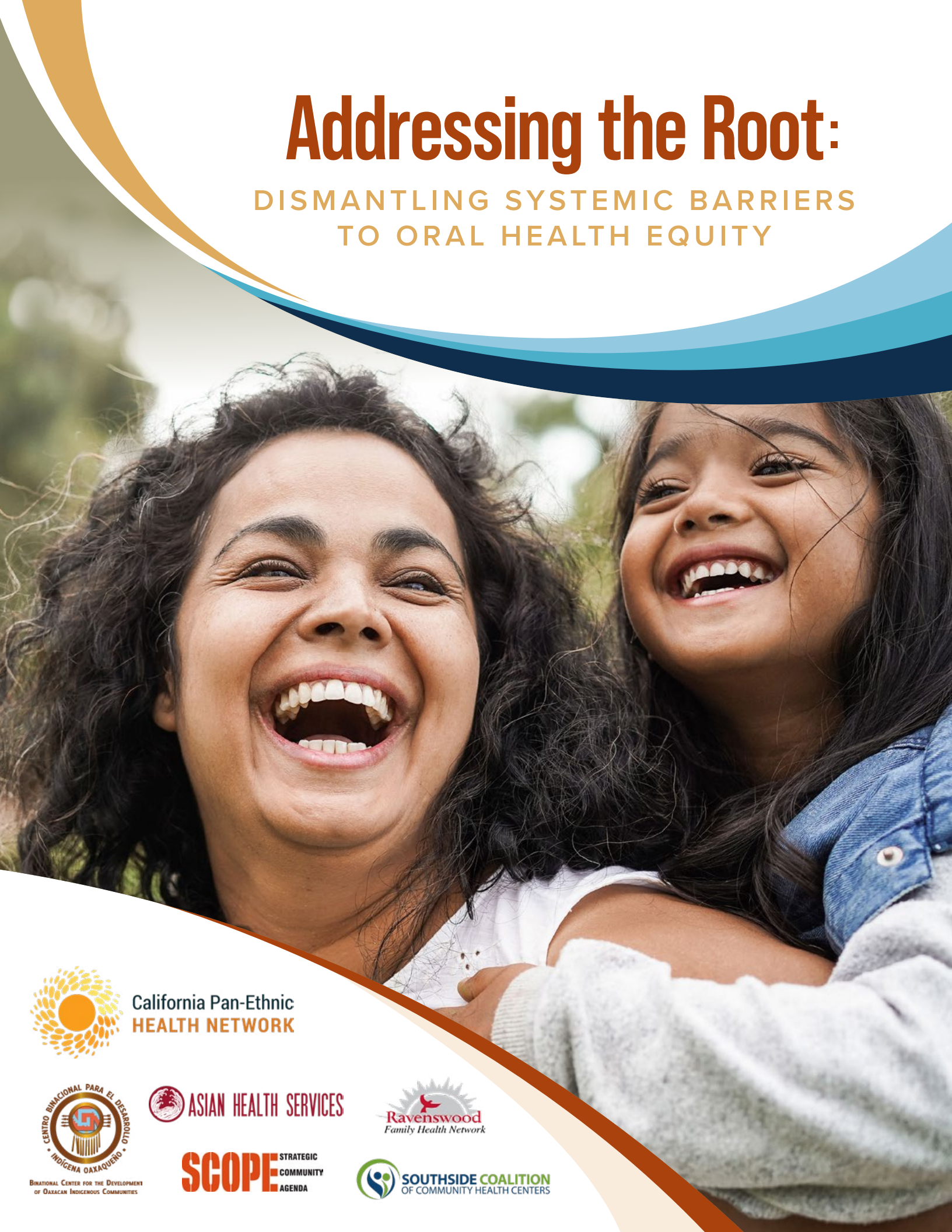
# Addressing the Root:

