A Systems Change Approach to Children’s Oral Health

First 5 California 2016 Summit
From Partnerships to Impact
November 8-10, 2016
Sacramento

Structure
1. The Social Determinants of Health Lens
2. State of the State
3. Envisioning Solutions through Systems Change
4. What we are doing in San Bernardino

The Social Determinants of Health
1. The conditions in which people are born, grow, live, work, and age.
2. Shaped by the distribution of money, power, and resources.
3. Mostly responsible for health inequities - the unfair and avoidable differences in health status.

Social Determinants of Health

- Environment
- Health Services
- Health Behaviors
- Socioeconomic Factors

Oral Health Inequities
- Blacks, Hispanics, and American Indians and Alaska Natives generally have the poorest oral health of any of the racial and ethnic groups in the U.S. population (U.S. Surgeon General)
- Mexican American children ages 12 to 23 months may experience dental caries than other race/ethnicity groups (Kaste et al. 1996b).
Inequities in California

- Only 40% of Denti-Cal beneficiaries see a dentist
- >26,000 ER visits/year
- Most kids get no sealants
- Only 25% of California dentists participate in Denti-Cal
- Four (4) counties (Yuba, Mariposa, Sierra and Alpine) with zero (0) Denti-Cal Providers

2. California

State of the State

Expenditure Trends 2009-2014

CA Expenditures by Sources

Insurance Coverage in CA 2015

Population and Medi-Cal

Insurance Coverage in CA 2015

Percentage of Population enrolled in Medi-Cal by Age Group:

- All Age Groups: 33.4%
  - 0-4: 27.6%
  - 5-17: 31.2%
  - 18-44: 30.5%
  - 45-64: 23.7%
  - 65+: 20.9%

Population: 38.8 million

Medi-Cal
33.4%

Other
66.6%

**Medi-Cal Enrollment**

- Medi-Cal Enrollment (MC) 2015 - 2010

**Age and Geography Variations**

Percentage of Population enrolled in Medi-Cal by Age Group:

- All Age Groups: 33.4%
- 0-5: 57.0%
- 0-18: 54.3%
- 19-44: 50.5%
- 45-64: 23.7%
- 65+: 20.9%

Percentage of Population enrolled in Medi-Cal by County:

- Tulare: 53.1%
- Merced: 51.1%
- Imperial: 49.9%
- San Bernardino: 40.9%
- Los Angeles: 37.8%
- Statewide: 33.4%

**Medicaid Expenditures/Enrollee 2009**

- Total expenditure/enrollee = $9,138.75

**Prevention Neglect**

Medicaid Dental Expenditures by Type of Service

- Preventive Care: 14%
- Perio: 4%
- Diagnostic Srvcs: 29%
- Restorative Care: 37%
- Oral Surgery: 11%
- Prosthetics: 17%
- Other Health, Residential, and Personal Care: 64.73%

**Medi-Cal Trends 1991 - 2010**

- Medi-Cal Statistical Brief, California Department of Health Care Services.
Payments Private vs. Public

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<tbody>
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<td>California</td>
<td>$105.55</td>
<td>$117.24</td>
<td>11.1%</td>
<td>$42.61</td>
<td>$34.00</td>
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<td>$127.71</td>
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<td>Massachusetts</td>
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<td>$65.62</td>
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<tr>
<td>District of Columbia</td>
<td>$115.85</td>
<td>$141.04</td>
<td>21.7%</td>
<td>$38.72</td>
<td>$82.31</td>
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Dental Workforce

- Approximately 36,000 Dentists in California
- Reported to be enrolled in DentiCal = 11,400 but only 7,706 active
- Ratios:
  - All Dentist : General Population = 1:1,050
  - DentiCal Dentist : DentiCal Population = 1:2,733
- But only 1 in 6 DentiCal Dentists receive $10,000 or more in Medicaid payment/year
- Therefore, the actual ratio would be = 1:12,000
- 25% of DentiCal dentists serve 80% of all Denti-Cal children


3. Envisioning Solutions
A Systems Change Lens

Systems Change Framework

**FINANCING**
- Sufficient funding to support care, prevention and training
- Alignment of payment with evidence, prevention, disease management and outcomes

**POLICY**
- Oral health is a key component of health policy
- Policy consistent at local, state and federal levels
- Oral health measurement systems in place
- Policy to allow expanded workforce functions

**CARE**
- Improving Oral Health

**COMMUNITY**
- Improving Oral Health
1. **Systems Change Framework**

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   **COMMUNITY**
   - Oral health integrated into education and social services
   - Optimal oral health literacy
   - Strong community prevention and care infrastructure

   **CARE**
   - Dental workforce sufficient to meet needs efficiently and effectively
   - Care based on evidence, prevention, disease management and outcomes
   - Oral health integrated into all aspects of health care

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4. **Action Plan**

   **The San Bernardino Investment**

   **Historical Context**

   First 5 San Bernardino Oral Health Funding—Recent history
   - Bulk of services provided by a single contractor connected to our county hospital
   - Network of 50+ dental providers utilized by agency
   - Treatment and preventive services billed to First 5
   - As funding decreased, service counts decreased
     - FY2010-2011: Highest point—$2,477,067; 15,818 screenings
     - FY 2014-2015: Lowest point—$1,467,197; 8,468 screenings
2014-RFP for contract cycle 15-16

- Funding not to exceed $750,000 for oral health services
- Minimal support of treatment
- Services to focus on education, screening and navigation (find a dental home, access resources outside First 5)
- 2 viable proposals:
  - #1-Previous contractor
    - business as usual but at a much lower scale
    - $750,000; 5,420 screenings
  - #2-Center for Oral Health
    - Direct service support for education, screening and navigation
    - Systems level support for immediate and ongoing treatment
    - $693,750; 14,200 screenings

Stakeholders Meeting
- Decided to form a Coalition
- Group recommended “Inland Empire” to be the geographic focus

OHAC-IE
- Mission
- Vision
- Goals
- Logic Model
- Subcommittees

CHNA
- Access to Care
- Utilization of Benefits
- Oral Health - highest priorities

Community meetings
- Oral Health identified as “gap”
- Public $$$ decreased
- Programs cut or defunded
- CA Legislature calls Oral Health “Optional” during the Great Recession

2014-2016

The Role of OHAC-IE
- Build consensus, develop a common agenda, and mobilize for action
- Ensure accountability
- Build and foster partnerships
- Collaborate and promote integration
- Leverage resources
- Support communities
- Measure progress and review policies and programs

Members
- 32 member organizations
  - Community clinics
  - CCASBC
  - Independent dental providers
  - State, price, programmatic graphing agencies
  - Public health agencies
  - Dental hygiene programs

Vision Mission Strategic And Enabling Pillars

VISION
To improve overall health by eliminating oral disease among vulnerable populations in the Inland Empire

MISSION
To improve the oral health of vulnerable populations in the Inland Empire Region

STRATEGIC & ENABLING Pillars

- Data-Driven strategic system to monitor progress
- "Local Contract" Promote dental health - "Take 2" strategy
- Maximize HRSA designations
- Strategic & enabling system
- Improved Public Health
- Knowledge dissemination
- Increased Public Awareness
- "Local" Contract
- Increased oral health
- Strengthened safety net
- Improved oral health
Systems Change Framework

FINANCING
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- Alignment of payment with evidence, prevention, disease management and outcomes

CARE
- Dental workforce sufficient to meet needs efficiently and effectively
- Care based on evidence, prevention, disease management and outcomes
- Oral health integrated into all aspects of health care
- Consumer focused care delivery

COMMUNITY
- Oral health integrated into education and social services
- Optimal oral health literacy
- Strong community prevention and care infrastructure
- Provider base representative of community

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- Oral health is a key component of health policy
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- Policy to allow expanded workforce functions

Improving Oral Health

Thank you

Conrado E. Barzaga, MD
Center for Oral Health
309 E. Second St.
Pomona, CA 91766
cbarzaga@tc4oh.org
www.centerfororalhealth.org

Scott McGrath
First 5 San Bernardino
735 E. Carnegie Drive, Suite 150
San Bernardino, CA 92408
smcgrath@fcf-sbcounty.gov
www.first5sanbernardino.org