Strengthening Dental Care for Children Utilizing California's Federally Qualified Health Centers

December 2016

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Executive Summary

Tooth decay (dental caries) is the most common chronic, yet largely preventable health problem among children in California. Mounting evidence points to the importance and value of early interventions to establish a foundation for optimal oral health during childhood and throughout life. However, recent analyses indicate that only 25 percent of children under age 6 who are enrolled in Medi-Cal/Denti-Cal received a preventive dental service in 2015. Left untreated, tooth decay or early childhood caries (ECC) can lead to consequences that predispose young children to academic failure, chronic disease and social isolation. Untreated dental disease also frequently requires expensive treatment in emergency departments and hospitals. Advocates, researchers and policymakers alike are undertaking efforts to improve the dental health of California's most vulnerable children, but access to care remains a major barrier – a barrier that federally qualified health centers could help to further alleviate if steps are taken to expand their capacity to provide oral health care for children.

Federally Qualified Health Centers (FQHCs) are a critical component of the health care safety net whose purpose is to ensure that underserved populations, regardless of income, insurance type, and immigration status, can access health care and preventive dental services. However, less than half of California FQHC facilities have dental clinics co-located with primary care clinics, and those that do often serve only a fraction of children who receive medical services, underscoring the need for additional efforts to expand oral health care capacity in FQHCs. Integration of medical and dental services in co-located facilities is one promising way for children served by FQHCs – especially young children – to receive professionally recommended oral health care.

Findings from initiatives such as the UCLA-First 5 LA 21st Century Dental Homes Project have demonstrated that improvements in oral health care delivery for high-risk young children are possible in these settings. However, expanding the capacity for FQHCs to meet the growing oral health care needs of California children requires attention from policymakers and support from health center leadership to address systemic barriers that limit the vital role that FQHCs can play in improving children's oral health.

Toward that end, this policy brief outlines four recommendations for expanding the capacity of California FQHCs to improve access to quality oral health care for California's children:

1. Expand programs to increase co-location of dental and medical clinics at FQHC sites.
2. Support programs to improve FQHCs' oral health care capacity through medical-dental integration.
3. Expand investments in information technology and personnel to enhance care coordination, dental home referrals, outreach and preventive services consistent with current children's oral health care guidelines.
4. Prioritize children's oral health care in Medi-Cal/Denti-Cal Quality Improvement Plans, including provisions for care provided by FQHCs.

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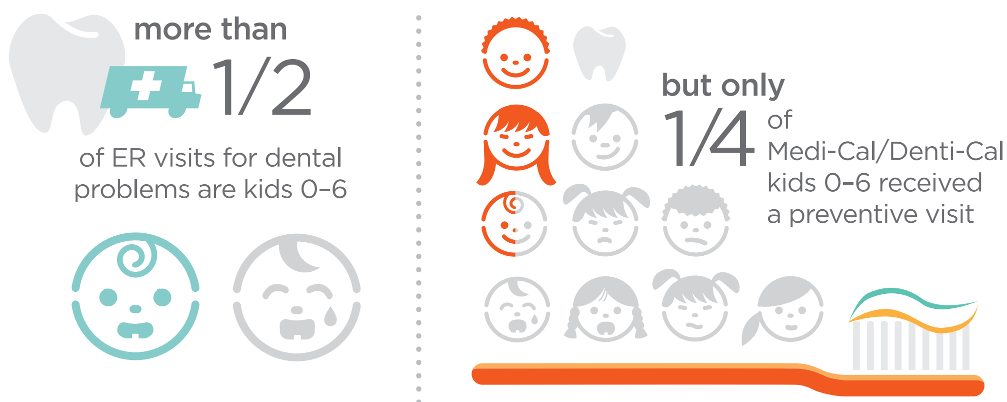
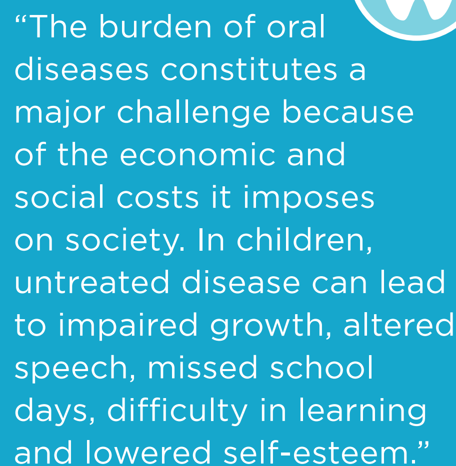
Introduction

Tooth decay is the most common, yet largely preventable, chronic childhood disease – five times more prevalent than childhood asthma.[1] Mounting evidence points to the importance and value of early interventions to establish a foundation for optimal oral health during childhood and throughout life. Left untreated, tooth decay or early childhood caries (ECC) lead to consequences that can set young children on a trajectory of academic failure, chronic disease and social isolation. Untreated dental disease also frequently requires expensive treatment in hospitals under general anesthesia or emergency departments.