## DISMANTLING SYSTEMIC BARRIERS TO ORAL HEALTH EQUITY



California Pan-Ethnic HEALTH NETWORK

Binational Center for the Development of Oaxacan Indigenous Communities

ASIAN HEALTH SERVICES

Ravenswood Family Health Network

SCOPE Strategic Community Agenda

SOUTHSIDE COALITION OF COMMUNITY HEALTH CENTERS

## CPEHN Author

**Ruqayya Ahmad, MPP,** Policy Manager
*(she/her/hers)*

## CPEHN Contributors

**Carolina Valle, MSW,** Senior Policy Director
*(she/her/hers)*

**Kiran Savage-Sangwan, MPA,** Executive Director
*(she/her/hers)*

## Oral Health Equity Core Group

**Gina Charusombat, MPP,** Policy & Research Associate, Strategic Concepts in Organizing and Policy Education
*(she/her/hers)*

**Gloria Medina,** Executive Director, Strategic Concepts in Organizing and Policy Education
*(she/her/hers)*

**Margarita Santiago Vasquez,** Project Coordinator, Centro Binacional para el Desarrollo Indígena Oaxaqueño
*(she/her/hers)*

**Sarait Martinez, EdD**, Executive Director, Centro Binacional para el Desarrollo Indígena Oaxaqueño
*(she/her/hers)*

**Yogita Thakur, DDS, MS,** Chief Dental Officer, Ravenswood Family Health Network
*(she/her/hers)*

**Huong Le, DDS, MA,** Chief Dental Officer, Asian Health Services
*(she/her/hers)*

**Andrea Williams, MPA,** Executive Director, Southside Coalition of Community Health Centers
*(she/her/hers)*

## Additional contributions and technical assistance

**Carmen Brammer,** Grants Implementation Program Manager, California Black Health Network
*(she/her/hers)*

**Eileen Espejo,** Senior Managing Director of Health, Children Now
*(she/her/hers)*

**Doreena Wong, Esq.,** Policy Director, Asian Resources, Inc.
*(she/her/hers)*

**Rejie Baloyos,** Program Director, Asian Resources, Inc.
*(she/her/hers)*

**Amber Christ,** Managing Director of Health Advocacy, Justice in Aging
*(she/her/hers)*

**Amanda Carbajal, MPH,** Associate Director of Health Center Operations, California Primary Care Association
*(she/her/hers)*

**Gabriella Barbosa, JD,** Managing Policy Director, The Children's Partnership
*(she/her/hers)*

# About CPEHN

The California Pan-Ethnic Health Network (CPEHN) is a multicultural health policy organization dedicated to improving health of communities of color in California. CPEHN's mission is to advance health equity by advocating for public policies and sufficient resources to address the health needs of the state's new majority. We gather the strength of communities of color to build a united and powerful voice in health advocacy. More about CPEHN can be found at: **www.cpehn.org**

California Pan-Ethnic
HEALTH NETWORK

# Table of Contents

# Introduction

Oral health is essential to overall health. Poor oral health can contribute to chronic disease, chronic pain, difficulties obtaining employment, and school absences.[1] For example, periodontal disease (gum disease) is related to higher risks of cancer and cardiovascular disease, and individuals who have asthma, diabetes, heart disease, and/or obesity are more likely to suffer from periodontal disease.[2] These same chronic conditions persist most often among Black communities, Indigenous communities, and other communities of color.[3]

The hidden costs of poor oral health include being stigmatized, feeling embarrassed in social settings, and challenges finding employment. Studies have shown that people judge an individual's social skills, intellectual achievement, and attractiveness based on their dental appearance.[4] Nearly a third of Californians report that they avoid smiling due to the condition of their mouth and teeth and 1 in 4 feel embarrassed due to the condition of their mouth and teeth.[5] Additionally, 1 in 4 Californians feel that the appearance of their mouth and teeth negatively affects their ability to interview for a job, rising to more than 1 in 3 among Californians with low-incomes.[6]

Despite the clear and convincing need for all Californians to have good oral health, proper dental care is often expensive, difficult to find, and challenging to understand. In 2016, after extensive community engagement, the California Pan-Ethnic Health Network (CPEHN) published "Taking a Bite Out of Oral Health Inequities,"[7] a landmark report demonstrating racial inequities in oral health and proposing policy reforms. Since that time, California has made important progress in the area of oral health, yet racial disparities remain largely unchanged.

