. Pregnant people with good oral health have reduced risk of developing gum inflammation ("pregnancy gingivitis," a common plaque-related perinatal condition) or losing a tooth due to advanced gum disease (periodontitis). Control of oral diseases in pregnant people protects their health and quality of life before and during pregnancy, and has the potential to reduce the transmission of pathogenic bacteria from mothers to their children.[103] Yet many pregnant people do not seek—and are not advised to seek—dental care as part of their prenatal care, although pregnancy provides a "teachable moment."

In many cases, prenatal and oral health providers may still be limited in providing dental care during pregnancy by their lack of understanding about its impact and safety. Many dentists needlessly withhold or delay treatment of pregnant patients because of fear about injuring either the woman or the fetus—or because of fear of litigation. Many prenatal providers fail to refer their patients regularly to dental providers (or fail to see in the prenatal health history the lack of a dental visit) because they have not been trained to understand the relationship between oral health and overall health.[104]

To promote oral health care during pregnancy and afterwards, in April 2022, Medi-Cal expanded its pregnancy-only benefit to include coverage throughout the pregnancy and up to 1-year (365

days) postpartum. This extension also provides more time for the pregnant parent to access dental care before their pregnancy-only benefit runs out.[105] In December 2022, Medi-Cal published a new pregnancy landing page to *SmileCalifornia* and alerted perinatal service coordinators in each California county as part of the 2022 Comprehensive Perinatal Service Program (CPSP) expansion project.[106]

Populations Experiencing Homelessness

To gain a better understanding of the population currently experiencing homelessness, Sacramento County, along with communities across the country, conducts a survey to estimate the number of individuals and families who are experiencing homelessness. The survey usually takes place every two years but was canceled in 2021 due to the pandemic. The 2019 Sacramento County Homeless Point-in-Time Count found more than 5,500 people were homeless, a 19% increase over two years. The findings indicated that 1,670 (30%) of the individuals were sheltered, while 3,900 (70%) were unsheltered. Of importance in health planning, the majority of these individuals experiencing homelessness were 35 years of age or older (61%), 20% were families with children, and a disproportionate number were Black and American Indian/Alaska Native.[107] Sacramento Steps Forward, the nonprofit that conducts the point-in-time count every two years, 22% of homeless people report having a mental disability, and 21% have a psychiatric disability. Of the 8,813 people who accessed the Sacramento County Continuum of Care Homelessness Response System in 2021, 5,044 were individuals and 3,826 were people in families with children. There were 941 unaccompanied youth included in individual and family groups.[108]

People who accessed Sacramento Homelessness Response System	5,044 individuals	3,826 people in families with children	941 unaccompanied youth

Individuals with Disabilities and Special Needs

Going to the dentist can be especially difficult for people with an underlying fear and anxiety about dentistry. For those with physical and intellectual disabilities, the fears and anxieties are compounded by sensory issues, negative behaviors, and the lack of dentists who are willing to see them.[109] Access to dental care for patients with special needs (SN) may also be limited by the ability of their caregiver to effectively evaluate their oral condition and/or by the person's own inability to express their pain or discomfort.[110] In addition to experiencing unique barriers, individuals with developmental disabilities experience higher rates of dental disease. [111] Additionally, many of these individuals end up needing dental work done under general anesthesia due to extensive dental decay at a young age and/or cooperation challenges that make some dental procedures unsafe for the patient as well as the dentist without it.

The Department of Developmental Services does not have a tracking system to know how many individuals in Sacramento County have special dental needs. Using recent U.S. estimates for children, approximately one in six, or about 17%, of those aged 3 through 17 have one or more developmental disabilities—chronic physical, developmental or behavioral conditions.[112] A similar proportion, 17.6%, has been estimated for that age group in Sacramento County.[113] Extrapolating the U.S. proportion in Sacramento means an estimated 51,938 children age 3-17 could have developmental disabilities.[114] If we include younger children, the estimated SN child population age 0-17 becomes 61,877. A rough estimate of the number of Sacramento adults age 18+ with SN suggests 119,571 could be expected (calculated by subtracting the estimated number of children from the estimated 181,448 Sacramento residents with disabilities).[115] Another calculation, this one from American Community Survey data on disability characteristics, shows 166,011 (10.9%) of Sacramento adults and children with cognitive or mobility issues[116]—two disabilities that could make receiving dental services more challenging than for those without those disabilities. It should be recognized that these are undercounts if one expands the projection to include emotional and other disabilities. A significant but unknowable number of them may need anesthesia when receiving dental services where the more-preferred alternative approaches are not feasible.

The Department of Health Care Services supports a Dental Case Management program for Medi-Cal members with special health care needs who are unable to schedule and coordinate complex treatment plans involving one or more medical and dental providers. Examples of qualifying special healthcare needs include physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or other limiting condition that requires medical management, hospital dentistry, health care intervention, and/or use of specialized services or programs. Referrals for case management services are initiated by the member's medical provider, dental provider, case worker or healthcare care professional and are based on a current, comprehensive evaluation and treatment plan. To refer a Medi-Cal member, the member's medical provider, dental provider, case worker or healthcare care professional must complete an online case management referral form. Referrals are evaluated to determine eligibility criteria, and those that don't meet the case management criteria are routed to the Telephone Service Center for care coordination assistance. These representatives are expected to assist members with locating a general or specialist dentist, accessing appointments, translation services, and transportation assistance.

The Department of Developmental Services contracts with 21 Regional Centers to provide services and supports to persons with developmental disabilities, including dental services. Sacramento County is served by Alta California Regional Center (ACRC), which serves approximately 16,000 Sacramento children and adults; about 200 Service Coordinators are assigned to help link these families with services. (Results from the ACRC Service Coordinator Survey are reported on page 66.)

Seniors

The topic of dental care so often gets overlooked for seniors, despite its critical importance to nutrition and health. Dental care for seniors tends to be complex and expensive and, except for in-hospital dental treatment, dental is not covered by Medicare or by supplemental plans. While

most dental coverage for adults with Medi-Cal has been restored, the majority of seniors have no coverage for dental care at all. The Sacramento County Area Agency on Aging (AAA) 2018 Age-Friendly Community Survey of over 1,300 adults ages 45 and older asked about the importance of dental services and perceptions about availability of the services in the community. The results shown in Figures 18 and 19 below indicate dental issues are "extremely" or "very" important to more than 80% of the respondents. While staff said the sample for Sacramento County may not be as representative as they would have liked it was reflective of the type of individuals who respond to surveys conducted by AAA.[117]

Figure 18. Perceived Value of Dental Services to Sacramento Adults

Importance of Dental Services	Extremely	Very	Somewhat	Not Very	Not al all	Not Sure
%	44.0%	37.0%	13.0%	3.0%	2.0%	1.0%

Source: Agency on Aging Area 4 2018 Survey

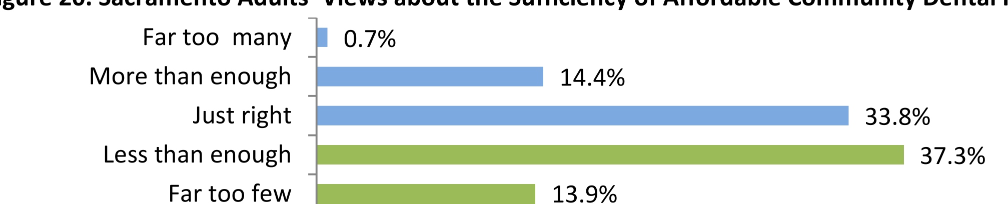
Figure 19. Sacramento Adults' Opinions about the Availability of Dental Services

Perceived Availability of Community Dental Services	Always	Often	Sometimes	Rarely	Never	Don't Know
%	20.0%	22.0%	19.0%	12.0%	5.0%	22.0%

Source: Agency on Aging Area 4 2018 Survey

The AAA survey respondents were also asked whether they thought Sacramento had enough affordable community providers. As Figure 20 shows, slightly over half (51.2%) believed the number was insufficient.[*]

Figure 20. Sacramento Adults' Views about the Sufficiency of Affordable Community Dental Providers



Source: Agency on Aging Area 4 2018 Survey

According to an AAA Intake Coordinator we spoke with, dental concerns "rose to the top" for their agency years earlier but "is not much of an issue now that Medi-Cal restored most adult dental benefits."[118] We then looked at how frequently oral health came up as a topic for 2-1-1 callers.

Other Referral Resources that Promote Access

2-1-1 Sacramento is a regional resource for connecting callers—individuals who call directly or are referred by community agencies such as AAA—to community services. In 2021, there were 241 dental-related calls to 2-1-1 from Sacramento County callers involving close to 600 concerns (Table 18); these calls represented 0.2%% of the 75,405 total calls 2-1-1 received last year. According to staff, "this volume of calls very much fell in line with preceding years." [119] 2-1-1 does not track whether the dental-related calls it receives are from consumers or community referral sources.

Table 18. Number and Type of Calls to 2-1-1 Sacramento Related to Oral health, 2021 (n=241 calls)

Type of Dental Issue	#	Type of Dental Issue	#
General dental	173	Pediatric dental care	12
Emergency dental care	139	Dental sealants	11
Referrals to services	101	Dental bridges	7
Dentures	44	Fluoride treatment/supplements	6
Referrals specific to find M-C providers	32	Mobile dental care	5
Dental hygiene	31	Other (e.g., implants, surgery, veterans)	12
Dental screening	25	Total number of issues	598

Source: Community Link Capital Region, May 17, 2022. Note: Sacramento County callers only.

Access to Private Dentists

Local Dentist Supply

While dentist supply can affect access by the number of dentists available to treat the population, overall supply is not a limiting factor in Sacramento County. With 1,165 licensed dentists,[120] Sacramento County is considered to have an adequate supply based on an estimated dentist-to-population ratio of 1:1,247 in 2020. This is a slightly less favorable ratio than the statewide average, 1,130:1[121] and, as Figure 21 indicates, the ratio has become increasingly more favorable over the last decade.

Provider-to-patient ratios cannot take into account important factors such as the distribution of dentists in the community, willingness to see patients covered by Medi-Cal—directly in the fee-for-service (FFS) program or through enrollment with the GMC dental plans—the availability of specialists, or whether general dentists are trained and willing to see young children in their practices.

Figure 21. Sacramentans per Dentist (Dentist-to-Population Ratio) by Year

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Residents per Dentist	1489	1458	1399	1387	1369	1358	1319	1325	1305	1276	1247

Source: County Health Rankings.

Approximately 80% of the active dentists in Sacramento County are general or family dentists, with the remaining 20% split among the specialties.[122] Note that dentists are classified by county, but dentists living on the edge of counties or who practice in multiple locations may see patient populations that reside in surrounding counties. In addition to dentists, there are 838 licensed Registered Dental Hygienists and 1,917 Registered Dental Assistants in Sacramento County.

Dental Professional Shortage Areas

Dental Health Professional Shortage Area (DHPSA) is a federal designation recognizing communities that can demonstrate they have a shortage of dental professionals. DHPSA designation is a prerequisite for participating in a variety of state and federal funding programs designed to increase access to services. It is given to areas that demonstrate a shortage of healthcare providers, on the basis of availability of dentists. The designation is based on MSSA (medical service study area) boundary, population-to-dental practitioner ratios of 1:5,000, available access to healthcare and other factors.[123] Even with Sacramento County's improving dentist-to-population ratio described above, there are 7 designated Dental Health HPSAs reported in the county (Table 19). The HPSAs are assigned scores from 1-26; higher scores indicate greater need.

Table 19. FQHCs that Increase Access in Dental Health Professional Shortage Areas, Sacramento County

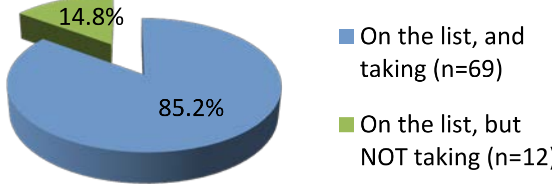
Entity	Rural Status	HPSA Score[1]	HPSA Designation Last Updated
Cares Community Health (FQHC)	Non-rural	25	9/9/21
Elica Health Centers (FQHC)	Non-rural	25	9/10/21
Sacramento County (FQHC)	Non-rural	25	9/10/21
WellSpace Health (FQHC)	Non-rural	25	9/9/21
Health and Life Organization H.A.L.O. (FQHC Look-Alike)	Non-rural	25	9/10/21
Sacramento Native American Health Center (Indian Health Service/Tribal)	Non-rural	18	9/10/21
Galt Medical Services (Rural Health Clinic)	Non-rural	17	9/11/21

Source: http://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx
[1] Scores range from 1-26; higher scores indicate greater need according to the HRSA criteria.

Sacramento Dental Offices Accepting Medi-Cal

According to the DHCS website, there are 83 local dentists or dental offices (some with multiple dental providers) who take Medi-Cal patients in Sacramento County. However, our telephone calls to 81 of these practices (2 did not respond) showed a 14.8% error rate. That is, only 69 (85.2%) currently accept Medi-Cal patients; the other 12 do not or never did (Figure 22). Of the 69 practices taking Medi-Cal, 16 (23.2%) are listed as specialists and 53 are listed as general dentists. This information is not clear-cut, though, as some practices list both "general practitioner" and one or more specialty, most commonly orthodontics, suggesting there could be a mix of providers in that office; others on the list are the same dentist/dental office but at multiple Sacramento addresses.

Figure 22. Sacramento Dental Practices Listed on the DHCS Provider Website as Currently Taking Medi-Cal Patients (n=81)



Sources: Medi-Cal Dental Services Program, https://dental.dhcs.ca.gov/Members/Medi-Cal_Dental/Find_A_Dentist/. Accessed June 16, 2022 and interviews with dental office staff June-July 2022. Two of the 83 dental offices listed did not respond.

The dental offices reported during the phone calls an average of about 2 weeks for a non-emergency appointment for Medi-Cal patients—the same, they said, as for all patients. The majority reported being able to see patients with special needs "if they were cooperative and could sit in the chair"—but a little less than half provide any kind of in-office sedation services. (See Attachment 10 for the Medi-Cal DDS provider list with more detailed information.)

GMC Dental Provider Networks

A key issue in Medi-Cal dental services is having an adequate number of providers willing to see the number of enrolled children and adults. The Geographic Managed Care Dental Plans provide access to dental services through a network of contracted dentists/dental practices and community dental clinics, referred to as the GMC dental network. The plans are also required to maintain a complete list of specialists by type within the network as well as guarantee access to community dental clinics. DHCS approves the plans the Dental Plans must submit to meet these various requirements, and is responsible for monitoring the extent to which they are accurate and implemented. The list of contracted providers is subject to change without notice as provider participation changes periodically. Dentists who wish to provide services to Dental Managed Care members must participate in the Plan's provider network (note: they do not also have to be enrolled in the Medi-Cal dental fee-for-service program). A few providers in neighboring Placer and Yolo Counties are also contracted to see GMC members because Sacramento County lies within the state's accessibility standards of the program.

Table 20 shows the number of private dental practices (some solo, some group) in the GMC network, to the extent the practice names were clear enough to us in reviewing the directories the plans shared. (Note: identifying a solo or, say, a two-person private practice from what could be a large group or clinic is challenging as many dental offices now name their dental practices for marketing purposes, e.g., “The Caring Dentist.”

Table 20. Number of GMC Dental Plan Network Private Provider Offices, by Type of Dental Provider, August 2022

	Access	Health Net	LIBERTY
General Dentist	206	90	92
Pediatric Dentist	30	22	15
Other Specialist Dentist	14	20	15
Orthodontics	10	10	9
Total[1]	260	142	131

Note: Dental practices do not include Western Dental or FQHC community dental clinics.
[4]Not a true total due to provider overlap among the Plans. Health Net and LIBERTY share many of the same providers.
Source: GMC Dental Plans’ Dentist Directories, provided to study author July – August, 2022.

While the number of GMC network dentists in the table above—at least general dentists—seems satisfactory, it should be noted that the number is not really a true representation. For example, Health Net and Liberty share 105 (58%) of the 182 (90 + 92) general dentists listed in their networks. Of these 105 general dentists, 45 of them (43%) also appear on the network list of Access’s general dentists (Table 21). In total for the GMC dental plans, then, it appears there are 100 unique dentists serving the Medi-Cal DMC population. Looking at the 81 Sacramento dental practices listed on the DHCS website as Medi-Cal providers we spoke with, we can see 25 of them (25%) participate in Medi-Cal through the contracts with the GMC plans. If that is the case, this seems to mean the remainder of private dentists, 56, participates by seeing only the FFS population. Given the challenges of interpreting this cross-walk, it may be appropriate for DHCS to take the information and dig more deeply into the question of provider capacity, possibly also looking at unique number of sites when approving networks to determine adequacy.

Table 21. GMC Dental Plan Dentist Network – Crossover and Duplicates with Medi-Cal Accepting Dentists

Health Net/Liberty Combined		Access Duplicates	Private Practice Duplicates
Type of Dentist	*Number*		
General	105	45	20
Pediatric Dentist	22	5	4
Other Specialists	19	5	0
Orthodontics	10	1	1
Total	156	56	25

Note: Dental practices do not include Western Dental or FQHC community dental clinics.

In addition to private dental practices, all of the GMC dental plans contract with the 5 Sacramento Federally Qualified Health Centers (FQHCs) and with Western Dental to serve Medi-Cal members, expanding the plans' dental network capacity.

Dental Specialists

Although somewhat improved since 2018, the GMC provider network is not adequate to reasonably meet the dental specialty needs of Medi-Cal members, despite incentives by some GMC plans such as paying specialists 25% over Medi-Cal FFS fees. Better access to appointments was again identified as a high need by the Medi-Cal Dental Advisory Committee, community advocates, focus group participants, and community dental providers interviewed for this assessment.

Access to Community Dental Services

Access to oral health care for low-income and uninsured populations in Sacramento County has improved in recent years as evidenced by Federally Qualified Health Clinic (FQHC) and Native American Health Center dental clinic expansions, and an uptick in Medi-Cal participation by local dentists. Enrollment in the GMC Dental Plans allows Medi-Cal members the option of receiving dental services through their networks of private dentists, community and corporate dental clinics (Western Dental). Table 22 that begins below lists the safety net resources with brief descriptions, and Attachment 9 shows these locations on a map.

Dental Clinics for Low-Income Populations in Sacramento County

Safety net clinics in Sacramento have an impressive track record of providing dental care for children. The integration of medical and dental delivery systems in many of them and the support services already in place makes them especially well positioned to provide dental care for adults as well as children. Expanding care or implementing new models that align with the needs of older adults or adults with disabilities and other special needs may represent new challenges, however. Table 22 which begins below describes these resources. A fuller description of each of the community dental clinics follows this chart on page 62; the clinics' utilization data are included in the Utilization section of this report.

Table 22. Community Dental Services for Low-Income Populations in Sacramento

Provider Organization	Address	Hours/New Pt. Non-Urgent Appointments	Dental Services	Special Needs? Sedation? (Y/N)	Payment Options
Community Dental Clinics					
Elica Health Centers https://www.elicahealth.org/	3701 J St Sacramento, CA, 95816	Mon-Fri 8 am-5 pm < 1 month	Comprehensive exams X-rays Sealants Fluoride treatment Cleanings/deep cleanings Composite fillings Extractions Root canals Crowns Dentures (full and partial)	Limited by client cooperation/ mobility; Nitrous oxide available only for children age 0-20	Medi-Cal/Dental, all major insurance, and a sliding fee scale discount program
	1750 Wright St, Sacramento, CA, 95825	Currently closed due to expansion remodeling; scheduled to re-open summer 2023			
	5385 Franklin Blvd, Ste. K Sacramento, CA 95820	Mon-Thurs 8 am-6 pm Wait time 2 mos.			
	4815 Watt Ave., North Highlands CA 95660	Mon-Fri 8 am-5 pm Wait time 2-4 wks			
	1276 Halyard Dr. West Sacramento 95691 (serves Sacramento pts)	Mon-Fri 8 am – 6 pm Wait time 2-4 wks			
	77 Cadillac Drive Sacramento, CA 95825	Mon-Thurs 8 am-6 pm Wait time 2 mos.	As above, but pediatric-focused dental services only here		

Table continues on next page

Provider Organization	Address	Hours/New Pt. Non-Urgent Appointments	Dental Services	Special Needs? Sedation? (Y/N)	Payment Options
Sacramento Native American Health Center **www.snahc.org**	2020 J St Sacramento, CA, 95811	Mon - Fri 8 am – 5 pm Wait time 3 mos.	Comprehensive oral exams Digital radiography Periodic oral exams Cleanings/deep cleanings Fillings Oral surgery Dentures (full and partial)	Limited by client cooperation/ mobility; no sedation is available	Medi-Cal, Delta PPO, sliding fee scale; there are no tribal or ethnic requirements to receive care
	OPENING IN DEC. 2022 3800 Florin Rd. Sacramento, CA	Will be: Mon –Fri 8:30 am – 5:30 pm	Will have: same as above – will have 12 dental operatories	Will have: nitrous capacity	Will have: same as above
WellSpace Health **www.wellspacehealth.org**	Galt Dental Center 216 N. Lincoln Blvd. Suite 10 Galt, CA 95632	Mon – Fri. 8 am – 5 pm Wait time: < 1 week	Ages 0- 20, and pregnant people age <21 Fluoride treatment Sealants Cleanings Fillings Crowns (age 13 and above) Digital x-rays Emergency appointments	Based on pt. ability to cooperate Nitrous oxide available	Medi-Cal is accepted; patients are assisted in applying to programs that help cover the cost of their care through a sliding fee scale based on income
	Hiram Johnson Dental Center 3535 65th Street, Building C Sacramento, CA 95820	Mon – Fri. 8 am – 5 pm Wait time: < 1 week			
	North Highlands Multi-Service Center 6015 Watt Avenue, Suite 2 N. Highlands, CA 95660	Mon – Fri. 8 am – 5 pm Wait time: < 1 week			
	Oak Park Community Health Center 3415 Martin Luther King Jr. Blvd. Sacramento, CA 95817	Mon – Fri. 8 am – 5 pm Wait time: < 1 week			
	Rancho Cordova Health Center: 10423 Old Placerville Road Sacramento, CA 95827	2-3 Mondays/mo. 8 am – 5 pm Wait time: < 1 week			
	South Valley Community Health Center 8233 E. Stockton Blvd, Sacramento, CA 95828	Mon – Fri. 8 am – 5 pm			
	Sunrise Community Health Center 7777 Sunrise Blvd, Suite C Citrus Heights CA 95610	Mon – Fri. 8 am – 5 pm Wait time: < 1 week		Same as above but no nitrous available at Sunrise site	

Table continues on next page

Provider Organization	Address	Hours/New Pt. Non-Urgent Appointments	Dental Services	Special Needs? Sedation? (Y/N)	Payment Options
Health and Life Organization, Inc. dba Sacramento Community Clinics http://www.halocares.org	Southgate Dental Clinic 7275 E Southgate Drive, Suite 204-206 Sacramento, CA 95823	Mon – Fri 8:30 – 4:30 Wait time: 1-2 weeks	Comprehensive exams Cleanings X-rays Oral health education Urgent dental care Fillings Root canals Extractions Crowns Partial/full dentures	Limited by client cooperation/ mobility; no sedation is available; some dentists use patient de-sensitization to reduce the need for sedation	Medi-Cal Dental; fees determined by sliding scale
	Assembly Court Dental Clinic 5524 Assembly Court Sacramento, CA 95823	Mon – Fri 8:30 – 4:30 Wait time: 4 weeks			
	7215 55th Ave. Sacramento, CA	Mon – Fri 8:30 – 4:30 Wait time: 1-2 weeks			
	Watt Dental 4986 Watt Ave. North Highlands, CA 95660	Mon – Fri 8:30 – 4:30 Wait time: 2 weeks			
	El Camino 965 El Camino Ave. Sacramento, CA 95815	Mon – Fri 8:30 – 4:30 Wait time: 1-2 weeks		The El Camino site is best equipped to see patients with special needs	
	Del Paso Blvd. Dental Clinic 2138 Del Paso Blvd Sacramento, CA 95815	Mon – Fri 8:30 – 4:30 Sat. 8:00 am – 5:00 pm Wait time: 1-2 weeks	Same as above, except Saturday clinic is only exams and cleaning for children		
	Explorer 3030 Explorer Drive Sacramento, Ca 95827	Mon – Fri 8:30 – 4:30 Sat. 8:00 am – 5:00 pm Wait time: 3 weeks	Same as above, except Saturday clinic is only exams and cleaning for children		
One Community Health https://onecommunityhealth.com/	1500 21st St, Sacramento, CA 95811	Mon – Fri 8 am – 7 pm Sat. 9 am – 5 pm	Comprehensive exams Cleanings X-rays Oral health education Urgent dental care Fillings Root canals Extractions Crowns Mouth guards Partial/full dentures	Limited by patient cooperation Child referrals to local DDSs Adult referrals generally to UCSF Contemplating adding nitrous in ~ 6 mos.	Medi-Cal Dental is accepted. Sliding fee scale available
	Arden-Arcade 1442 Ethan Way, Suite 100 Sacramento, CA 95825	M, Tu, Th, Fri 8 am – 5 pm Wednesday 10 am – 7 pm			

Table continues on next page

Provider Organization	Address	Hours/New Pt. Non-Urgent Appointments	Dental Services	Special Needs? Sedation? (Y/N)	Payment Options
Other Dental Clinic Resources					
Carrington College Dental Hygiene Clinic https://carrington.edu/location/sacramento-dental-hygiene-clinic/	8909 Folsom Boulevard, Sacramento, CA, 95826	Mon-Thurs 8:00-4:30 but hours vary by school semester	Dental hygiene clinic open to college students and community members, ages 2-3 and up Cleanings Root planing Fluoride applications Sealants X-rays Oral health education	Limited by patient manageability Nitrous is available whenever the clinic is open	Free
Sacramento City College Dental Hygiene Clinic www.scc.losrios.edu/	3835 Freeport Blvd Rodda Hall South Sacramento, CA 95822	8:30 "seating" and "1:00 seating" (appts are 2-3 hours Hours vary by school semester; Mon and Wed. fall semester 2022	Dental hygiene clinic open to college students and community members Cleanings Root planing Fluoride applications Sealants X-rays Oral health education	Limited by patient manageability Nitrous is offered but only in the final part of the senior cohort's spring semester (mid-March-mid-May) and not any other time during the year	Free or low cost

Note: Willow Clinic, an all-volunteer clinic, provides only medical services in Sacramento County (1200 N. B St.); its dental services are provided only in *Davis* (Yolo County) where clinic hours are 8 am – noon, 1 time per month on Saturdays; 7-8 dental patients can be seen.
Source: Organizations' websites, email exchanges and site visit interviews conducted with FQHC dental clinic personnel in July and August 2022.

FQHC Organizations

The following information is based on the FQHCs' website material and in-person site visit meetings with staff to gain additional perspectives about needs, concerns and recommendations. (See Attachment 1 for a list of the personnel interviewed.)

Elica Health Centers

The roots of this FQHC trace back to 1979 from a small group practice that served the primary care needs of the region's emerging immigrant communities. Elica is now a network of 10 health center facilities (7 for dental services) located in both Sacramento and West Sacramento, which provided services for 38,594 individuals in 2020. Dental makes up about 19.5% of the overall patient base.

Staff reported about 30% of the FQHC's *medical* patients use its dental services. The lack of more bidirectional use was said to be largely due to the challenge of trying to help clients who want to switch plans; staff spend an inordinate amount of time on the phone but are not able to actually carry out the transfer themselves. Two of the plans (Health Net and Liberty) do allow mid-month transfers but Access does not; Access members must wait until the first of the month to switch.

Staff said the goal is to re-open Saturday hours at most of the dental sites but not having enough staff—specifically registered dental assistants—currently to support the providers has limited their ability to open more appointments. RDAs have informed them of their fear of returning to work due to COVID risk and some have said they changed careers specifically because of COVID.

One of Elica's collaborative relationships is with NYU dental residency program where every year 2 "advanced education in general dentistry" residents spend a year working in the Elica clinics, frequently providing some of the specialty services the clinics would otherwise have to refer for. (Rockville Smiles accepts referrals for the more complex pediatric cases.) Nonetheless, staff identified the lack of enough outside dental specialists, especially endodontics, as a major access issue and the main reason for the 2-month wait to be appointed. An associated problem was described as the GMC plans' not forwarding the referral details to the specialists who then have to reach back out to the Elica dentists to obtain the details that had been in the original referral document.

Sacramento Native American Health Center

SNAHC is a community-owned and operated Federally Qualified Health Center (FQHC), located in Midtown Sacramento. There are no tribal or ethnic requirements to receive care. The Center serves an extremely low-income population with an estimated 92% of patients living under 100% of the Federal Poverty Level.

The majority of Medi-Cal dental patients are seen through contracts with the 3 GMC dental plans, and about 2% are fee-for-service billed to Delta Dental. Children make up about 25% of the dental patients. The health center is at capacity with the wait time for a new dental appointment at 90 days; recalls are 1 week out; non-urgent treatment is generally provided within 6 weeks. Only about 30% of SNAHC's medical patients receive their dental care there. While capacity is an issue, the main reason is auto-assignment at Medi-Cal enrollment to different medical and dental providers requiring patients to "go all over town to get their care" rather than from the same provider that offers integrated health services.

Similar to Elica Health Centers, one of the workforce challenges staff identified that affects access was recruiting dental support staff such as registered dental assistants (RDAs). Many RDAs have decided to stay home post-COVID, some see dental work as "too risky" to COVID exposure, and some RDAs invited for interviews simply don't show up for the interview.

SNAHC plans to open a second medical/dental/behavioral health center in December 2022 at 3800 Florin Rd. in Sacramento. The dental clinic will be open Monday-Friday 8:30-5:30 and have 12 operatories. Other upcoming plans include adding school-based services at Grant High School, and

in fall 2023, serving as a rotation site for dental students to provide community-based experience and inspire post-graduation practice.

WellSpace Health

WellSpace Health has provided health care services in Sacramento since 1953, emerging as a regional presence through the braiding of multiple organizations. It was designated as an FQHC in 2009 (having very early on been known as The Aquarian Effort free clinic and later The Effort). In 2013, The Effort became WellSpace Health, which currently provides medical, dental, and behavioral and substance abuse care to low-income and other populations.

While medical services are offered to all age groups, dental services are limited to children and pregnant patients under age 21. The historic focus of the dental program on children is largely due to the significant support of First 5 Sacramento to expand children's dental services in Sacramento County and WellSpace's readiness to create the capacity to offer it. There is current discussion about the need to expand dental to include adults. In 2020, WellSpace served close to 19,000 dental patients at its 7 sites; upcoming plans include opening a dental clinic in Roseville sometime in 2023 to meet the high need of the low-income population in Placer County.

Although promotion of medical-dental integration is an important tenet of WellSpace, staff estimates about 50%-60% of its Medi-Cal primary care patients who meet the age criteria uses its dental services. (WellSpace *adult* medical patients are referred to HALO and Elica for dental services.) As mentioned above, part of the reason is that Medi-Cal members are often auto-assigned to a different dental provider than to their assigned medical provider, creating an unnecessary access barrier.

Another access concern staff identified is the significant lack of dental specialists available to see Medi-Cal patients. While the GMC plans have been responsive when there are problems (e.g., long waits for appointments which can result in the referral process timeline running out and "having to start all over again," referrals to specialists who no longer accept Medi-Cal, etc.), patients still fall through the cracks. Periodontists were mentioned as the least available specialist.

One Community Health Center

Formed from the early '80s Center for AIDS Research, Education and Services (CARES) serving people with HIV/AIDS, One Community Health has since 1989 provided medical and dental services to an extremely diverse and low-income population. For instance, 86.3% of clients are reported to be living in public housing. About 20% of the 14,451 patients seen by the FQHC in 2021 were dental patients. Because of its history of serving primarily adults—and in recognition of WellSpace's focus on children 0-20—about 5-8%% of these patients are children.

Seven dental operatories are available at the agency's midtown site and two (with two more planned to be added) at the Arden-Arcade location. Currently (August 2022), the clinics are booked out 90 days for non-urgent appointments for both children and adults, with about 300 on the waiting list for each age group. Because of the high oral health needs of most of the clients,

there is a high demand for urgent care with many patients requiring up to 10 visits to complete treatment, which limits appointment slots for preventive care. Although the dental and medical records are integrated, and there is frequent communication between dental and primary care staff, only about 20% of the medical patients get their dental care through the FQHC's dental clinics because of the high demand appointments. Pregnant patients and those with diabetes and certain other medical conditions, however, are given higher priority for available dental appointments.

Finding referral sources for endodontic and oral surgery cases has had mixed success, most difficult for individuals with Medi-Cal, especially those enrolled through Access Dental Plan where patients have to be referred to an Access in-network provider. To facilitate referrals, the agency uses its Ryan White dental grant to help support treatment costs, and "has no problem" getting dental specialists to accept their patients when it pays market rate.

Health and Life Organization (HALO)

HALO was designated as an FQHC-Look Alike in 2008, serving as a provider for ethnically diverse and underserved populations residing in Sacramento County. About one-quarter of the patients report a language other than English as their primary language.

Dental services are offered at 7 of the 9 health center sites. Alta California Regional Center refers its clients with special needs to the El Camino Ave. site, which with its special chair is equipped to accommodate children and adults with mobility issues. In 2020, HALO reported serving 19,307 unique dental patients. As dental visits during pregnancy are not part of the state or federal reporting system, it is not known how many of the agency's 419 prenatal patients who delivered in 2020 received a dental visit.

Upcoming expansion plans include collaboration with Natomas Unified School District to build a medical/dental center by 2024.

Willow Clinic

Willow Clinic is included here because of the confusion about the scope and location of its services. Willow is an all-volunteer clinic. It only provides *medical* services in Sacramento (at the Salvation Army, 1200 N. B St.), on Saturdays only. Its *dental* services are only provided in Davis (Yolo County) 1 time per month on Saturday dependent upon availability of the volunteer dentists. While there are always about 17-20 people on the dental wait list to be called, only about 7-8 patients can be seen during each clinic session, translating to 90 patients per year. If any medical patient at the Sacramento site presents with an urgent dental condition *when the Davis site is open*, Willow will try to arrange transport there for the patient.[124]

Access Barriers Observed by Alta CA Regional Center

Regional Center Services

Lack of access to dental care for individuals with special needs is a decades-long problem. The Department of Developmental Services contracts with 21 Regional Centers (RC) to provide services and supports to persons with developmental disabilities, including dental services. Sacramento County is served by Alta California Regional Center (ACRC). ACRC was one of the very few regional centers that did not have a Dental Coordinator position. Instead, they assigned a multidisciplinary dental committee to assist the 182 Service Coordinators in helping to link families with services—an onerous charge. However, in light of the recognized need for greater dental attention for clients, ACRC hired a dental hygienist Dental Coordinator on December 1, 2022.[125] This position will also play a key role in the development of the Shorten the Line Project collaboration and the development of specialized services through the HALO Clinic.

ACRC reported supporting 17,543 Sacramento clients as of July 1, 2022, approximately 47% (8,331) of whom were children ages 0-17.[126] Many of these children also received services from the California Children's Service (CCS) program. (There were about 6,100 children enrolled in CCS in Sacramento County according to the most recently available data[127].) While not all clients with SN are or need to be enrolled in RC services, all of them, like anybody else, needs to be connected with a regular source of dental care, and one that is adapted to their unique needs.

Service Coordinator Input

Seventy-seven (43%) of about 180 ACRC Service Coordinators responded to our survey about clients' access to oral health services. The staff assigned to adults (37 of the respondents) carried an average monthly caseload of 70.5 clients; the 44 SCs with responsibilities for children reported an average monthly caseload of 76.6 children. While most of the SCs were assigned to either adults or children, 4 (5.2%) of the respondents had both in their caseloads. Asked about "in a typical month" the SCs reported helping an average of 2.6 individuals in getting regular dental care and an average of 3.5 in receiving dental care via IV sedation/general anesthesia (GA). For children, SCs reported monthly average referrals for 2.6 and 2.0 children for regular office-based and hospital-based care, respectively (Table 23). These referral averages are slightly *higher* than what ACRC SCs reported in our 2020 survey,[128] which could mean more recognition of oral health issues by ACRC or an increase in needed dental services among their population.

Table 23. Average Number of ACRC Clients Needing a Dental Referral from a Service Coordinator in a Typical Month (n=77)

Adult Clients				Child Clients*			
# of SCs	Average Caseload	Avg # referred to DDS for regular dental care	Avg # referred to DDS for IV sedation/GA	# of SCs	Average Caseload	Avg # referred to DDS for regular dental care	Avg # referred to DDS for IV sedation/GA
37	70.7	2.6	3.5	44	76.6	2.6	2.0

*ACRC defines children as age 0-17; adults as age 18+.
Source: Alta CA Regional Service Coordinator Dental Survey, study author, July 2022.

In general, about 35% of the SCs thought families were "mostly aware"– and 3.9% were "very aware"– about oral health issues when it came to things like the relationship to general health, ways to prevent dental disease, and the importance of taking a child for a first dental visit by age 1 (Figure 23). However, 18.2% thought families were "not very aware" of these issues, and 42.9% were only "somewhat aware."

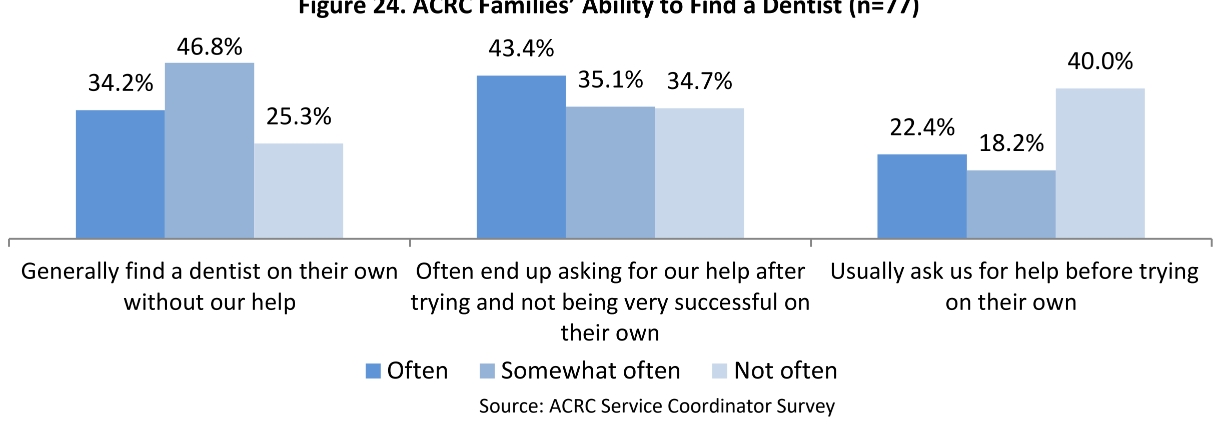
Figure 23. ACRC Perceptions of Client Awareness about Oral Health (n=77)

42.9%
35.1%
18.2%
3.9%
Not Very Aware
Somewhat Aware
Mostly Aware
Very Aware

Source: ACRC Service Coordinator Survey

SCs are not always aware of all of the needs in their caseloads if the person or parent finds resources on their own. The extent to which SCs said they were aware families were able to find a dentist or the frequency with which they asked the SC for help are shown in Figure 24. Their responses indicate that one-third (34.2%) are "often" able to find a dental provider on their own for regular and ongoing care, while 22.4% of families "often" do not even try but rely on the SC before seeking services. Most commonly (43.4%), though, families often ask ACRC for help finding a dentist after trying unsuccessfully on their own.

Figure 24. ACRC Families' Ability to Find a Dentist (n=77)



Source: ACRC Service Coordinator Survey

The main needs or issues the SCs reported encountering in trying to help *adult* clients find dental care is summarized in the chart below (Table 24) along with solutions they reported using to try to address the issue. The general observation expressed by the respondents was that "there are too few dentists who are familiar with this population;" this was followed in frequency by over two-thirds of the SCs identifying the need for a larger referral network of dentists accepting Medi-Cal, most especially for individuals requiring general anesthesia (GA). The majority described situations with "untenable" delays for GA. The steps SCs took to help clients were either to "follow the process and wait it out," or employ work-arounds such as referring clients out of county or to the ER. Specific comments that elucidate the problems included:

- *"If there were more quality doctors that were able to give the clients more time, the need for sedation dentistry could be avoided for some clients giving them quicker, quality and more opportunities to take care of their oral hygiene."*
- *"Unfortunately, have to use the emergency room to get teeth pulled as they can't be seen in a regular office setting and it is usually an emergency at that point."*
- *"I look online for dental providers to help families but most clients end up not going to the dentist; many of my clients haven't been seen in 5-10 years."*

Table 24. Main Issues/Needs in Finding/Using Dental Services for ACRC *ADULT* Clients, and Service Coordinator Solutions*

Issue/Need (n=36)	Solutions Used by SCs (n=32)
▪ Too few DDSs able to see Medi-Cal patients with severe medical or behavioral issues ▪ DDSs not taking Medi-Cal patients (even if they *do* serve clients with disabilities/special needs) ▪ Long delays waiting for general anesthesia referrals (Dr. Bughao's waitlist is too long) ▪ Medi-Cal denials of requests for general anesthesia ▪ Patient behavior during exams (non-compliance) ▪ Unpleasant experience (poor customer service) at dental office ▪ Dentist not providing a thorough job on client's dental cleaning ▪ Finding an office that can see a client in a manual or power wheelchair; finding a dentist who will treat clients with spastic Cerebral Palsy ▪ Dentists pull the teeth of Medi-Cal patients because no coverage (or approval) for crowns ▪ Clients say they don't have a need to see a dentist ▪ Most care homes not happy with Western Dental but can't find an alternative that accepts Medi-Cal ▪ Difficult phone menu systems; no "live" responses	▪ Seek support and review by ACRC Dental Committee to obtain approval for sedation dentistry ▪ Request referral from current DDS or letter from MD stating why consumer needs hospital dentistry ▪ Send clients to Highland Hospital in Oakland for GA ▪ Switched clients to electric tooth brushes and trained staff on how to brush and floss other people [to improve oral hygiene to reduce the need for GA] ▪ Get dental hygienist to make home visits ▪ Referral to Medi-Cal Case Management ▪ Use pictures to help families understand the process ▪ Refer client to the ER

Source: ACRC Service Coordinator Survey
* In frequency of mention. Comments are lightly edited for clarity or brevity, but otherwise are verbatim.

With regard to *child* clients, a summary of the main issues SCs encountered and solutions they used is shown in Table 25 on the next page. Fifteen of the 19 respondents that identified a problem brought up the lack of trained dentists comfortable or willing enough to serve this population. As with adult clients, the most commonly identified problem was the lack of adequate access to sedation/general anesthesia needed for treatment. The "solutions" SCs reported using were less a real resolution than an unsatisfactory answer such as when families are forced to choose to pay out of pocket for sedation surgery rather than to continue delaying treatment. Additional comments that offer insight about limited resources and inadequate support include:

- *“Parents are often told that sedation is not covered under medical or dental benefits, including for Medi-Cal, and owe thousands of dollars out of pocket.”*
- *“Many children have an aversion/sensitivity for objects entering their mouth. Many also can’t sit still during even a cleaning. Dentists need more training—or willingness to become trained—to be better equipped to work with children with special needs.”*
- *“Families don’t take children to the dentist at all for years and say their teeth are fine and there are not any dental needs.”*
- *“I have to do my own research – find dentists, create a list of who takes special needs, who takes Medi-Cal, who provides GA.”*
- *“Parents haven’t asked about dental care so I haven’t brought it up.”*
- *“Some clients can wait months to access Dr. Bughao, but for a client in pain there are not any local services other than a referral to the ER.”*

Table 25. Main Issues/Needs in Finding/Using Dental Services for ACRC *CHILD* Clients, and Service Coordinator Solutions*

Issue/Need (n=19)	Solutions Used by SCs (n=27)
▪ Can’t find enough willing DDSs to work with client's with special needs—some clients will not let anyone look or go inside mouth to be cleaned ▪ Not enough resources for IV/sedation/general anesthesia dental care, long waits and “run arounds” ▪ Child unable to tolerate the multiple dental visits required for sedation referrals ▪ Can’t find DDS accepting Medi-Cal, or one taking new Medi-Cal patients ▪ Family belief about no need for dentist visit	▪ Provide a list of DDSs who serve this population—but parents have to call each one to inquire about acceptance of insurance ▪ Parents are solving the problem independently ▪ SCs or therapists attend the dental appointments with the children/families ▪ Families are advised to ask family and friends for recommendations ▪ Several families just decide on paying out of pocket for sedation surgery due to not wanting to have their child wait any longer

Source: ACRC Service Coordinator Survey
* In frequency of mention. Comments are lightly edited for clarity or brevity, but otherwise are verbatim.

Invited to offer one recommendation for improved adult dental services—to be addressed by MCDAC/SCOHP or ACRC specifically—the Service Coordinators suggested the following:

ACRC Service Coordinator Recommendations

- ACRC to vendor more dentists who can provide hospital/sedation dentistry
- ACRC assistance for covering dental costs not covered by Medi-Cal
- Provide a dental clinic trained on how to best serve clients with disabilities
- Provide a list of DDSs that focus on working with clients with mental health, behaviors, and medical issues; have set days and times for clients with these issues
- Mobile dental clinics for home-based services
- More community awareness of the community dental clinics
- Fuller Medi-Cal coverage of fillings, crowns, root canals
- Have ACRC hire a dental hygienist

Access to Specific Services: Hospital and Surgery Center-Based Dental Procedures

Not all dental treatment, including treatment of early childhood caries, can be accomplished without general anesthesia (GA). While alternative approaches can reduce the need for GA—some have estimated by half[129]—local anesthesia/conscious sedation and non-pharmacological behavior guidance techniques are not viable for some dental patients.[130] People with special health care needs in particular have treatment conditions, acute situational anxiety, uncooperative age-appropriate behavior, immature cognitive functioning, disabilities, or medical conditions that require GA to undergo dental procedures safely and humanely.

California has some of the highest patient monitoring standards for the administration of minimal, moderate, and deep sedation and general anesthesia to dental patients of all age groups and especially for children. California statutes generally exceed the guidelines of all the organizations that are involved in the administration of anesthesia to children in dental offices.[131]

Our 2020 report *Painful Realities: General Anesthesia Access in Sacramento GMC Dental Managed Care*[132] provided details about the extent of the access problem and offered recommendations that MCDAC and other advocates have been working to implement. This section updates some of those earlier data—and the results are positive.

Challenges

In the Medi-Cal *dental* program, pre-approval from the beneficiary's Medi-Cal *health/medical* managed care plan is required for dental treatment under GA. This is because the medical portion pays for the facility fee and anesthesia fee (when the GA provider is a medical professional) and the dental portion pays for the dental procedure, which includes the dentist's professional fee (including a dental anesthesiologist if that is who provides the anesthesia). The GMC Dental Plans authorize and pay dentists for the hospital/facility-based encounters. Authorization for the hospital and associated charges is provided directly by the medical plan.

Until very recently, in Sacramento County, some Medi-Cal managed health care plans denied the validity of some dental plans' and FFS dental providers' GA referrals for dental treatment, with Anthem Blue Cross an outlier, doing so disproportionately, and other medical plans approving 100% of the time. For the most part, the denials had been based on a health plan review that concluded there was "no medical necessity."[133]

A California DHCS 2015 All Plan Letter (APL), a 2017 Treatment Plan Flow Chart providing guidelines for what should be considered, our GA report, and subsequent interventions by MCDAC and DHCS have apparently helped to reduce the problem.

Medical Plan Authorization Request Experience

In CY 2021, there were 626 requests submitted by GMC and FFS dental providers to the Medi-Cal managed health care plans for GA dental services for children; only 25 (4%) were denied, with no plan an outlier. Anthem and Health Net were consistent in their proportion of approvals for children with and without developmental disabilities (DD), and approved an average of 94% of the requests. Kaiser and Molina Health Plans approved 100% of the GA requests for children, for both members with DD and members without (Table 26).

Table 26. Sacramento GMC Medi-Cal Health Plans' Approval Rates for CHILDREN's Dental TARs With and Without Developmental Disabilities (DD), CY 2021

	Anthem		Health Net		Kaiser		Molina	
	Non-DD	DD	Non-DD	DD	Non-DD	DD	Non-DD	DD
Total requests	272	29	53	34	104	132	2	0
Total approved	255	27	49	32	104	132	2	0
Total denied	17	2	4	2	0	0	0	0
Approval rate	***93.8%***	***93.1%***	***92.5%***	***94.1%***	***100%***	***100%***	***100%***	***NA***

Source: Department of Health Care Services, Medi-Cal Dental Division, data obtained through Public Record Act, October 7, 2022.
Note: GMC plan-submitted data in accordance with APL 15-012 (general anesthesia administered by an MD for dental procedures), not by CPT codes.

Kaiser, which reported the greatest number of adult GA requests, approved all of them. Anthem denied 6.5% of the requests for adults without DD but approved all requests for members with DD; the reverse was the case for Health Net. Molina reported no requests (Table 27).

Table 27. Sacramento GMC Medi-Cal Health Plans' Approval Rates for ADULTS' Dental TARs With and Without Developmental Disabilities (DD), CY 2021

	Anthem		Health Net		Kaiser		Molina	
	Non-DD	DD	Non-DD	DD	Non-DD	DD	Non-DD	DD
Total requests	46	10	3	17	7	120	0	0
Total approved	43	10	3	16	7	120	0	0
Total denied	3	0	0	1	0	0	0	0
Approval rate	***93.5%***	***100.0%***	***100.0%***	***94.1%***	***100%***	***100%***	***NA***	***NA***

Source: Department of Health Care Services, Medi-Cal Dental Division, data obtained through Public Record Act, October 7, 2022.
Note: GMC plan-submitted data in accordance with APL 15-012 (general anesthesia administered by an MD for dental procedures), not by CPT codes.

Aetna Better Health of California, one of the GMC medical managed care plans also covering Sacramento County, again as before in FY 2018-19, did not report any requests for GA during CY 2021.

Dental Prior Authorization Experience

The 2016 American Dental Association *Guidelines for the Use of Sedation and General Anesthesia by Dentists*[134] provide detailed sedation information, outline educational requirements and lay out comprehensive clinical guidelines dentists should use including the appropriate pre-operative assessment process for patients prior to undergoing general anesthesia. They do not address *patient selection*, that is, *who* should receive IV sedation/GA as dentists are expected to use their professional judgement in applying appropriate criteria.

GMC-contracted dental providers submit requests for GA to the patients' dental plans where they are reviewed by the GMC dental directors; FFS providers submit GA requests to Delta Dental. Table 28 displays the CY 2021 Treatment Authorization Request (TAR)/Prior Authorization (PA) histories of 5,271 requests for dental GA to show the number of initial approvals/denials/appeals/ final approvals for GMC and Sacramento FFS.

Almost none of the denials for children and relatively few of the adult denials were appealed; the reasons for not appealing are not clear. Of the adult appeals, FFS had only 1 and approved it; Health Net had 7.8% adult appeals (later approving 3 of the 16); and, Liberty had 24.7% (approving 7 of the 23). The main reason for denials by Health Net and Liberty dental plans was "GA not indicated based on medical necessity"—similar to the main reason given by the managed medical care plans—while Access's were largely related to inadequate documentation and questions about patient eligibility—essentially the same as our findings as 3 years ago. Liberty and Health Net have indicated they are working on educating providers on proper documentation so that referrals can be routed correctly and denials can be decreased.

Table 28. GMC Dental Plans and Delta Dental TAR/PA Approval Rates for Sacramento GA Dental Services, CY 2021

	Access			Health Net			Liberty			Sacramento FFS		
	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+	Age 0-7	Age 8-20	Age 21+
# of GA requests	321	71	83	1534	411	634	1293	384	287	88	86	79
# of TARs/PAs approved upon 1st request	233	56	74	1508	373	428	1276	342	194	81	78	55
# of TARs/PAs denied upon 1st request	88	15	9	26	38	206	17	42	93	7	8	24
Initial approval rate (%)	***72.6***	***78.9***	***89.2***	***98.3***	***90.8***	***67.5***	***98.7***	***89.1***	***67.6***	***92.0***	***90.7***	***69.6***
Number of TARs/PAs denied upon 1st request that were appealed	0	0	0	0	2	16	0	7	23	0	0	1
Number of TARs/PAs denied upon 1st request appealed and approved	0	0	0	0	0	3	0	2	7	0	0	1
Final Approval rate after initial denial (%)	***72.6***	***78.9***	***89.2***	***98.3***	***90.8***	***68.0***	***98.7***	***89.6***	***70.0***	***92.0***	***90.7***	***70.9***
Avg lag time (days) between original TAR/PA submission and dental procedure (delivery of treatment services) for CDT D9222	22	19	15	74	55	54	62	51	56	38.5	51.3	71.9

Source: Department of Health Care Services, Medi-Cal Dental Division, data obtained through Public Record Act, October 24, 2022.
Note: Data pulled using CDT Code 9220.

Looking at Delta Dental and the GMC dental plans' *initial* approval rates from Table 28 above to highlight the variation by age group (Figure 25 on the next page), we can see in the case of Health Net and Liberty that approvals for children were high but dropped significantly for adults; Delta

Dental approval rates for children and denials for adults were similar to these two dental plans. The findings for Access, however, were the reverse: approvals increased as the age of the members increased.

Figure 25. GMC Dental Plans and Delta Dental Initial Approval Rate of GA Requests by Age Group, CY 2022

	Age 0-7	Age 8-20	Age 21+
Access Dental	72.6%	78.9%	89.2%
Health Net Dental	98.3%	90.8%	67.5%
Liberty Dental	98.7%	89.1%	67.6%
Delta Dental (FFS)	92.0%	90.7%	69.6%

Source: Department of Health Care Services, Medi-Cal Dental Division.
Data obtained through Public Record Act, October 7, 2022.

In GMC, the average lag time (number of days) between the original TAR/PA submission and the dental procedure (delivery of treatment services) for children age 0-7 was extraordinarily short for Access patients—22 days—compared to 74 days for Health Net and 62 days for Liberty patients (Table 28 on the previous page); in the FFS system, the age 0-7 lag time was an average of 38.5 days. The differences between the 3 dental plans for adult members was also striking, again with Access reporting a 15-day "turnaround," Health Net 54 days and Liberty 56 days; adults in FFS had the longest wait, however—71.9 days.

An Upcoming Opportunity to Address Access

The FY 22/23 Governor's budget includes a one-time, $50 million investment to build and expand facilities and infrastructure to provide care for dental patients with special health care needs.[135] The aim is for additional care settings to significantly expand access to dental care for individuals who are unable to undergo dental procedures in traditional dental offices either due to special health care needs or the complexity of the care needed, sometimes requiring special accommodations for mobility issues, stabilization or deep sedation. Development of physical infrastructure will be done via a grant program, facilitated by the CA Health Facility Financing Authority, and be used specifically for building/capital outlay – not ongoing funding. Entities will be able to apply for up to $5 million in grant funding and need to be Medi-Cal providers as well as agree to serve the special needs population for at least 10 years upon completion of the construction.

Access to Commonly Denied Dental Procedures

We queried DHCS for the top 5 most commonly denied dental procedures in Medi-Cal—and the main reasons for the denials—as a result of concerns about patient access expressed by MCDAC and several of the key informants. The detailed information in Tables 29 on this page (for children) and 30 on the next page (for adults) is provided to increase understanding and providers' chances of future successful claim submissions, reduce frustration, and call attention to areas where advocacy for review and revision may be warranted.

Table 29. Top 5 CDT Procedures Denied for Children in Sacramento County Medi-Cal FFS and GMC, 2021

Children					
FFS			**GMC**		
CDT Code	*Description*	*Reason **	*CDT Code*	*Description*	*Reason*
D8670	Periodic orthodontic treatment visit	269C,326, 275, 200A	D9223	Deep sedation/general anesthesia, inhalation of nitrous oxide, intravenous moderate (conscious) sedation/analgesia	Documentation required to evaluate for authorization or payment
D9223	Deep sedation/general anesthesia, inhalation of nitrous oxide, intravenous moderate (conscious) sedation/analgesia	555C, 267I, 300	D4341	Periodontal scaling and root planing	Submitted information did not indicate need for requested procedure based on x-rays and/or documentation for treatment not needed at this time
D8680	Orthodontic retention/ removal of appliance	269C,326,300	D0330	Panoramic film	Service requested is not medically necessary
D0350	Oral/facial photographic images	275, 269A, 326	D1120	prophylaxis—age 13 or younger	Service requested is not medically necessary
D9222	Deep sedation/GA – first 15 minutes.	555C, 267I, 300	D9310	Consultation by a dental specialist	Procedure Code Modified

**Reason Code*	
269C	Procedure associated with another denied procedure.
326	Denied due to invalid response to the RTD or, if applicable, failure to provide radiographs/attachments for this EDI document
275	Procedure has been modified/disallowed to reflect the maximum benefit under this program
200A	Adjustments of banding and/or appliances are allowable once per quarter
555C	Authorization of this line is no longer valid: A new claim/TAR is being processed
267I	Documentation submitted is incomplete
300	Procedure recently authorized to your office
269A	Procedure denied for the following reason: Included in the fee for another procedure and is not payable separately

Source: DHCS, Medi-Cal Dental Services Division, from raw data provided by the ASO and DMC plans, provided to study author December 2, 2022.

Table 30. Top 5 CDT Procedures Denied for Adults in Sacramento County Medi-Cal FFS and GMC, 2021

Adults					
FFS			GMC		
CDT Code	*Description*	*Reason **	*CDT Code*	*Description*	*Reason*
D4341	Periodontal scaling and root planing	081, 555C, 088, 266C	D4341	Periodontal scaling and root planing	1) Approval requires submission of diagnostic quality x-ray(s); the submitted x-rays are non-diagnostic; 2) Service is not medically necessary
D2740	Prosthetic crown (porcelain/ceramic) placed over a chipped, cracked, damaged, or decayed tooth	113C, 113, 271B, 271H	D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	1) Approval requires submission of diagnostic quality x-ray(s); the submitted x-rays are non-diagnostic; 2) Service is not medically necessary
D4342	Periodontal scaling and root planing (if the radiographic evidence of bone loss is only visible on 1 -3 teeth)	081, 555C, 555A, 088	D2740	Prosthetic crown (porcelain/ceramic) placed over a chipped, cracked, damaged, or decayed tooth	Service requested is not medically necessary
D2751	Crown – porcelain fused to predominantly base metal (there is recurrent decay and this needs to be removed and a new crown made	113, 113C, 271H, 271B	D2950	Buildup procedure when necessary prior to restoring a tooth with a crown; holds crown on when there is inadequate tooth structure left	Service requested is not medically necessary
D5110	Complete upper denture	269C, 274, 129, 155	D3320	Root canal, bicuspid (excluding restoration)	1) Approval requires submission of diagnostic quality x-ray(s); the submitted x-rays are non-diagnostic; 2) Service is not medically necessary

** Reason Code*	
81	Periodontal procedure cannot be justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidenced by the submitted radiographs
555C	Authorization of this line is no longer valid: A new claim/TAR is being processed
88	Procedure is a benefit once per quadrant every 24 months
266C	Payment and/or prior authorization disallowed. Radiographs or photographs are non-diagnostic
113C	Laboratory processed crowns for adults are not a benefit for posterior teeth except as abutments for any fixed prosthesis or removable prosthesis with cast clasps or rests. Please reevaluate for alternate treatment.
113	Tooth does not meet the Manual of Criteria for a laboratory processed crown
271B	Procedure is disallowed due to apical radiolucency
271H	The replacement of tooth structure lost by attrition, abrasion or erosion is not a covered benefit
555A	Authorization of this line no longer valid. Patient is/was being treated elsewhere
269C	Associated with another denied procedure
274	Comprehensive (full mouth) treatment plan is required for consideration of services requested
129	Procedure is a benefit once in a 5-year period except when special circumstances are adequately documented.
155	Procedure requires a properly completed prosthetic DC054 form.

Source: DHCS, Medi-Cal Dental Services Division, from raw data provided by the ASO and DMC plans, provided to study author December 2, 2022.

Non-surgical Periodontal Therapy

Periodontal maintenance is needed for people who have periodontal disease—like many Medi-Cal adult populations with poor oral hygiene and chronic dental needs—and deep cleaning is needed to stop periodontal disease from advancing. Yet, as is clear from Table 30 above, non-surgical periodontal therapy (scaling and root planing – SRP) was routinely the top of the 5 most commonly denied treatment authorization requests (TARS) for adult Medi-Cal members,[136] whether they were enrolled in FFS or GMC. The rationale for denying TARs for periodontal services is that the "service requested is not medically necessary" or the request is not "justified on the basis of pocket depth, bone loss, and/or degree of deposits as evidenced by submitted radiographs." This seems to pose a Catch-22: the patient has to have more advanced disease before treatment is allowed to halt the progression of the disease.

The review of "medical necessity" for SRP needs to be consistent with best-practice for staging periodontal treatment such as consideration of bleeding on probing, clinical attachment loss, and contributing factors (tobacco use, medical conditions) that are not visible on radiographs. Guidelines in the July 2016 DHCS bulletin (vol. 32, no.12), *recently published in the Provider Handbook November 2022,* allow acceptance of photographs rather than radiographs for those unable to tolerate x-rays due to their physical, medical or cognitive situation. Asking DHCS to routinely provide data on periodontal denials by provider type, age group, geographic and residential criteria would offer more transparency in the assessment of need. Because the high denial rate for these SRP TARs is largely due to providers not submitting the correct information—as it is time-consuming— focusing on more provider education to reduce the number of these denials would make a large impact.

Emergency Department Use for Preventable Dental Conditions

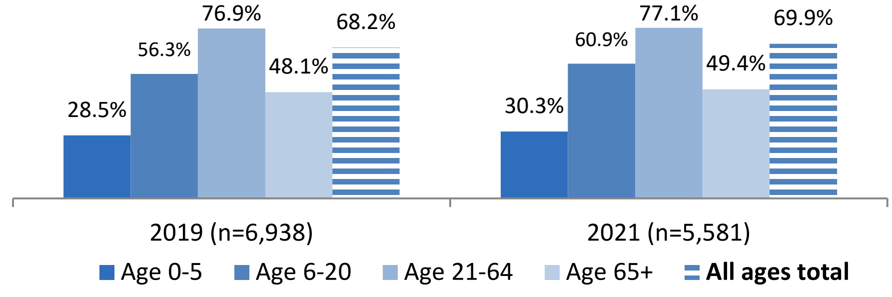
The use of an emergency department (ED) for non-traumatic dental problems serves as a marker for disparities in the quality and access to a regular dental home, and suggests inadequate access to readily available community dental services. Importantly, inadequate access to oral health care provided in the ED creates a pattern of repeat non-traumatic dental condition ED visit.[137] Findings from an analysis of national data[138] on Medicaid adult health beneficiaries' use of hospital EDs for cavities or dental abscesses that might have been prevented with regular dental care are particularly informative for the adult focus of this needs assessment and have applicability for Sacramento County:

- Medicaid beneficiaries seek care for these oral health conditions in EDs at rates three times higher than commercially insured patients.[139]
- Over the last 10 years, dental pain has been a top reason for opioids prescribing upon discharge from the ED, thereby contributing to the opioid epidemic.[140]
- Having public insurance coverage or being uninsured was a predictive factor of ED visits for non-traumatic dental conditions (NTDCs), and adults were more likely to use the ED for NTDCs compared to children and older adults.[141]

Visits to an ED for NTDCs are identified by primary ICD-10 diagnosis codes. Some of the codes are considered to be for *ambulatory care sensitive conditions* (ACS), i.e., those that reflect the conditions "that would likely or possibly benefit from better prevention or primary care,"[142] and are therefore potentially avoidable.

Looking at Sacramento County experience in 2019 (to eliminate the potential 2020 COVID effect), and at 2021 data that could reflect "some COVID recovery," shows in 2019 residents made 6,938 visits to an ED due to a primary oral condition diagnosis (this represents 1.04% of all ED visits for any reason); 68.2% of the dental ED visits were considered to be an ACS ("preventable") condition. In 2021, the number of ED visits was somewhat lower, 5,581 but the percentage considered ACS was similar as in 2019, 69.9% (Figure 26). By comparison, during the same two time periods, the ACS proportion of non-traumatic oral conditions ED visits in California was 59.5% (data not shown).

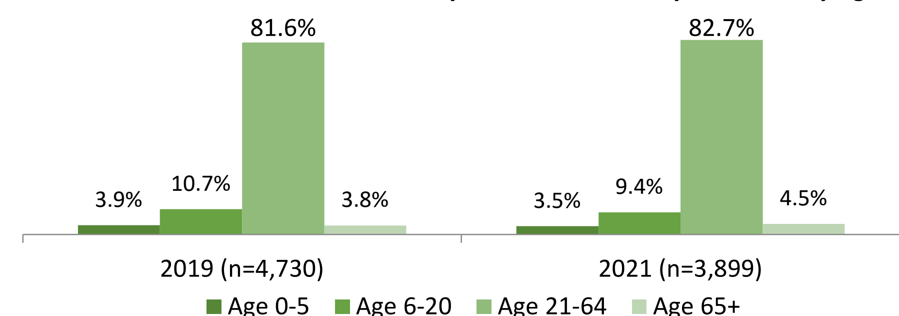
Figure 26. Percent of ED Dental Visits Considered Preventable, of all ED Visits for a Non-Traumatic Dental Condition, Sacramento County Residents, 2019 and 2021



Source: Department of Health Care Access and Information (formerly OSHPD), September 2, 2022.

Close to 4% of the preventable ED dental visits were made by Sacramento children age 0-5; about 10% of the visits were by children age 6-20. Adults age 21-64 had the highest proportion of use. The difference between the two time periods for adults 21-64 was only slight; however, for seniors there was an 18% increase in this type of ED use in 2021 (Figure 27).

Figure 27. The Percent of Preventable ED Dental Visits by Sacramento County Residents by Age Group, 2019 and 2021



The impact to each Sacramento County hospital for avoidable dental ED visits by children and adults can be seen in Table 31 below. The slightly lower number of these visits in 2021 (about 5%) may reflect some people's hesitancy to go to an ED, regardless of tooth pain, due to fear of COVID risk.

Table 31. Number of Visits Made by Sacramento County Residents to a Sacramento ED for an Avoidable Dental Condition, 2019 and 2021

	2019			2021		
	Children 0-20	*Adults 21+*	*Total*	*Children 0-20*	*Adults 21+*	*Total*
Kaiser Foundation Hospital - Sacramento	98	576	674	80	591	671
Kaiser Foundation Hospital - South Sacramento	102	484	586	81	450	531
Mercy General Hospital	21	192	213	17	133	150
Mercy Hospital of Folsom	30	213	243	25	155	180
Mercy San Juan Hospital	92	673	765	68	493	561
Methodist Hospital of Sacramento	69	328	397	31	242	273
Sutter Medical Center, Sacramento	102	644	746	74	503	577
University of California Davis Medical Center	36	295	331	34	268	302
Total	550	3,405	3,955	410	2,835	3,245

Note: By county of facility.
Source: Department of Health Care Access and Information (formerly OSHPD), September 2, 2022.

Use of the ED for avoidable dental conditions is expensive, especially when compared to the price of prevention. Public programs—nearly entirely represented by Medi-Cal for individuals under age 65—picked up the tab for the clear majority of Sacramento County residents' preventable ED dental visits in both 2019 and 2021 (Figure 28 below). These percentages are consistent with the earlier Sacramento County oral health needs assessment (2016-17 data). The disproportionately high percentage of ED visits covered by Medi-Cal—on average 77.8% (on average 73.8% statewide for the same period)—continues to support the need for increased outreach and access to

preventive dental services by dental *and* medical managed care plans, and other advocates. Note that it is the Medi-Cal patient's *medical* managed care plan, not their dental managed care plan, which pays for these visits.

Figure 28. Payer Source for ED Visits Made by Sacramento County Residents for an Avoidable Dental Condition, 2019 and 2021

	2019 (n=4,730)		2021 (n=3,899)	
	Age 0-20	Age 21+	Age 0-20	Age 21+
Private Insurance	9.0%	11.1%	11.8%	15.0%
Public Program	80.0%	77.2%	78.0%	75.8%
Self-Pay	11.0%	11.6%	10.2%	9.2%

By county of residence.

Source: Department of Health Care Access and Information (formerly OSHPD), September 2, 2022.

At this time, there is no systematic communication link in Medi-Cal between hospital EDs and DMC plans to inform the dental plans that a member has used the ED for a non-traumatic dental visit so that the plan can follow up, making sure treatment beyond palliative care is provided, ensuring the member knows who their dental provider is and is comfortable going there, and encouraging regular use of preventive services in the future. Advocates are aware this is an issue that needs improvement. The plans have been discussing this concern with DHCS and are hopeful better communication will occur when the CalAIM program takes effect for dental.[143] The dental plans have also initiated conversations with Sacramento Covered about their patient navigators placed in the local EDs (Monday-Friday, 8-hour day shifts) to route any dental-related ED visits back to the plan. Sacramento Covered reported it has begun to use the web-based system, MDRAN (see page 83 for a detailed description), that helps to facilitate and track dental referrals.[144]

The *rates* of non-traumatic ED dental visits considered avoidable by age and race/ethnicity group are shown in Table 32 on the following page. Relative to age, the majority of these visits both locally and statewide were among young adults (18–34 years of age), similar to findings from other studies,[145] but significantly higher in Sacramento County than the state.

Racial disparities in the utilization of EDs for dental conditions are a consistent finding in research. Relative to its population in both Sacramento County and statewide, Black/African Americans had the highest rates of ACS dental visits, significantly so in Sacramento County. This finding is consistent with national data that demonstrate that Black/African Americans, especially those with no or public insurance and of low socioeconomic status, have higher rates of ED visits than other groups.[146]

Table 32. Rate of ACS Dental Visits to an ED by Patient Age and Race Ethnicity, 2017-2019

	Sacramento County	California
Age Group		
All	760.7	359.8
<1 year	387.5	329.1
1-2 years	463.9	379.3
3-5	543.5	310.2
6-9	499.6	265.7
10-13	247.5	144.2
14-17	329.3	178.0
18-34	1480.8	572.0
35-64	743.1	365.8
65+	224.0	171.2
Race/Ethnicity		
Asian	186.7	62.5
African American	1152.3	665.8
Other	546.9	473.4
White	444.3	248.5
Hispanic	634.9	330.7

All rates are crude rates per 100,000 population.
Source: Department of Health Care Access and Information (formerly OSHPD). ED Visits 2014-2019. Reference: Manz, M.C. (Updated January 2021). *Recommended Guidelines for Surveillance of Non-Traumatic Dental Care in Emergency Departments.* Reno, NV: Association of State & Territorial Dental Directors. Analysis by Office of Oral Health; Prepared by M Gadgil (September 2021)

Lastly, it is important to note that dental procedures are seldom performed in an ED. This results in palliative care being provided rather than definitive care. As a result, 90% of dental-related ED visits result in prescription medication to manage pain and infection rather than appropriate dental procedures. This is because EDs are not equipped to provide extensive dental care. Consequently, the majority of these visits require follow-up care with a dentist.[147] In informal interviews with a random sample of local ED physicians (n=7) from Kaiser, UC Davis and Mercy San Juan, we heard:

- *"I offer the [adult] patients with a lot of pain a nerve block. I'm probably one of the few who does that."*
- *"Many of these adults look like they've never been to a dentist as a child and have no idea about prevention."*
- *"Pediatric patients present with pain but usually have huge caries and/or dental abscess and at least some degree of facial cellulitis."*
- *"I probably see about 1 patient per shift with tooth pain/infection; many request opioid pain medications, sure, but that's not always what's driving them to come in, you should see their teeth."*
- *"No, we [MDs] don't know about local dental clinics, we consult our Health Care Navigators who are to assist these patients with dental follow-up."*

Other Supportive Community Oral Health Resources: Existing and Planned

Other local organizations play important roles in supporting oral health efforts in Sacramento County. This includes establishing collaborative relationships, conducting awareness campaigns, making referrals, providing community oral health education, preparing the workforce, and co-locating dental screenings.

Sacramento Covered

Sacramento Covered (different from Covered California, the marketplace) is a nonprofit organization dedicated to achieving health care access and care coordination for residents in the Sacramento region. Its mission is to improve the overall health and well-being of individuals and communities by connecting people to health coverage, primary and preventative care, behavioral health care, housing, food, and other health-related supports. Field-based community health workers, health and patient navigators work to coordinate services such as dental to ensure individuals get the wraparound services they need.[148] In 2021, the organization provided dental education and navigation services for 841 clients, 392 (47%) on behalf of children age 0-18 and 449 (53%) for adults age 19 and older.[149]

Early Smiles Sacramento

In 2016, Center for Oral Health established the Early Smiles Sacramento Program with the support of Liberty Dental Plan, Health Net and Access to serve underserved children in Sacramento County. The services consist of an oral health examination looking for visible decay and any abnormalities, oral hygiene instruction, and topical application of fluoride and navigation to dental care. Children age 0-20 years old at 145 preschools and 91 schools received oral health education and tooth brushing kits in FY 2021-22. The kit included a tooth brush, toothpaste, flossers and timers, and a tooth brushing chart to incentivize children. [150] The project also helped students seek dental treatment by providing navigation services to their dental plans, along with translation, and transportation services to and from appointments as needed. It also partnered with Sacramento Covered and Sacramento District Dental Society to help find services for the uninsured and privately insured.

Sacramento County Department of Health Services - Public Health Division

Sacramento County Oral Health Program (SCOHP)

As described earlier in this report, the Sacramento County Oral Health Program plans, implements, and evaluates projects to support the goals of the California Department of Public Health – Oral Health Program's *2018-2022 California Oral Health Plan*. Program activities include surveillance of school-based/linked oral health preventive programs, promoting compliance with the

Kindergarten Oral Health Assessment mandate, water fluoridation and training medical professionals to apply fluoride varnish, providing tobacco-cessation and sugar-sweetened beverage reduction resources to dental providers, and improving overall health literacy.

Sacramento County Obesity Prevention Program (SCOPP)

The goal of the Sacramento County Obesity Prevention Program is to reduce the prevalence of obesity and the onset of related chronic diseases in the SNAP and/or SNAP eligible populations. Program components include nutrition and physical activity education, collaborative efforts and training and technical assistance for policy, system and environmental change implementation. The program also administers activities to promote Rethink Your Drink messaging, a statewide initiative that focuses on reducing the consumption of sugar-sweetened beverages.

Sacramento County Tobacco Education Program (SCTEP)

The Sacramento County Tobacco Education Program (TEP) is one of 61 designated Local Lead Agencies that receives funding from the California Tobacco Control Program through a combination of Proposition 99 and Proposition 56 tax revenues. It is charged with the development, implementation, and evaluation of a comprehensive tobacco control plan. As part of this scope of work, TEP strives to: protect the public from second- and third-hand smoke; decrease youth access to tobacco; reduce tobacco-related disparities; implement local tobacco-related policies; improve access to cessation services; and engage the community through the Greater Sacramento Smoke & Tobacco Free Coalition.

Sacramento District Dental Society (SDDS) and SDDS Foundation

Smiles for Kids® (SFK)

The Sacramento District Dental Foundation provides dental services and oral health education to some of the community's children. School screenings and pro-bono care is provided to those who otherwise would not be able to afford it, focusing especially on children. Smiles for Kids® (SFK) provides oral health education through puppet show presentations (virtual and live), member dentists who screen and provide pro-bono care to thousands of children who benefit each year. From screenings and direct referrals, underinsured and underserved children are referred to SDDS member dentists. These children are treated in private dental offices on SFK Day each February. More than half of those children are then "adopted" for further pro bono treatment—including specialty and orthodontic treatment.

Smiles for BIG Kids® (SFBK)

Patterned after Smiles for Kids (SFK), this program provides necessary dental services to uninsured and low-income adults. It provides donated dental treatment for uninsured, low-income adults age 19+ who are in need of urgent dental care, as well as education on maintaining proper oral health. This program is available to all area adults who meet the program's eligibility requirements, and especially targets the needs of the community's low-income elderly population as well as the parents of children served by the SFK program.

SDDS Dental Screenings

Early Smiles (Center for Oral Health) now provides the screening and referral services previously offered by SDDS. For patients who are not insured, or are under-insured and/or with emergencies, however, Early Smiles still refers to SDDS for the needed dental care. Additionally, SDDS provides dental screenings to the Sacramento County schools that Early Smiles does not. Because of COVID-19 and school closures, though, these screenings ceased with the hope they will be re-started in fall 2022.

First 5 Sacramento

While First 5 Sacramento is no longer directly funding oral health as part of its community grants program, the organization has had a long history of supporting oral health in Sacramento County. The investments it made in a comprehensive approach to increasing awareness about the importance of good oral hygiene beginning at birth through support for dental screening, community dental clinics, promotion of community water fluoridation, parent education, and evaluation of the Geographic Managed Care dental program has had a positive long-term impact in the community. The organization continues to play an advocacy role and participates as a member of the Medi-Cal Dental Advisory Committee.

MDRAN

The Medical Dental Referral and Navigation System (MDRAN)[151] was designed as part of the Sacramento County Dental Transformation Initiative (DTI) program, Every Smile Counts!, to bridge medical and dental care for Medi-Cal members in Sacramento County. MDRAN is a simple, web-based system that helps to facilitate and track dental referrals originating from various sites such as the physician's office, school-based screening programs, and community-based programs, and to monitor care coordination supports such as translation services, transportation services, and appointment assistance. Using data provided by the three Medi-Cal managed care dental plans in Sacramento County, MDRAN gives users the capability to:

- Identify whether a Medi-Cal member has utilized their dental benefit in the past 12 months.
- Identify a member's assigned dental plan and provider.
- Generate an auto-populated referral to the member's assigned dental provider that can be printed and/or stored in the member's electronic medical record.
- Alert the member's assigned dental plan that a referral has been generated to initiate plan-provided care coordination supports and track the supports provided.
- Track the generated referral to ensure it results in a successful dental visit.
- Alert the referring user when a dental referral results in a dental claim indicating a dental visit was completed.

To evaluate user performance and system utilization, MDRAN monitors and tracks metrics such as number of referrals generated, number of referrals completed, dental procedures completed and billed for, and fluoride varnish application.

With support of the three managed care dental plans in Sacramento County, MDRAN has been able to expand the type of and grow the number of users across Sacramento County following the end of DTI in December of 2020. MDRAN currently includes data for the entire Medi-Cal population in Sacramento County, allowing referrals to be generated for Medi-Cal members regardless of age. At present there are 15 partner organizations, representing over 200 users across Sacramento County.

California Northstate University – College of Dental Medicine (CDM)

The nation's newest dental school, CNSU College of Dental Medicine (CDM), located in Elk Grove, represents an important new oral health resource for Northern California and Sacramento in particular. CDM welcomed its first cohort of students in January 2022, and added another cohort in July. CMD's philosophy is based on the understanding that the integration of oral health into human health requires dentists who are capable of performing at the highest level in an ever more complex and demanding environment of emerging technology, social change, human disease management, and evolving health systems. CDM's mission also includes an emphasis on community services. In addition to preparing future dentists who it is hoped will choose to stay and work in Sacramento, CDM started a Registered Dental Hygienist in Alternative Practice (RDHAP) Education Program. In time, CDM plans to add dental residency programs, such as pediatrics, that will add dental specialty services for patients who access services at the 20-chair dental clinic the College plans to develop at the recently purchased building site at 2200 Broadway in Sacramento.[152]

California Northstate University plans to build a new state-of-the-art Medical Center and teaching hospital in Natomas (the former location of Arco/Sleep Train Arena), though the construction timeline is currently undetermined. While the Planned Hospital Services listed on the website[153] do not include a mention of "dental," the school reports that 2 of the 16 operating rooms will have dental surgery *capability* (not dedication). In addition, leaders report if adequate funding becomes available, such as the support for dental surgery centers in the Governor's 2022-2023 Budget, an ability could be created for CNSU to develop a critically-needed outpatient dental surgery center.[154]

University of the Pacific Dental School

Another new community dental resource still in the planning stages is the medical education clinic the University of the Pacific expects to build in Oak Park by 2024. The clinic would be part of an integrated teaching model linking UOP's medical, nursing and pharmacy services, and would allow the school to add about 30 new dental students each year to staff the clinic. (Because of prior experience as dentists in their home countries, many having worked in integrated settings, these will be international students at first.) To serve the Medi-Cal population, UOP expects to contract with Delta Dental and the dental managed care plans.

Two operatories and a recovery room are planned for the facility, with dental cases anticipated as the highest use. Leadership reports they are still "working through the anesthesia [levels] question," and understands the need for greater access to hospital dentistry/general anesthesia in

Sacramento.[155] It should be noted that the UOP Arthur A. Dugoni School of Dentistry has a long record of providing services to clients with special needs.

Virtual Dental Home

The Virtual Dental Home (VDH) is a community-based oral health delivery system that provides preventive and simple therapeutic services to children and adults in community settings where they live or receive educational, social or general health services. It is intended to become the person's dental home, not a mobile or "screen and refer" model. [156]

Mention of the VDH is included here because of its historical importance in Sacramento County. VDH was implemented as part of the County's Local Dental Pilot Project under the Dental Transformation Initiative (DTI) of the Medi-Cal 2020 waiver with the aim of increasing Medi-Cal-enrolled children's use of preventive, risk-based, and continuous dental care. The VDH had the full collaboration among the GMC dental plans and community dental clinics, and was initially implemented in 14 schools across Sacramento County with four providers. However, staff shortages and campus closures due to COVID-19, and the end of the DTI grant, did not allow enough time to fully develop sustainability plans leaving the providers unable to fully demonstrate the potential impact of the VDH.[157] It is possible that in the future some schools may want VDH back because of its success bringing dental care to children who most likely would not have gotten that care otherwise.

DENTAL UTILIZATION

"I'm afraid if I use my husband's insurance to go to the dentist he'll be able to find where I am." – Focus Group Participant in safe environment housing

The dental utilization data in this section are presented first for the general population of Sacramento County, and later for the population enrolled in Medi-Cal. Within each population group, data are shown for children first followed by adults. Dental utilization by pregnant women is included in the general adult population.

Annual Dental Visit (ADV) is currently the commonly-used quality of care metric for measuring "success," according to the National Committee for Quality Assurance (NCQA). This is because regular dental visits provide access to cleaning, early diagnosis, treatment and education about caring for teeth to prevent problems. Among the 90 HEDIS® (Healthcare Effectiveness Data and Information Set) measures, ADV is listed under the Access/Availability of Care domain.

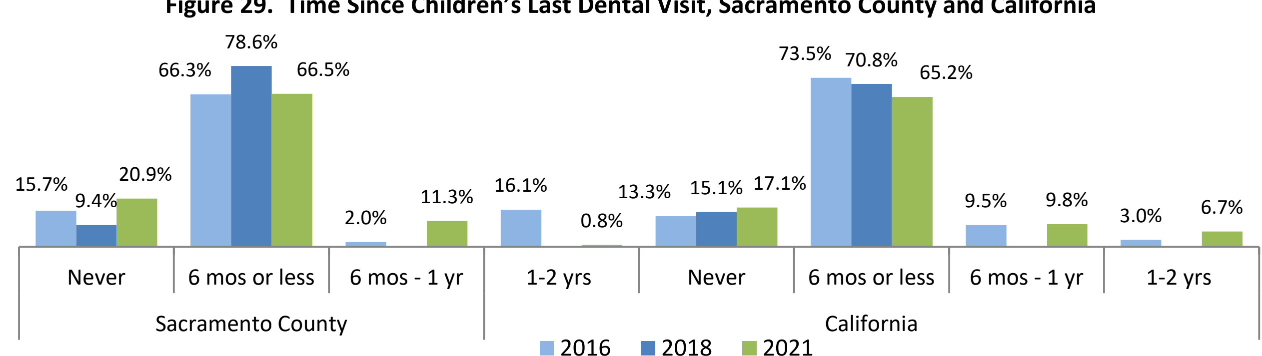
POPULATION-BASED UTILIZATION

CHILDREN

Annual Dental Visit

According to the parent respondents to the 2021 CHIS (California Health Interview Survey), 20.9% of the general population of Sacramento children age 3-11 had never visited a dentist. While a greater percentage of Sacramento than statewide children had "never" had a dental visit in 2021, looking at all visits within the last year, children's recency of dental visits in Sacramento was more favorable than the statewide average, 77.8% vs. 75.0%, respectively (Figure 29).

Figure 29. Time Since Children's Last Dental Visit, Sacramento County and California



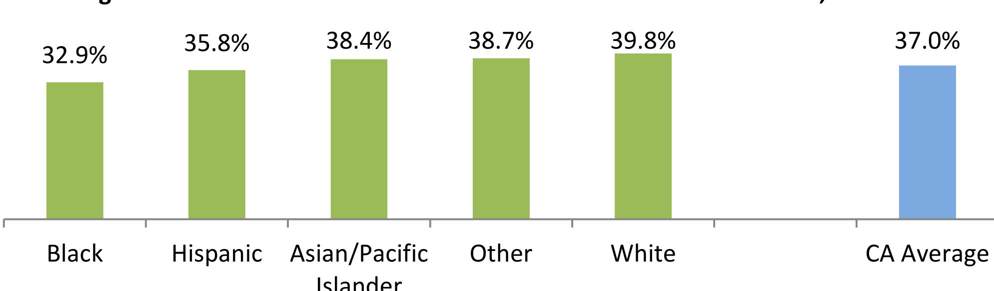
Source: California Health Information Survey

Asked of all children 3-11 years of age, and also asked children under 3 years of age who have teeth. Some years have missing data.

Dental Sealants

Dental sealants—a thin, plastic coating painted on the chewing surfaces of the back teeth—act as a barrier to help protect teeth from bacteria and acids and are recommended for all children ages 6-9 and 10-14. Children without sealants have almost three times more cavities than those with sealants.[158] According to the *2018-2019 California Third Grade Smile Survey,*[159] 37% of 3rd grade California children had received dental sealants.* Important differences existed by race/ethnicity. African American children had the lowest prevalence of dental sealants as Figure 30 indicates.

Figure 30. Percent of California Third Graders with Dental Sealants, 2018-19

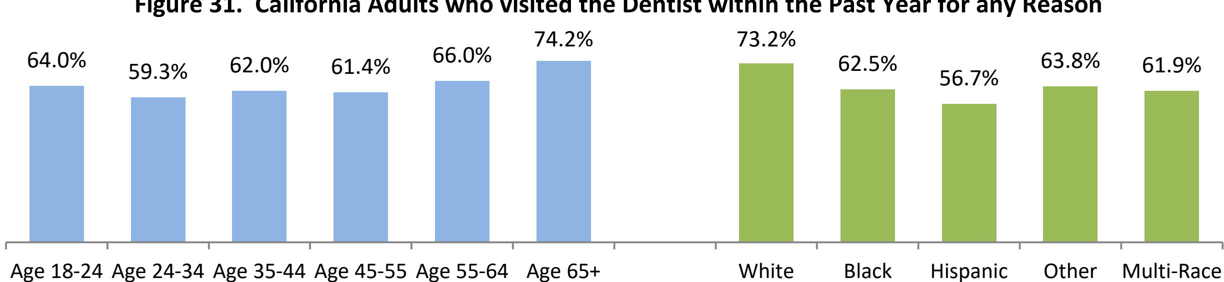


Source: Oral Health Status of Children. California Department of Public Health, June 2021.

ADULTS

Other population-level data that may provide a potential baseline for future surveillance in Sacramento County are from statewide sources. California surveillance data from the 2020 CDC Behavioral Risk Factor Surveillance System (BRFSS)[160] survey showed 64.6% of adults had made a dental visit for any reason in the last year. Figure 31 shows the breakouts of these residents by age and race/ethnicity, with relatively large differences between some of the groups.

Figure 31. California Adults who visited the Dentist within the Past Year for any Reason



Source: 2020 CDC Behavioral Risk Factor Surveillance System

* County level data is not available from this data source.

Looking at Sacramento, about two-thirds (63.2%) of all adults—and 57.9% living at <200% FPL—responding to the 2021 CHIS reported making a dental visit within the last year, generally mirroring populations with access to commercial insurance. The difference in these two populations for "never" making a dental visit and making one "5 or more years ago" is striking: the proportion of low-income adults who "never had a dental visit" was 5 times higher than the total sample of adults.

Figure 32. Time Since Last Dental Visit, Sacramento County Adults and Adults Living Under 200% Federal Poverty Level

	Never	< 6mos	6 mos-1 yr	1-2 yrs	2-5 yrs	5+ yrs
All Adults	2.7%	52.9%	10.3%	16.8%	10.2%	7.1%
Adults <200% FPL	14.0%	42.6%	15.3%	5.0%	9.4%	13.6%

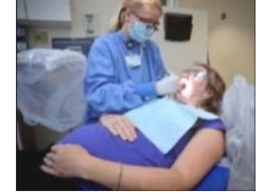
Source: 2021 California Health Interview Survey

As Figure 33 makes clear, in 2021 poorer adults in Sacramento County visited the dentist for a specific dental problem significantly more often than the general population of adults did, 24.1% vs. 16.0% and less often for just a routine exam and cleaning.

Figure 33. Reason for Adults' Last Dental Visit, Sacramento County Adults and Adults Living Under 200% Federal Poverty Level

	Routine ck-up/cleaning	Special problem	Both
Sacramento County, All	73.0%	16.0%	11.0%
Sacramento County <200% FPL	60.9%	24.1%	15.0%

Source: 2021 California Health Interview Survey



Oral Health and Pregnancy

Good oral health and control of oral disease protects a person's health and quality of life before and during pregnancy, and has the potential to reduce the transmission of pathogenic bacteria from mothers to their children. During pregnancy, teeth and gums need special attention. Of people who had a live birth in Sacramento County in 2019-2020, 46.0%—slightly higher than statewide at 43.8%—reported a dental visit during their pregnancy (Table 33).[161] Of the 35 counties with data

large enough to report, Sacramento County ranked right in the middle, number 19, between a high of 74.8% (Marin County) and a low of 20.4% (San Bernardino County).

In Sacramento, Black mothers, young mothers, those living under 100% Federal Poverty level, and those with Medi-Cal received the lowest amount of dental care during pregnancy. Education (data not shown) was also correlated with making a dental visit: people with lower levels of education had lower utilization.

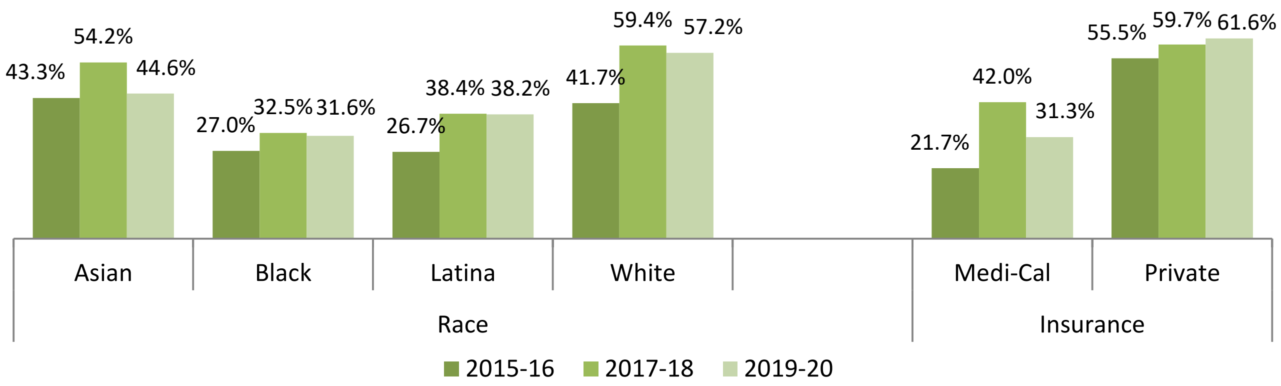
Table 33. Receipt of a Dental Visit during Pregnancy among Sacramentans with a Recent Live Birth, 2019-20

DDS Visit Total	Race/Ethnicity				Age			Family Income			Health Insurance	
	Asian/PI	*Black*	*Latina*	*White*	*15-24*	*25-34*	*35+*	*0-100% FPL*	*101-200% FPL*	*> 200% FPL*	*Medi-Cal*	*Private*
46.0%	44.6%	31.6%	38.2%	57.2%	27.6%	49.2%	51.3%	29.6%	32.5%	64.3%	31.3%	61.6%

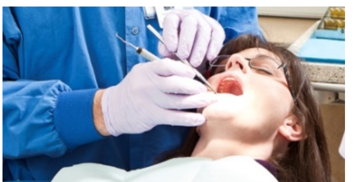
Source: CDPH, Maternal and Infant Health Assessment (MIHA) Survey. July 2022.

Looking at just the variables of race/ethnicity and insurance (as differences by age and family income were smaller), Figure 34 displays dental utilization during pregnancy over the last 7-year period. Utilization increased from 2015-16 to 2017-18 for every race/ethnic group except for Latina mothers, which stayed the same, then decreased slightly in 2019-20. Overall, in each period Black and Latina individuals made the lowest proportion of dental visits. Individuals with Medi-Cal, the majority of whom were GMC members, never reached parity with privately insured individuals (who were relatively consistent in visits), though in 2017-18 they came a little closer, 42.0% vs. 59.7%. In 2019-20, the people with Medi-Cal made half the percentage of dental visits during their pregnancy than those with private insurance did, 31.3% and 61.6%, respectively.

Figure 34. Receipt of Dental Visit during Pregnancy among Sacramentans with a Recent Live Birth, Selected Variables and Years



Source: CDPH, Maternal and Infant Health Assessment (MIHA) Survey. July 2022.



MEDI-CAL DENTAL UTILIZATION

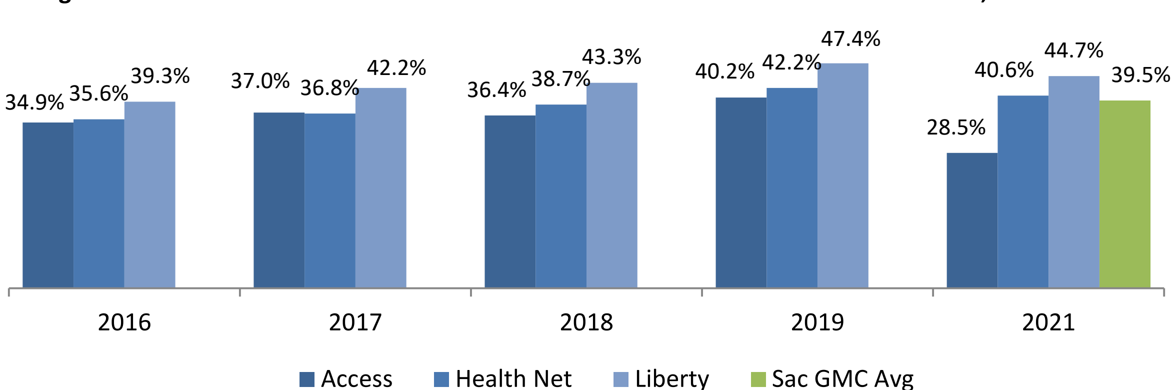
Currently, DHCS monitors performance in the Dental Managed Care and Medi-Cal Dental fee-for-service (FFS) delivery systems using the following measures: 1) Annual Dental Visits and 2) Preventive Dental Services for children and adults, and 3) the Use of Sealants for children. Beginning in FY 2015-16, each of these measures is comprised of beneficiaries with 90-days continuous eligibility, and in the case of DMC, 90 days continuous enrollment in the same plan within the measurement period. Below are the Medi-Cal dental utilization data—first for children, then adults—available at the time this report was produced (December 2022). We intentionally omit showing most data for 2020 as it was evident the low numbers of dental visits were affected by COVID.

Children's Utilization

Annual Dental Visit

Looking at the trends in children's annual dental visits (ADV) for the dental managed care population in Sacramento County, with one exception (Access Dental) there was generally an increase in utilization from CY 2016 to CY 2021 (Figure 35), though some of the "COVID affect" can still be seen in the 2021 figures. Among the Plans, Liberty had the highest utilization in each of the 5 years.

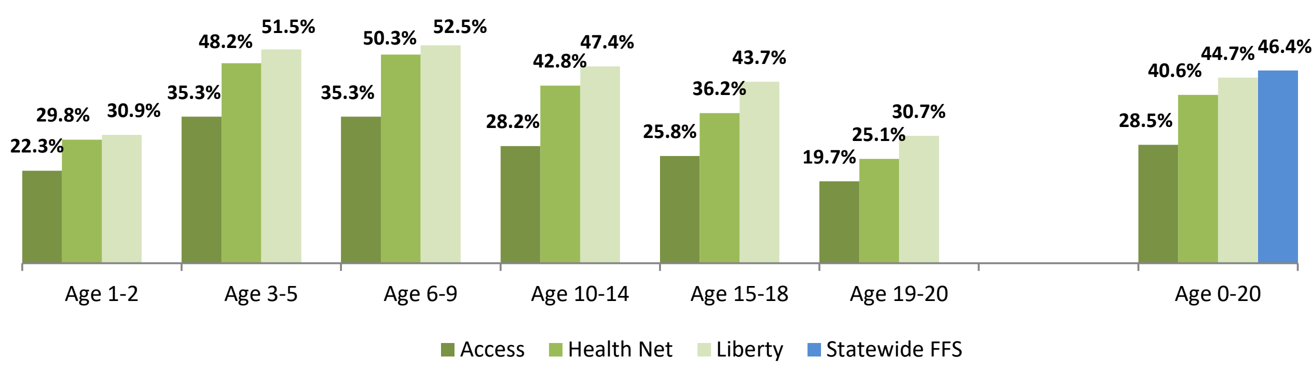
Figure 35. Annual Dental Visits of Sacramento Children Enrolled in GMC Dental Plans, Selected CYs



Source: Department of Health Care Services, Medi-Cal Dental Managed Care Performance Measures.

Figure 36 below breaks out children 0-20 by age group for the ADVs in 2021. Children in age groups 3-5 and 6-9 in each GMC plan made the highest proportion of annual dental visits: Annual dental visits by 6-9 year-olds were 35.3% (Access), 50.3% (Health Net) and 52.5% (Liberty). On average (the blue bar in the graph), a higher proportion of children 0-20 statewide in FFS Medi-Cal than in GMC, 46.4%, made an ADV in 2021.

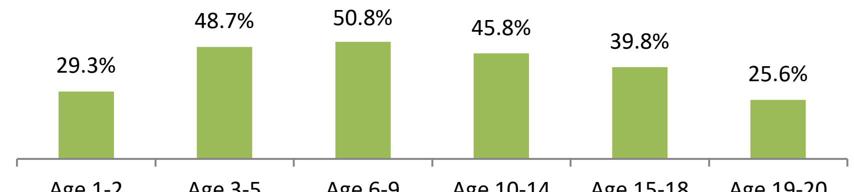
Figure 36. Annual Dental Visits of Sacramento Children by GMC Dental Plan and Age Group, CY 2021



Source: Department of Health Care Services, Medi-Cal Dental Managed Care Performance Measures.

To see what the annual dental visits of all Sacramento children with Medi-Cal look like (a combination of dental managed care and FFS), we have to use CY 2019 as the most recent data as the CY 2021 FFS data by county will not be published until 2023. Figure 37 allows a qualified comparison. The utilization rates in the bar graph below reflect the proportion of FFS children in aid codes known to have lower utilization rates. These combined utilization rates match closest the Health Net GMC utilization rates above.

Figure 37. Annual Dental Visits of All Sacramento Children with Medi-Cal (GMC + FFS) by Age Group, CY 2019



Source: Department of Health Care Services, Medi-Cal Dental Utilization Measures and Sealant Data by County and Age Calendar Year
Note: The total 0-20 age group data is not provided by DHCS. CY 2021 FFS data for this measure are not yet available.

Use of Sealants

A very low percentage of GMC children with Medi-Cal have received sealants. Pre-COVID (CY 2019) use by 6-9 year-olds ranged from 10.2% (Access) to 13.8% (Health Net) to 17.1% (Liberty). The rates for 10-14 year-olds were even lower that year: 5.7%, 7.0% and 9.3%, respectively (Figure 38 on the next page). Sealant use by children enrolled in Liberty was consistently the highest among the dental plans.

When sealant data for GMC and FFS are combined—looking only at the 2019 data for the same reason described in the first paragraph—the age 6-9 rate was 14.0% and age 10-14 rate 7.4%.

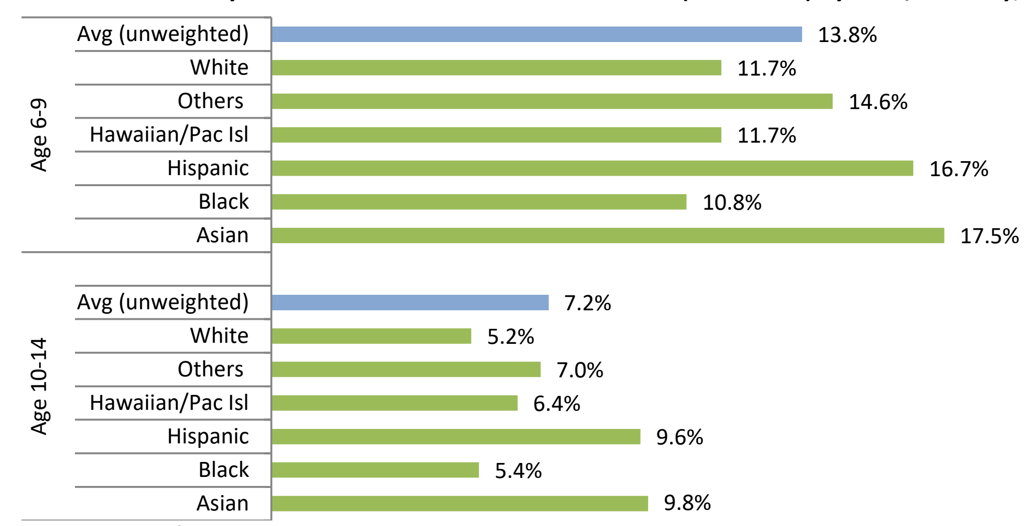
Figure 38. Sacramento County Children's Use of Dental Sealants by GMC Dental Plan, Selected CYs

Year	Age group	Access	Health Net	Liberty
2016	Age 6-9	11.3%	12.6%	15.5%
2016	Age 10-14	4.6%	5.1%	7.5%
2017	Age 6-9	10.2%	12.7%	16.1%
2017	Age 10-14	4.7%	5.8%	8.4%
2018	Age 6-9	10.1%	13.8%	16.9%
2018	Age 10-14	5.3%	6.9%	9.3%
2019	Age 6-9	10.2%	14.8%	17.1%
2019	Age 10-14	5.7%	7.0%	9.3%
2021	Age 6-9	5.4%	9.7%	8.5%
2021	Age 10-14	2.5%	4.4%	4.2%

Source: Department of Health Care Services, Medi-Cal Dental Managed Care Performance Measures.

Medi-Cal sealant data for by race/ethnicity is only available for GMC and FFS combined. (A Public Records Act request is required to obtain the data by dental system.) Again, 2019 is the most recently available data *by county*. As Figure 39 shows, children of Asian and Hispanic descent had the highest rates of dental sealant use for both the 6-9 year-old and the 10-14 year-old age groups. Black children in both age groups received the lowest proportion of dental sealants. The average (unweighted) proportion of sealants placed in 6-9 year-olds, 13.8%, was almost double that of 10-14 year-olds, 7.2%.

Figure 39. Sealant Use by All Sacramento Children with Medi-Cal (GMC + FFS) by Race/Ethnicity, CY 2019



Source: Department of Health Care Services, Medi-Cal Dental Utilization Measures and Sealant Data by County, Ethnicity, & Age.

Adult Utilization

Annual Dental Visits

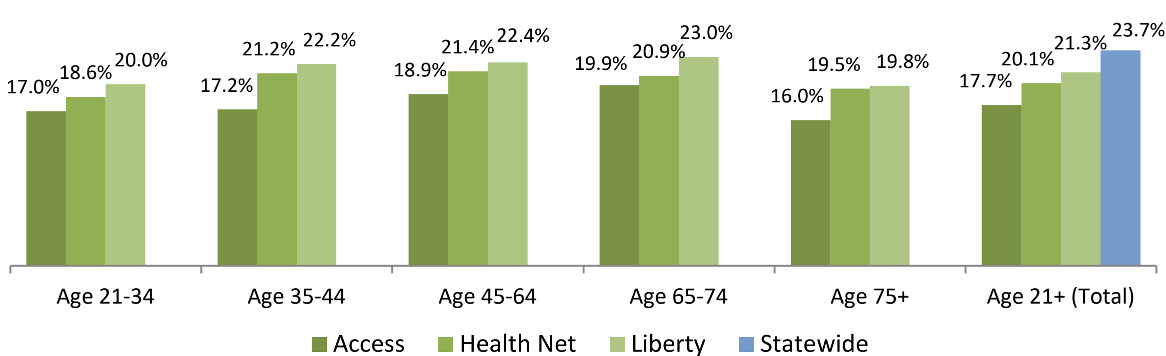
Trends in adult use of annual dental visits (ADV) since 2016 can be seen in Figure 40. The positive finding is that there was a slightly gradual increase across the time period—with Liberty providing the highest proportion of visits; however, overall, only about 1 in 4-5 adults ever utilized their dental benefits, essentially similar to the prior oral health needs assessment.

Figure 40. Annual Dental Visits of Sacramento County Adults Enrolled in GMC, Selected CYs

Source: Department of Health Care Services, Medi-Cal Dental Managed Care Performance Measures.

Looking at adults by age group in only 2021 shows relatively little variation in annual dental visits after age 35 until age 75 and older where there is a decline (Figure 41). The pattern of use by GMC plan remained the same across all age groups with a lower proportion of adults served in the Access plan than the other plans each year. The statewide FFS average (the blue bar in the graph) was higher overall than in GMC.

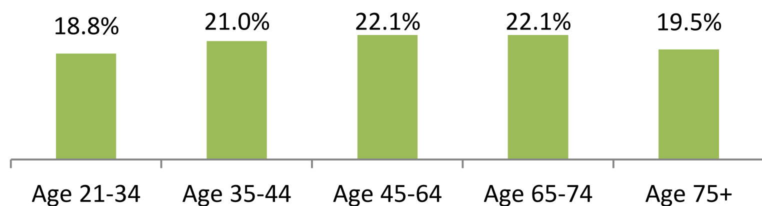
Figure 41. Annual Dental Visits of Sacramento Adults by GMC Dental Plan and Age Group, CY 2021



Source: Department of Health Care Services, Medi-Cal Dental Managed Care Performance Measures.

As with the child population, we have to use CY 2019 as the most data to look at annual dental visits of *all* Sacramento adults with Medi-Cal (GMC plus FFS), as the CY 2021 FFS data by county will not be published until 2023. The proportion of ADV utilization in the combined FFS and GMC systems is similar to the average of Health Net and Liberty members' use (Figure 42).

Figure 42. Annual Dental Visits of All Sacramento Adults with Medi-Cal (GMC + FFS) by Age Group, CY 2019



Source: Department of Health Care Services, Medi-Cal Dental Utilization Measures by County and Age Calendar Year.
Note: The data for total age group 21+ is not provided by DHCS. CY 2021 FFS data for this measure are not yet available.

Adults and Children

Annual Dental Visits (ADV) by Medi-Cal Program

Table 34 shows 2021 Annual Dental Visits, separated for children and adults in fee-for-service (FFS)-only Medi-Cal dental from those enrolled in a GMC dental plan.

Table 34. Sacramento County Medi-Cal Members in FFS with an Annual Dental Visit in 2021

	Children <21	Adults 21+
Members in an exempt (non-mandatory) aid code who chose to remain in FFS	7,639	56,287
ADV for members in exempt code who chose to remain in FFS	2,509	10,858
ADV Utilization rate	32.8%	19.3%

Source: Department of Health Care Services, Medi-Cal Dental Division, November 23, 2022, obtained through PRA request.

Comparing *children's* annual dental visits in Medi-Cal dental managed care and FFS (Figure 43 on the next page) shows the highest utilization in 2021 occurred for members in statewide FFS; Liberty performance followed closely; Access lagged significantly behind. Interestingly, though, Access utilization in Los Angeles County Prepaid Health Plan (PHP) was higher than the other 2 dental managed care plans in LA. Sacramento County FFS-only (which excludes the GMC-enrolled clients) had the lowest utilization. This would be expected as these children are unique from children in GMC and FFS statewide; they largely include children with disabilities and in foster care and other aid categories who may have greater access issues. For *adults,* ADV utilization in all of the programs was

lower than the statewide average, but not by much, and there was little difference among the dental programs.

Figure 43. Annual Dental Visit by Medi-Cal Program, CY 2021

	Ages 0-20	Ages 21+
Access/Sac	28.5%	17.7%
Health Net/Sac	40.6%	20.1%
Liberty/Sac	44.7%	21.3%
Sac FFS-only	32.8%	19.3%
CA FFS	46.4%	23.7%
Access/LA	38.9%	19.0%
Health Net/LA	34.3%	20.4%
Liberty/LA	37.8%	21.2%

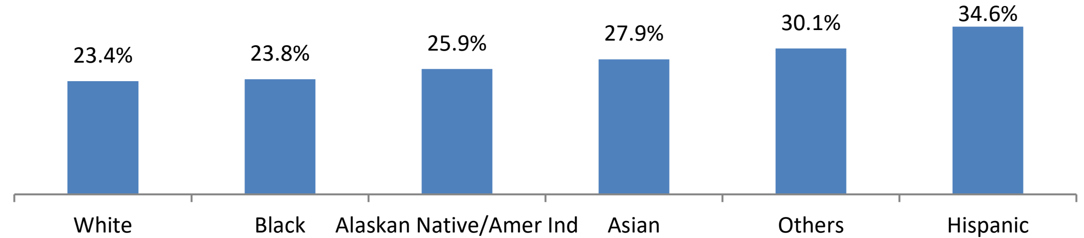
Source: Department of Health Care Services, Medi-Cal Dental Division, November 15, 2022, obtained through PRA request.

Annual Dental Visit by Race/Ethnicity – All Ages

Disparities have existed for decades across race/ethnicity and insurance status when it comes to dental care visits, with lower utilization by non-White populations.[162,163] However, Medi-Cal/ Medicaid expansions and extensive dental benefits have narrowed racial and ethnic differences, including use of preventive and treatment services, however.[164]

Looking at Annual Dental Visits by GMC members of all ages served in 2021, it is quite interesting to see that, at least in this population, non-Hispanic Whites had the lowest utilization rates. Hispanics and "Others" (e.g., people who identify as multi- and bi-racial), had the highest dental rates (Figure 44). These findings are unusual and somewhat inconsistent with national data of utilization by low-income groups. The differences between utilization of ADVs by the other race/ethnic group—the same pattern of use when we examined each GMC Plan separately—are relatively marginal.

Figure 44. Sacramento County Medi-Cal Annual Dental Visits (ADV) by Race/Ethnicity, All Ages, 2021



Source: Department of Health Care Services, Medi-Cal Dental Division, October 24, 2022 and November 7, 2022. MDSD Tableau Dashboard July 2022, obtained through PRA request.

Annual Dental Visit by Zip Code – Children and Adults

To do adequate planning to implement improvement strategies, whether in delivering oral health messaging or oral health services, it is useful to examine the most basic level of Medi-Cal dental

community data. Zip code-level utilization tells us where the gaps are by age groups and community locations and allows oral health programs to more specifically target their efforts in high-need neighborhoods. The data can also be used to link under-utilization with access issues such as provider location. Using the zip codes with the lowest utilization rates from the 2018 Oral Health Assessment, we obtained and updated the Medi-Cal utilization data.* The utilization of children age 0-20 in these 9 Sacramento County zip codes with adequate data for reporting ranged from a low of 17.9% in zip code 95819 (East Sacramento) to a high of 36.3% in zip code 95690 (primarily Walnut Grove/Isleton). For adults age 21+ utilization ranged from a low of 9.4% in zip code 95690 (primarily Walnut Grove/Isleton) to a high of 16.8% in zip code 95630 (Folsom) (Table 35).

Table 35. Sacramento County Medi-Cal Annual Dental Visit Utilization by Selected Zip Codes, CY 2021

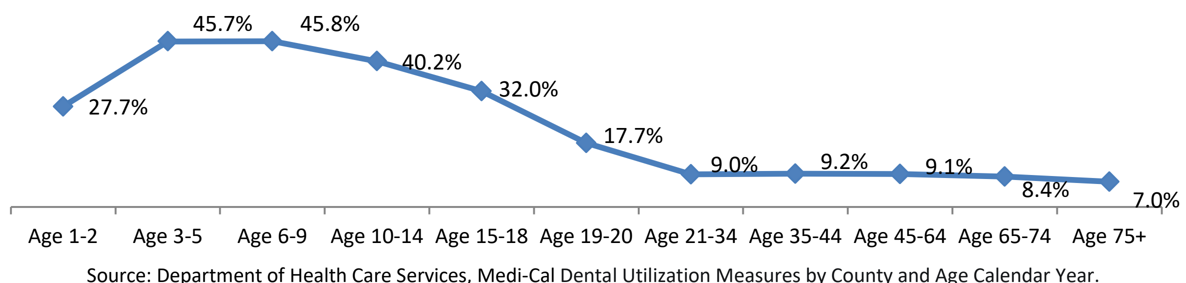
Children Age 0-20				Adults Age 21+			
Zip Code	Total FFS+GMC	Total Users	% Utilization	Zip Code	Total FFS+GMC	Total Users	% Utilization
95626	931	262	28.1%	95626	1,458	201	13.8%
95628	3,843	1067	27.8%	95628	6,939	1042	15.0%
95630	3,972	1127	28.4%	95630	7,006	1174	16.8%
95643	*	*	*	95643	*	*	*
95683	291	58	19.9%	95683	386	49	12.7%
95690	471	171	36.3%	95690	620	58	9.4%
95693	676	205	30.3%	95693	904	95	10.5%
95819	672	120	17.9%	95819	1,495	202	13.5%
95831	3,977	1197	30.1%	95831	6,860	1115	16.3%

Source: Department of Health Care Services, Medi-Cal Dental Division, August 25, 2022.
*Numbers below 11 have been suppressed

Preventive Dental Services by Age Group

The use of preventive dental services counts the members with 90 days continuous eligibility (or, in GMC, enrollment in the same GMC plan) who received any preventive dental services in the measurement period. Aggregated GMC data by age group is available only in combination with Sacramento FFS data and only as recent as 2019. Figure 45 displays these results, making clear the benefit of a preventive dental visit as a kindergarten requirement, and tapering off in occurrence as children get older and adults age.

Figure 45. Use of Preventive Dental Services by Sacramento Children and Adults with Medi-Cal (GMC + FFS) by Age Group, 2019

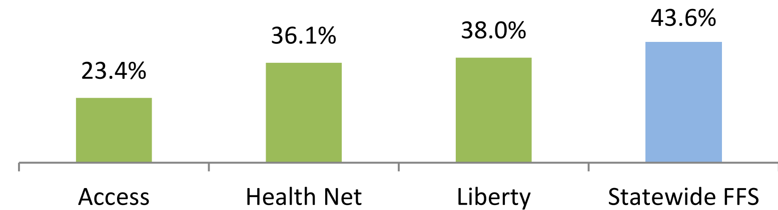


Source: Department of Health Care Services, Medi-Cal Dental Utilization Measures by County and Age Calendar Year.

* We do not show the 2018 zip code data because utilization rates at that time were for "any dental service" rather than for "annual dental visit" in the more current data. To see the earlier zip code data, go to the 2018 OH Needs Assessment report cited in Ref. #12 (p. 150).

Just as they do in their delivery of annual dental visits, the GMC plans differ in reaching members for utilization of preventive services, Access Dental markedly less often than Health Net and Liberty, none of them reaching parity with the statewide FFS average (Figure 46).

Figure 46. Use of Preventive Dental Services by Sacramento Children and Adults in GMC and Statewide FFS, 2021



Source: Department of Health Care Services, Medi-Cal Dental /FFS-vs-DMC-Fact-Sheet-August2022.pdf.

FQHC Utilization Data – All Ages

Each calendar year, federal Health Center Program awardees such as Federally Qualified Health Centers (FQHCs) and Look-Alikes are required to report a core set of information as part of the federal Uniform Data Reporting System (UDS). Additional data on primary care utilization are also reported to the state's Department of Health Care Access and Information (formerly called OSHPD). (Note: while the Sacramento FQHCs informed us they reported their 2021 data to these sources, the data were not posted on the official websites in time for this report; thus, we present below the 2020 data. The data pertain to all dental patients and dental encounters regardless of payer.) Looking at the 2020 data—which represent 52,493 unique patients—we can see they do not differ appreciably from 2019, the pre-COVID prior year, except to some degree at HALO and Sacramento Native American Health Center. The percent of dental patients in most of the FQHCs remained relatively consistent from 2017 – 2021 (with 2020 being a unique year due to COVID), except Elica's and One Community Clinic's which rose each year (Table 36).

Table 36. Percentage and Number of Dental Patients at Sacramento Community Clinics, All Ages, 2017-2021

	Elica Health		HALO		Native American		One Community Clinic[1]		WellSpace	
Year	# Dental Pts	% Dental Pts	# Dental Pts	% Dental Pts	# Dental Pts	% Dental Pts	# Dental Pts	% Dental Pts	# Dental Pts	% Dental Pts
2017	1,356	6.1%	16,013	45.2%	4,167	43.9%	781	10.1%	19,174	33.1%
2018	2,894	10.5%	16,728	46.6%	4,958	44.9%	1,587	16.6%	20,279	26.3%
2019	4,636	13.5%	18,404	51.7%	5,560	43.0%	2,431	18.6%	20,410	20.7%
2020	7,476	19.4%	19,307	46.9%	3,936	37.8%	2,788	19.3%	18,986	20.8%
2021	11,095	23.5%	20,855	55.8%	4,025	39.8%	3,129	19.4%	20,405	21.1%

[1]Data reported under the name Cares Community Health.
Sources: Sacramento Native American Health Center which reports its data to the federal Indian Health Services (IHS) National Data Warehouse (NDW) using NextGen's NDW data utility via HL7 files. Other FQHC data reported to UDS at https://data.hrsa.gov/tools/data-reporting/program-data?grantNum=LALCS00018 accessed December 16, 2022. For HALO, data reported under Look-Alike community clinics.

The proportion of children age 6-9 who received dental sealants from the reporting clinics rose noticeably from 2017 to 2019, and at WellSpace and slightly at Elica continued to increase through 2021 (Table 37). At WellSpace, while the *number* of children receiving sealants decreased from

2019 to 2020, the *proportion* who received them increased. Recall that Medi-Cal-specific sealant use data was provided above and is also a valuable source for understanding sealant experience in these health centers.

Table 37. Children Ages 6-9 Who Received Dental Sealants at Sacramento Community Clinics, 2017-2021

	Elica Health		HALO		Native American		One Community Clinic[1]		WellSpace	
Year	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children	# of Children	% of Children
2017	33	21.5%	216	36.9%	12	3.8%	NR[2]	NR	864	42.9%
2018	40	31.3%	293	49.6%	76	18.5%	NR	NR	1,083	63.3%
2019	113	45.6%	287	49.4%	112	26.9%	NR	NR	842	46.0%
2020	156	47.3%	147	43.5%	61	21.6%	NR	NR	833	66.7%
2021	196	37.2%	213	27.9%	61	27.6%	NR	NR	1,092	71.0%

[1]Data reported under the name Cares Community Health.
Sources: Sacramento Native American Health Center which reports its data to the federal Indian Health Services (IHS) National Data Warehouse (NDW) using NextGen's NDW data utility via HL7 files. Other FQHC data reported to UDS at https://data.hrsa.gov/tools/data-reporting/program-data?grantNum=LALCS00018 accessed December 16, 2022. For HALO, data reported under Look-Alike community clinics.
[2]NR = Not Reported. HALO stated their 2021 sealants for 6-9 year-olds were "44%."

Having a dental cleaning and oral exam twice a year or every six months is a standard recommendation across the dental profession. Looking at the 2021 primary care clinic data reported for dental encounters, the average number of encounters or visits per patient ranged from 1.34 at Elica to more than two-and-a-half times higher, 3.49, at One Community Clinic (Table 38). WellSpace and HALO patients made close to the same average number of dental visits. The differences among the 5 FQHCs likely reflect factors like accessibility of services and extent of treatment needs, and patient demand characteristics.

Table 38. Number of Dental Encounters and Average Encounters per Patient at Sacramento Community Clinics, 2021[1]

Elica Health		HALO[1]		Native American		One Community Clinic[2]		WellSpace	
Dental Encounters (Visits)	Avg Dental Visits/Pt	Dental Encounters (Visits)	Avg Dental Visits/Pt	Dental Encounters (Visits)	Avg Dental Visits/Pt	Dental Encounters (Visits)	Avg Dental Visits/Pt	Dental Encounters (Visits)	Avg Dental Visits/Pt
14,895	1.34	55,767	2.67	12,250	3.04	10,919	3.49	61,136	2.99

[1]Data reported under the name Sacramento Community Clinic.
[2]Data reported under the name Cares Community Health.
Source: Primary Care Clinics Annual Utilization Report for 2021. Encounter data reported to HCAI (OSHPD) at https://data.chhs.ca.gov/ accessed December 16, 2022. SNAHC data provided to study author December 19, 2022.

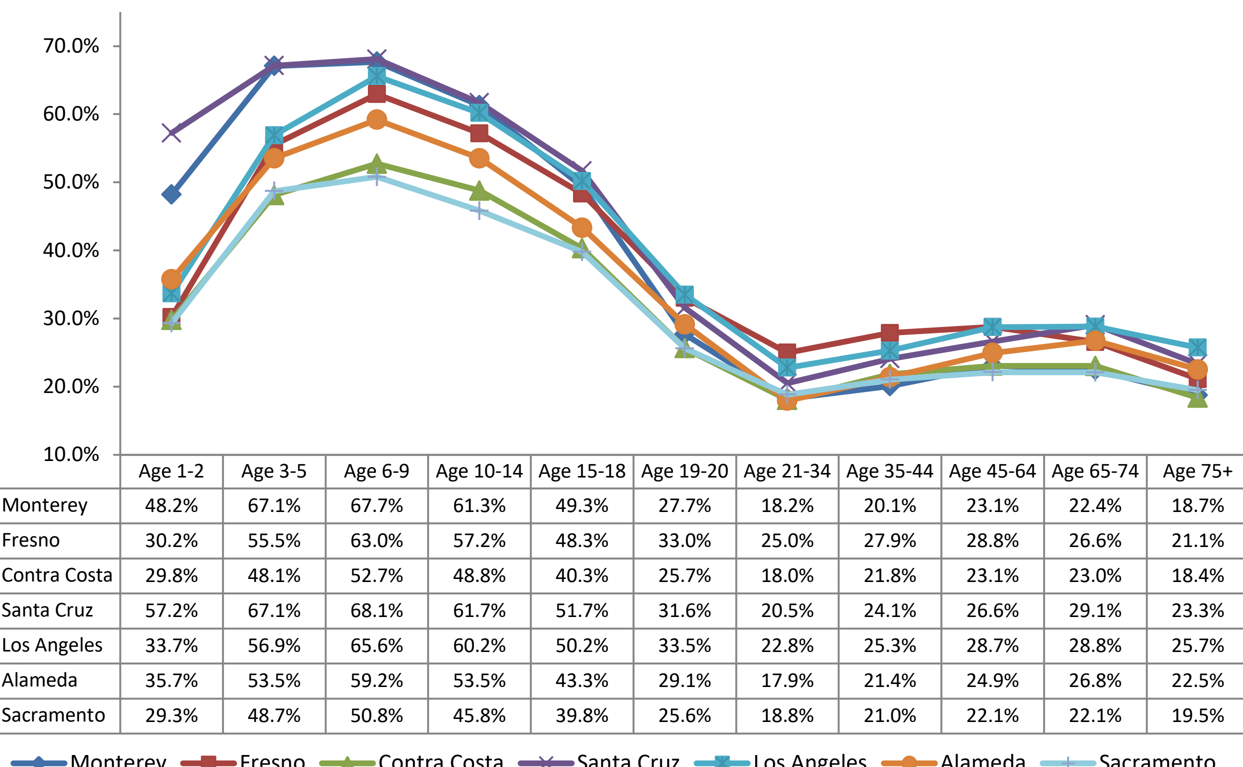
Medi-Cal Dental Visits in Comparison Counties by Age Group

Sacramento County Medi-Cal dental utilization has for many years lagged behind most other California counties—a continuing frustration to oral health advocates and DHCS. Because Medi-Cal dental in Sacramento County is almost exclusively managed care, in the present study we were asked to identify a comparison FFS county and look at the factors that might account for higher Medi-Cal dental utilization rates.

Using comparable rationale to what had been used in a 1999 Mercer study of the Sacramento County GMC Dental Program, we chose Fresno as the proxy FFS county in our previous oral health studies (see endnote #12) because its demographics, service delivery system and population shared similar characteristics with Sacramento County. In the present needs assessment, we again used Fresno but expanded the comparison and looked at 6 additional counties generally using the following criteria: population size; the Census Bureau Diversity Index;[*] [165] the population-to-dentist ratio; the proportion of dentists that accept Medi-Cal; the presence of FQHC dental clinics; and the Rurality Classification for California Counties.[166] While clearly there are no perfect matches, the following counties met most of the criteria: Fresno, Contra Costa, Monterey, Alameda and Santa Cruz; and, ignoring its size, we also added Los Angeles County because close to 20% of its Medi-Cal population chooses to enroll in dental managed care. Data from Calendar Year 2019 was used to avoid 2020 ("the COVID year"), and because Medi-Cal utilization rates by county by age have not yet been posted for CY 2021. The Sacramento county ADV data are a combination of GMC + FFS members.

This brief analysis illustrates the shortcomings of Sacramento County utilization in relation to the comparison counties utilizing Annual Dental Visit as the key measure. On the whole, all of the counties surpassed Sacramento County's utilization for children. The percentages begin to look similar at about age 21-34, however (Figures 47 below and 48 on the next page).

Figure 47. Medi-Cal Annual Dental Visits by Age, Sacramento and Six Comparison Counties, 2019

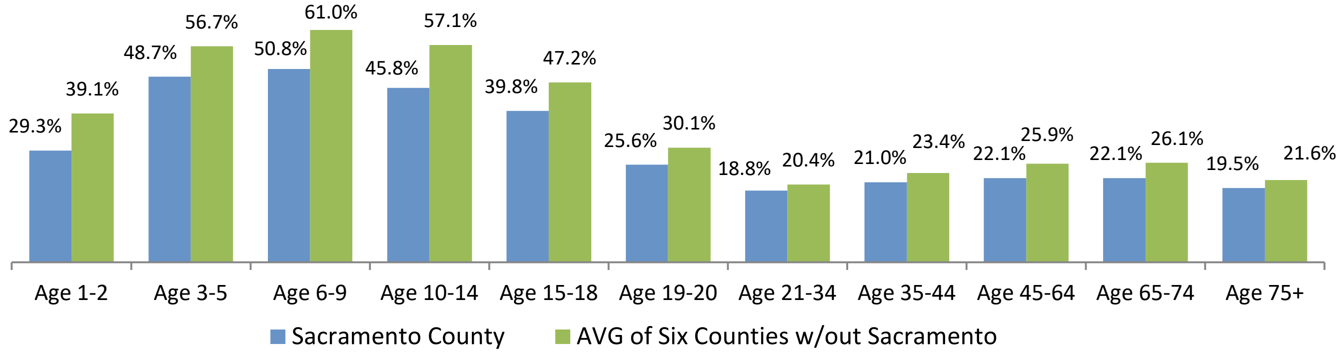


	Age 1-2	Age 3-5	Age 6-9	Age 10-14	Age 15-18	Age 19-20	Age 21-34	Age 35-44	Age 45-64	Age 65-74	Age 75+
Monterey	48.2%	67.1%	67.7%	61.3%	49.3%	27.7%	18.2%	20.1%	23.1%	22.4%	18.7%
Fresno	30.2%	55.5%	63.0%	57.2%	48.3%	33.0%	25.0%	27.9%	28.8%	26.6%	21.1%
Contra Costa	29.8%	48.1%	52.7%	48.8%	40.3%	25.7%	18.0%	21.8%	23.1%	23.0%	18.4%
Santa Cruz	57.2%	67.1%	68.1%	61.7%	51.7%	31.6%	20.5%	24.1%	26.6%	29.1%	23.3%
Los Angeles	33.7%	56.9%	65.6%	60.2%	50.2%	33.5%	22.8%	25.3%	28.7%	28.8%	25.7%
Alameda	35.7%	53.5%	59.2%	53.5%	43.3%	29.1%	17.9%	21.4%	24.9%	26.8%	22.5%
Sacramento	29.3%	48.7%	50.8%	45.8%	39.8%	25.6%	18.8%	21.0%	22.1%	22.1%	19.5%

Source: https://data.chhs.ca.gov/dental-utilization-measures

[*] Sacramento is one of the most racially and ethnically diverse counties in the nation. Using a Diversity Index, the Census Bureau in 2020 determined which counties with populations "significantly larger than 5,000" were the most diverse. Sacramento County ranked 3rd highest in the state and 14th in the U.S., followed by Contra Costa County at number 15. The Diversity Index tells the chance that two people chosen at random will be from different racial and ethnic groups. In Sacramento County, the chance is 73.3%. Sacramento is third highest in diversity in California after Solano and Alameda Counties, at 75.6% and 75.1%, respectively.

Figure 48. Medi-Cal Annual Dental Visits by Age, Sacramento County and Six Comparison Counties' Average, 2019

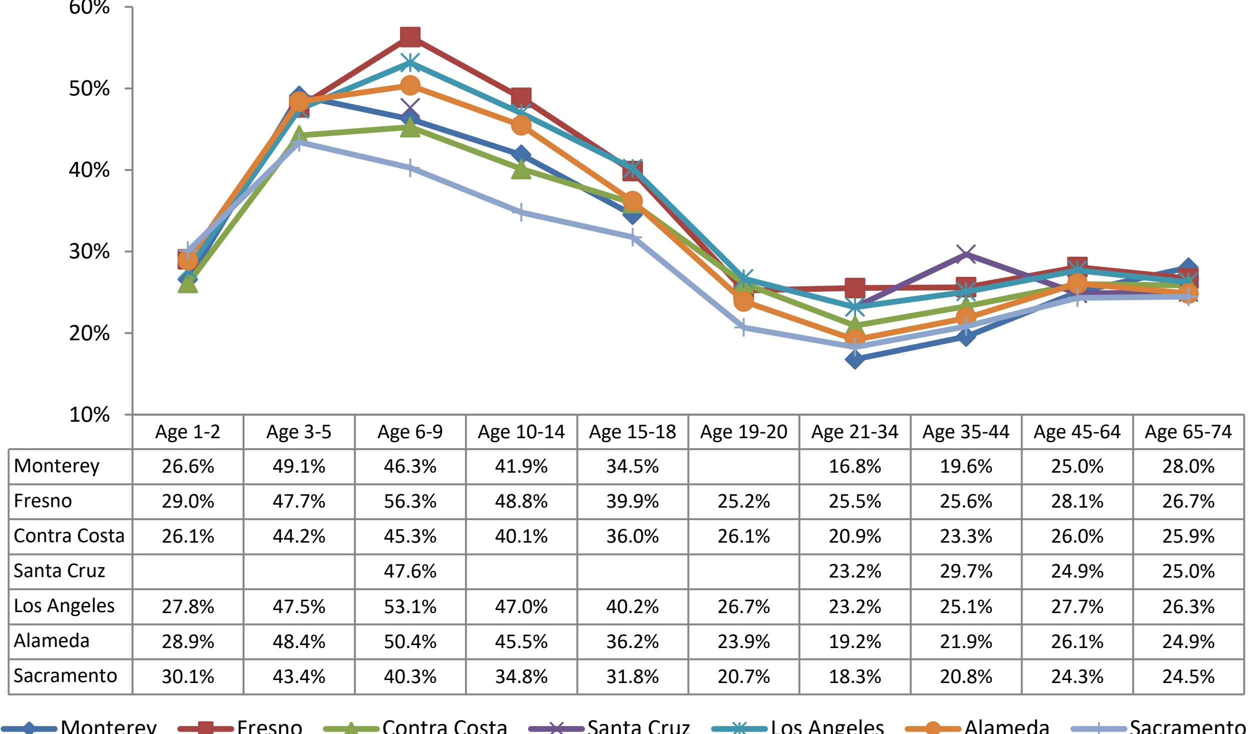


Source: https://data.chhs.ca.gov/dental-utilization-measures

Note: The comparison counties are the same 6 counties as in Figure 47 above.

Looking only at the Medi-Cal patients who were Black—a population with low relative utilization—shows that except for the age 1-2 years group (where Sacramento County is actually the highest), Sacramento annual dental visit rates were the lowest for children and adults age 45+ in relation to the 6 comparison counties (Figure 49).

Figure 49. Medi-Cal Annual Dental Visits Made by Black Patients by Age, Sacramento and Six Comparison Counties, 2019



	Age 1-2	Age 3-5	Age 6-9	Age 10-14	Age 15-18	Age 19-20	Age 21-34	Age 35-44	Age 45-64	Age 65-74
Monterey	26.6%	49.1%	46.3%	41.9%	34.5%		16.8%	19.6%	25.0%	28.0%
Fresno	29.0%	47.7%	56.3%	48.8%	39.9%	25.2%	25.5%	25.6%	28.1%	26.7%
Contra Costa	26.1%	44.2%	45.3%	40.1%	36.0%	26.1%	20.9%	23.3%	26.0%	25.9%
Santa Cruz			47.6%				23.2%	29.7%	24.9%	25.0%
Los Angeles	27.8%	47.5%	53.1%	47.0%	40.2%	26.7%	23.2%	25.1%	27.7%	26.3%
Alameda	28.9%	48.4%	50.4%	45.5%	36.2%	23.9%	19.2%	21.9%	26.1%	24.9%
Sacramento	30.1%	43.4%	40.3%	34.8%	31.8%	20.7%	18.3%	20.8%	24.3%	24.5%

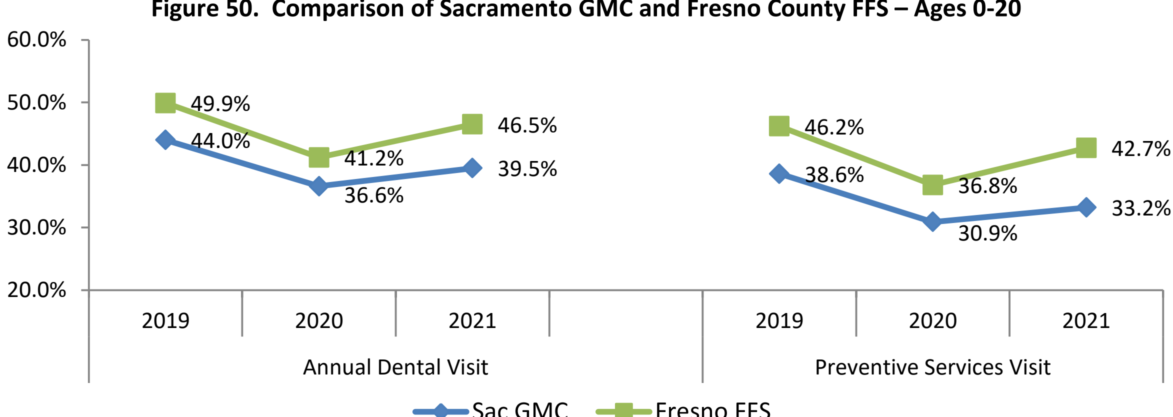
Source: https://data.chhs.ca.gov/dental-utilization-measures

Fresno Alone as a Proxy County

DHCS occasionally publishes dental utilization data comparing FFS and Dental Managed Care using Fresno as a proxy FFS county. The following ADV and Preventive Services comparison data (Figures 50 and 51 below) were presented by DHCS at the December 1, 2022 MCDAC meeting.

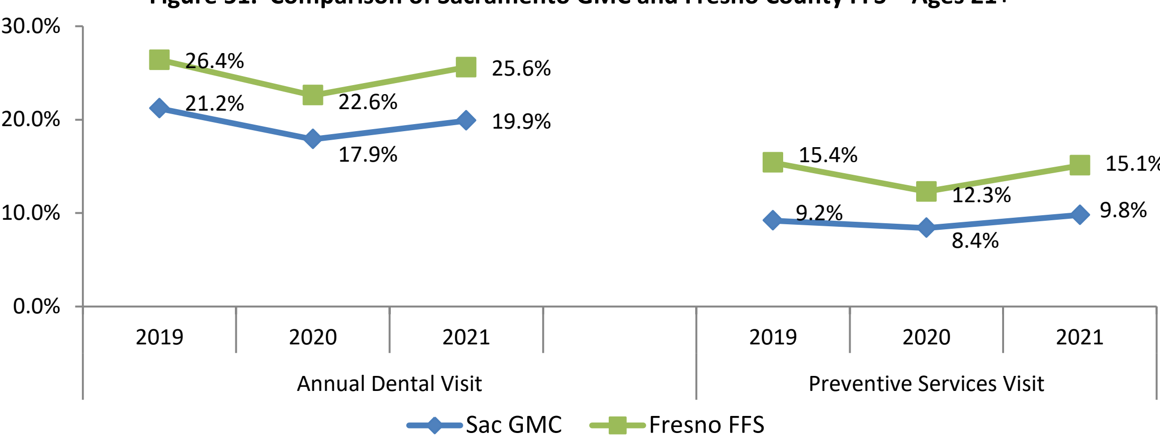
For each of the two visit types—annual dental visit and preventive services—for both children and adults, a greater proportion of Fresno County than Sacramento County Medi-Cal members used their dental benefits.

Figure 50. Comparison of Sacramento GMC and Fresno County FFS – Ages 0-20



Source: Department of Health Care Services, Medi-Cal Dental Services Division, Sacramento County Fact Sheet, December 2022

Figure 51. Comparison of Sacramento GMC and Fresno County FFS – Ages 21+



Source: Department of Health Care Services, Medi-Cal Dental Services Division, Sacramento County Fact Sheet, December 2022

Possible Explanations for Higher Utilization in Comparison Counties

We spoke with local oral health representatives from the 6 comparison counties and asked what they thought accounted for their relatively more favorable Medi-Cal dental utilization rates, at least for children age 0-21, given that they are all fee-for-service counties where beneficiaries are responsible for finding their own dentists.[167] The bottom line, except possibly with regard to Fresno and Santa Cruz Counties, is that there really is no magic answer. That is, all of these counties seem to have about the same: relative supply of Medi-Cal dentists and recruitment assistance from Smile California/local dental societies; FQHC dental clinics (many with multiple sites); established school-based programs; infusion of First 5 or other foundation monies that

supported oral health; various types of pilot programs (e.g., DTI); and promotional efforts for oral health education through social media and community partnerships. The level of education among adults age 25+ also did not seem to be a factor, as the proportion of the population with a high school diploma/GED ranged widely in these counties; Monterey County, for example, that had one of the highest children's utilization rates has the population with the lowest education level, i.e., 73% compared to Sacramento at 87.9%.

Fresno County, which has a disproportionately high percentage of dentists who accept Medi-Cal patients to start with, attributes its favorable Medi-Cal utilization rates to having "worked hard to create a network of "'quality providers.'" All referrals are followed up by the oral health staff and when "adverse experiences" are noted, no repeat referrals are made to the offices that "up charged" or had staff reported to be rude or to clinics with high turnover. (This has resulted in Western Dental being dropped from referrals.) Only by referring to dentists who can see patients timely, seen by the same dentist at each visit and not being charging for services not covered by Medi-Cal, the program's care coordinators have established patient trust in a dental home. Program staff also identified two other factors that seem important: an active partnership with Anthem Blue Cross Medi-Cal to educate medical providers about oral health and conduct "intense" community outreach and education; and a user-friendly spreadsheet provided by Smile California of Medi-Cal Dental providers that are handed out by physicians and school nurses to individuals in need of a dentist. The program found the state's website "impossible to print out for consumers and too cumbersome for people not tech savvy enough" to use it.

Santa Cruz County. Despite relatively low private dentist participation in Medi-Cal, an important factor for Santa Cruz could be its leadership and very active *Oral Health Access Santa Cruz County*, a group that was formed after a comprehensive 2016 oral health needs assessment revealed major access issues.[168] The advocacy group is led by a "dental champion" Board of Supervisors member, has active continuing support from the local First 5 and Public Health Department, and committed involvement from the county's Medi-Cal medical managed health care plan. Santa Cruz also has two large FQHCs adequately staffed to serve the Hispanic community, one of which is a dental-only FQHC (Dientes Community Dental), which widely covers the county.

Summary

In sum, while these comparison counties' strategies may possibly have occurred more intensely or more frequently or more broadly or over longer periods of time than in Sacramento, it should be recognized that Sacramento County providers, partners, MCADC and the GMC dental plans *have* undertaken many of these same strategies, yet without the same outcome for Medi-Cal dental utilization.

COMMUNITY INPUT

"The kids [school screenings] with the worst teeth had the parents with the worst teeth" – Key informant interviewee

Included in this section of the report are findings from the Key Informant interviews, the Sacramento County Community Oral Health Survey, and the focus groups. These rich qualitative data give a "voice" to the statistics and generate a deeper understanding about the oral health needs and issues addressed in this report.

Key Informant Interviews

Thirty-two key informants participated in telephone interviews lasting up to an hour. The key informants represented a good cross-section of Sacramento County community-based organizations, advocates, dental plan representatives and others with an informed perspective about oral health needs (Attachment 1). While most of the interviewees spoke to the issues they knew best from their professional roles, many were also able to consider and describe the needs of other groups when prompted with questions to help them think about population characteristics, geographic locations, political landscape and other factors that influence oral health knowledge, attitudes and access to services. The summary below aims to do justice to the richness of their comments.

Identified Improvements

The key informants were asked to think about all aspects of oral health—from community awareness to technology to service delivery—and identify what in their view had improved or "changed for the better" in Sacramento over the last 4-5 years. Table 39 lists the perceived improvements in order of frequency.

Table 39. Key Informants' Perceptions of Oral-Health Improvements in Sacramento County [1]

Positive Changes
▪ More community partner engagement, increased collaborative relationships, particularly with the GMC dental plans ▪ Expanded school-based OH education programs / ↑ oral health assessments

Table continues on next page

- More awareness by *some* parents of OH messaging = behavior change, e.g., ↓ sugar/soda drinks
- Some screening evidence suggests a decreased number of kids with acute evidence of tooth decay
- Availability of the MDRAN database (contributed to tightened relationship between medical and dental)
- Restoration of/increased adult Medi-Cal dental benefits, e.g., dentures
- Some increase in Medi-Cal Dental reimbursement
- Increased points of access; expanded dental plan provider networks
- Increased relationships between dental plans and oral surgeons because of dental plan agreement to pay for out-of-network
- Fluoridation of the Arden Arcade water district; none of the current water districts have pulled out of the contracts to remain fluoridated
- More schools contributed Kindergarten assessment data, e.g., 12 districts in FY 20/21
- More dentist presence on the First 5 Sacramento Commission
- Increased awareness of OH at CA Department of Developmental Services (maybe because more Regional Centers now have Dental Coordinators?)
- Some increased collaboration between medical managed care plans and Delta Dental FFS system, e.g., for member assistance
- Increased ability of CCS Case management nurses to connect for help from the dental plans

Other Supportive Positive Changes

- Availability of Prop. 56 funding and resources to support OH
- Change in immigration law that will allow more people to be seen
- More responsiveness of DHCS with MCDAC, e.g., "less adversarial" relationship
- Greater openness to the idea of virtual care, people more comfortable with it because of COVID
- Sacramento-based OH studies produced over the last decade have informed OH policies and service delivery

[1]In frequency of mention.

Nearly half of the interviewees had observed an increased collaboration among oral health-related entities—many represented on the Medi-Cal Dental Advisory Committee—including "better relationships with the GMC dental plans. Examples of benefits of the improved collaboration included the increased ability of school nurses to refer children with worrisome screening results with dental disease and "less political tension around GMC continuation with MCDAC." Some interviewees thought an increase in oral health messaging (e.g., First Tooth First Birthday) had begun to make a positive impact in some families' awareness of the important of oral health and behavior change, and some had observed a decrease in the proportion of children with evidence of dental decay in the school screening assessments. The web-based Medical Dental Referral and Navigation System (MDRAN) was lauded by several individuals as helping to bridge medical and dental care for Medi-Cal members in Sacramento County and help to facilitate and track dental referrals.

Issues Slow-to-Improve

When COVID-19 was removed from the question, for obvious reasons, key informants thought the most important things that "got worse" or failed to improve to the extent expected or hoped for in the last few years were still not enough school-age children being screened; utilization of dental

benefits—particularly among adults—"too slow to rise;" fear as a barrier not being well-enough addressed in dentistry; and, the Virtual Dental Home "sort of disappearing" because of COVID ("school closures took away the technological opportunity COVID gave us to use VDH").

But, as Table 40 indicates, the #1 issue the key informants identified as failing to be resolved was the continuing access problem for needed hospital dentistry cases, with one interviewee saying, "I'm sick of talking about it without a solution." Another interviewee echoed that sentiment with a similar statement: "This has been on the MCDAC agenda for so many years without resolution that I'm going to scream. I'm skeptical anything is really being done; the committees aren't making a difference."

It was recognized that in prioritizing children in oral health improvement strategies—which the interviewees agreed was appropriate—adults had been "too long ignored." Some observed that adults "need more help navigating" what for them might seem like a complex delivery system ("for my population [homeless], nothing changes; oral health will always be a low priority"). Others cited the barrier of fear/anxiety and "past bad experiences" that need special messaging to address. One individual noted, "there's a system disconnect between not really understanding what the drivers are for not seeking care and matching it to how we can better reach/serve adults." Another suggested, "there's a general mindset that the dental system is hard to access, so that we need to bring care to where people are; that's not necessarily true."

Despite some key informants observing an improvement in children's oral health status, others noted change was slow in coming. One individual pointed to immigrant parents as an example and had observed that when these families come to the U.S. things like sugar snacks and sodas feel like a luxury, and they want to fit in ("their kids don't want to be the ones eating hummus and carrots when their friends are eating donuts and coke"). It was also noted that with schools not holding in-person classes children who had essentially only brushed their teeth at school hadn't been brushing regularly (schools hear parents say "we're always in a hurry at home;" " we often forget").

Table 40. Key Informants' Perceptions of Insufficient Improvements Related to Oral Health [1]

Insufficient Progress
▪ Access to hospital dentistry
▪ Utilization rates among adults with Medi-Cal
▪ Denials of authorization for treatment, e.g., crowns and root canals (lack of clear, open communication channels, e.g., Department of Managed Care and DHCS not communicating effectively)
▪ Not enough schools, including elementary and junior high, participating in oral health assessments
▪ Lack of awareness/confusion re Medi-Cal benefits because of previous reductions in adult dental
▪ Untimely, inconsistent data
▪ Children's dietary habits/oral health behaviors still poor in many communities
▪ Parents' lack of follow through with referrals to treatment from school-based screening programs
▪ Still too few Medi-Cal dental providers/insufficient capacity, particularly specialists
▪ People settling into the belief that widespread screening and referral "has solved everything"
▪ Center for Oral Health not billing for screening makes it vulnerable = high dependency on private funding, e.g., GMC dental plans

[1]In frequency of mention.

Additional perspectives from the dental managed care plans about challenges serving their Medi-Cal members—and improving utilization rates—are highlighted in Table 41. The state's lists of members assigned to them were said to be "about 20% inaccurate," such as with missing or wrong telephone numbers (puzzling when most people now have cell phones), hampering plans' abilities to contact members. One plan stated that it was common for members to screen calls and not answer when the plan name appeared on the screen or the caller identified themselves as being from the plan; or when members do pick up the phone there is a 22% hang-up rate.

While improved, the adult scope of benefits lacking inclusion of certain standards of care remains disappointing; examples included members not having 2 cleanings per year and the ADA recommendation that patients older than 18 years of age and adults with root caries receiving 2.26% fluoride varnish at least every 3-6 months.[169] Another obstruction to access mentioned was the lack of assignment to an FQHC with dental services for the same patients who are assigned there for *medical* services (a frustration also brought up in the FQHC interviews and discussed earlier in this report in the overview of Medi-Cal enrollment).

Table 41. Particular Issues Identified by Dental Managed Care Plans that Challenge Progress for Medi-Cal Members

Insufficient Progress
▪ Medi-Cal member list inaccuracies; wrong or missing phone numbers ▪ Scope of adult benefits does not include the recommended fluoride varnish for people age 21+ or 2 cleanings/year ▪ Some Sacramento community-based organizations seem siloed as cultural hubs, not connecting well with broad diversity needs ▪ Not having a clear enough understanding of the drivers for people not seeking care—and matching it to better delivery of services to adults ▪ The challenge of finding and connecting members who are homeless to care ▪ Still insufficient engagement from the medical side ▪ FQHCs that provide dental services that are assigned members on their *medical* side but not the same patients assigned there for their dental services ▪ The continuing challenge of trying to expand the network of dental specialists despite financial incentives offered

Unmet Needs

The key informants were asked to identify the top one or two oral health problems/needs in Sacramento County that should be addressed "in the next year or two," keeping in mind the adult focus of the study. The interviews yielded fairly consistent results with the focus group responses and community survey conducted for this assessment though they represented a broader picture. Table 42 below identifies the highest needs which, unsurprisingly, relate back to the challenges they cited above.

Table 42. Most Important Oral Health-Related Needs/Suggestions Identified by Key Informants[1]

Issue
▪ Press hospitals to open up more OR (operating room) capacity for dental cases ("don't just wait for dental schools to build surgery center capacity")
▪ Expand community clinic capacity to serve adults (especially N. Highlands, Natomas and Florin Rd.)
▪ Push more utilization of preventive services, especially among the elderly ("to avoid pulling teeth")
▪ Obtain approval by Medi-Cal for crowns other than silver (" which don't seal well enough")
▪ Create more opportunities for mobile dental care, especially for the homebound and individuals in facilities
▪ Increase incentives for specialists to participate in Medi-Cal FFS dental/join Dental Managed Care networks
▪ Increase awareness of adult dental benefits ("don't assume people read/understand/know their scope of benefits materials")
▪ Design and promote a campaign around good oral health = good general health
▪ Get the medical care system on board with dental, particularly the OB-GYNs and other prenatal providers
▪ Implement a referral management and care coordination system to track dental screening referrals

[1]In frequency of mention.

Some of the specific comments that offer additional insight included the following:

- "If we achieve nothing else in the next 5 years, let us please solve the problem of limited access to general anesthesia dentistry [note: either through OR capacity or adoption of alternative approached], especially for people with disabilities/special needs."

- "If DHCS is going to keep GMC they ought to help make it more attractive to local dentists; they aren't doing enough to make it easier for the plans to recruit the dentists."

- Among the individuals who saw the need to create more referral opportunities to specialists, three specifically said "create options other than Western Dental," and two stated "GMC members do not like going to Western (where they're treated like cattle)."

- "The ethnic diversity of Sacramento requires more tailored approaches to oral health outreach and education, especially for the many refugees who come here. For immigrants, dental care is a luxury in their home country; they aren't used to accessing regular care."

- "Sometimes it's the partner who has the dental insurance (or the car), and women living in a safe house don't have access to it without revealing where they are; that's one group who could benefit from more mobile dental services."

- "If everyone these days has a cell phone, why is it so hard to have a more accurate list of Medi-Cal members from the state? How are we supposed to contact these people who haven't been to the dentist?"

- “Address oral health disparities [to improve access and utilization] by targeting factors beyond just awareness of the availability of services.”

Plateau in Demand?

It has been observed in various economic analyses that aggregate *supply* of dental services is increasing, but the *demand* for dental services is level at times and decreasing at times.[170] In noting this, some have questioned whether utilization among the Medi-Cal population in Sacramento has reached a plateau because it has not risen to the level hoped for. About half of the key informants who answered this question thought demand had flattened since about 2015, and some of these individuals were skeptical that any strategies could be effective to influence it to a significant degree. The other half, however, did not believe we’ve reached a plateau in consumer demand in Sacramento, with a couple saying “the FQHC dental clinics can be more helpful in promoting dental services, especially from the medical side.” Some noted that as Medi-Cal eligibility in California expands—and additional refugee populations continue to come into the state and county—there could be an increased demand on the dental delivery system, especially the clinics and Community Health Centers serving these patient populations.

Barriers to Care

Consistent with the literature, the key informants identified the main reasons why adults delay or avoid going to the dentist—or skip and never keep appointments they make (Table 43). Some of these barriers overlap and some alone are not the limiting factor. Many apply for children as well as adults.

Table 43. Factors Associated with non-Use of Dental Care Observed by Key Informants

- Lack of insurance (or, for Medi-Cal members, lack of awareness or confusion around benefits)
- Fear/anxiety of dental procedures, needles; “dental phobia” and the feeling of loss of control
- Cost for treatment not covered by insurance
- Previous “bad experiences”
- Transportation challenges
- Fear of being charged for benefits not covered even if the assumption is false
- Relative importance— assignment of low priority relative to other things or belief that home care is adequate, baby teeth don’t count
- Inability to make multiple appointments for family members on the same day
- Long wait times on the phone—sometimes with multiple menu steps—and people give up
- Treatment and follow-up visits provided over multiple appointments → transportation and child care issues
- Discontinuing regular use after retirement or relocation to a new community; irregular use

Promoters of Care

Basically, the opposite of what deters or discourages dental care use enables or promotes it, according to the interviewees. On the plus side, having a source of payment and perceiving a need based on self-determined value were the two most commonly cited factors. Additionally, making it easier for people (especially those with disproportionate challenges) to go to the dentist was

mentioned by several individuals. They gave as examples creating "friendlier" office environments (to reduce anxiety), using more teledentistry and mobile dentistry, and offering more weekend and evening office/clinic hours. As one individual stated, "understanding these motivators should make us better prepared to find solutions."

And, on the negative side—and just as we heard during the focus groups—pain and enough of it and for long enough, was identified as being "the big prompt" for a person to seek care, often in the emergency department.

Table 44. Factors Key Informants Believe are Associated with Dental Care Use

Positive Factors

- Having dental insurance (and being aware you have it)
- Perceiving a need/assigning high enough value to it, and following through by acting on it
- Patient adherence to self-care behaviors
- Having your medical provider *ask* you about it (not just checking a box on the health form)
- Ease of appointments—weekend and evening appointments, shorter wait times during the visit
- Wanting cosmetic improvement—impact for employment, e.g., a customer service job
- Having a usual source of care
- Getting the name of a dentist or dental clinic from someone you trust

Undesirable Factors

- Pain
- Inability to chew, enjoy food (severe malocclusion, many missing teeth)
- Limited capacity to "see beyond today"—inability to grasp the concept of prevention and recognize that it can save time and money in the long run
- People not understanding that they have benefits when they do, or thinking they still have to pay so avoid going to the dentist

Solutions

The suggested solutions offered by the key informants—and what they said they hoped would come out of this study—stem directly from what they had observed as keeping people from using their benefits or motivating them make a dental visit. All of the improvement strategies, in one form or another can be found in the Recommendations section of this report where they were incorporated with the informative community survey and focus group input.

Focus Groups

About 110 individuals were reached through the 9 community focus groups convened for this assessment. Attachment 2 identifies the organizations that hosted the sessions. While no one group was expected to be representative of Sacramento County, *in the aggregate* the groups reflected a diversity of residents and locations, particularly those individuals with needs most often addressed by community needs assessments.[171] The participants were typically 35-65 years of age, with some of the groups oversampled for older adults. The groups ranged in size from 7 to 16 people. To supplement the information from sessions with translators, we included the opportunity for participants to also fill out a brief questionnaire (Russian and Spanish languages) with a few key questions such as "What keeps you from regularly going to the dentist?" About 35 individuals also completed these questionnaires.

Last Dental Visit

The participants all seemed to understand and say they valued good oral health—including many acknowledging the relationship with good general health, the ability to chew well, and for some the ability to get a job—yet fewer than half practiced that belief by making regular dental visits. Overall, one-third to one-half of all the participants reported having made a dental visit in the last year. Most of the rest had gone to the dentist "sometime in the last 2-3 years," but about a dozen people said they had never gone to the dentist (one saying, "I'm just not a dentist type person"). While some of the adults were negligent about their own oral health, nearly all of those with children at home reported being vigilant about taking their children to the dentist in the past year. About 80% were aware of the recommendation for "First Tooth First Birthday"—while guesses by the other participants ranged from "when they turn 3 years old" to "when they're in 3rd grade."

Barriers to Care

The participants identified specific barriers that had kept them or family members/friends they knew from seeking regular care, and responded to questions such as, What are the main reasons people don't go to the dentist? Their reasons are consistent with the literature, and all previous Sacramento County oral health assessments. As Figure 52 on the next page indicates, financial concerns (no insurance—or benefits not fully covered by Medi-Cal) and dental fear were the two barriers mentioned most frequently, each by about 40% of the participants. Important issues related to financial concerns included:

- A number of people with Medicare said they couldn't afford to buy the "extra" insurance to receive dental benefits.
- Many of the adults with Medi-Cal described having only part of the needed treatment covered; having to pay for the remainder of the services ("deep cleaning" was mentioned several times) meant forgoing treatment completion—or avoiding going altogether.
- Adults without coverage said they could not even pay the lower end of dental clinics' sliding fee schedules so they didn't bother to try to make an appointment.

Figure 52. Main Barriers to Oral Health Cited by Focus Group Participants

Barrier	Percentage
Financial (no insurance; worry about share of cost)	40%
Dental fear/anxiety	40%
Low priority ("too busy," my teeth are fine")	16%
Long wait time during appointment	3%
Transportation problem	1%

Note: percentages are approximates

Fear and anxiety. Past experience with pain, or "hearing scary stories from people you know" (e.g., "getting deep cleaning and then losing your teeth"), or the belief that something was *going* to be painful was the other main reason for avoided dental visits. So were misperceptions about what was going to happen at the dental office ("I'm afraid they're going to pull my teeth, that's what they do"). One person said they "do not like to be hassled by the dentist about what I should be doing or not doing because it just increases my anxiety and makes me procrastinate to go back," and another acknowledged they had to "get past my trust issues." Only one participant mentioned having avoided dental visits due to COVID-19.

Low patient priority. A surprising number of focus group participants—most reported to have Medi-Cal—either explicitly stated (or marked in the supplementary questionnaire) that while having good oral health was important, going to the dentist was a low priority. Two people stated they were "too lazy to go" and three people said "I need to go [one saying they had "bad cavities"] but I'm too busy;" most of the others said it was because their teeth "were fine." For this latter group, there was a genuine belief that if they took care of their teeth it reduced the need for dental visits ("I try to brush whenever I'm not too stressed so then I don't need to go to the dentist"). It seemed a challenge to suggest they consider otherwise.

Dental service issues, for the participants who mentioned them, included the following:

- Dental plans that kept switching dentists on members without their being told or agreed to
- Perception (real?) of subpar dental services in Medi-Cal (one dental company frequently identified)
- Members with Medi-Cal feeling "disrespected" by dental office (one dental company frequently identified), e.g., being spoken to rudely; being "on hold forever then getting hung up on"
- A long wait *during* the dental visit

Other personal barriers, mentioned by a few individuals, included:

- Transportation problems
- No childcare
- Not wanting the medical benefits of Medi-Cal, just the dental benefits ("because if I have medical they will tell me I have to have certain tests I don't want")

- Not knowing where to go or who their dentist is, even as a Medi-Cal member

Other participant input that sheds light on what influences oral health behavior included:

- For many, pain/discomfort was frequently the motivator for going to the dentist ("When it gets really bad I go because I want to prevent worse from happening")—paradoxically even among those who said they "value good oral health."
- Among certain cultures and in certain generations it was mentioned that going to the dentist was not so important but going to the doctor was, so "a new mindset had to happen" to make oral health a higher priority.
- Young people are notorious for feeling invincible and unable to see themselves as older so "some of them have to be knocked in the head about getting it" regarding the value of prevention, i.e., making the investment in oneself includes committing the time and resources.

Medical Provider Interaction

Similar to previous findings, all but 2 or 3 focus group participants said their medical provider "never" asked about their oral health or looked at their gums or teeth. Several remembered a place on the health history form they were to indicate their last dental visit. When asked by the facilitator whether any of their medical providers noticed if they had marked on the form something like "it was a few years ago" or "never" and had inquired about it, the answer uniformly was no.

Participant Recommendations

Participants were asked what would make it easier for them—as well as the individuals who reported going to the dentist within the last year—to make a dental appointment or help promote the importance of oral health. We heard:

- Pain for some is the motivator, the *promoter* is having insurance. Adult treatment needs may be more extensive than children's, especially when they haven't taken care of their teeth, but without access to the full scope of needed treatment, many simply can't afford it because the co-pay is too high.
- People with Medi-Cal who receive medical services through an FQHC should automatically be assigned to that same FQHC for their dental services "without having to wrangle for it."
- Do not switch Medi-Cal dental providers without notifying members and obtaining their agreement (unless it's unavoidable because the provider has dropped out of the network).
- Find ways to reduce the wait time to see a dental specialist.
- Promote the importance of oral health to the same degree other health and related issues are *visibly* promoted in the community through various media such as tobacco cessation, getting mental health help, reading to your children, eating 5 servings of fruit and vegetables/day.
- Get doctors to tell people to go to the dentist and why that is important ("act like they care about it").
- Figure out how to scare people with this-could-be-you photos (e.g., the example of the black lung in old-school tobacco education programs) without being "overly dramatic" about it. (Note: This was suggested by participants in more than one group.)

Community Oral Health Survey

Survey Sample and Respondent Characteristics

The online-only Community Oral Health Survey yielded 283 usable survey responses, a somewhat lower number than had been anticipated. (Note: although there were 1,705 responses to 2018 Needs Assessment Oral Health Survey, 91.7% of them were completed in hard copy.) Some of the factors that may have accounted for the relatively low return in 2022 include “survey fatigue” (people being overly surveyed during COVID because of restricted data collection methods);[172] limited access for some to the internet; low interest in the topic; feeling too overwhelmed with other things to participate in a survey; no one putting a paper survey in front of them, such as might occur at a family resource center, and asking them to complete it; and low attention/social media promotion by some Sacramento County oral health partners, especially those that serve large groups multi-ethnic communities. Nonetheless, the data are considered high quality, and the findings are consistent with the other sources of community input and previous oral health surveys.

Nearly all (93.1%) of the surveys were completed in English despite the availability of taking the survey in 6 other languages (Figure 53). It was therefore not feasible to analyze the data by language type.

Figure 53. Oral Health Survey Responses by Survey Language (n=283)

English	Spanish/ Español	Farsi/ سپانیایی	Pashto/ پښتو	Vietnamese/ Tiếng Việt	Ukraine/ Українська	Russian/ русском языке
93.1%	5.9%	0.5%	0.0%	0.5%	0.0%	0.0%

Over half (52.1%) of the respondents were in the age group 41-64 (Table 45). The 18-25 year-olds were under-represented for their relative population in the county, at less than 2%. When looking at the results by race/ethnicity, the sample is relatively close to the 2020 Census for Sacramento County population.

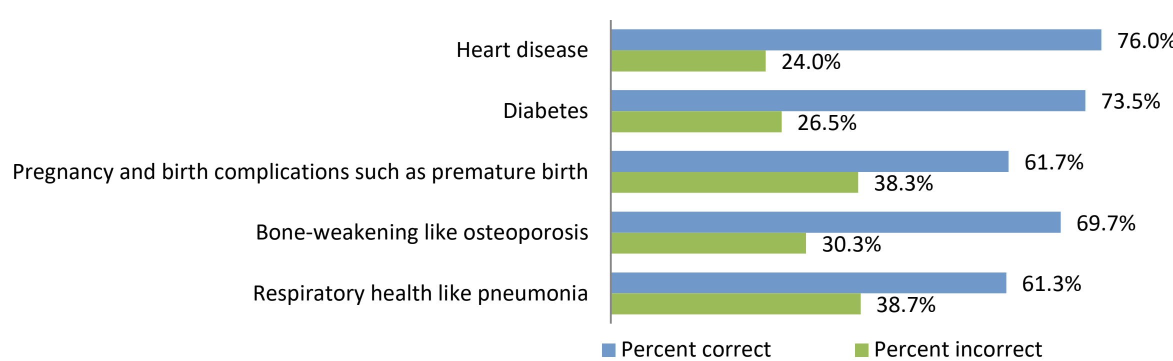
Table 45. Characteristics of the Survey Respondents (n=271)

Characteristic			
Age		Ethnicity	
Age 18-25	1.6%	White, non-Hispanic	49.5%
Age 27-40	30.3%	Hispanic/Latino	19.7%
Age 41-64	52.1%	Black	9.0%
Age 65+	16.0%	Asian	13.3%
		American Indian	0.5%
		Multi-race	4.8%
		Other	3.2%

Oral Health Knowledge

Consumer agreement with oral health's connection to general health is important for supporting the regular use of dental services. Respondents were told that "oral health offers clues about a person's overall health," and asked whether they knew certain medical conditions were linked to poor oral health. As Figure 54 indicates, more than half of the sample answered the questions correctly. They were most sure about heart disease (76.0% answered correctly) and least sure about respiratory health like pneumonia (61.3% correct). The relatively higher level of knowledge of the present group vs. the groups in the previous needs assessment about the relationship of oral health to overall health suggests a possible relationship to the community oral health education efforts over the last 5 years.

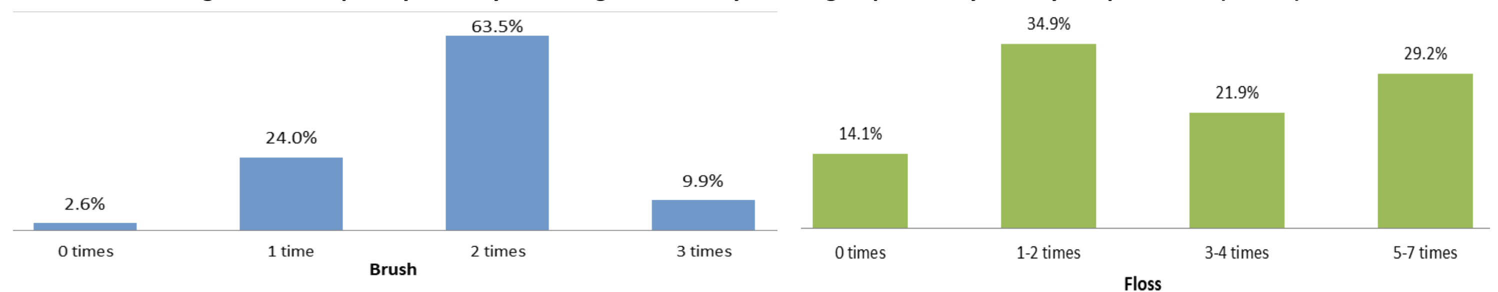
Figure 54. Survey Respondents' Knowledge about Oral Health Relationship to Other Health Conditions (n=266)



Oral Health Behaviors

Among the factors responsible for oral diseases, oral hygiene is considered a significant factor for the prevention of oral diseases and the preservation of oral health. In this survey sample, 2.6% individuals reported they "never" brushed their teeth and 14.1% said they "never" flossed. On other hand, two-thirds (63.5%) brushed twice a day and almost one-third (29.2%) flossed 5-7 times a week (Figure 55).

Figure 55. Frequency of Daily Brushing and Weekly Flossing Reported by Survey Respondents (n=270)



Consequences of Poor Oral Health

The negative impacts of poor dental health go beyond just having bad teeth. The survey respondents were asked whether they ever had experienced any of several difficulties because of an oral health/dental issue. Nearly half (43.5%) of them felt they'd spent too much money

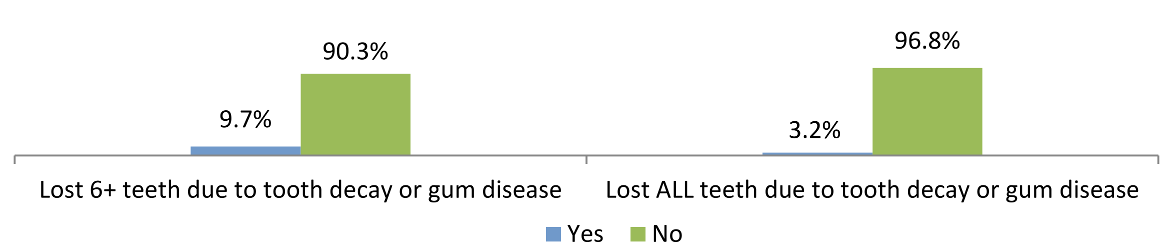
attending to a dental problem, while more than one-third (37.9%) had experienced sleep problems and about one-third (35.8%) had missed school or work for the same reason (Figure 56).

Figure 56. Difficulties due to a Dental Issue Experienced by Survey Respondents (n=277)

	Yes	No
Lost sleep/couldn't sleep because of pain	37.9%	62.1%
Missed work or school	35.8%	64.2%
Felt very embarrassed on a date or job interview because of bad teeth	25.4%	74.6%
Spent too much money that I/my family needed for other things	43.5%	56.5%

Although tooth loss in adults has decreased in recent decades, it remains more of a problem for some population groups.[173] Among the respondents age 65+ (the only ones to be asked these questions) about 10% had experienced the loss of 6 or more teeth due to tooth decay or gum disease, and 3.2% had lost all of their natural teeth for the same reason (Figure 57). These findings are fairly similar to the overall California older adult experience discussed on page 39.

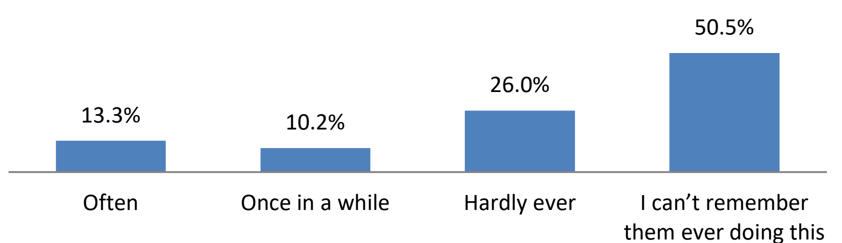
Figure 57. Percent of Survey Respondents Age 65+ With Tooth Loss (n=45)



Medical Provider Connection with Oral Health

Primary care providers are well positioned to promote oral health but do not always capitalize on this opportunity. Among the survey population with a physician, half of the adults said they could never remember their medical doctor ever asking about their dental health, and one-quarter (26.0%) said it was "hardly ever" (Figure 58).

Figure 58. Percent of Adult Whose Doctor Asks About Dental Health (n=253)



Access and Utilization

Dental Insurance

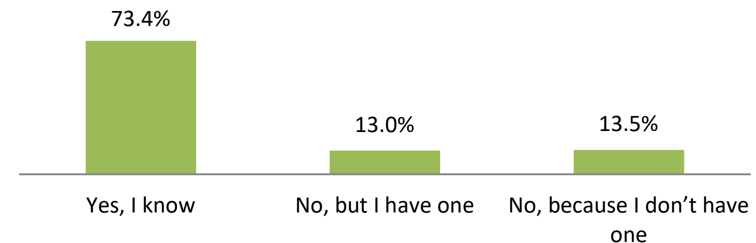
Having and *using* one's dental benefits reduces future dental care costs. Overall, 84.9% (81.6% in the previous needs assessment) of the survey respondents reported having dental insurance as the pie chart in Figure 59 shows. Privately purchased or employer-based insurance accounted for the majority of the coverage, 60.7%, with 24.8% of the respondents having Medi-Cal.

Figure 59. Percent of Survey Respondents with Dental Insurance and Type of Insurance (n=259)

15.0%
85.0%
Have insurance
No insurance
60.7%
24.8%
1.9%
12.6%
Private insurance (purchased or employer-based)
Medi-Cal Dental
Covered California
Private pay (out-of-pocket

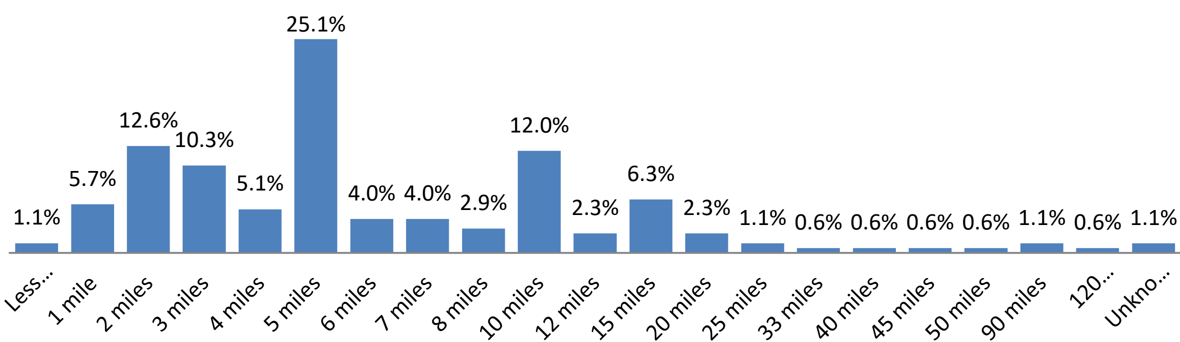
Recalling the name of one's dentist is not necessary a given, especially if the provider changes from visit to visit. Of the individuals who reported having a dentist, 13% could not identify the dentist by name (Figure 60); some mentioned they couldn't remember the name of their dental plan.

Figure 60. Percent of Survey Respondents Who Could Name their Dentist (n=212)



Overall, travel to the dentist was relatively moderate (at least for those who had transportation); 82.9% of respondents reported traveling 10 or fewer miles from home or work to their dentist's office. The most commonly traveled distance was 5 miles (Figure 61).

Figure 61. Reported Distance from Respondents'' Homes or Work to their Dental Office (n=202)



Last Dental Visit

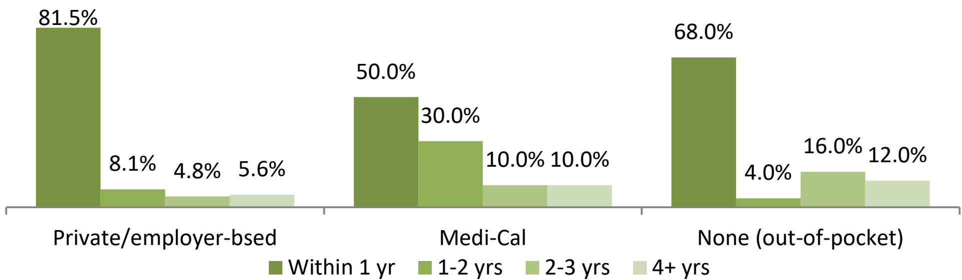
The majority of survey respondents (71.5%) reported making a dental visit within the last year. For the remainder of the respondents, it had been 1-2 years for 12.6% and longer for about 15% (Figure 62).

Figure 62. Survey Respondents' Last Dental Visit (n=280)

71.5%
12.6%
7.7%
7.2%
1.0%
Within the last year
1-2 years ago
2 - 3 years
4 or more years
Never

Looking at last dental visit by type of insurance to see what effect that may have had, we can see from Figure 63 individuals with private insurance reported the most recent dental visits, 81.5% within the last year. Half of the Medi-Cal respondents reported visiting the dentist within the last year, but were surprisingly exceeded by the proportion with no insurance, 68.0% vs. 50%, who saw a dentist that recently.

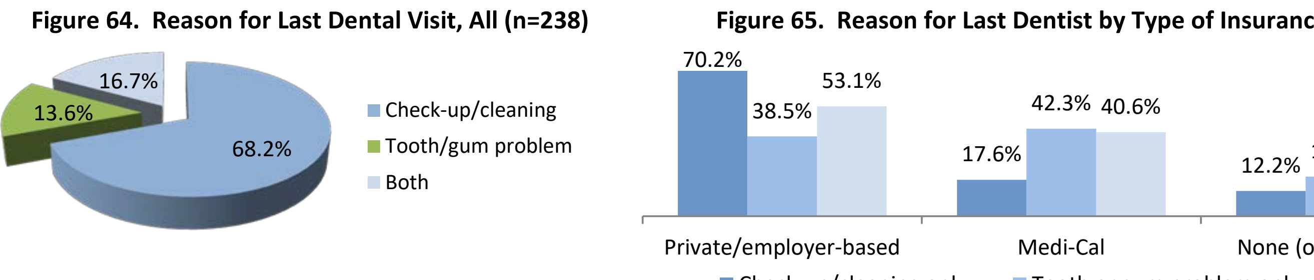
Figure 63. Frequency of Survey Respondents' Last Dental Visit by Type of Insurance Coverage (n=264)



About two-thirds (68.2%) of the survey respondents made their last dental visit—regardless of when—for the purpose of a dental exam and cleaning; another 13.6% had gone to the dentist because of a tooth or gum problem (Figure 64 pie chart). Looking at the reasons by type of insurance (Figure 65) we can see that visiting a dentist for a problem accounted for a greater proportion of the Medi-Cal respondents' visits than either the privately insured or those who paid out of pocket; only 17.6% of the Medi-Cal group making their last dental visit for a regular check-up and cleaning suggests a lower use of preventive services comparatively.

Figure 64. Reason for Last Dental Visit, All (n=238)

Figure 65. Reason for Last Dentist by Type of Insurance (n=219)



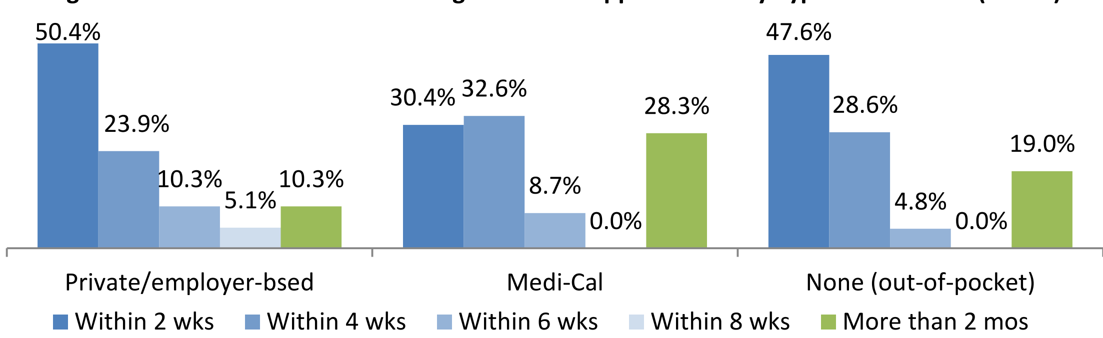
Overall, most (44.4%) of the surveyed adults were able to get a dental appointment for a non-emergency visit within 2 weeks, and another 25% within 4 weeks. For 18.4%, however, the availability of an appointment was 8 weeks or longer (Figure 66).

Figure 66. Timeliness of Last Non-Urgent Dental Appointment, All (n=212)

within 2 weeks	within 4 weeks	within 6 weeks	within 8 weeks	more than 2 months	I've never made a dental visit
44.4%	25.0%	8.7%	3.1%	15.3%	3.6%

There were some differences worth noting regarding the timeliness of non-urgent appointments and the type of dental insurance people had. About half of the privately insurance and private pay patients (50.4% and 47.6%, respectively) reported being able to get appointed within 2 weeks; however, this was the case only for one-third (30.4%) of the respondents with Medi-Cal (Figure 67). In fact, 28.3% of the Medi-Cal group said it took more than 2 months compared to the other 2 groups, 10.3% and 19.0%, respectively, who reported waiting for 2 months.

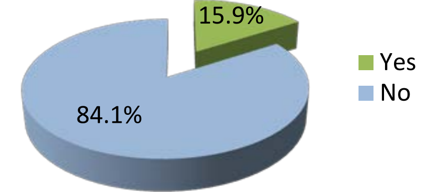
Figure 67. Timeliness of Last Non-Urgent Dental Appointment by Type of Insurance (n=211)



Pregnancy and Dental Care

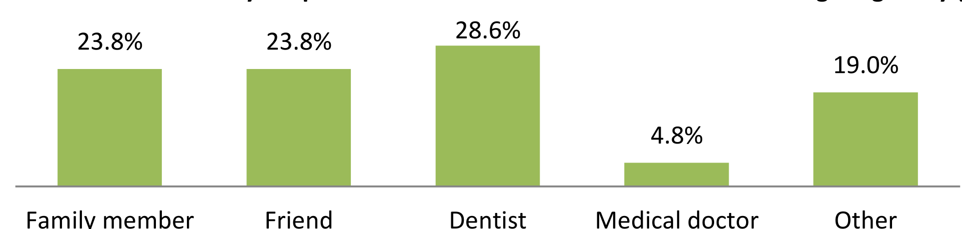
Most dental services and procedures can safely be done during pregnancy. However, some prenatal providers do not ask about or encourage patients to see a dentist, some dentists are reluctant to treat pregnant patients, and some well-meaning family and friends discourage it. Close to 16% of the survey respondents for whom the question applied reported ever being told they should not go to the dentist or have dental treatment during pregnancy (Figure 68).

Figure 68. Percent of Survey Respondents Told Not to Have Dental Treatment During Pregnancy (n=206)



Although the numbers are small, it is of interest that dentists—significantly more than physicians—were the primary source for telling women they should not get dental treatment when they were pregnant. Friends and family members were also influential for these respondents (Figure 69).

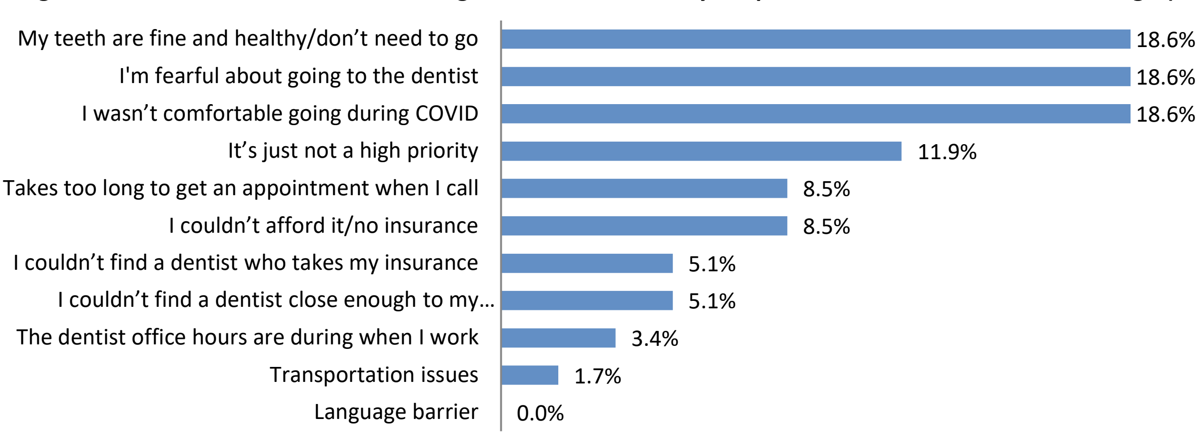
Figure 69. Who Told Survey Respondents Not to Have Dental Treatment During Pregnancy (n=32)



Barriers

Adults avoided going to the dentist for a variety of reasons; some barriers were due to personal factors while others were related to the delivery system. For the respondents who indicated their last dental visit was more than 1 year ago, 3 reasons, equally reported, emerged from the data: a belief that their teeth were fine negated the reason for going to the dentist; feeling fearful about going to the dentist; and being uncomfortable about going due to the COVID pandemic (Figure 70). Four "Other" reasons were written in: *"ADHD makes it hard to remember to schedule;" "the dental appointments are too long;" "Medi-Cal dentists are bad quality dentists, the worst dentists get assigned;" and "I'm just too lazy."*

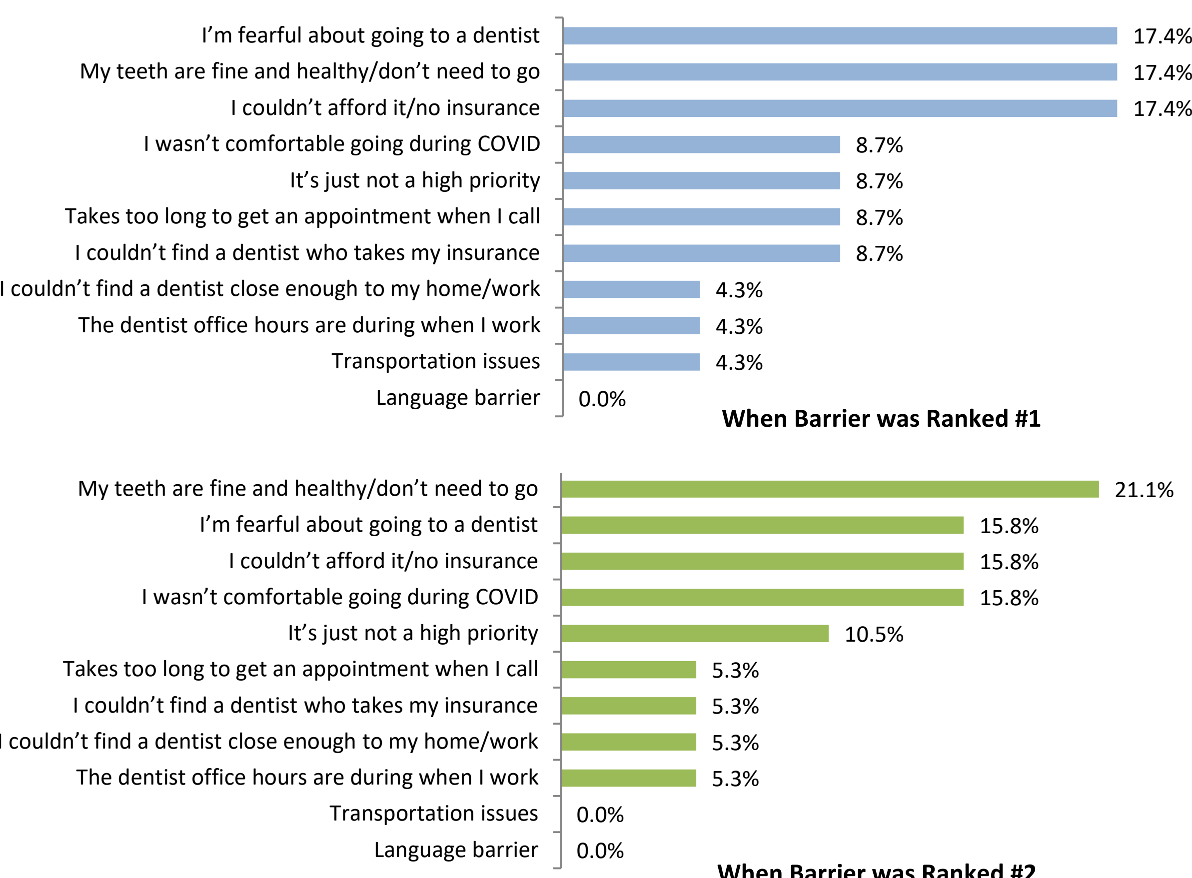
Figure 70. Main Reasons for Not Making a Dental Visit, Survey Respondents with Last Visit >1 Year Ago (n=84)



Note: Respondents could mark up the 3 reasons as well as write in "Other."

While looking at the reasons by the order in which respondents ranked them (the 2 graphs in Figure 71 on the next page) does not particularly shed new light on the overall reasons for not making a timely dental visit, the ranked data show greater detail and consistency in importance of each of the common barriers.

Figure 71. Main Reasons for Not Making a Recent Dental Visit by Rank Order (n=84)



The only 2 barriers or reasons for not making a recent (within 1 year) dental visit that seemed more important for the respondents with Medi-Cal, and then only somewhat, were fear of the dentist and feeling they didn't need to go because their teeth "were fine."

Use of the ED for a Dental Condition

Only 10 respondents said in the last 5 years they had ever gone to a hospital emergency department for a non-traumatic dental issue. The number of ED visits among these 10 respondents ranged from 1 per person to 3 per person.

Access Related to Disabilities

One-quarter (25.8%) of the survey respondents reported having someone at home with "disabilities/special needs that has difficulty (e.g., physical, behavioral or cognitive challenges) receiving dental services in a traditional dental office." The person referred to was an adult in 51.1% of the cases (48.9% were children). While in the majority of cases, 57.4%, respondents said the person had been able to receive services (exam, cleaning, treatment) within the last year, 42.6% had been unable to (Figure 72 below). The reported access barriers—familiar to MCDAC and other oral health advocates—are described in Table 46 on the next page.

Figure 72. Family Member/Person at Home with Disabilities Ability to Receive Needed Dental Services

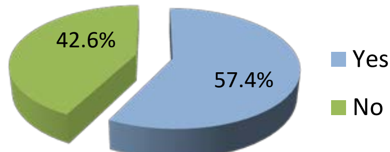


Table 46. Reasons Family Member/Person at Home with Disabilities Was Unable to Receive Needed Dental Services*

- Unable to get appointment
- No one can take him
- He has autism, so doesn't like to see people wearing white medical gowns
- My son is 17 with epilepsy. He's very fearful of dentists
- No dentists taking patients. Dentists are such poor quality that my son can't get appropriate dental care
- Will not let the dentist use any tools in his mouth. He doesn't like the noises the polisher and suction tools make. He has regular visits to the dentist, but hasn't been able to have a full cleaning, he will only let them brush and floss
- ADHD makes it hard to remember to schedule for myself and my child. Also, had to switch dentists to one that is ADHD friendly
- No openings for the treatment or dentist unfamiliar with this type of patient
- Unable to tolerate chair dentistry: spasticity, unable to follow instructions
- Needed teeth pulled due to them being beyond repair
- No dentist will take
- Lack of dentists
- Only sedation dentistry offered, this is only covered 1 x every 2 year
- No providers are willing to take someone who may need extra time or behavioral support
- They need to be put to sleep but we are still waiting for an appointment
- Throughout elementary school, my child had anxiety about the dentist and had emotional breakdowns while at the dentist. As a result, the dentist could not give her a filling and it was left to worsen. She outgrew her anxiety but had decay
- Special healthcare needs, unable to access dental services; quite common occurrence

**Most comments are verbatim, edited for clarity or length.*

Half (51.1%) of the respondents with a family member (or person at home) with special needs or disabilities reported the need for IV sedation or general anesthesia for them to be able to receive dental treatment (Figure 73). In these cases, for almost three-quarters of them (73.7%), it took longer than 4 months to receive the treatment (Figure 74).

Figure 73. Person Needed IV Sedation or General Anesthesia Anesthesia to Receive Needed Dental Treatment

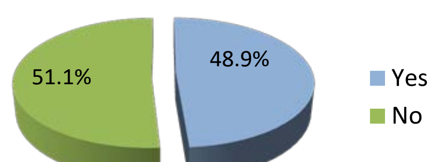
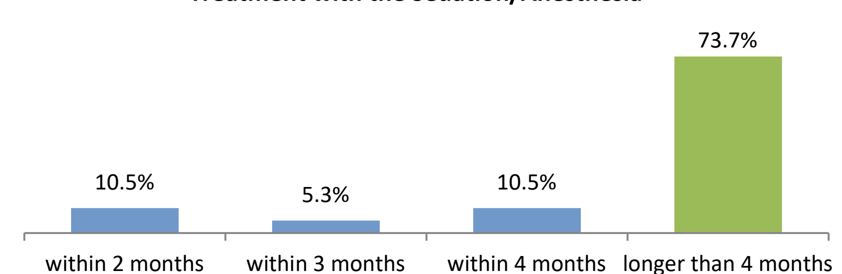


Figure 74. Length of Time for this Person to Get Treatment with the Sedation/Anesthesia



Children

Survey respondents with children at home ages 2-17 (n=144) were asked about the dental experience of their *youngest* child. Three-quarters (74.5%) of them reported the child's last dental visit had occurred within 6 months; another 14.7% said it had been within the last year. Close to 7%, however, said it had been 2 years or more or "never."

Figure 75. Percent of Survey Respondents' Child's Last Dental Visit (n=143)

Within 6 months	Within the last year	1-2 years ago	2 years or more	Never
74.5%	14.7%	3.9%	3.9%	2.9%

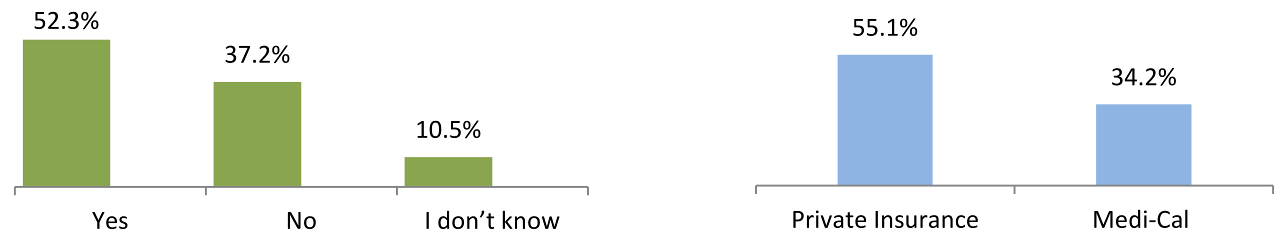
Parents' main reasons for a child's last dental visit more than 1 year ago are shown in Table 47. The numbers are very small; nevertheless the information confirms much of what we know to be associated with avoided or irregular dental care.

Table 47. Main Reasons Child did not Have a Dental Visit in the Last Year (n=19)

Reason	%
Fear of needles/shots	52.9%
Bad past experience	47.1%
Transportation problems	35.3%
Hard to schedule with my work/school	35.3%
Behavioral issues/inability to cooperate	23.5%
My child's teeth are fine/healthy	23.5%
Too expensive/couldn't afford it	23.5%
Hard to schedule appointments with the dental office	11.1%
Language barrier	0.0%
Didn't know where to go	0.0%
Wait time while at the dental office	0.0%
Concerned about going during COVID	0.0%

Overall, about half (52.3%) of the respondents for whom the youngest child was at least 6 years old reported their child had dental sealants put on their teeth. About 10% of them reported being unaware of whether this had occurred. There was a marked difference, however, by type of insurance. Just over 55% of parents with private insurance vs. 34.2% of parents with Medi-Cal affirmed the children age 6+ had had sealants (Figure 76 on the next page).

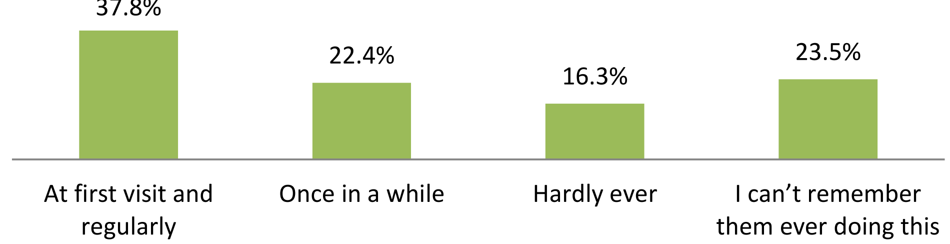
Figure 76. Percent of All Survey Respondents' Children Age 6 and Older with Sealants, and by Type of Insurance



Medical Provider Connection with Oral Health

Pediatric providers were reported to be more responsive to questions about patient oral health than what adults reported about their own medical visit experience. More than one-third (37.8%) of respondents with children said their child's doctor asked about their oral health at the first well-child check-up and regularly thereafter; another 22.4% said it was "once in a while," and 16.3% said "hardly ever." Close to one-quarter of the parents (23.5%) could not remember being asked (Figure 77).

Figure 77. Survey Respondents' Whose Doctor asked about Child's Oral Health During Well-Child Exam



SUGGESTED IMPROVEMENTS

"If we can develop comprehensive systems that include approaches like behavior support systems, at least half the patients on the wait list for general anesthesia could be predicted to avoid it for the treatment they need."
– Paul Glassman, DDS, Key Informant

Despite disparities and other gaps in access to oral health services, Sacramento County has many assets upon which to expand these services. Many organizations with commitment and expertise have come together since the 2018 Oral Health Needs Assessment, working to address oral health in community and school settings, clinics, and the public health system. Sacramento County is fortunate to have forward-thinking MCDAC and SCOHP dental health leadership and advocates, though progress in certain areas has been slower than hoped for.

The following recommendations are intended to improve access to oral health services and improve the oral health of Sacramento children and adults. There is no particular significance to their order. Some of the same strategies can address multiple needs. As always, deciding which recommendations to implement and in what priority order is the appropriate role of local stakeholders; it should be based on criteria such as the tolerance for status quo; member organizations' strategic planning goals; the degree of challenge members are willing to take on in addressing the need; the politcal will that exists; the cost of implementation; alignment with legislative mandates; and the impact to other systems where changes are made. As a next step, MCDAC/SCOHP and DHCS might identify leads and an accountability plan for each recommendation that becomes a priority.

1. **Create additional capacity in Sacramento hospitals and surgery centers for general anesthesia (GA) dental procedures.** This is the "problem that won't go away" and hasn't been satisfactorily addressed according to many interviewees who, frankly, expressed a great deal of frustration at the limited progress. The issue was extensively studied in 2020, and while denials by certain medical Medi-Cal managed care plans have been greatly reduced, the lengthy wait for treatment continues to be unacceptable. As a group, Sacramento hospitals have not helped to create more access. Although dental desensitization and "shorten the line" models for behavioral support are alternative approaches, GA will always be needed.

2. **Invest in a professionally-designed countywide targeted OH educational campaign with messaging aimed at adults.** Research backs up the significant effects mass media campaigns using television, radio, newspaper and other electronic and print media can have on major public health risk factors such as tobacco use, cancer screening rates, and sun protection and oral health behaviors. Educating people about how important oral health is to their general health is not going to "move" some people who only live only in the present, however, nor necessarily is appealing to "vanity" by asking if they want a nice smile (who doesn't?). Moreover, the ethnic diversity of Sacramento requires more tailored approaches to oral health

outreach and education, especially for the many refugees who come here. Applying specific community input from this needs assessment, effective messages—targeted to specific audiences—suggests the following:

- Build a specific strategy around dental fear/anxiety to counteract previous negative experiences and dispel misperceptions; tackle the issue forthrightly by acknowledging the problem and highlight expectations of more kid-friendly offices, "calm" office décor, approachable dental team members, etc.
- Make the point that oral diseases restrict activities in school, at work and at home causing millions of school and work hours to be lost each year.
- Highlight the psychosocial impact of poor dental health often significantly diminishes quality of life.
- Implement widely-viewed "If you have a toothache, call [phone number with a warm line]." We know from input to this study, pain creates effective demand; capitalize on it. Once treatment is completed, if the experience was positive, it would be hoped the person would be convinced—and assisted—to return or establish a dental home for regular ongoing dental services.
- Messages should also focus on how often a person has sugary foods and drinks and what tooth decay can look and feel like as a result of over-consumption; some focus group participants said *"don't be afraid to use negative photos."*
- Involving the use of non-dental personnel to deliver key messages can be effective to harness wider community influencers and social networks, people who can shape perceptions and change behaviors.

3. **Reduce the use of the emergency department for non-traumatic dental conditions** because ED dental visits are a significant and costly public health problem:
   - Increasing regular use of preventive services is the obvious first-choice strategy. Because adults aged 20-39 years and those with Medicaid have the greatest odds of an ED dental visit, it makes sense to reduce the peak prevalence of ED dental visits during young adulthood; [174] direct more outreach and media attention to adolescents (possibly focusing initially on youth with Medi-Cal) when dental utilization rates drop and oral health behaviors are shown to worsen.
   - It was not possible to know from the data we collected how many of the ED patients were "frequent flyers," or returned for the same problem as their previous visit. We also don't have enough information about the treatment modalities used or the ED users who were there to seek more pain medication. It would be valuable to support a specific study to answer these questions.
   - We learned that most ED staff is not aware of community dental resources. A simple poster or flyer with the names and addresses of the FQHC dental sites serving adults should be created—and kept updated—and distributed to the Sacramento ED managers for distribution to their provider staff.

- There needs to be a systematic communication link established in Medi-Cal between hospital EDs and DMC plans to inform the dental plans that a member has used the ED for a non-traumatic dental visit. This way the plan can follow up, make sure more than palliative treatment is provided, ensure the member knows who their dental provider is, and encourage regular use of preventive services in the future.

4. **Increase community clinic capacity for seeing adult patients.** Increasing the number of private Sacramento dentists who see Medi-Cal patients has had limited success—and nothing suggests the situation will change in the near future. Community clinics have become a critical and trusted provider of dental care for Sacramento County's low-income population; some of these sites could be expanded if a source of funding was identified—such as the sizeable support First 5 Sacramento gave for building up children's dental services. Use the utilization-by-zip-code data in this report to expand services. Bringing in more specialty services would need to be part of the investment. The new dental clinic CA Northstate Dental College plans to open should help respond to the need when the first cohorts of students are ready to see patients. Additionally, create more opportunities for mobile dental care for homebound seniors and others in facilities.

5. **Improve disparities and inequities in oral health care.** To advance progress requires a clear identification of which populations are experiencing service gaps and the extent of those gaps. Older seniors represent such a group. While gaps between individuals of different racial and ethnic groups are influenced by a multitude of factors at the individual, community, and broader system levels, our findings also point to the need for targeted outreach to non-Hispanic Black and non-Hispanic American Indian Medi-Cal members.

6. **Make an all-out effort to recruit *at least* one more oral surgeon in Sacramento who would see Medi-Cal patients.** This report would be incomplete without this recommendation, head-banging as it is. Since Delta Dental and the Sacramento District Dental Society have not been as successful as hoped for in recruiting enough dental specialists to participate in Medi-Cal (it is a statewide problem as well), use a successful model from other approaches—for example, how OB providers have been recruited and retained to practice in rural California counties—as a template, obtaining a grant from a private foundation to support the incentive. Determine the percentage of Medi-Cal patients the provider(s) would be required to see in the practice setting and the minimum time commitment.

7. **Work to get more local Alcohol and Drug programs (both public and private) engaged in oral health.** Drug abuse contributes to the risk of dental disease yet is rarely integrated into discussions about oral health. The direct effects of meth use, for example, as well as accompanying risk factors, significantly increase dental risks. At a minimum, involve someone from an AOD organization treating adults who is a "champion" type individual by offering them a seat on MCDAC, and then provide thorough onboarding and support for retention.

8. **Increase sealant delivery and utilization**. In line with the SCOHP (Sacramento County Oral Health Program) subcommittee's recommendations:

- Expand existing school programs to deliver sealants.
- Use an electronic referral management system to track sealant referral and delivery.
- Increase/continue education to the dental community to encourage prioritization of sealant placement.
- Work with FQHCs to expand intermittent sites that provide sealants.
- Continue and expand outreach to medical care providers to encourage oral health referrals including for dental sealants.

9. **Improve the reliability of the Kindergarten Oral Health Assessment (KOHA) screening data to benefit understanding of caries prevalence in Sacramento County.** The issues with KOHA reporting and the System for California Oral Health Reporting (SCOHR) are complex (e.g., the potential for duplication in reporting), and while they were beyond the scope of this needs assessment to address fully this is an area of further work for SCOHP. Screening data is not that reliable for a number of reasons and would benefit from analysis, calibration, education, and systems change, and contrasting the results of KOHA data with the results coming from individual screening programs.

10. **Implement a referral management and care coordination system to track dental screening referrals for treatment.** In too many cases, schools are unaware if parents have followed through in taking their child to a dental provider for treatment when warranted by evidence of decay. Referrals to providers typically use a paper-based referral form. There is no process in place to track these paper-based referrals to ensure that referrals are successful and that children's treatment needs are resolved. Schools report that paper-based referrals are often lost, and without a standardized electronic tracking system, it is impossible to determine the true number of unsuccessful or lost referrals. The lack of a tracking system also confounds efforts to collect and disseminate timely and accurate oral health surveillance and performance data. The software would also facilitate linkages between clinical providers and community settings.[175]

11. **Revamp the Medi-Cal system to auto assign members to the same FQHC when the organization provides both medical and dental services.** The lack of more bidirectional use was said to be largely due to the challenge of trying to help clients who want to switch plans; staff spend an inordinate amount of time on the phone because there is no available electronic system available for providers to use. Two of the plans (Health Net and Liberty) do allow mid-month transfers but Access does not; Access members must wait until the first of the month to switch. Perhaps if providers could do this themselves through a portal it would open up access.

12. **Ask DHCS to promote more awareness of the Treatment Authorization Request (TAR) guidelines for scaling and root planing by publishing an All Plan Letter (not just including the guidelines in the Provider Handbook); routinely provide data on periodontal denials by provider type, age group, geographic and residential criteria for more transparency in the assessment of need; and, implement additional provider education strategies for submitting proper TAR documentation.** Periodontal maintenance is needed for many adults with Medi-Cal who have periodontal disease from poor oral hygiene and chronic dental needs—and deep

cleaning is needed to stop periodontal disease from advancing. Requiring these patients to have more advanced disease before treatment is allowed to halt the progression of the disease is counterintuitive.

More provider awareness is needed of the guidelines in the July 2016 DHCS bulletin (vol. 32, no.12), *added to the Provider Handbook in November 2022,* granting acceptance of photographs rather than radiographs for those unable to tolerate x-rays due to their physical, medical or cognitive situation. Because the high denial rate for these TARs are largely due to providers not submitting the correct information because it is time-consuming— focusing on more provider education would also make a large impact.

13. **Ask DHCS to use the information in this report to do a deeper dive on provider network capacity to determine adequacy.** The number of private dentists in the GMC plans' directories is not a true total due to provider overlap among the Plans. DHCS could, for example, also look at unique number of sites to get a clearer picture of access.

14. **Increase the proportion of Sacramento County with access to fluoridated drinking water.** Community water fluoridation is considered one of the greatest disease-preventive measures of the twentieth century. Leaving one-third of the county without a fluoridated water system fails to protect vulnerable populations from dental caries (tooth decay or cavities) and periodontal disease, despite being largely preventable.

15. **Continue to increase opportunities for integration of oral health in general health settings, and promotion by medical/primary care providers.** Medical-dental integration is an approach that improves patient care by integrating and coordinating dental medicine into primary care and behavioral health to support individual and population health. The concept has gained some traction in Sacramento County—for example the Medical-Dental Partnership pilot that trained pediatricians and support staff to provide oral health education, conduct a dental screening, apply fluoride varnish for children—but greater opportunities for adults, such as with prenatal and internal medicine providers, should be identified and steps taken for training and support. The community input for this study validates the continuing absence of these conversations.

16. **Include oral health in more types of needs assessments/surveys, particularly for seniors.** When questions about participants' health needs are asked, they generally only address medical and sometimes mental health and related social service needs but not dental issues. There would be value in learning more about access from the inclusion of explicit oral health questions, especially from lower-income populations.

17. **Institute regularly scheduled GMC Plan Dental Directors' meetings (virtual or otherwise) among one another, and with the Sacramento FQHC Dental Directors.** Neither convening occurs at this time; however, there would be great benefit in formally opening these channels of communication to share information, gather input and suggestions, discuss and set policies, coordinate various efforts, including planning and implementing advocacy strategies, and responding to administrative or clinical problems and concerns.

APPENDICES

"If they have no pain, it's harder for me to educate and convince them to go for a dental visit for it to sink in" – Key informant interviewee

Attachment 1: Key Informant Interviewees

Attachment 2: Focus Group Host Organizations

Attachment 3: Most-Commonly Used Medi-Cal Dental Benefits

Attachment 4: Links to Medi-Cal Dental Provider Handbook Sections

Attachment 5: Community Oral Health Survey

Attachment 6: Alta CA Regional Center Service Coordinators Survey

Attachment 7: Focus Group Questions

Attachment 8: Map of Community Water Fluoridation

Attachment 9: Map of Sacramento County Community Dental Clinics

Attachment 10: Sacramento Dentists Currently Accepting Medi-Cal Patients

Attachment 11: Glossary of Commonly-Used Acronyms

Attachment 12: School Consent Form for Dental Screening and Fluoride Varnish (Sacramento)

Attachment 1

Key Informant Interviewees[1]

(In alphabetical order by first name)

Name	Affiliation/Organization at the time of interview
MCDAC/SCOHP Members and Others	
Ana Soria	Delta Dental
Beth Hassett	Women Escaping a Violent Environment (WEAVE)
Cathy Levering	Sacramento District Dental Society
Cherag Sarkari, DDS, Danielle Cannarozzi, Edward Bynum	LIBERTY Dental Plan
Christi Kagstrom	Twin Rivers School District
Debra Payne	Medi-Cal Dental Advisory Committee (MCDAC)
Gricelda Ocegueda	Sacramento Employment and Training Agency (SETA)
Hudson Graham, DDS, Carol Leonard, Sharon Kramer,	Access Dental Plan
Roseanna Jackson, Joanna Aalboe, Shannon Conroy	California Department of Public Health Oral Health Program
Jan Resler, Deborah Blanchard, Jennifer Fitzpatrick	Sacramento County Oral Health Program
Jeanette Diaz	CA Department of Developmental Services
Julie Gallelo	First 5 Sacramento
Katie Andrew	Children Now
Kelsey Reyne	Alta California Regional Center
Maritza Valencia	Sacramento Covered
Mary Jess Wilson, MD	Pediatrician/Medi-Cal Dental Advisory Committee
Mira Yang	Center for Oral Health/Early Smiles Sacramento
Paul Glassman, DDS	California Northstate University College of Dentistry
Paula Kuhlman	Sacramento City Unified School District
Robin Banks-Guster	Advocate/ Medi-Cal Dental Advisory Committee
Thomas Lovinger	Golden Age Dental Care
Timothy Martinez, DDS, Dorothy Seleski, Felisha Fondren	Health Net Dental Plan
Sacramento Dental Clinics and Community Health Centers	
Jay Anderson, DDS	One Community Health Center
Britta Guerro, Maria Rodriguez, Priscilla Gonzalez, Fue Yang, DDS	Sacramento Native American Health Center
Sunanda Bandyopadhyay, DDS	H.A.L.O. Health Center
Brenda Shipp, Ben Avery, Elsie Vaughn-Smith, Jonathan Porteus	WellSpace Health
Bianca Sahagun, Nina Tesco, DDS, Sunnie Coleman	Elica Health Centers

[1] Some names appear in both sections when the individual participated in both interviews.

Attachment 2

Focus Group Host Organizations

The following organizations graciously allowed us to meet with their clients to engage in facilitated discussions about oral health needs, concerns, and experiences.

Organization/Program
Adult and Aging Commission[1]
Mary House / Loaves and Fishes
Asian Community Center, Senior Services
Carmichael Seventh-day Adventist Church, Community Services
La Familia Counseling Center, Maple Neighborhood School
Alta CA Regional Center / Community Integrated Support Services
Asian Resources, Inc., Adult Education Class
SETA Head Start, Parent Council
Sacramento City Unified School District, Immunization Clinic

[1]Virtual meeting; all other groups were in-person.

Attachment 3

A High Level Description of the Most Commonly Used Medi-Cal Dental Benefits

Children (Age 0-4)

The Medi-Cal Dental Program provides the following free or low-cost services for babies:

- Baby's first dental visit
- Baby's first dental exam
- Dental exams (every 6 months; every 3 months from birth to age 3)
- X-rays
- Teeth cleaning (every 6 months)
- Fluoride varnish (every 6 months)
- Fillings
- Tooth removal
- Emergency services
- Sedation (if medically necessary)

Children (Age 5-12)

The Medi-Cal Dental Program provides the following free or low-cost services for kids:

- Dental exams (every 6 months)
- X-rays
- Teeth cleaning (every 6 months)
- Fluoride varnish (every 6 months)
- Molar sealants
- Fillings
- Root canals
- Tooth removal
- Emergency services
- Sedation (if medically necessary)

Teens (Age 13-17)

The Medi-Cal Dental Program provides the following free or low-cost services for teens:

- Dental exams (every 6 months)
- X-rays
- Fluoride varnish (every 6 months)
- Molar sealants
- Teeth cleaning (every 6 months)
- Orthodontics (braces) for those who qualify
- Fillings
- Crowns*
- Root canals
- Partial and full dentures
- Scaling and root planing
- Tooth removal
- Emergency services
- Sedation (if medically necessary)

**Crowns on molars or premolars (back teeth) may be covered in some cases.*

Pregnancy

Medi-Cal covers pregnancy and 12 months after the birth of the baby. Medi-Cal will pay up to $1,800 in a year for covered dental services. You may qualify for more than the $1,800 yearly limit,[1] if you have a medical need.[2] The Medi-Cal Dental Program provides the following free or low-cost services during pregnancy:

- Dental exams *
- X-rays
- Teeth cleaning *
- Scaling and root planing
- Fluoride varnish *
- Fillings
- Crowns**
- Root canals
- Partial and full dentures
- Denture relines
- Tooth removal
- Emergency services

** Every 12 months if over 21 years of age or every 6 months if under 21 years of age.*
***Crowns on molars or premolars (back teeth) may be covered in some cases.*

Adults (Age 18-54)

Medi-Cal will pay up to $1,800 in a year for covered dental services. You may qualify for no yearly limit if you are pregnant. Dental services may go over the $1,800 limit[1] if shown to be medically needed.[2] The Medi-Cal Dental Program provides the following free or low-cost services for adults:

- Dental exams (every 12 months)
- X-rays
- Teeth cleaning (every 12 months)
- Scaling and root planing
- Fluoride varnish (every 12 months)
- Fillings
- Crowns*
- Root canals
- Partial and full dentures
- Denture relines
- Tooth removal
- Emergency services
- Sedation (if medically necessary)

**Crowns on molars or premolars (back teeth) may be covered in some cases.*

Seniors (Age 55+)

Medi-Cal will pay up to $1,800 in a year[1] for covered dental services. You may qualify for no yearly limit. The Medi-Cal Dental Program provides the following free or low-cost services for seniors:

- Dental exams (every 12 months)
- X-rays
- Teeth cleaning (every 12 months)
- Scaling and root planing
- Fluoride varnish (every 12 months)
- Fillings
- Crowns*
- Root canals
- Partial and full dentures
- Denture relines
- Tooth removal
- Emergency services
- Sedation services

**Crowns on molars or premolars (back teeth) may be covered in some cases.*

Source: https://smilecalifornia.org/covered-services Accessed May 26, 2022. [1]If a member is at the cap amount for benefits ($1,800) and there is a service that is medically necessary, DHCS will review the claim or TAR and may allow it. [2]The medically needed justification to exceed $1,800 is done by the dentist; however, under some circumstances, a physician's documentation may be more effective in identifying medical conditions that justify the medical necessity for some dental treatment. DMC follows the same list of benefits available under FFS, although DMC can go above/offer more, their minimum must be equal to FFS. DMC uses the same medical necessity justification identified in our dental manual of criteria for services that may exceed the $1,800 cap; however, DMC could be flexible with the cap.

Attachment 4

Provider Handbook

The California Medi-Cal Dental Program Provider Handbook (this update from May 2022) provides detailed information for providing dental services under this program—from eligibility and conditions for participating to payment. In a Word version of this report, click on the links below to view sections of interest, or go to:
https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_handbook/handbook.pdf#page=16
Note that the printed Handbook contains 578 pages.

Handbook Sections

Section 1 - Introduction
(Revision Date May 2022) | Tags: Provider Handbook
Section 2 - Program Overview
(Revision Date May 2022) | Tags: Provider Handbook
Section 3 - Enrollment Requirements
(Revision Date May 2022) | Tags: Provider Handbook
Section 4 - Treating Members
(Revision Date May 2022) | Tags: Provider Handbook
*Section 5 - Manual of Criteria and Schedule of Maximum Allowances
(Revision Date May 2022) | Tags: Provider Handbook
Section 6 - Forms
(Revision Date May 2022) | Tags: Provider Handbook
Section 7 - Codes
(Revision Date May 2022) | Tags: Provider Handbook
Section 8 - Fraud, Abuse, and Quality of Care
(Revision Date May 2022) | Tags: Provider Handbook
Section 9 - Special Programs
(Revision Date May 2022) | Tags: Provider Handbook
Section 10 - CDT 22 Tables
(Revision Date May 2022) | Tags: Provider Handbook
Section 11 - Glossary
(Revision Date May 2022) | Tags: Provider Handbook
Section 12 - Bulletin Index
(Revision Date May 2022) | Tags: Provider Handbook
Section 13 - Index
(Revision Date May 2022) | Tags: Provider Handbook

Attachment 5

2022 COMMUNITY ORAL HEALTH SURVEY*

Dear Sacramento Community Member,
Thank you for participating in this oral health (dental) survey. It should take about 6 or 7 minutes to complete. Your answers will help us improve oral health services for adults and children in Sacramento County.

Take this survey in:

- ***English***
- ***Spanish***
- ***Farsi***
- ***Pashto***
- ***Vietnamese***
- ***Ukraine***
- ***Russian***

ADULTS, PART 1
Please complete this survey based on your experiences.

Oral health offers clues about a person's overall health. Which of the following medical conditions do you think are linked to poor oral health?
Heart disease
Diabetes
Pregnancy and birth complications such as premature birth
Bone-weakening like osteoporosis
Respiratory health like pneumonia

Have you ever had any of the following because of an oral health/dental issue?
Lost sleep/couldn't sleep because of pain
Missed work or school
Felt very embarrassed on a date or job interview because of bad teeth
Spent too much money that I/my family needed for other things

Do you have dental insurance?
Yes
No

If Yes, what type?
Private (from a job)
Medi-Cal (where a Dental Plan has dentists)
Medi-Cal (where I find my own dentist who takes Medi-Cal)
Covered California
I don't have insurance (I pay out of pocket)

Do you know who your dentist is?
Yes
No, but I have one
No, because I don't have one

* Note: this is text only. The survey was formatted for online use so the skip patterns are not apparent here.

Approximately when was your last visit to a dentist?
Within the last year
1-2 years ago
2 - 3 years
4 or more years
Never

What were the 3 main reasons you put off going to the dentist? Please read each of the reasons below. Then, check only 3, telling us in order of importance the #1 most-important reason, the 2nd most important reason, and the 3rd most important reason.
My teeth are fine and healthy/don't need to go
I couldn't find a dentist close enough to my home/work
I wasn't comfortable going during COVID
It's just not a high priority
The dentist office hours are during when I work
I couldn't find a dentist who takes my insurance
I'm fearful about going to a dentist
I couldn't afford it/no insurance
Language barrier
Transportation issues
Takes too long to get an appointment when I call
Other (Please Specify):

What was the reason for your last visit to the dentist (whenever it was)?
Check-up/cleaning only
Tooth/gum problem
Check-up/cleaning + tooth or gum problem
Braces
I've never made a dental visit

How soon were you able to get an appointment for your last *non-emergency* dental visit?
within 2 weeks
within 4 weeks
within 6 weeks
within 8 weeks
more than 2 months
I've never made a dental visit

How many miles away from home or work is your dentist's office or dental clinic?
I don't have a dentist
Number of miles: ____

In the last 5 years, did you ever go to a hospital emergency room for a dental condition not for something traumatic like a car accident, but for a toothache, bleeding gums, chipped tooth, or crown that came off?
Yes
No

How many times did you go to a hospital emergency room for a dental condition that was for something that was not traumatic? ______

How often has your *medical* doctor asked about your dental health when you went for a regular medical visit?
Often
Once in a while
Hardly ever
I can't remember them ever doing this

Have you ever been told that you should NOT go to the dentist or have dental treatment during pregnancy?
Yes
No
N/A (I've never been pregnant)

If yes, who told you this?
Family member
Friend
Dentist
Medical doctor
Other

Do you have anyone at home with disabilities/special needs who has difficulty (e.g., physical, behavioral or cognitive challenges) receiving dental services in a traditional dental office?
No
Yes

Is this person a child or adult?
Child
Adult

Was this person able to receive the dental services they needed (check-up, treatment, etc.,) in the last year?
Yes
No

Please briefly describe the reason: ____

Did this person need IV sedation or general anesthesia in order to receive the dental services they needed?
Yes
No

How long did it take for this person to get treatment with the sedation/anesthesia?
within 1 month
within 2 months
within 3 months
within 4 months
longer than 4 months

In a typical *day*, how many times do you brush your teeth?
0 times
1 time
2 times
3 times

In a typical *week*, how many times do you floss?
0 times
1-2 times
3-4 times
5-7 times

PARENTING STATUS

Do you have a child at home who is between 2-17 years of age?
Yes
No

Please answer these questions for your *youngest* child age 2 – 17.

When was this child's last dental visit?

Within 6 months
Within the last year
1-2 years ago
2 years or more
Never

What were the main reasons this child didn't make a recent dentist visit? (Check only the main reasons)

Fear of needles/shots
Hard to schedule with my work/school
Bad past experience
Hard to schedule appointments with the dental office
Behavioral issues/inability to cooperate
Transportation problems
My child's teeth are fine/healthy
Language barrier
Didn't know where to go
Wait time while at the dental office
Concerned about going during COVID
Too expensive/couldn't afford it
Other (Please Specify)

Has this child ever had dental sealants on their teeth?

Yes
No
I don't know
This child is not yet 6 years old

How often has this child's *medical* doctor asked about their teeth during a well-child check-up?

At first visit and regularly
Once in a while
Hardly ever
I can't remember them ever doing this

Please tell us about yourself (the person completing this survey):

What is your age group?

15-20 years
21 – 34 years
35-64 years
65+ years

Have you lost six or more of your teeth due to tooth decay or gum disease?

Yes
No

Have you lost ALL of your natural teeth due to tooth decay or gum disease?

Yes
No

What ethnic group do you identify with?

White
Latino/Hispanic
Black/African American
Other
Asian/Pacific Islander
American Indian
Multi-race

Attachment 6

Alta California Regional Center Service Coordinators Oral Health Survey*

Thank you for agreeing to help us identify dental access issues for the populations you serve. We are updating the 2018 Oral Health study for Sacramento County Public Health and want to again include information about persons with developmental disabilities and other special needs, and the role of ACRC. We are especially concerned about adult clients as they are often an underserved population for oral health. Your input is important to us. Please respond <u>by July 12, 2022.</u> Thank you.

1. During 2022, how many adults and children who live in Sacramento are you typically assigned to (the number in your caseload)? adults______ children_____
2. How often, currently, are the following situations the case for the families you serve?

The families…….	Often	Somewhat Often	Not often
generally find a dentist on their own without our help			
often end up asking for our help after trying and not being very successful on their own			
usually ask us for help before trying on their own			

3. In a *typical* month during 2022, about how many individuals (whether in your own caseload or otherwise) living in Sacramento were you asked to help with the following :

   ADULTS
   ____ referral to find a dentist - for regular dental care
   ____ referral to find a dentist – to provide dental care needed under IV sedation/general anesthesia

   CHILDREN
   ____ referral to find a dentist – for regular dental care
   ____ referral to find a dentist - to provide dental care needed under IV sedation/general anesthesia

4. In general, how aware would you say your families are about oral health, such as the relationship of oral health to one's general health, ways to prevent dental disease, the importance of taking a child for her/his first dental visit by first birthday?

   ___ Not very aware
   ___ Somewhat aware
   ___ Mostly aware
   ___ Very aware

5. What are the 1 or 2 *main* issues/needs you've encountered in trying to help families find/use dental care in Sacramento? What solutions have you used? (Please be specific; provide examples when you can.)

   FOR ADULT CLIENTS:

Issue:____
Solution(s)____

   FOR CHILD CLIENTS:

Issue:____
Solution(s)____

6. What ONE recommendation for improved dental services regarding <u>adults</u> would you want to see included in our final report? __________
   ____

*Note: this survey was formatted for use in SurveyMonkey.

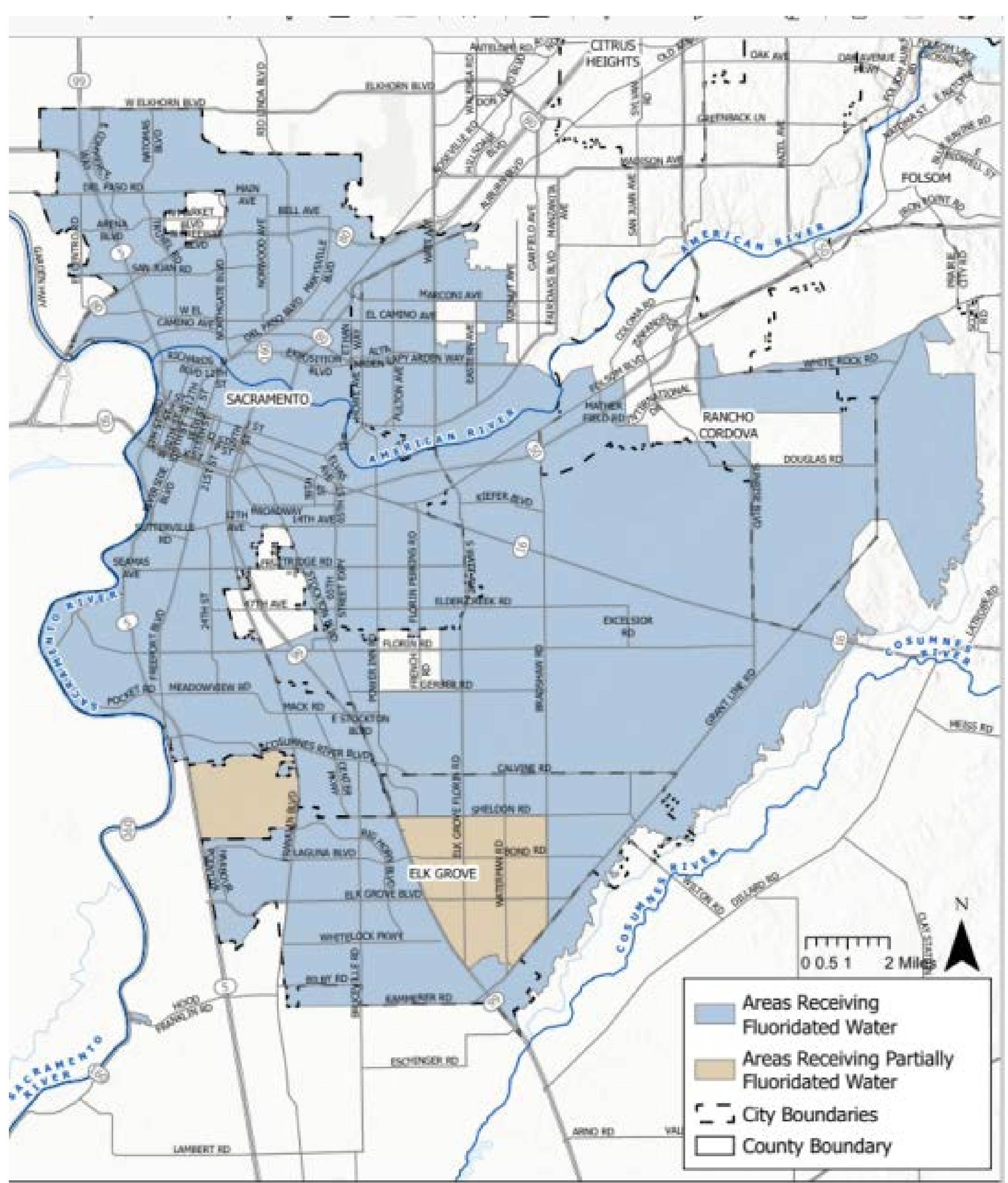
Focus Group Questions*

Main Question	Purpose
1. Thinking about preventive health measures people can take, how important would you say OH is, on a scale of 1 to 10?	Explore the relative importance to people of oral health; listen for information about oral hygiene practices
2. Do you know when children should have their first dentist visit?	Understanding importance of baby teeth; knowledge of First Tooth First Birthday
3. How many of you were able to have a dentist visit within the last year?	Recency of last dental visit (if any)
4. Did you experience any problems making an appointment or when you went to the dentist?	Determining the extent to which common (and uncommon) barriers exist and clarifying what these really mean; learning how they may have dealt with the problem.
5. What promotes you [most adults] to go to the dentist? What would it take to make a dental visit?	Explore general oral health attitudes and beliefs, motivators, and barriers; listen for any ideas offered to increase effective approaches
6. Did you know where to go for dental services?	Determine awareness of services
7. Why do you think people with insurance, say Medi-Cal, don't always go to the dentist when they have benefits? What are some of the reasons for no/delayed dental visit?	Listening for any specific oral health attitudes and beliefs, motivators, and barriers, particularly culture group-based; identifying any additional barriers
8. At your regular medical visits, does your doctor usually talk to you about your oral health?	Looking for awareness of oral health by primary care providers, ideas regarding better medical-dental integration
9. Where do you get your OH information from? Do you have a preferred way to learn about it?	Identifying sources of information, satisfaction with it, most preferred ways of getting this information, identifying any health literacy issues
10. If you could improve 1 thing for adults about oral health in this community, what would it be? Is there anything about dental care for adults you'd want to see changed?	Identifying needed improvements

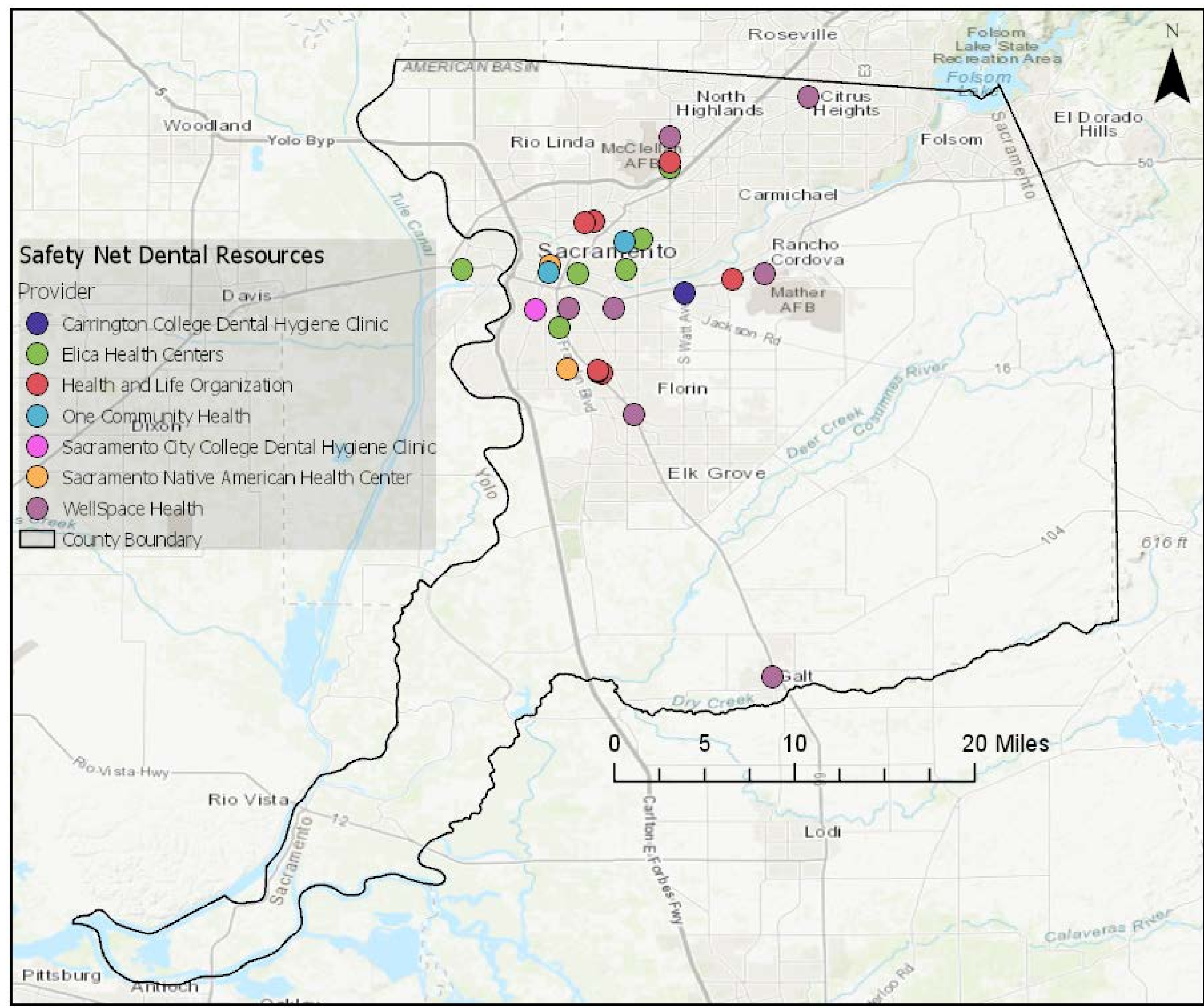
*Not all questions were asked of every group, and were not always asked in this order. Some questions were worded slightly differently depending upon the group. This list does not include the follow-on questions that were asked when time allowed.

Attachment 8

Water Fluoridation in Sacramento County, 2022



Sacramento County Dental Clinics for Low-Income Populations



Source: Dhaliwal R, Suchard C. Sacramento County Public Health. December 2, 2022.
As of August 2022

Attachment 10

SACRAMENTO DENTISTS LISTED ON DHCS DENTAL PROVIDE WEBSITE (JULY 2022) AS TAKING MEDI-CAL PATIENTS

Name	Address	Specialty	Accepting M-C pts now? Any restrictions?	Contract with a GMC Dental Plan? Or FFS only? Or both?	How many weeks for a non-emergency appt for new M-C patients?	Serve special needs? Y/N (If no, where referred?)
LISTED AS TAKING M-C						
A MIRACLE SMILE BY DR DEZHAM DENTAL GROUP	3009 K ST STE 255 SACRAMENTO , CA 95 816-5252	GENERAL PRACTITIONER	Yes	Both. "Won't deal with Western Dental; uncaring, difficult"	1 Week	Yes, if cooperative. If not, referred to specialist through dental plan . No specific specialists used. No sedation.
ABBAS DENTAL CORPORATION TRUXEL DENTAL GROUP ABBAS DENTAL GROUP	3880 TRUXEL RD STE 600 SACRAMENTO, CA 958 34-3615	GENERAL PRACTITIONER	Yes if <12	Both	1-2 Weeks	Yes, if cooperative. Can use network to find a specialist. Use conscious sedation if needed.
ACOSTA CUEVAS, JOSE, DDS INC	9340 W STOCKTON BLVD , STE 100 ELK GROVE , CA 95758-8014	GENERAL PRACTITIONER	Adults	Delta Dental FFS	1-4 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan. No sedation.
AHMED DDS PC IVY DENTAL	9700 BUSINESS PARK DR , STE 400A SACRAMENTO , CA 95 827-1718	GENERAL PRACTITIONER	Yes	Delta Dental FFS	2-3 Weeks	Both if cooperative. No sedation.
ALMUSAWI, MAHA, DDS INC SACRAMENTO KIDS DENTISTRY	2821 EASTERN AVE STE 2 SACRAMENTO , CA 95 821-5445	GENERAL PRACTITIONER	Yes if <21	Both	1 week	No restrictions. No sedation.
AZOUZ DENTAL PRACTICE OF SACRAMENTO INC	5414 SUNRISE BLVD STE D CITRUS HEIGHTS , CA 95610-7803	GENERAL PRACTITIONER	Yes	GMC Dental Plan	2-3 Weeks	Yes, both if cooperative. If not referred to specialist. No sedation.
BARAKAT, JOHN H, DDS	6940 FAIR OAKS BLVD , STE A CARMICHAEL , CA 956 08-3316	GENERAL PRACTITIONER	Yes	Delta Dental FFS	1 Week	Yes, both if cooperative. If not referred to specialist through insurance. No sedation.
BUI, MAI Q, DDS PACIFIC DENTAL	6880 65TH ST STE 8 SACRAMENTO , CA 95 828-1265	GENERAL PRACTITIONER	Yes	Both	2 Weeks	Yes, both if cooperative. If not referred to specialist. No sedation.
CHAE, CHRISTOPHER PYUNGBAE, DDS	9837 FOLSOM BLVD SACRAMENTO , CA 95 827-1356	GENERAL PRACTITIONER	Yes - Referrals only.	GMC Dental Plan	<1 Week	No.
CHANG, CHEE, DDS A PROFESSIONAL CORPORAT	4360 ARDEN WAY STE SACRAMENTO , CA 95 864-3153	GENERAL PRACTITIONER	Yes	GMC Dental Plan	2-3 Weeks	Not usually. Refer to insurance plan for referral. No sedation.
CHANG, CHEE, DDS A PROFESSIONAL CORPORAT	9198 GREENBACK LN , STE 210 ORANGEVALE , CA 956 62-5901	GENERAL PRACTITIONER	Yes	GMC Dental Plan	3 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan . No specific specialists used. No sedation.
CHOI, SAMUEL S, DDS	3046 WATT AVE SACRAMENTO , CA 95 821-3527	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	No.
CHUNDURI, RAJESH, DMD PC STAR PLUS DENTAL	1620 W EL CAMINO AVE , STE 170 SACRAMENTO , CA 95 833-3631	GENERAL PRACTITIONER	Yes	GMC Dental Plan	3-4 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan. No sedation.

Name	Address	Specialty	Accepting M-C pts now? Any restrictions?	Contract with a GMC Dental Plan? Or FFS only? Or both?	How many weeks for a non-emergency appt for new M-C patients?	Serve special needs? Y/N (If no, where referred?)
CORPUZ, LUZMINDA C, DMD INC	3711 TRUXEL RD STE 1 SACRAMENTO , CA 95 834-3610	GENERAL PRACTITIONER	Yes	Delta Dental FFS	1 Week	Yes, if cooperative. If not, referred to specialist through dental plan. No sedation.
DIAZ, FRIZ J, DDS INC	77 CADILLAC DR STE 165 SACRAMENTO , CA 95 825-5480	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-4 Weeks	Yes, after evaluation by Dr. to see if they are cooperative. If not, refer to dental plan. No sedation
DR JEFFREY A SALADIN DENTAL CORP CHILDREN'S CHOICE DENTAL CARE DENTAL	4150 TRUXEL RD STE B SACRAMENTO , CA 95 834-3761	GENERAL PRACTITIOINER ORTHODONTIST PEDIODONTIST	Yes	GMC Dental Plan	2-4 Weeks	Yes. No restrictions. Does conscious sedation. Nitrous.
DR JEFFREY A SALADIN DENTAL CORP CHILDREN'S CHOICE DENTAL CARE DENTAL	1580 HOWE AVE STE A SACRAMENTO , CA 95 825-3358	GENERAL PRACTITIOINER ORTHODONTIST PEDIODONTIST	Yes	GMC Dental Plan	2-4 Weeks	Yes. No restrictions. Does conscious sedation. Nitrous.
ELSEMARY & SALEM DENTAL CORPORATION ELK GROVE KIDS DENTIST AND ORTHODONTICS	9045 BRUCEVILLE RD , STE 110 ELK GROVE , CA 95758-5950	GENERAL PRACTITIOINER ORTHODONTIST	Yes	Delta Dental FFS	2-3 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan . No sedation.
EVRIGENIS, GREGORY W, DDS, MSD	1954 DEL PASO RD SACRAMENTO , CA 95 834-7707	CERTIFIED ORTHODONTIST	Yes	Delta Dental FFS	1-2 Weeks	Yes, will accommodate if cooperative. If not, referred to specialist through dental plan. No sedation.
EZE DENTAL PROFESSIONAL CORPORATION BUBBLES DENTAL A DENTAL GROUP OF EZE DEN	6030 S LAND PARK DR SACRAMENTO , CA 95 822-3315	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	Yes. No restrictions. Referred to specialist through dental plan. In process of moving toward sedation.
FERNANDEZ, VIVIAN, DDS INC FERNANDEZ DENTAL OFFICE FAMILY AND COSME	9320 ELK GROVE BLVD , STE 170 ELK GROVE , CA 95624-5061	GENERAL PRACTITIONER	Yes	GMC Dental Plan	2-3 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan. No sedation.
GADDIS, JORDAN, DDS A PROFESSIONAL DENTAL	2835 EASTERN AVE STE 3 SACRAMENTO , CA 95 821-5400	GENERAL PRACTITIONER	Yes	Delta Dental FFS	1 Week	Yes, if cooperative. If not, referred to specialist through dental plan . No sedation.
GONZALES, YOLANDA, DMD INC	2378 FRUITRIDGE RD SACRAMENTO , CA 95 822-3148	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-2 Weeks	Yes, after evaluation by Dr. to see if they are cooperative. If not, refer to dental plan. No sedation
HAFEZ & GHONEIM DENTAL CORP TOOTH BERRY KIDS DENTAL	4850 MARCONI AVE CARMICHAEL , CA 956 08-4111	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	Yes. No restrictions. Does conscious sedation. Nitrous and general.
HASSAN KHALIL DENTAL INC DELIGHT DENTAL GROUP DRS.FAY KHALIL	1625 CREEKSIDE DR , STE 100 FOLSOM , CA 95630-	GENERAL PRACTITIONER	Yes	Delta Dental FFS	<1 Week	Will take when they have the right equipment. Now refer to Dimples Dental.
HER, POGE, DDS U SMILE FAMILY DENTISTRY DENTAL OFFICE	7601 HOSPITAL DR STE 204 SACRAMENTO , CA 95 823-5408	GENERAL PRACTITIONER	Yes	Delta Dental FFS	2-3 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan . No sedation.
HO, BRENDA, DDS INC GREENHAVEN PEDIATRIC DENTISTRY	905 SECRET RIVER DR , STE E SACRAMENTO , CA 95 831-3437	PEDIODONTIST	Yes <13	GMC Dental Plan	3-4 Weeks for office visit. 3-4 months for surgery	Yes. No restrictions. Conscious sedation in office (Nitrous). General for surgery at surgicenters.

Name	Address	Specialty	Accepting M-C pts now? Any restrictions?	Contract with a GMC Dental Plan? Or FFS only? Or both?	How many weeks for a non-emergency appt for new M-C patients?	Serve special needs? Y/N (If no, where referred?)
HOYBJERG, CHRISTIAN, DDS A PROF DENT COR	9550 MICRON AVE STE A SACRAMENTO , CA 95 827-2621	CERTIFIED ORTHODONTIST	Yes	Delta Dental	2-3 Weeks	Yes, if cooperative. If not, referred to specialist either through dental plan or directly to Specialist. No sedation.
JANG, S, DDS INCORPORATED SMILE TIME DENTAL PRACTICE	2260 E BIDWELL ST , STE 110 FOLSOM , CA 95630-3555	GENERAL PRACTITIONER ORTHODONTIST PEDIODONTIST ORAL SURGEON	Yes	GMC Dental Plan	1-4 Weeks	Yes. No restrictions. Does conscious sedation. Nitrous.
JANG, S, DDS INCORPORATED SMILE TIME DENTAL PRACTICE	6406 SUNRISE BLVD STE B CITRUS HEIGHTS , CA 95610-5992	GENERAL PRACTITIONER ORTHODONTIST PEDIODONTIST ORAL SURGEON	Yes if >14	GMC Dental Plan	1-4 Weeks	Yes. No restrictions. Does conscious sedation. Nitrous.
JANG, S, DDS INCORPORATED SMILE TIME DENTAL PRACTICE	9184 E STOCKTON BLVD # B ELK GROVE , CA 95624-9510	GENERAL PRACTITIONER ORTHODONTIST PEDIODONTIST ORAL SURGEON	Yes if >14	GMC Dental Plan	1-4 Weeks	Yes. No restrictions. Does conscious sedation. Nitrous.
JANG, S, DDS INCORPORATED SMILE TIME DENTAL PRACTICE	3433 ARDEN WAY STE B SACRAMENTO , CA 95 825-2018	GENERAL PRACTITIONER ORTHODONTIST PEDIODONTIST ORAL SURGEON	Yes if >14	GMC Dental Plan	1-4 Weeks	Yes. No restrictions. Does conscious sedation. Nitrous.
JANG, S, DDS INCORPORATED SMILE TIME DENTAL PRACTICE	7227 29TH ST STE B SACRAMENTO , CA 95 822-5005	GENERAL PRACTITIONER ORTHODONTIST PEDIODONTIST ORAL SURGEON	Yes if >14	GMC Dental Plan	1-4 Weeks	Yes. No restrictions. Does conscious sedation. Nitrous.
JANG, WEONSUK, DMD INC SNOW WHITE DENTAL	6416 TUPELO DR CITRUS HEIGHTS , CA 95621-1741	GENERAL PRACTITIONER	Kids - 7+	Delta Dental FFS	1-3 Weeks	Yes, based on 1st visit. If cooperative, OK. If not, referred to Pediodontist or other specialist. No sedation.
JUAREZ, JOSE V, DDS INC	2340 SUNRISE BLVD STE 25 GOLD RIVER , CA 95670-4369	GENERAL PRACTITIONER	Yes if <18	Delta Dental FFS	3-4 Weeks	Yes, if cooperative. Use conscious sedation if needed. Nitrous.
KIM, LOUIS M, A PROFESSIONAL DENTAL CORPSTAR DENTAL PRACTICE	1824 AVONDALE AVE SACRAMENTO , CA 95 825-1378	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	Yes, if cooperative. If not, referred to specialist through dental plan. No sedation.
KIM, LOUIS, DDS INC ELDER CREEK DENTAL GROUP	3811 FLORIN RD , STE 8 SACRAMENTO , CA 95 823-1818	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-2 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan. No sedation.
KRAVCHUK, LYUDMILA, DENTAL CORPORATION	6240 SAN JUAN AVE STE F CITRUS HEIGHTS , CA 95610-5642	GENERAL PRACTITIONER	Yes	Delta Dental FFS	1-2 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan . No specific specialists used. No sedation.
KUE, JUDITH, DENTAL CORPORATION	7260 E SOUTHGATE DR , STE B SACRAMENTO , CA 95 823-2609	GENERAL PRACTITIONER	Yes if <21	GMC Dental Plan	4 Weeks	Yes, if cooperative. If not, referred to specialist through dental plan . No specific specialists used. No sedation.
LEE, ALBERT S, DDS INC	1355 FLORIN RD STE 15 SACRAMENTO , CA 95 822-4200	GENERAL PRACTITIONER	Yes	Delta Dental FFS	4 Months Only open 3 days	Yes, if cooperative. If not, referred to specialist through dental plan. No sedation.

Name	Address	Specialty	Accepting M-C pts now? Any restrictions?	Contract with a GMC Dental Plan? Or FFS only? Or both?	How many weeks for a non-emergency appt for new M-C patients?	Serve special needs? Y/N (If no, where referred?)
LUONG, ELIZABETH, DDS INC 4.0 DENTAL DENTAL OFFICE OF DR ELIZABETH	1747 CREEKSIDE DR , STE 100 FOLSOM , CA 95630-3928	GENERAL PRACTITIONER	Yes	Both	1 Week	Yes, if cooperative. If not, referred to specialist through dental plan . No sedation.
MAHDI, AMAR, DENTAL INC LAGUNA PREMIER DENTAL DENTAL OFFICE	9141 E STOCKTON BLVD , STE 230 ELK GROVE , CA 95624-9502	GENERAL PRACTITIONER	Yes	Delta Dental FFS	2-3 Weeks	Both if cooperative and can stay in the chair. No sedation.
MOMANI DDS INC SUAVE DENTAL DENTAL OFFICE OF AHMAD MOMA	2693 FLORIN RD SACRAMENTO , CA 95 822-4524	GENERAL PRACTITIONER	Yes	Both	1-2 Weeks	Yes, both if cooperative. If not referred to specialist. No sedation.
MUSSER, JAMES R, DDS INC	10425 FAIR OAKS BLVD , STE 101 FAIR OAKS , CA 95628-7559	PEDIODONTIST	Yes. <11	GMC Dental Plan	1 Week for office visit. 3-4 Months for surgery	Yes. No restrictions. General for surgery at surgi-centers.
NNEBE, IFEATU, DDS INC BSC DENTAL SMILES DENTAL PRACTICE	2700 E BIDWELL ST , STE 300 FOLSOM , CA 95630-6434	GENERAL PRACTITIONER	Yes	Delta Dental FFS	2-3 Weeks	Try to if they cooperate. If not. Refer to hospital dentist (UCD). No sedation
PANDYA, TORAL, PROFESSIONAL DENTAL CORPO	7471 WATT AVE STE 107A NORTH HIGHLANDS , CA 9566 0-2632	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	Yes, both if cooperative. If not referred to specialist through insurance. No sedation.
PARK DDS MPH INC GALT DENTAL GROUP	1067 C ST STE 125GALT , CA 95632-1759	GENERAL PRACTITIONER ORAL SURGEON	Yes	GMC Dental Plan	1-2 Weeks	Yes, if cooperative. If not, referred to specialist either through dental plan or directly to Dr Musser. No sedation.
PARK, DAVID, DENTAL CORP HIGHLAND DENTAL GROUP	3901 MADISON AVE STE 5NORTH HIGHLANDS , CA 9566 0-5079	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-2 Weeks	Yes, if cooperative. If not, referred to specialist either through dental plan or directly to Dr Musser. No sedation.
PARK, S, DDS INC GROVE DENTAL GROUP	9727 ELK GROVE FLORIN RD , STE 155 ELK GROVE , CA 95624-2291	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-2 Weeks	Yes, if cooperative. If not, referred to specialist either through dental plan or directly to Dr Musser. No sedation.
PARK, S, DDS INC SMILE DENTAL OF SOUTH SACRAMENTO	6163 MACK RD SACRAMENTO , CA 95 823-4654	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-2 Weeks	Yes, if cooperative. If not, referred to specialist either through dental plan or directly to Dr Musser. No sedation.
PARK, SANGHO, DDS INC PREMIER DENTAL GROUP	3517 MARCONI AVE , STE 104/105 SACRAMENTO , CA 95 821-5328	GENERAL PRACTITIONER ORAL SURGEON	Yes	GMC Dental Plan	1-2 Weeks	Yes, if cooperative. If not, referred to specialist either through dental plan or directly to Dr Musser. No sedation.
PHAN, VINH DINH, DDS	3337 EL CAMINO AVE SACRAMENTO , CA 95 821-6307	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-2 Weeks	Don't see. Provide conscious sedation.
PIVNIK, DMITRIY, DDS INC GOLD RIVER PEDIATRIC DENTISTRY DENTAL	11230 GOLD EXPRESS DR , STE 302 GOLD RIVER , CA 95670-4484	PEDIODONTIST	Yes. <17	Both	4-6 Weeks	Yes, will accommodate if cooperative. If not, referred to specialist through dental plan. IV.
RASKIN, PAUL DAVID, DDS NEUBITE DENTURE CENTER	2344 BUTANO DR STE C SACRAMENTO , CA 95 825-0617	GENERAL PRACTITIONER	Only patients with no teeth.	GMC Dental Plan	1 Week	Yes. No restrictions. No referrals. No place to send patients with no teeth. No sedation.

Name	Address	Specialty	Accepting M-C pts now? Any restrictions?	Contract with a GMC Dental Plan? Or FFS only? Or both?	How many weeks for a non-emergency appt for new M-C patients?	Serve special needs? Y/N (If no, where referred?)
RATTU, ROHINI, DDS INC	1665 CREEKSIDE DR , STE 103 FOLSOM , CA 95630-	PEDIODONTIST	Yes. <20	GMC Dental Plan	1-2 Weeks	Yes. No restrictions. Does conscious sedation. Nitrous.
SALAMA AND ABOELALA DDS INC STAR SMILES DENTAL GROUP	7897 WALERGA RD STE 119 ANTELOPE , CA 95843-5725	GENERAL PRACTITIONER	Yes	Delta Dental FFS	1 Week	Yes, both if cooperative. If not, given a list of specialists from which to choose. No sedation.
SANDERS, MATTHEW, DDS INC SUNRISE ORTHODONTICS	2483 SUNRISE BLVD GOLD RIVER , CA 95670-4344	CERTIFIED ORTHODONTIST	Yes	GMC Dental Plan	1-4 Weeks	Yes, will accommodate if cooperative. If not, referred to specialist through dental plan. No sedation.
SARCHISIAN, ADRIAN ARA, DDS INC SACRAMENTO DENTAL GROUP	6611 COYLE AVE CARMICHAEL , CA 956 08-6311	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	Yes, both if cooperative. If not referred to specialist. No sedation.
SATTOUT DENTAL CORPORATION LAGUNA PAVILION DENTAL	7440 LAGUNA BLVD STE 105 ELK GROVE , CA 95758-5072	GENERAL PRACTITIONER	Yes	Both	1 Week	Yes, after evaluation by Dr. to see if they are cooperative. If not, referred to hospital. No sedation
SERGIO PEREIRA & SIMONNE PEREIRA PATRICK PRIME DENTAL GROUP	2628 EL CAMINO AVE , STE C10 SACRAMENTO , CA 95 821-5925	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-2 Weeks	Yes, if cooperative. If not, patient must find specialist. No sedation.
SHAARI, SAID, DDS	77 CADILLAC DR STE 270 SACRAMENTO , CA 95 825-8338	GENERAL PRACTITIONER	Yes	GMC Dental Plan	2-3 Weeks	Yes. For exam only. Send to insurance plan for referral. No sedation.
SU, CHARLES Y, DDS	7275 E SOUTHGATE DR , STE 205 SACRAMENTO , CA 95 823-2629	GENERAL PRACTITIONER	Adults	Delta Dental FFS	3-4 Weeks	Yes, but try not to. Assist patients to go to Western Dental. No sedation.
TAN, MARILOU C, DDS PROF DENTAL CORP PIONEER FAMILY DENTAL PRACTICE	7850 STOCKTON BLVD , STE 160 SACRAMENTO , CA 95 823-438	GENERAL PRACTITIONER	Yes	GMC Dental Plan	2-3 Weeks	Yes, but try not to. Assist patients to go to Western Dental. No sedation.
TRAN, CHARLES C, DDS	6175 STOCKTON BLVD , STE 260 SACRAMENTO , CA 95 824-4521	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1-2 Weeks	Yes. For exam only. Send to insurance plan for referral. No sedation.
TRAN, CHARLES C, DDS	6930 65TH ST STE 107BSACRAMENTO , C A 95823-2341	GENERAL PRACTITIONER	Temporarily closed due to lack of staff	GMC Dental Plan		
WORKNEH, SIRAK, DDS INC UNIQUE DENTAL CARE	430 PINE ST GALT , CA 95632-2045	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	Yes, if cooperative. If not, referred to specialist through dental plan . No sedation.
YANG, GERYOUNG, DDS INC	1355 FLORIN RD STE 8 SACRAMENTO , CA 95 822-4200	GENERAL PRACTITIONER	Yes if <21	Both	1-2 Weeks	Yes if cooperative. If not referred to Pediodontist. No sedation.
YASMEEN, FARAH, DDS INC US DENTAL CARE DENTAL OFFICE OF FARAH YA	1901 WATT AVE STE 6 SACRAMENTO , CA 95 825-2152	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	
YURCHAK, VALERIYA, DMD INC	2828 MILLS PARK DR STE C RANCHO CORDOVA , CA 95670	GENERAL PRACTITIONER	Yes	GMC Dental Plan	1 Week	Yes, after evaluation by Dr. to see if they are cooperative. If not, refer to dental plan. No sedation

Name	Address	Specialty	Accepting M-C pts now? Any restrictions?	Contract with a GMC Dental Plan? Or FFS only? Or both?	How many weeks for a non-emergency appt for new M-C patients?	Serve special needs? Y/N (If no, where referred?)
LISTED AS TAKING M-C BUT NOT TAKING M-C						
LAI, MARK W, DDS	7171 BOWLING DR STE 1110 SACRAMENTO , CA 95 823-2040	GENERAL PRACTITIONER	No. Existing Patients Only	Delta Dental FFS	3 Weeks	Yes, both if cooperative. If not referred to specialist. No sedation.
CARRANZA DENTAL CORPORATION	6023 FLORIN RD STE 100 SACRAMENTO , CA 95 823-2495	GENERAL PRACTITIONER	No. Booked up with non-M/C patients			
ENAYA, AMR M, DDS INC GALT HEALTHY SMILE	216 N LINCOLN WAY STE 40 GALT , CA 95632-1715	GENERAL PRACTITIONER	No. "M-C not worth the trouble"			
HUANG, STANLEY, DDS	4617 FREEPORT BLVD STE E SACRAMENTO , CA 95 822-2015	GENERAL PRACTITIONER	No, only Existing Patients >65. Practice full with non M-C	Delta Dental FFS	1 Week	Yes, if cooperative. If not referred to specialist. No sedation.
MAHAL DENTAL CORP INC AUBURN OAKS FAMILY DENTISTRY	8421 AUBURN BLVD STE 100 CITRUS HEIGHTS , CA 95610-0398	GENERAL PRACTITIONER	No as of 1/2022. "M-C payment too slow, too much trouble."			
HILDER, RONALD R, DDS	425 PINE ST STE 3 GALT , CA 95632-2055	GENERAL PRACTITIONER	Never. "Didn't need to, we have enough pts."			
DR ANOSH DDS INC PROCARE DENTAL PRACTICE	11050 COLOMA RD STE 17 RANCHO CORDOVA , CA 95670-2870	GENERAL PRACTITIONER	No. Only existing pts or pts who transfer back to office	Delta Dental FFS	3-4 Weeks	Yes, both if cooperative. If not referred to specialist. No sedation.
STUART, CYNTHIA A, DDS	2 SCRIPPS DR STE 101 SACRAMENTO , CA 95 825-6207	GENERAL PRACTITIONER	No. Existing pts only. "Will not send patients to Western; they treat pts horribly, like cattle. M-C too much trouble, low reimbursement." Refers patients to Dr. Musser.	Delta Dental FFS	1 Week	Yes. No restrictions. Takes referrals. Does conscious sedation. Nitrous.
TRIEU, MY HANH H, DDS A PROF DENTAL CORP PERFECT SMILE DENTAL PRACTICE	8735 CENTER PKWY STE 150 SACRAMENTO , CA 95 823-7924	GENERAL PRACTITIONER	No as of 1/2022			
BAL DENTAL INC	5959 GREENBACK LN , STE 110 CITRUS HEIGHTS , CA 95621-4700	GENERAL PRACTITIONER	No. Stopped years ago. "M-C payment too slow"			

Name	Address	Specialty	Accepting M-C pts now? Any restrictions?	Contract with a GMC Dental Plan? Or FFS only? Or both?	How many weeks for a non-emergency appt for new M-C patients?	Serve special needs? Y/N (If no, where referred?)
LEE, GARRETT A, DDS INC DR. GARRETT PEDIATRIC DENTISTRY DENTAL P	8241 BRUCEVILLE RD , STE 180 SACRAMENTO , CA 95 823-2365	PEDIODONTIST	No. Existing pts only. "Too much work for the reward"	GMC Dental Plan	2-3 Weeks for office visit. 2 months for office procedure. 6 months for surgery	Yes. No restrictions. Conscious sedation in office (Nitrous). General for surgery at surgi-centers.
BRIAN C CRAWFORD AND PAOLO A POIDMORE PRECISION ORTHODONTICS	4408 ELVERTA RD STE 200 ANTELOPE , CA 95843-6723	CERTIFIED ORTHODONTIST	No as of 1/2022			
UNREACHABLE/NO RESPONSE						
WORK, JANICE R, DDS A PROF DENT CORP DENTISTRY FOR CHILDREN	9045 BRUCEVILLE RD , STE 180 ELK GROVE , CA 95758-5951	PEDIODONTIST	called 6 times and left messages; no response			
DONG, BRIAN W, DDS	5665 FREEPORT BLVD STE 3 SACRAMENTO , CA 95 822-3517	GENERAL PRACTITIONER	Called 4 times and left messages; no response			

Sources: DHCS Medi-Cal Dental Services Program, accessed on June 16, 2022 at https://dental.dhcs.ca.gov/Members/Medi-Cal_Dental/Find_A_Dentist/ and telephone interviews with DDS provider offices June 25, 2022 – July 28, 2022.

Glossary of Commonly-Used Terms and Acronyms in the Report

(in alphabetical order)

ACRC	Alta California Regional Center
ADV	Annual Dental Visit (the percentage of members who had at least 1 dental visit during the measurement period)
CDT	Current Dental Terminology (a nomenclature code for OH services)
DD	Developmentally disabled
DHCS	Department of Health Care Services
DMC/GMC	(Medi-Cal) Dental Managed Care/Geographic Managed Care
DTI	Dental Transformation Initiative within Medi-Cal
ED	Emergency department (same as emergency room)
Encounter	An office/clinic visit for a medical or dental service
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center (used interchangeably with "community clinic")
GA	General anesthesia
KOHA	Kindergarten Oral Health Assessment
MCDAC	Medi-Cal Dental Advisory Committee
Medi-Cal Member	An individual enrolled in DMC/GMC or receiving Medi-Cal services via FFS
OH	Oral Health
RDA	Registered Dental Assistant
RDH	Registered Dental Hygienist
RDHAP	Registered Dental Hygienist in Alternative Practice
SCOHR	The system for California Oral Health Reporting that school districts are required to submit
SCOHP	Sacramento County Oral Health Program
Utilization Rate	The percentage of individuals eligible to receive a service who actually used it

School Consent Form for Dental Screening and Fluoride Varnish

(Used in Sacramento County)

EARLY SMILES
A Center for Oral Health Program

If you want your child to receive this dental service, please complete this form.

RETURN THIS FORM TO YOUR CHILD'S SCHOOL WITH YOUR SIGNATURE

Center for Oral Health

CONSENT FOR DENTAL SCREENING AND FLUORIDE VARNISH APPLICATION

Dear Parent / Guardian,
Your child's school has partnered with Early Smiles to provide dental screenings to your child at no charge to you. The service will be performed by a licensed dental hygienist. The hygienist will screen your child's teeth and provide a fluoride varnish treatment to help prevent tooth decay. You will receive your child's screening results. Your child will also receive a free toothbrush kit. This program does not replace or interfere with any dental care that your child currently receives. If you have questions about the program, please call (916) 245-1674 or email Esacramento@tc4oh.org.

* Child's Name: ________________________________ * Date of Birth: ____/____/____
First Name Last Name Month Date Year

* Phone Number: ____________________ ☐ •Cell Phone Number

* Health Insurance:

☐ Medi-Cal → Insurance ID Number: [   ]
Used to help find your child a dentist if they do not have one

State of California Benefits Identification Card

☐ Private (HMO / PPO) ☐ No Insurance ☐ Don't Know

PLEASE SELECT ONE:

☐ YES: I want my child to receive
* A Dental Screening AND
* Fluoride Varnish Application

OR

☐ YES: I want my child to receive
* A Dental Screening ONLY

I understand that Early Smiles may use my child's health information for treatment, payment / reimbursement and health care operations, and for evaluation of the program. I authorize Early Smiles to share information regarding my child's screening and results with the Center for Oral Health, First 5 Sacramento, an official designated by my child's school, my insurance plan, my dentist or a referring dentist for coordination of dental care for my child, or associated / approved program staff. I give Early Smiles and / or its health and dental plan partners consent to contact me via phone call or text message regarding my child's dental needs and to coordinate dental care. Message and data rates may apply. I understand that these services do not substitute an examination by a dentist. I understand that my child may continue to receive dental care from any other provider of my choice.

Occasionally, the school district and / or Early Smiles will take photos and videos during the program for use in educational material or reports. The photos will be the property of the Early Smiles and no compensation will be paid for the use of these photos. If you DO NOT want your child to be photographed or video-graphed please check here ________.

SIGN HERE SIGNATURE (PARENT/GUARDIAN) DATE RELATIONSHIP TO CHILD

Funded by: Access Dental Health Net Liberty Dental Plan

FOR PROGRAM USE ONLY

KG Assessment: ☐

D1120 [X]	D1310 [X]	D0999 [X]	Untreated ☐	Untreated	Urgency	Health Plan
D0190 [X]	D1330 [X]	D0191 [X]	ECC ☐		1 ☐	Access ☐
			Treated ☐		2 ☐	HN ☐
			Sealants ☐		3 ☐	LDR ☐
			KOHA ☐			

Comments:

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