Advocates, researchers and policymakers are undertaking efforts to improve the dental health of California's most vulnerable children, but access to care remains a major barrier, especially for young publicly insured children. Over half of children who live in California – 53 percent – are enrolled in the State's public health insurance program, Medi-Cal, and its dental benefit, Denti-Cal.[2] However, federal reports indicate that only 25 percent of Medi-Cal/Denti-Cal preschoolers are receiving preventive dental services, while half of all emergency room visits for dental problems are for kids ages 0-6 enrolled in Medi-Cal.[3,4] Federally Qualified Health Centers (FQHCs) play an important role in providing primary care to Medi-Cal children. Addressing common barriers through policies based on proven strategies would allow California FQHCs to play a greater role in improving children's oral health.

This brief highlights the role of FQHCs in providing primary care and dental services, and the potential to increase their capacity to provide dental services for children in California. We summarize the state of oral health among young California children ages 0-6, provide an overview of FQHCs' delivery of primary care and dental services, outline barriers that limit FQHCs' capacity to provide dental services to young children, and provide policy recommendations to expand the role of FQHCs in improving children's oral health care based on findings from an innovative program supported by First 5 LA.



"The burden of oral diseases constitutes a major challenge because of the economic and social costs it imposes on society. In children, untreated disease can lead to impaired growth, altered speech, missed school days, difficulty in learning and lowered self-esteem."

– Jayanth Kumar, DDS, California State Dental Director, Testimony to the Little Hoover Commission.[5]

State of children's oral health in California

The most recent state-wide oral health needs assessment, conducted in 2006, found that more than half of California's kindergartners had experienced tooth decay, and over a quarter had untreated ECC. That assessment also found that low-income children have higher rates of decay, untreated decay and urgent dental care needs,[6] with clear disparities by race/ethnicity and insurance type. Nationally, among children ages 1 to 17, Hispanic children (25 percent) and non-Hispanic Black children (38 percent) are much more likely to experience one or more oral health problems than white children (15 percent). Similarly, California children ages 1-17 insured by Medi-Cal are more likely to experience one or more oral health problems compared to children with private health insurance (28 percent vs. 17 percent).[7]

The oral health status of California's youngest and most vulnerable children puts them even more at risk for experiencing negative academic, physical and social-emotional consequences.

> **Academic consequences:** Dental disease is one of the top reasons children in California miss school. More than half a million of California's school-aged children miss at least one school day per year due to dental problems, resulting in a total of 874,000 missed school days and costing districts almost $30 million in lost average daily attendance (ADA) dollars per year.[8,9] Additionally, studies have shown that students who report oral pain are four times more likely to have a below-average GPA compared to students who report having no pain.[10]
>
> **Physical consequences:** Dental decay can affect a child's ability to eat and sleep.[11] Untreated dental disease also is linked to a variety of additional health issues, including delayed development, ear and sinus infections, weakened immune systems, diabetes, and lung and heart disease.[12]
>
> **Social-emotional consequences:** Dental disease in children can lead to slower social development and lack of self-esteem due to esthetic issues caused by tooth decay and effects on speech development.[13]
>
> **Economic consequences:** Lack of preventive services can result in substantial economic consequences as a result of increased hospital admissions, emergency department care and general anesthesia costs.[14]

To avoid these potential consequences and reduce the prevalence and severity of dental disease, young children must obtain ongoing preventive dental services starting early in life, ideally by age one. However, locating and accessing a dentist for low-income children can be difficult. Limited access to dental care and a shortage of Denti-Cal pediatric dental care providers are likely to be exacerbated by recent federal and state trends increasing the number of children with Medicaid dental coverage, including extension of health care benefits to all children in California regardless of immigration status.[15] Within this context, FQHCs have the potential to help provide greater access to dental services for California's most vulnerable children. However, analyses of state data and experience gained from collaborations with FQHCs have shown that additional investments are necessary to realize this potential.

Overview of FQHCs' role in providing primary care and dental care to children

As a part of the Federal Health Center Program,[16] FQHCs are a critical component of the health care safety net designed to improve access to primary health care services for underserved populations, including low-income and uninsured individuals.[17] Positive attributes of FQHCs include their location within underserved areas, their ability to co-locate medical and dental services within primary care clinic sites, and their access to enhanced Medicaid payment rates through the cost-based prospective payment system (PPS), which are intended to reflect the type, intensity and duration of service that FQHCs provide.[18]

In addition to providing medical primary care services, federal requirements specify that FQHCs are to provide preventive dental services, which include but are not limited to oral hygiene education, dental cleanings, and fluoride varnish applications.[19] FQHCs with dental clinics also provide various dental treatment services beyond preventive care, such as fillings or other treatments for decayed or missing teeth.