In 2020, adults of color were less likely than white adults to report the condition of their teeth as good, very good, or excellent (Figure 1).[8]

## Condition of Teeth by Race/Ethnicity, 2020

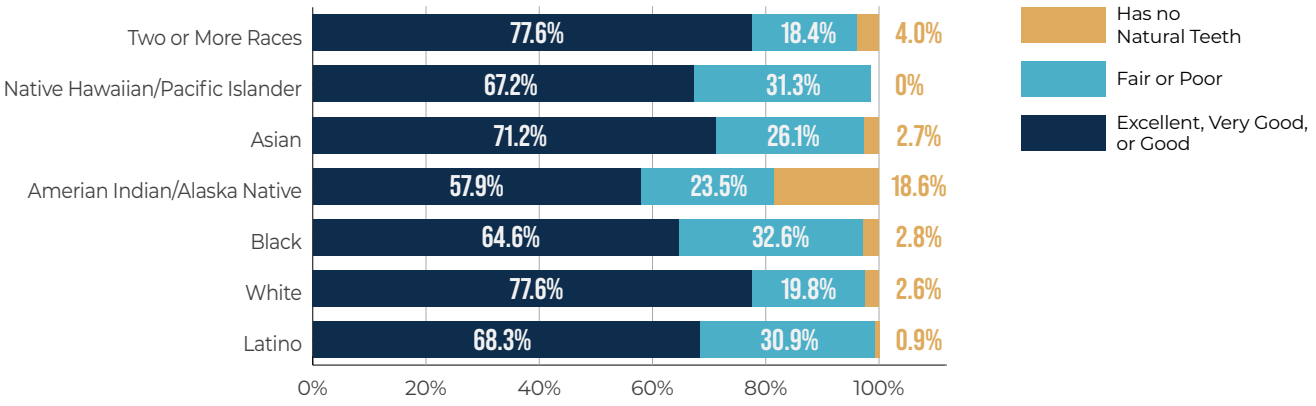



FIGURE 1

*Source: California Health Interview Survey, 2020*

Adults enrolled in Medi-Cal, California's Medicaid program primarily for children and adults with low-incomes, were less likely than those who are commercially insured to report good, very good, or excellent teeth condition (Figure 2).[9]

## Condition of Teeth by Health Coverage Type, 2020

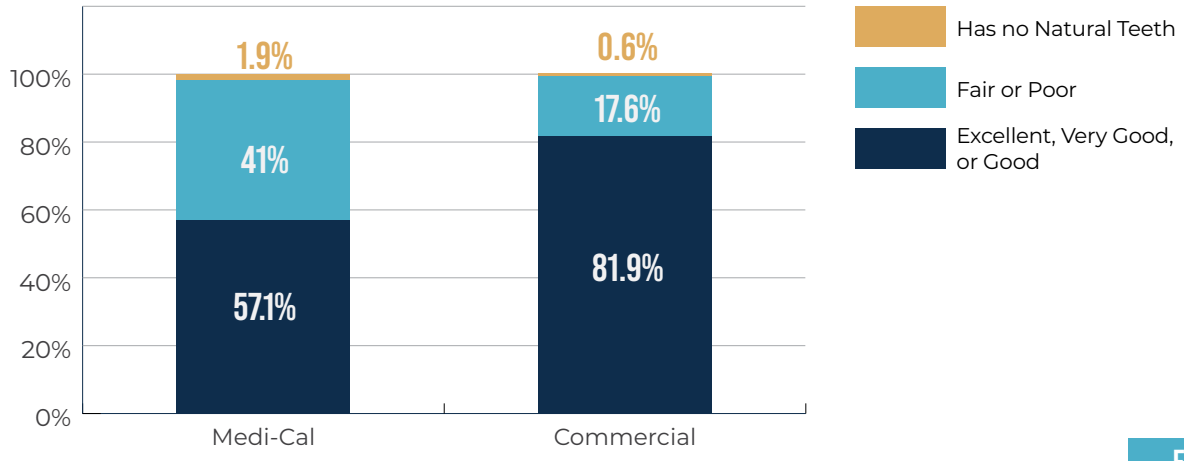



FIGURE 2

*Source: California Health Interview Survey, 2020*

It is against this backdrop that CPEHN, with the support of the CareQuest Institute, convened oral health equity leaders from throughout the state to understand the impact of structural racism on oral health and to produce the updated policy recommendations in this paper.

# California's Recent Progress

## EXPANDED COVERAGE

- Eliminated immigration status as a barrier to health coverage for low-income Californians (currently those ages 0-26 and 50+ and by 2024 will include those ages 27-49)
- Expanded full-scope Medi-Cal services, including dental coverage, to pregnant individuals 12 months postpartum
- Reinstated dental coverage in Medi-Cal in 2018 and added laboratory processed crowns in 2022

## SUPPORTED PROVIDERS

- Provided incentive payments to Medi-Cal dental providers to increase child and adult preventive care
- Offered student loan forgiveness to dental providers who participate in the Medi-Cal program

## INCREASED OUTREACH

- Provided $30 million annually to local public health departments to conduct oral health literacy and prevention work
- Conducted a statewide public education campaign to make families aware of the dental care available to them through Medi-Cal

## SPURRED INNOVATION

- Funded 15 pilot projects across the state to develop methods of improving oral health in low-income communities
- Established the California State Dental Director and the Office of Oral Health
- Integrated oral health care into primary care by requiring Medi-Cal health plans to provide dental screenings for every Medi-Cal member

# Structural Racism and Oral Health

Structural racism is the systemic distribution of resources, power, and opportunity in society to benefit people who are White, excluding Black, Brown, Indigenous, and other people of color communities. It primarily results from the way that institutions and structures are designed, rather than personal animus (or lack thereof). Structural racism often intersects with other forms of oppression, including homophobia and sexism. California has a long history of perpetuating structural racism, including:

- The 1909 eugenics law that made it legal for a health professional to sterilize patients considered "mentally ill, handicapped, sexually deviant, criminal" – which led to forced sterilization of a disproportionate number of people from the Latino community, women, and people with disabilities [10]
- Permitting Ku Klux Klan rallies in the Central Valley as late as the 1930s, among other racist laws and practices [11]
- Sanctioning the sterilization of incarcerated women between 2006 and 2010 – which authorized the coerced sterilization of predominately Black and Latina women, a number of them trans [12]

The persistence of structural racism and its impact on the health and opportunities of Black, Brown, Indigenous, and other people of color

communities depends on differential racialization, which refers to the process by which the dominant society racializes certain groups at different times in response to shifting needs.[13] Differential racialization explains legal structures that a dominant society devises for each group – such as English-only laws for Latino people,[14] alien land laws for Asian and Pacific Islander people,[15] and Jim Crow laws for Black people.[16] As a result, different groups must contend with different sets of discriminatory laws and practices. Structural racism is not simply a system of the past; the impact of white supremacist laws and policies is embedded and felt throughout all of our institutions today.

Today, structural racism and the design of the oral health delivery system deprives Black, Brown, Indigenous, and other people of color communities of good health. Due to racialized poverty, Medi-Cal enrolls a disproportionate share of Black, Brown, Indigenous, and other Californians of color, and Medi-Cal dental coverage is not comprehensive, consistent, or easily accessible.

At the federal level, Medicaid dental benefits are optional for each state, resulting in California having changed the scope of adult dental benefits three times in the last decade. Adult Medi-Cal members, particularly Black, Brown, and Indigenous communities and limited English proficient (LEP) individuals, struggle to find Medi-Cal dental providers, obtain culturally and linguistically appropriate services, and achieve positive oral health outcomes. Twelve other states in the country rank higher than California in terms of coverage and the extent of that coverage.[17] As a result, Black and Latino populations in California experience tooth decay, periodontal disease, and oral and pharyngeal cancer at higher rates compared to other racial groups.[18]

Furthermore, Medicare, federal health insurance for people 65 years of age and older and some people under 65 with certain disabilities and conditions, does not provide dental coverage for older adults and persons with disabilities. Nearly half of all older adults with Medicare have not visited a dentist within the past year because they lack dental coverage. Those numbers are closer to 70% for Black Medicare recipients, Hispanic Medicare recipients, and Medicare recipients with lower incomes.[19]

One of the most insidious ways structural racism has impacted oral health is the deep-seated belief that Black, Brown, and Indigenous communities don't care about their oral health. Black and Latino community residents with low incomes in South Los Angeles, who work with the Oral Health Equity Core Group member Strategic Concepts in Organizing and Policy Education (SCOPE), say their communities value and understand the importance of oral health. However, when faced with limited resources including time and money, community members often have to prioritize working multiple jobs, paying rent, buying food for their families, and caretaking for family members while sacrificing other priorities, including oral health. Additionally, the lack of linguistically and culturally concordant Medi-Cal dental providers in their community, the challenges of qualifying for and retaining Medi-Cal, and other systemic barriers cut off access to care. Stories of social and economic struggles are the structural factors, not individual behaviors, that drive disparities. Communities feel oral health equity is not only a health care issue but also a racial and economic justice one.

# Oral Health Equity Core Group

Over the past year and with support from the CareQuest Institute, the California Pan-Ethnic Health Network (CPEHN) developed and led the Oral Health Equity Core Group, a collaboration of racial equity-focused grassroots and safety-net organizations representing the racial, ethnic, and regional diversity of California. The Equity Core Group grew out of the idea that advancing racially equitable oral health policy in California must be grounded in community voice and lived experience, by creating space for community members to engage meaningfully in oral health policy development, advocacy, and implementation. Over the past year, the Equity Core Group focused on developing this community-defined oral health policy agenda to reduce racial disparities and achieve true oral health equity in California. The following are the Oral Health Equity Core Group members:

### STRATEGIC CONCEPTS IN ORGANIZING AND POLICY EDUCATION

- **Location:** South Los Angeles
- **Mission:** To create social and economic justice for low-income, female, immigrant, black, and brown communities in Los Angeles.

### CENTRO BINANCIONAL PARA EL DESARROLLO INDÍGENA OAXAQUEÑO

- **Location:** Fresno, Madera, and Monterey counties
- **Mission:** To foster and strengthen the civic participation, economic, social, cultural development of the indigenous communities, as well as the resistance of the indigenous communities.

### ASIAN HEALTH SERVICES

- **Location:** Alameda County
- **Mission:** To serve and advocate for the medically underserved, including the immigrant and refugee Asian community, and to ensure equal access to health care services regardless of income, insurance status, language, or culture.

### RAVENSWOOD FAMILY HEALTH NETWORK

- **Location:** San Mateo County
- **Mission:** To improve the health of the community by providing culturally sensitive, integrated primary and preventative health care to all, regardless of ability to pay or immigration status, and collaborating with community partners to address the social determinants of health.

### SOUTHSIDE COALITION OF COMMUNITY HEALTH CENTERS

- **Location:** South Los Angeles
- **Mission:** To sustain, coordinate and improve health care access and delivery to the impoverished and vulnerable community members of South Los Angeles.

# Defining Oral Health Equity

The phrase “oral health equity” is often used in health advocacy spaces, but can be interpreted differently by various people, groups, and communities. Due to the ambiguous nature of the term, the Oral Health Equity Core Group collectively defined the term so that there is a shared definition that can be used and understood by all.

Oral health equity is achieved when systemic barriers to quality oral health care are dismantled, resulting in the best possible oral health outcomes for all communities, regardless of their race, ethnicity, income, spoken language, gender identity, sexual orientation, age, immigration status, disability status, or zip code. We envision oral health equity within a system focused on public health, not private profit.

## Oral health equity is...

- Racially equitable
- Physically, culturally, linguistically, and financially accessible
- Trans-inclusive
- Gender expansive


Coverage
Workforce
Data
Cultural & Linguistic Access
ORAL HEALTH EQUITY

# Systemic Barriers and Policy Recommendations

The following recommendations are a direct result of the Equity Core Group's input. To create these recommendations, CPEHN facilitated an intentional process over the course of a year. We recruited diverse and often excluded organizations to form the Equity Core Group to ensure our priorities aligned with true community interests. Then, CPEHN facilitated a grounding session with the Equity Core Group members to develop a shared definition of oral health equity. To understand community level oral health equity issues across regions and communities of color, CPEHN conducted interviews with Equity Core Group members to better understand the main barriers to oral health care in 2022. After developing proposed priorities, CPEHN re-engaged with the Equity Core Group to validate and strengthen our recommendations through collective feedback sessions.

California's healthcare delivery system is fragmented, particularly for Medi-Cal recipients who must navigate across multiple complex managed care and fee-for-service delivery systems in order to access oral healthcare. Dental care is provided by a separate fee-for-service delivery system or a dental managed care plan, depending on the county. Inconsistent oral healthcare coverage in California has largely impacted Black, