Welcome and Introductions

1:00 PM  Moderator: Gil Ojeda, Director, California Program on Access to Care (CPAC),
UC Berkeley School of Public Health
Wynne Grossman, Executive Director, Dental Health Foundation

1:10 PM  Lead Presenter: Francisco Ramos-Gomez DDS, Professor, UCLA School of Dentistry
Oral Health Disparities among Latino Children: Implications for a State and National Agenda

1:30 PM  Ariane Terlet DDS, Dental Director, La Clinica de la Raza, Oakland
Future Trends in the Oral Health Workforce

1:45 PM  Paul Reggiardo DDS, Head Start, Region IX, Oral Health Consultant; Public Policy Advocate, California Society of
Pediatric Dentistry
Prevention Efforts and Program Innovations

2:00 PM  Jane Garcia, Chief Executive Officer, La Clinica de la Raza, Oakland
Access to Oral Health Care: the Role of Community Clinics and Health Centers

2:15 PM  Gil Ojeda, Director, CPAC
State and Federal Policy Trends: Their Influence on Oral Health

2:30 PM  Reactors:
Wynne Grossman, Executive Director, Dental Health Foundation
Kelly Hardy, Director of Health Policy, Children Now
Roger Dunstan, Principal Consultant, Senate Health Committee

2:45PM  Questions and Answers
Oral Health Disparities among Latino Children: Implications for a State and National Agenda

Francisco Ramos-Gomez, DDS, MS, MPH
Professor UCLA Section Pediatric Dentistry
Center to Address Children’s Oral Health Disparities
Hispanic Dental Association
CPAC-UC California Program on Access to Care
frg@dentistry.ucla.edu

CPAC Sacramento MAY 2010
Health Status of Latino Children and the Immigrant Paradox

- Low Birth Weight
- Infant Mortality
- Growth – Obesity and Stunting
- Asthma
- **Dental Health**
- Perceived Health Status
ASSOCIATIONS OF ORAL INFECTIONS AND MANY DISEASES

- CV Diseases
- Diabetes
- HIV
- Trauma
- Preterm
- LBW babies
- Nutritional problems
- Cancer
- ECC

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ECC in a Hispanic three year old
Tooth decay is the single most common chronic childhood disease...

Five times more common than asthma
Seven times more common than hay fever
The effects of ECC

- Pain
- Infection
- Self-esteem
- Growth

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ORAL HEALTH AND LEARNING

51 million school hours lost annually

12 X lost days for children from low-income families
Latino Demographics in CA

• One out of 3 Californians is Latino

• 44% of US Mexican immigrants live and work in California

• San Diego has the largest binational population in the entire country
Percent of Population 2006
Hispanic or Latino

Map showing the percentage of the population that is Hispanic or Latino by county in the United States for the year 2006. The map uses a color scale to indicate the percentage, with darker shades representing higher percentages. The source is the U.S. Census Bureau, Population Estimates, July 1, 2006.
Background and Significance

• Latino children have higher rates of untreated dental disease than any other children in the country.

• Poor oral health has been associated with multiple medical problems.

• Oral health problems can also lead to pain, poor nutrition and development, impaired speech, loss of employment, time away from school, and low self-esteem.
Press Release

For Immediate Release:
April 30, 2007

Contact:
National Center for Health Statistics
Office of Communication, (301) 458-4800

Oral Health Improving for Most Americans, But Tooth Decay Among Preschool Children on the Rise

Americans of all ages continue to experience improvements in their oral health. However, tooth decay in primary (baby) teeth increased among children aged 2 to 5 years, according to a report released today by the Centers for Disease Control and Prevention (CDC).

Based on data from CDC's National Center for Health Statistics, the report, "Trends in Oral Health Status—United States, 1988-1994 and 1999-2004," represents the most comprehensive assessment of oral health data available for the U.S. population to date.

Tooth decay in primary (baby) teeth of children aged 2 to 5 years increased from 24 percent to 28 percent between 1988-1994 and 1999-2004.
Severe ECC

Chronic Infectious Disease that is transmissible but PREVENTABLE

First Smiles
Dental Health Begins at Birth
Key Statistics (Dental)

• Latino children are at the highest risk of not having seen a dentist
• More than 50% of Latino children showed a “suboptimal” condition
  – 72% had dental caries
  – 26% had rampant dental caries
  (this figure is nearly twice the rate for non-Hispanic whites)

* 2006 California Smile Survey
Poor children and children of color are more likely to have tooth decay and suffer the consequences of untreated disease.
Findings

The following factors contributed to the unmet dental needs of the Latino population:

1. Lack of dental insurance
2. Lack of education about dental care
3. Lack of diversity and cultural competency among dental providers
4. Lack of access to dental care, including transportation and work leave time
Prevalence of Dental Decay

Dental decay is the most common chronic disease of childhood.

1 Year Olds: 8% decay, 92% no decay
2 Year Olds: 22% decay, 78% no decay
3 Year Olds: 35% decay, 65% no decay
4 Year Olds: 33% decay, 67% no decay
Can ECC be Prevented?

Yes!

- Interventions with pregnant women and mothers of infants
- Interventions with babies and young children
MAYA PROGRAM COLLABORATION UCSF-UCLA WITH SYHC
CANDO
Perinatal & Infant Oral Care

PROMOTING INFANT ORAL CARE VISIT
TWO IS TOO LATE !!!
Policy Implications and Recommendations

CALIFORNIA STATE DENTAL INFRASTRUCTURE AND OFFICE CAN SET UP AN ORAL HEALTH LEGISLATIVE TASK FORCE TO COORDINATE A COMPREHENSIVE PLAN TO ADDRESS ORAL HEALTH PRIORITIES IN THE STATE OF CALIFORNIA
National Legislative
Oral Health Task Force

Dental health areas in need for the State:

* Implementing advocacy and policy programs to improve the dental health of Latinos focusing on pregnant women and their infants – AGE ONE VISIT

* Providing culturally sensitive dental education to Latino patients and providers

* Exploring new dental services, research and new access models for Latino Families

* Expanding the dental health workforce to include more Latinos as providers.
The costs and consequences associated with unmet dental needs among our Latino Children are too great to ignore!

CARIRES FREE GENERATION
2000, 2010, 2020 ??

©UCLA – Ramos-Gomez 2010
Thank You!
Demographic Change Summary for Latino Children

• 1 in 4 US children will be Latino, and 1 of every 2 new additions to the US populations is Latino.

• 60% or more of Latino children live in an immigrant family; one or both parents are foreign born
  – Risk
    • Poverty
    • Commonly with less than a high school education
    • Frequently not fluent in English
  – Strengths
    • 70% have two parent families
    • Multi-generational families.

• Pediatric Practices, general and subspecialties, will see increasing numbers of Latino children and adolescents and most will live in an Immigrant family
Future Trends In Oral Health Workforce

Ariane Terlet, DDS
Dental Director
La Clinica de La Raza
May 18, 2010
Current Models

• Private Practice: Solo Practice  
  Dentist, Hygienist, Dental Assistants

• Community Health Center: Group Practice
Challenges in Treating Children

- Children are **not** small adults
- Dental education programs primarily focus on adults
- Providers are not comfortable with treating under 5 year olds
Workforce Challenges

- Improving efficiencies in delivery of care
- Changes in scope of practices
- Defining billable providers
- Flexibility in providing care in nontraditional settings
- Affordable educational programs
Necessity is the mother of invention

• There were not enough dental providers willing to work at CHCs. No longer the case in this current economy.
• Dental Assistant scope of practice changed to allow dentists to be able to provide more care to patients.
• RDHAP (Registered Dental Hygienist in Alternative Practice)
Many groups recognized the needs of providing care to our patients

- National Pipeline Project
- The California Endowment
- First Five Oral Health California
- POHAP (Pediatric Oral Health Access Program)
Providing Care Outside the Box

- School based health centers
- Virtual Dental Home
- Residency Programs within health centers
- WIC Programs
Workforce Educational Programs Changing

• Changing dental education curriculums
• Spanish-Speaking Unity Council Dental Assisting Program
• Welcome Back Program
Identifying the Issues

• Every child taken to the OR for dental treatment went to every well-baby check.
• Dental caries are a transmissible and preventable disease.
• Dental education needs to include pre-natal and peri-natal care. Many dental schools discourage the treatment of pregnant women.
• Children need to be seen at age 1.
Conclusion

• Dental is an expensive service to provide. We need to be efficient in our delivery systems and teams
• Prevention does work and is cost effective
• Coordination of services statewide would benefit all
Future

- Many ideas
- No coordinated plan
- Legislative and economic challenges
Latino Children’s Oral Health: The Neglected Epidemic
Prevention Efforts and Program Innovations

Paul Reggiardo, DDS
Head Start Regional Oral Health Consultant

May 18, 2010
Head Start 101
History of Head Start

- **Head Start**
  Established in 1965 as an 8-week summer program to get children ready for kindergarten

  Federally funded pre-school for low income children 3 – 5 years of age

- **Early Head Start**
  Established 1995 for children 0 – 3 years of age.

  ~10% of HS children are in EHS.
Head Start / Early Head Start

Provides grants to local public and private non-profit and for-profit agencies to provide comprehensive child development services to economically disadvantaged children and families

Promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families
## 2008-2009 Program Statistics/U.S.

<table>
<thead>
<tr>
<th>ENROLLMENT</th>
<th>1,055,674</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages:</td>
<td></td>
</tr>
<tr>
<td>Number of 5 year olds &amp; older</td>
<td>3 %</td>
</tr>
<tr>
<td>Number of 4 year olds</td>
<td>51 %</td>
</tr>
<tr>
<td>Number of 3 year olds</td>
<td>36 %</td>
</tr>
<tr>
<td>Number under 3 years of age</td>
<td>10 %</td>
</tr>
<tr>
<td>Number of Pregnant Women</td>
<td>1 %</td>
</tr>
</tbody>
</table>
2008-2009 Program Statistics/U.S.

<table>
<thead>
<tr>
<th>Racial/Ethnic Composition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>40 %</td>
</tr>
<tr>
<td>Hispanic / Latino</td>
<td>34 %</td>
</tr>
<tr>
<td>Black/African American</td>
<td>30 %</td>
</tr>
<tr>
<td>Bi-Racial/Multi-Racial</td>
<td>8  %</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>4  %</td>
</tr>
<tr>
<td>Asian</td>
<td>2  %</td>
</tr>
<tr>
<td>Hawaiian/Pacific Islander</td>
<td>1  %</td>
</tr>
<tr>
<td>Unspecified/Other</td>
<td>17 %</td>
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</table>
### 2008-09 Program Statistics

<table>
<thead>
<tr>
<th>Category</th>
<th>Data</th>
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</thead>
<tbody>
<tr>
<td># of Grantees (2007)</td>
<td>1,604</td>
</tr>
<tr>
<td># of Centers</td>
<td>18,875</td>
</tr>
<tr>
<td># of Classrooms</td>
<td>51,933</td>
</tr>
<tr>
<td>Avg. Cost/Child</td>
<td>$7,727</td>
</tr>
<tr>
<td>Paid Staff</td>
<td>211,962</td>
</tr>
<tr>
<td>Volunteers</td>
<td>175,579</td>
</tr>
</tbody>
</table>
2008-2009 Program Statistics

- 93% of Head Start children had health insurance.

- 89% of those with health insurance were enrolled in Medicaid EPSDT or S-CHIP programs.
Eligibility

Head Start is a child development program for preschoolers from low income families

- Birth to 3 (EHS)
- Ages 3-5
- Meet family income guidelines
- Slightly higher income if space available
- Children in foster care regardless of income
- Children who are homeless
- Families receiving public assistance (TANF or SSI) regardless of income
- 10% of enrolled children must be reserved for children with disabilities
## 2009 HHS Poverty Guidelines

<table>
<thead>
<tr>
<th># in Family</th>
<th>48 Contiguous States and DC</th>
<th>Alaska</th>
<th>Hawaii</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$10,830</td>
<td>$13,530</td>
<td>$12,460</td>
</tr>
<tr>
<td>2</td>
<td>$14,570</td>
<td>$18,210</td>
<td>$16,760</td>
</tr>
<tr>
<td>3</td>
<td>$18,310</td>
<td>$22,890</td>
<td>$21,060</td>
</tr>
<tr>
<td>4</td>
<td>$22,050</td>
<td>$27,570</td>
<td>$25,360</td>
</tr>
<tr>
<td>7</td>
<td>$33,270</td>
<td>$41,610</td>
<td>$38,260</td>
</tr>
<tr>
<td>8</td>
<td>$37,010</td>
<td>$46,290</td>
<td>$42,560</td>
</tr>
</tbody>
</table>

**Source:** *Federal Register, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201*
Head Start Act

- The Head Start Act outlines the intent of the Congress for the program, the types of services provided, the population served, reporting and evaluation requirements, and administrative requirements.

Head Start Program Performance Standards

- The code of Federal regulations—45 CFR PART 1304—contains the program performance standards for the operation of Head Start programs by grantee and delegate agencies.

- The program performance standards are the mandatory regulations that grantees and delegate agencies must implement in order to operate a Early Head Start and/or Head Start program.
Head Start Program Performance Standards

Provide Head Start grantee regulations for...

- early childhood education
- health and safety
- nutrition
- transition
- social and emotional development
- disabilities
- parent involvement
- family partnerships
- community partnerships
- administrative and financial management, and facilities
Within 90 days of enrollment, each child must receive an examination by a licensed dentist.

All oral health needs identified on initial or subsequent examinations must be resolved by comprehensive, timely, appropriate treatment.

All diagnostic, preventive and treatment services must subsequently be provided according to the state EPSDT schedule.

If a child does not have a Dental Home (ACCESS), grantees must assist families in accessing a source of continuous, comprehensive care.
<table>
<thead>
<tr>
<th>2007-08 PIR Data</th>
<th>CA</th>
<th>Reg. IX</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>C16 Dental Home</td>
<td>93%</td>
<td>93%</td>
<td>97%</td>
</tr>
<tr>
<td>C17 Completed Professional Examination</td>
<td>91%</td>
<td>91%</td>
<td>89%</td>
</tr>
<tr>
<td>C17a Received Preventive Care</td>
<td>94%</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>C17b Needs Treatment</td>
<td>31%</td>
<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>C17c Received/Receiving Treatment</td>
<td>91%</td>
<td>91%</td>
<td>84%</td>
</tr>
</tbody>
</table>
## Denti-Cal Service Use
### By Age Group (2007)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Beneficiaries</th>
<th>Percent of Age Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than 1</td>
<td>412</td>
<td>0.1%</td>
</tr>
<tr>
<td>1</td>
<td>11,784</td>
<td>4.0%</td>
</tr>
<tr>
<td>2</td>
<td>35,347</td>
<td>13.7%</td>
</tr>
<tr>
<td>3</td>
<td>61,765</td>
<td>26.3%</td>
</tr>
<tr>
<td>4</td>
<td>80,361</td>
<td>36.3%</td>
</tr>
<tr>
<td>5</td>
<td>94,104</td>
<td>44.4%</td>
</tr>
<tr>
<td>6 to 12</td>
<td>490,814</td>
<td>38.0%</td>
</tr>
<tr>
<td>13 to 20</td>
<td>353,435</td>
<td>26.6%</td>
</tr>
<tr>
<td>21 to 64</td>
<td>602,349</td>
<td>20.7%</td>
</tr>
<tr>
<td>65 and older</td>
<td>249,966</td>
<td>25.4%</td>
</tr>
<tr>
<td><strong>Total (all ages)</strong></td>
<td><strong>1,980,337</strong></td>
<td><strong>24.7%</strong></td>
</tr>
</tbody>
</table>
Among ethnic groups, the percentage of Medi-Cal beneficiaries who used dental services in 2007 ranged from 23% to 31%, with Latinos showing the lowest utilization rate.
<table>
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<td>32%</td>
<td>24%</td>
</tr>
<tr>
<td>C17c Received/Receiving Treatment</td>
<td>91%</td>
<td>91%</td>
<td>84%</td>
</tr>
</tbody>
</table>
California Head Start Enrollment, 2009

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Cumulative Enrollment</th>
<th>Latino Enrollment</th>
<th>% Latino Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 9</td>
<td>116,454</td>
<td>82,097</td>
<td>70.50%</td>
</tr>
<tr>
<td>Region 11 - AIAN</td>
<td>688</td>
<td>98</td>
<td>14.24%</td>
</tr>
<tr>
<td>Region 12 - MSHS</td>
<td>6,167</td>
<td>6,154</td>
<td>99.79%</td>
</tr>
<tr>
<td></td>
<td><strong>123,309</strong></td>
<td><strong>88,349</strong></td>
<td><strong>71.65%</strong></td>
</tr>
<tr>
<td>Region</td>
<td>Number of Programs</td>
<td>Programs with &gt; 50% Latino Enrollment</td>
<td>% Predominant Latino Enrollment</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>Region 9</td>
<td>186</td>
<td>148</td>
<td>79.57%</td>
</tr>
<tr>
<td>Region 11 - AIAN</td>
<td>13</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Region 12 - MSHS</td>
<td>11</td>
<td>11</td>
<td>100.00%</td>
</tr>
<tr>
<td></td>
<td>210</td>
<td>159</td>
<td>75.71%</td>
</tr>
</tbody>
</table>
California Head Start Staff, 2009

<table>
<thead>
<tr>
<th>Region</th>
<th>Non-Supervisory child development staff</th>
<th>Hispanic Non-Supervisory child development staff</th>
<th>% Hispanic Non-Supervisory child development staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 9</td>
<td>11,737</td>
<td>6,644</td>
<td>56.61%</td>
</tr>
<tr>
<td>Region 11 - AIAN</td>
<td>80</td>
<td>8</td>
<td>10.00%</td>
</tr>
<tr>
<td>Region 12 - MSHS</td>
<td>1,217</td>
<td>1,101</td>
<td>90.47%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13,034</strong></td>
<td><strong>7,753</strong></td>
<td><strong>59.48%</strong></td>
</tr>
</tbody>
</table>
California Head Start Staff, 2009

<table>
<thead>
<tr>
<th>Region</th>
<th>Non-Supervisory child development staff</th>
<th>Non-Supervisory child development staff proficient in a language other than English</th>
<th>% Non-Supervisory child development staff proficient in a language other than English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 9</td>
<td>11,737</td>
<td>6,235</td>
<td>53.12%</td>
</tr>
<tr>
<td>Region 11 - AIAN</td>
<td>80</td>
<td>20</td>
<td>25.00%</td>
</tr>
<tr>
<td>Region 12 - MSHS</td>
<td>1,217</td>
<td>1,144</td>
<td>94.00%</td>
</tr>
<tr>
<td></td>
<td><strong>13,034</strong></td>
<td><strong>7,399</strong></td>
<td><strong>56.77%</strong></td>
</tr>
</tbody>
</table>
AAPD / OHS
Dental Home Initiative
Access to Oral Health and the Role of Community Clinics and Health Centers

Jane Garcia
CEO, La Clinica de la Raza
Member, CPCA Board of Directors
May 18, 2010
Presentation Overview

1. Background on CCHCs and Dental
2. Challenges in Serving Children
   - State Budget Cuts
   - Workforce
   - Four Walls
3. Opportunities on the Horizon for CCHCs
   - Health care reform
   - ARRA
La Clínica- Who we are?

- Service locations: 6 locations spanning 3 Counties
- Patients: 22,573 patients seen in 2009
- Visits: 68,661 visits in 2009
- Chairs: 47
- Services offered: Dental Exams, Fluoride and Sealant Treatment, Cleaning and Polishing, Dental Hygiene, General Dentistry, Periodontics, Orthodontics, Pedodontics, Endodontics
- 18,833* of total patients seen under 100% of the FPL
- FY 2009- $12.9 Million Operating Budget
Community Clinics and Health Centers: The Safety Net for California

- 825 clinics in CA
- Private and nonprofit
- Serve all who come through their doors
- Primary care = medical, dental and mental health
Community Clinics and Health Centers: The Safety Net for California

- CCHCs serve 4,267,063 patients
- 2,763,337 under 100% of the FPL
- Most uninsured or on Medi-Cal
- Primarily women and children
- 55% Hispanic
- 45% ESL
Community Clinics and Health Centers and Dental in California

- Dental = primary care
- 262 clinics offer dental
- 1,355 dental FTEs
- 1,457,207 dental encounters
- FQHCs cannot restrict to children
Challenges in Serving Children: Budget Cuts

- 2009-10 Budget
  - Elimination of Medi-Cal optional benefits
    - Optional benefits include dental, optometry, podiatry, chiropractic
  - Elimination of funding for Traditional Clinic Programs
    - Includes the Expanded Access to Primary Care (EAPC), Seasonal and Agricultural Migratory Workers (SAMW), and Rural Health Services Development (RHSD) programs
CCHCs and Adult Dental

- Results from CPCA’s survey of membership in Fall of 2009
  - $30 million in revenue lost
  - 77 dental providers laid off
  - 2 dental clinics closed
  - Expect to see worse results in future surveys
CCHCs and Adult Dental

“We have heard that people are having a harder time finding jobs because their teeth are so bad. Their perception is that they are not presenting well in interviews.”

“Unfortunately, our patients have to take the brunt of this situation. Our patients that previously received benefits that have now been eliminated now have to pay out of pocket. Dental services are a necessity when our patients are in pain.”
Hope on the Horizon

- Health Care Reform
  - $11 billion for FQHCs
  - $1 billion to California FQHCs

- Health Information Technology
  - $36 billion for Medicare/Medicaid electronic health records incentive funds
  - $2 billion for supporting services

- Some concerns remain
Questions?
Oral Health Policy Impacting Latino Children

Issues in California and the Nation

by

Gilbert Ojeda, Director
California Program on Access to Care
UC Berkeley School of Public Health

For Presentation at the State Capitol
May 18, 2010
I. Point of View

- CPAC established in 1997 by UC to create institute to improve knowledge base thru academic based thinking for California’s decision makers on access to health care for immigrants and the working poor.
- Monitor State initiatives including Medi-Cal, Healthy Families, and State based health care reform towards preserving and strengthening services for vulnerable populations.
- Serve as “incubator” for health care access initiatives, including Health Initiative of the Americas, Medicaid Research Institute, State-only programs, bi-national coverage, and non-profit care for vulnerable populations.
II. Recent State Oral Health Policy Actions

• Greater take-up of dental care in Health Families under age of five; State coverage for immigrant children under State only programs.
• Maintenance of dental care for pregnant women through Medi-Cal and State’s Prenatal Care Program, which serves predominantly Latino immigrant women.
• Suspension of State’s Dental Disease Prevention Program for 300,000 school children focused on oral health promotion and prevention.
• Mandating movement of Healthy Families children to capitated plans for 1st two years, likely to lead to less access and preventive care.
• Imposing $1,500 yearly limit on dental care for Health Families kids.
III. Policies under Federal Health Care Acts

- Expansion of 1,000’s of National Health Service Corp positions, including for training of dentists, under recent ARRA legislation and the Health Care Reform Act (HCR).
- The S-CHIP Re-Authorization (2009) requires states to provide dental coverage to enrollees, not allowing states to back-out of coverage.
- 2009 Act may also require HF to improve dental care to meet minimum requirements, if HF program survives the proposed elimination.
- Under HCR: state dental requirements mandated to include review of adequacy of provider payments & improved oral health data collection.
- Under HCR: there will be grants to states for school-based dental sealant programs, which could lead to start-up of California’s suspended Dental Disease Prevention Program.
- Under HCR: there will be $11 billion over 5 years for community clinics- $9.5 B for expansion, $1.5 B for infrastructure.
- Also under HCR, CDC grants to improve outreach, oral health public education campaigns, and mandated pediatric dental for health plans.
IV. State Budget: Past Years, Current Year

- The elimination of Medi-Cal’s adult dental program undercut dental infrastructure and core funding base of hundreds of clinics—public, non-profit and private providers, which have traditionally served Denti-Cal patients.

- Last year’s State budget proposed the elimination of Healthy Families Program; it was saved at the 11th hour thru 1-time support derived from private health insurers and the State First Five Commission.

- This year’s May Revise State Budget again calls for eliminating the entire Health Families Program serving over 900,000 children, over 55% Latino.

- With bipartisan support for children and community clinics, it is hoped that another “last minute” compromise will be secured to protect Health Families children.
V. New Initiatives for Tough Times

• In California, passage of a beverage/soda tax with directed funds to prevent obesity/diabetes, dental caries with an emphasis on parent education and funding for oral health care.

• In CA, new rules on the Free and Reduced Lunch Program in the schools; recipients, disproportionately Latino suffer from higher rates of tooth decay.

• In CA, increased promotion of flouride varnishes and dental sealants through both Medi-Cal and Healthy Families due to proven State budget cost savings; could attract demonstration project funding through health care reform.

• Create incentives for private dentists thru HR expanded coverage to sign-up for the State’s public programs; declines in dental care for children thru Medi-Cal (31%) and Healthy Families (56%) thought to be directly dependent on provider availability.
VII. What do we do now?

- In dire times we plan for better times
- We protect what we have in CA, and bring back what we can thru federal opportunities and mandates under HCR
- We learn from other States, whether it be Washington with its ABDC program or Massachusetts with its Toothbrush Time in the pre-school and kindergarten.
- We do the simple things that don’t cost lots of public dollars, but that save public dollars and wait for federal opportunities.
- Remember once HCR is in full gear in 2014 or even if CA opts for expanded Medi-Cal in 2011 the opportunities for expanded public coverage will proliferate.
- We plan, we wait, we act…