In 2014, California FQHCs provided medical services to over 3 million adult and child patients; however, dental services were only provided to approximately 738,000 patients – less than one-quarter of all FQHC patients.[20]

Analyses of state-level data further show that only 1-in-5 California FQHC patients aged 0-18 received dental services in 2014. For children ages 0-5, FQHCs provided health services to over 500,000 children,[21] of which 82 percent were Medi-Cal beneficiaries. However, as shown in Figure 1, of the 502,226 children ages 0-5 seen at California FQHCs in 2014, less than 20 percent received dental services.

California FQHC's Share of Child Patients, 2014[22]	
Children 0 - 18 enrolled in Medi-Cal	5,051,000
Child Patients 0 - 18 seen in CA FQHCs	1,223,804
Child Dental Patients 0 - 18 seen in CA FQHCs	242,313
Child Patients 0 - 5 seen in CA FQHCs	502,226
Child Dental Patients 0 - 5 seen in CA FQHCs	99,440

figure 1

The gap between the number of young children receiving primary medical services and the number receiving dental services in FQHCs also has been documented in work conducted in Los Angeles where, in the 12 FQHCs with co-located medical and dental services participating in the UCLA-First 5 LA 21st Century Dental Home Project, 10,000 more children were receiving medical services than were receiving dental services at baseline (i.e. prior to initiation of the project).

Factors limiting FQHCs' capacity to provide dental/oral health care services for children

The findings regarding California FQHCs are consistent with data from national reports[23, 24] and suggest that there are FQHC capacity barriers that limit the provision of dental services to young children. One factor highlighted in a recent analysis conducted by the UCLA Center for Health Policy Research[25] is that less than 40 percent of California FQHC sites have co-located dental and medical services at the same facility (i.e., the ability to provide dental services at the same location where primary medical services are provided). **Limited co-location of dental clinics in FQHC primary care facilities creates a substantial structural gap in FQHC oral health care capacity. This structural gap makes accessing dental care more difficult for those utilizing FQHC services, who already experience a number of barriers to care.** Therefore co-location of dental and medical services is an important long-term strategy for expanding access to dental care for underserved populations which has contributed to significant increases in FQHC dental care utilization over the past decade.[26]

Several additional factors limiting delivery of oral health services to children in FQHCs with co-located medical and dental clinics have been identified through assessments conducted as part of the UCLA-First 5 LA 21st Century Dental Homes Project and Children's Dental Care Program. **Common barriers include inadequate oral health care infrastructure (personnel, information technology), 'siloed' medical and dental operations with little or no history of collaboration, limited pediatric oral health care training among medical and dental clinical personnel, and limited attention to oral health care in FQHC quality improvement initiatives**. Addressing these common systems barriers with proven strategies can help increase FQHCs' capacity to provide dental care and preventive oral health services to vulnerable children.

Expanding FQHCs' capacity to provide dental/oral health services for children

A prominent area of focus nationwide and in California is on promoting greater integration of oral health care by medical and dental providers. Providing oral health services during medical visits can expand screening and preventive services – such as caries risk assessment and fluoride varnish applications – and help create new integrated care pathways to increase access to dental services for disadvantaged children. FQHC medical providers also can

serve as a major source of referrals to dentists within or outside their clinics to help children establish community-based dental homes. A 2014 report issued by the Health Resources and Services Administration (HRSA) acknowledged the importance of integrating oral health and primary care practice and outlined a framework for promoting medical-dental integration within the Health Center Program.[27] A risk-based integrated oral health and dental care pathway developed for use in the UCLA-First 5 LA Quality Improvement Learning Collaborative provides a practical guide for improving accessibility and quality of care provided to young children and perinatal women. [28]

Use of fluoride varnish has received considerable attention as a means to prevent, reduce or manage ECC. Although use of fluoride varnish is based on considerable evidence attesting to its effectiveness, fluoride varnish alone will not universally prevent dental caries (tooth decay) in children. Addressing pervasive and persistent disparities in dental disease requires multi-pronged preventive strategies – including health education, patient engagement, self-management goal setting and anticipatory guidance – employed over time in settings that promote ongoing continuity of care. FQHCs serve as sites for primary care services and, if steps are taken to address current barriers, could do more with respect to oral health care for young children.

Recommendations for expanding FQHC dental/oral health care capacity

Issue #1: Limited co-location of dental and medical services in California FQHCs

Issues impeding medical-dental integration by FQHCs include limited co-location of dental services within FQHCs and challenges in recruitment and retention of dental providers to serve children.

As noted in the September 2015 UCLA Center for Health Policy Research policy brief, having dental services and medical services available within the same FQHC location (co-location) increases the "ease of use of dental care and enhances the opportunity to provide whole-person and integrated care."[29] In spite of the benefits, **only 39 percent of California FQHC sites have co-located medical and dental services.** Forty-five percent of FQHC sites have no dental services available onsite, but offer dental services at another site within the organization, requiring additional travel on the part of patients and reducing opportunities for direct interaction of medical and dental providers. Sixteen percent of California FQHCs have no capacity to delivery dental services onsite or within their organization.

Recommendation #1: Expand initiatives to increase dental care capacity in California FQHCs through co-location of dental and medical clinics at FQHC sites.

Federal and state efforts to increase the number of FQHCs that co-locate medical and dental services should be expanded, prioritizing sites that have a high number of Medi-Cal children beneficiaries, so that FQHCs are better able to serve the various dental health needs of children and their families.

Additionally, California FQHCs often struggle to attract and retain dental providers due to financial challenges that stem from relatively low encounter-based reimbursement rates. Reduced revenue also contributes to reluctance on the part of most FQHCs to hire primary care dental specialists (i.e., pediatric dentists) who generally require higher incomes/salaries. To attract dental providers with the skills to effectively meet the oral health needs of California's most vulnerable children, FQHCs need additional support to develop attractive hiring and retention incentives. For example, the National Health Service Corps offers tax-free loan repayment assistance to support qualified health care providers, including dental providers, willing to work in underserved areas.[29] California also is a grantee of the State Loan Repayment Program (SLRP), a federally-funded grant program to states and territories that provides cost-sharing grants to assist with state-level educational loan repayment programs for providers working in Health Professional Shortage Areas (HPSAs). Although these programs to incentivize providers to work in high-need communities exist, funding levels often have not been sufficient to fill all available slots or to lure providers

away from more lucrative careers in private practice. Therefore, **California and federal agencies should expand resources available for incentives to recruit providers or recent graduates interested in working in underserved communities.**

Issue #2: Improvements in FQHC pediatric oral health care capacity and care delivery systems.

Co-location of dental and medical services at FQHC sites and adequate staffing levels are important components of a multi-year strategy for improving access to oral health care for California's young disadvantaged children. At the same time, additional investments are necessary to address common shortcomings that limit FQHCs' capacity – even in facilities with co-located medical and dental services – to serve as dental homes for young children and integrated oral health care delivery by medical and dental care providers.

Recommendation #2: Support pediatric oral health trainings for FQHC dental and medical personnel and use of quality improvement methods to enhance integration of oral health and primary care medical services.

Similar to dental care delivery in the private sector, dental services in FQHCs generally are provided by general dentists and allied dental health personnel (dental hygienists, dental assistants). Primary medical care services are provided by primary care physicians (family physicians, pediatricians), mid-level providers (physician assistants, nurse practitioners, midwives) and allied health personnel (medical assistants). Reports suggest that these groups of providers often lack training and/or confidence necessary to provide oral health care services for young children. These findings underscore the need for foundational training in the basics of oral health care for children (examination techniques, caries-risk assessment, prevention, disease management, motivational interviewing). Development of knowledge, skills and confidence is a critical precursor to expanding pediatric oral health services.

Adequately trained clinicians and clinic support staff are necessary, but not sufficient to develop efficient, reliable integrated care systems that take full advantage of encounters with medical and dental providers. Experience applying quality improvement (QI) methods has been shown to be successful in transforming care delivery systems to increase access to pediatric oral health care and quality.[31,32,33] QI learning collaboratives are important catalysts for creating the systems changes associated with improved performance.

There is growing recognition that prevention and management of chronic conditions requires delivery system enhancements that combine and link clinical services with services provided within community settings. Similarly, increased emphasis on population health highlights the importance of educational outreach, screening and preventive services targeted to high-risk segments of the population. Investments in community systems development and outreach programs – e.g., home visitation programs – have demonstrated positive results, but often neglect to include oral health among targeted conditions.[34]

Developing reliable integrated oral health care delivery systems in FQHCs requires investments in infrastructure, training and applications of quality improvement methods. Specific investments that have been applied in FQHC settings as part of the previously mentioned UCLA-First 5 LA programs include training dental and medical personnel in contemporary pediatric oral health care, support for IT infrastructure enhancements that assist with care coordination, support for a new member of the care delivery team (a Community Dental Home Coordinator), and participation in a Quality Improvement Learning Collaborative. Additional details are provided below and described in greater detail in related publications.[35]

Evaluation of progress during the initial phase of the UCLA-First 5 LA initiative demonstrated two-fold increases in FQHCs' capacity to provide dental diagnostic and treatment services for children ages 0-5, and a three-fold increase in their capacity to deliver preventive services. Experience gained in implementing these programs in Los Angeles reinforced the important role that FQHCs serve in the primary health care safety net for underserved children.

Issue #3: Support for improved care coordination

Patient-centered care within the context of the U.S. healthcare system increasingly depends on coordinating care across multiple providers and service delivery sites. Critical elements for effective care coordination include efficient, reliable systems for identification and referral of children who need recommended services, and processes and personnel to carry out care coordination activities.

Within the current reporting and payment structure, FQHCs do not report to Medi-Cal on the specific dental services that they provide. The majority of FQHCs in California are reimbursed by Medi-Cal using a PPS rate that is established by DHCS. However, new Medicaid rules effective in 2017 and changes resulting from implementation of the Medi-Cal 2020 Dental Transformation Initiative will require procedure-level reporting for dental services by FQHCs. Policymakers and Medi-Cal/Denti-Cal program officials should capitalize on this opportunity to create systems that not only satisfy new reimbursement reporting requirements, but also facilitate the sharing of important oral health information among medical and dental providers and entities that administer benefits in order to optimize oral health care in FQHCs and other care delivery settings. Having ready access to procedure-level data would aid medical-dental integration by allowing medical and dental providers to know which dental/oral health services a patient has received or might need, thereby facilitating improved care coordination and completion of treatment plans.

Moreover, preventive dental services (such as fluoride varnish applications) currently are subject to Medi-Cal/Denti-Cal frequency limitations that are not consistent with recommended guidelines for children at elevated risk for dental caries (tooth decay). In order for FQHCs to truly prioritize prevention, policies concerning oral disease preventive services provided by medical primary care providers and dental providers should be aligned with recommended guidelines for children at elevated risk for dental caries, and additional financial resources need to be provided for these preventive procedures.

Recommendation #3A: Improve the processes used to identify children with untreated dental disease and who are at elevated risk for dental disease, and revamp the dental home referral process for primary care medical providers.

Completion of a Confidential Screening/Report Claim Form, or PM 160, by medical providers is currently required when performing a health assessment of low-income children who participate in the California Medi-Cal Child Health & Disability Prevention (CHDP) Program. The form allows physicians to document procedures performed, as well as the outcomes of a medical visit including documentation of a dental screening. Recent law passed in 2015 requires CHDP medical providers to refer a child to a dentist at age one, a practice that CHDP had implemented years before, but had lacked a mandate. Still, a 2008 CHDP survey of seven California counties found that close to 75 percent of CHDP dental assessments were incorrectly documented on the PM 160, which resulted in children not being referred to a dentist.[36] In order to ensure that dental disease/caries risk is being assessed accurately and reliably, the process should be revised to be consistent with contemporary caries-risk assessment tools. **Improving the process to include a more thorough caries-risk assessment would allow documentation of risk factors to become part of a child's medical record, and would provide physicians with a better tool for assessing and referring high-risk children for dental care in a dental home. Additional efforts may be necessary to ensure that providers are accurately completing the form and referring children found to be at high risk for dental disease or who have existing dental disease.**

Recommendation #3B: Support additional demonstration projects to establish the value of community dental home coordinators (CDHCs).

Although FQHCs serve as important components of the dental safety net for California's low-income and underserved populations, traditional staffing arrangements and financial challenges often limit use of care

coordination positions to promote preventive oral health services for children ages 0-5. Coordinating care provided by medical and dental providers within FQHCs is critical for advancing medical-dental integration and ensuring children receive needed oral health/dental services, in part because of limited technological connectivity (interoperability) between electronic medical and dental record systems.

Personnel, such as the Community Dental Home Coordinators (CDHCs) used in the UCLA-First 5 LA Oral Health Program, can help ensure that children who come to the FQHC are getting preventive dental care. One of the most important responsibilities of CDHCs is to monitor medical appointment schedules to identify children who have not had a recent dental visit. CDHCs also provide families with the support necessary to navigate scheduling and care delivery systems by conducting outreach, scheduling appointments, and providing follow-up support when necessary. Although experience from the UCLA-First 5 LA programs has shown that CDHCs can provide crucial administrative and patient care support within FQHC settings, the CDHC model is relatively new and underutilized in FQHC settings, and not likely to be adopted by clinic administrators until its value has been demonstrated more broadly. Therefore, **additional support is recommended to demonstrate the value of care coordination within the FQHC setting and to explore cost-effective ways to sustain the valuable supports of CDHCs via FQHC financing mechanisms. Additionally, more support for demonstration projects is necessary to establish the value of care coordination to improve medical-dental integration. Attention should also be directed toward explicitly including oral health components in programs which target services to high-risk young children and families (such as home visitation programs[37]).**

Issue #4: Prioritizing children's oral health care in quality improvement initiatives

Incentive programs, such as pay-for-performance and other programs based on rewarding plans and providers for increasing the delivery of evidence-based care, have been shown to be effective tools for improving the quality of health care, but have not been used extensively to improve oral health care for children.

Recommendation #4: Prioritize children's oral health care in Medi-Cal/Denti-Cal Quality Improvement Plans, including provisions for care provided by FQHCs.

The trend in Medi-Cal (and most other State Medicaid programs) is toward greater reliance on managed care to administer Medicaid benefits. DHCS contracts encourage Medi-Cal providers to apply fluoride varnish for members less than 6 years old up to three times in a 12-month period, and promote use of fluoride varnish via quality improvement strategies and provider trainings. DHCS also has encouraged Medi-Cal managed care plans, including Denti-Cal managed care, to take full advantage of the Medicaid §1115 waiver renewal to coordinate managed care and carved out services as closely as possible, with the broader aim of creating an integrated, high-performing safety net.

Currently, Medicaid (Medi-Cal) dental managed care exists in two California counties: Sacramento and Los Angeles. In Sacramento County, dental managed care is the required delivery system for Medi-Cal recipients. In Los Angeles County, however, dental managed care serves as an optional alternative to the Denti-Cal Fee-for-Service program. In 2013, DHCS made several improvements to the contracts of Denti-Cal dental managed care organizations. One such improvement requires each managed care plan to develop and implement two Quality Improvement Plans (QIPs) that are approved by DHCS and validated by DHCS's external quality review organization. QIPs provide managed care organizations with the opportunity to increase the delivery of preventive oral health services to young children, particularly in FQHCs. For example, a review of dental managed care QIPs revealed that two of the three dental plans have identified the CMS Pediatric Oral Health Action Initiative goals as their QIP, with one of the goals to increase the percentage of children (ages 1-20) enrolled in Medi-Cal who receive a preventive dental service, such as fluoride varnish. By enforcing Medicaid dental managed care contracts and placing greater emphasis on the importance of providing dental services to children ages 0-5 in Medi-Cal QIPs, DHCS could promote improvements in dental services for young children in general and in FQHCs in particular in Sacramento and Los Angeles Counties to start, and then perhaps extend to the remaining counties that serve children who receive Medi-Cal dental services through fee-for-service.

An additional improvement made to the 2013 dental managed care contracts was the requirement that DHCS review provider contracts and compensation arrangements, whereby dental managed care plans are: 1) encouraged to build in incentive programs for providers, and 2) required to conduct outreach to expand the provider network to include FQHCs, along with other community health centers.[38] This contract improvement provides dental managed care with the opportunity to incentivize preventive dental care, including in the primary care setting; stimulate medical-dental integration; and increase utilization rates among children ages 0-5 within FQHCs. However, the current incentive payments built into the dental managed care provider contracts may not be substantial enough to impact the bottom line of FQHCs, and therefore, drive change. **By revising provider contracts with dental managed care organizations to reflect a value-based pay-for-performance model that offers a larger monetary incentive and is aligned with Dental Quality Alliance (DQA) measures,[39] dental managed care organizations could provide monetary motivation to improve medical-dental integration efforts within FQHCs. Ideally, this provider performance model would encourage FQHCs to allocate their resources for dental services based on risk-based disease prevention and management approaches.**

Looking Ahead

FQHCs play an important role in seeing that California's most vulnerable children have access to health services, including dental care. FQHCs exist within high-need communities, and have potential structural and financial advantages for providing children ages 0-5 with the care necessary to prevent or minimize the consequences of dental disease. Adopting and implementing the recommendations made in this brief will help position FQHCs to provide even more effective, integrated, efficient oral health care and improve access to dental care for California's most vulnerable children.

Overview of UCLA–First 5 LA Oral Health Program

Since 2013, the UCLA-First 5 LA Oral Health Program (OHP) has been leading a collaborative effort to increase access to quality dental/oral health care for children ages 0-5 in Los Angeles County. Funded by two contracts from First 5 LA, the OHP has partnered with 20 FQHCs, 2 dental safety net clinics and other organizations to implement the 21st Century Dental Homes Project (DHP) and the Children's Dental Care Program (CDCP). Key components of the OHP are highlighted below.

Partnering with Los Angeles Community Clinics: The OHP partners with 12 federally qualified health center clinics in the DHP, which collectively provide primary care health services to about 30,000 children ages 0-5. Ten additional clinics have been selected to participate in the CDCP beginning in summer 2015. A major emphasis of both projects is to increase oral health services for young children and pregnant women who receive primary care at these clinics.

Practice Management Technical Assistance: A major component of the OHP is assisting clinics to expand access to young children by improving their overall clinic operations. A partnership with Safety Net Solutions (SNS) helps to provide customized technical assistance to develop and implement plans to enhance clinic operations and productivity.

Quality Improvement: The OHP provides resources for each clinic to hire a part-time pediatric dentist and a Community Dental Home Coordinator (CDHC). The pediatric dentists help to train and mentor clinic personnel and treat patients with more complex care needs. CDHCs receive training from UCLA OHP faculty and staff, and are critical to coordinating on-site OHP program activities and engaging community partners to expand oral health care for young children. Additional resources are allocated to information technology improvements to support care integration and system performance monitoring.

Enhanced Infrastructure (including Clinic Staff Support): The OHP provides resources for each clinic to hire a part-time pediatric dentist and a Community Dental Home Coordinator (CDHC). The pediatric dentists help to train and mentor clinic personnel and treat patients with more complex care needs. CDHCs receive training from UCLA OHP faculty and staff, and are critical to

coordinating on-site OHP program activities and engaging community partners to expand oral health care for young children. Additional resources are allocated to information technology improvements to support care integration and system performance monitoring.

Training: OHP training curriculum is designed to provide online, didactic and on-site training to dental and medical providers in all participating clinics. The trainings enable general dentists to become more comfortable with treating young children and expand primary clinicians' involvement in oral health. Another training component supports clinics partnering with community-based organizations. UCLA provides clinics with technical assistance and training to providing dental services outside of the traditional clinics.

Service Learning Infrastructure: Three clinics received capital improvement funds to expand and renovate their physical facilities to treat more children. Two of these clinics are service-learning sites for UCLA dental students and pediatric dental residents.

Acknowlegements

Funding for this brief was provided by the UCLA-First 5 LA Oral Health Program.

This brief has benefited from the contributions of many individuals and organizations. We would especially like to thank Joni Chroman, AltaMed Health Services, Director of Dental Administration; Irene Hilton, National Network for Oral Health Access, Dental Consultant; Maritza Cabezas, Los Angeles County Department of Public Health, Dental Director; Meghan Nousaine, California Primary Care Association, Assistant Director of Health Center Operations and Dr. Bahar Amanzadeh, Dental Health Administrator at Alameda County Department of Public Health for lending their insight and expertise during interviews that informed this brief. Please note that the recommendations contained herein are the opinions of First 5 LA, UCLA, and Children Now, and therefore, might not reflect the individuals and organizations who were interviewed.

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Endnotes

1. Oral Health in the US: Key Facts." The Henry J. Kaiser Family Foundation, Jun. 2012. Web. April 2016. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8324.pdf.
2. Research and Analytic Studies Division, January 2016. Proportion of California Population Certified Eligible for Medi-Cal By County and Age Group—September 2015. Medi-Cal Statistical Brief. California Department of Health Care Services. "Medi-Cal: The Cornerstone of CA Kids' Health Care," Children Now infographic, accessed at https://www.childrennow.org/reports-research/medi-cal-infographic/, May 9, 2016.
3. Children Now analysis of data from "Find A Dentist." California Department of Health Care Services, 2013. Web. Oct. 2015. And Public Records Act Request to the California Department of Health Care Services regarding the oral health of children enrolled in Denti-Cal for calendar year 2011, received May 2013.
4. California's Dental Transformation Initiative aims to change how dental encounters are reported going forward to create more transparency in reporting and more accurate data.
5. Little Hoover Commission. (April 2016). "Fixing Denti-Cal." Report #230. Retrieved from: http://www.lhc.ca.gov/studies/230/Report230.pdf.
6. Mommy, It Hurts to Chew. The California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children, February 2006.
7. National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved [04/25/16] from www.childhealthdata.org.
8. Pourat, N. & Nicholson, G. (2009). Unaffordable Dental Care Is Linked to Frequent School Absences. Los Angeles, CA: UCLA Center for Health Policy Research.
9. Jackson S et al. "Impact of Poor Oral Health on Children's School Attendance and Performance," American Journal of Public Health 101(10), October 2011.
10. Seirawan, H, Faust S, & Mulligan R. (2012) The impact of oral health on the academic performance of disadvantaged children. American Journal of Public Health;102(9):1729-34.
11. Ibid.
12. The Kaiser Family Foundation, Children and Oral Health: Assessing Needs, Coverage, and Access, June 2012.
13. Ibid.
14. Casamasimo, P., Thikkurissy, S. Edelstein, B., Maiorini E. (2009). Beyond the dmft: The Human and Economic Cost of Early Childhood Caries. The Journal of American Dental Association.
15. SB 75 extended full-scope Medi-Cal benefits to children under 19 years of age regardless of immigration status, as long as they meet all other eligibility requirements (Welfare and Institutions Code section 14007.8.).
16. The Health Center Program is managed by the Health Resources and Services Administration (HRSA). FQHCs are a type of health center within the program that are funded through grants under Section 330 of the Public Health Service Act (PHS). For more details see: http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html.
17. 42 U.S.C. §254b(a)(1) and §254b (b)(1)(A)(i)(III) (hh)
18. The cost-based prospective payment system (PPS) is an all-inclusive per visit (or encounter) rate for reimbursement. The base PPS rate is set based on each FQHC's reasonable and allowable cost of providing Medicaid-covered services, which is based on projected actual costs of services determined by the historical use of FQHC services. The Medicare Economic Index (MEI) is used to adjust the PPS rates on an annual basis. https://www.cdc.gov/phlp/docs/brief-fqhc.pdf.
19. (42 C.F.R. §51c.102(h)(6))
20. UDS Data: http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014&state=CA
21. http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2014&state=CA
22. http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2014&state=CA
23. Health Resources and Services Administration, 2015 Health Center data, tables 3A through 9E, requested and accessed on 10/25/16.
24. Crall JJ, Pourat N, Inkelas M, Lampron C, Scoville R. Improving the oral health care capacity of federally qualified health centers. Health Aff (Millwood). 2016;35(12):2216-23.
25. Pourat N, Martinez AE, Crall JJ. Better together: co-location of dental and primary care provides opportunities to improve oral health. UCLA Center for Health Policy Research. 2015(Sep);(PB2015-4):1-8. (PMID: 26591904). http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/Dental-brief-sep2015.pdf.

26. Health Resources and Services Administration, "Oral Health Fact Sheet," November 2015.

27. Health and Human Services Administration. "Integration of Oral Health and Primary Care Practice;" 2014. http://www.hrsa.gov/publichealth/clinical/oralhealth/primarycare/integrationoforalhealth.pdf.

28. Crall JJ, Pourat N, Inkelas M, Lampron C, Scoville R. Improving the oral healthcare capacity of federally qualified health centers. Health Affairs (in press).

29. Pourat N, Martinez AE, Crall JJ. Better together: co-location of dental and primary care provides opportunities to improve oral health. UCLA Center for Health Policy Research. 2015(Sep);(PB2015-4):1-8. (PMID: 26591904). http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/Dental-brief-sep2015.pdf.

30. http://www.hrsa.gov/loanscholarships/index.html and
http://www.hrsa.gov/loanrepayment/stateloanrepaymentprogram/index.html.

31. Crall JJ, Pourat N, Inkelas M, Lampron C, Scoville R. Improving the oral health care capacity of federally qualified health centers. Health Aff (Millwood). 2016;35(12):2216-23.

32. Crall JJ, Illum J, Martinez AE, Pourat N. An innovative project breaks down barriers to oral health care for vulnerable young children in Los Angeles County. UCLA Cent Health Policy Res. 2016(Jun);(PB2016-5):1-8. http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/childdentalbrief-jun2016.pdf.

33. Ng MW. (2016) Quality Improvement Efforts in Pediatric Oral Health. The Journal of the California Dental Association; 44: 223-232 http://www.cda.org/Portals/0/journal/journal_042016.pdf.

34. Mariani M, Velazquez L, Kattlove J. Healthy Mouth, Healthy Start: Improving Oral Health For Young Children and Families Through Early Childhood Home Visiting. The Children's Partnership Res. 2016 (August): 1-12.

35. Crall JJ, Illum J, Martinez AE, Pourat N. An innovative project breaks down barriers to oral health care for vulnerable young children in Los Angeles County. UCLA Cent Health Policy Res. 2016(Jun);(PB2016-5):1-8. http://healthpolicy.ucla.edu/publications/Documents/PDF/2016/childdentalbrief-jun2016.pdf.

36. CHDP Dental Training: Focus on PM 160 Screening. California Child Health & Disability Prevention (CHDP) Program, Statewide Oral Health Subcommittee (August 2013). Retrieved from: http://www.dhcs.ca.gov/services/chdp/Documents/CHDPDental/FluorideVarnish.pdf.

37. http://www.childrenspartnership.org/wp-content/uploads/2016/07/Healthy-Mouth-Healthy-Start%E2%80%94Improving-Oral-Health-for-Young-Children-and-Families-Through-Early-Childhood-Home-Visiting_August-2016.pdf.

38. DHCS. Department of Health Care Services Activities Relating to Medi-Cal Dental Managed Care Report to the Legislature (April 2014). Retrieved from: http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Dental%20Managed%20Care/2014_M-C_Dental_MgdCareReport.pdf.

39. The Dental Quality Alliance (DQA) was established by the American Dental Association to develop performance measures for oral health care. The mission of the DQA is to advance performance measurement as a means to improve oral health, patient care, and safety through a consensus-building process.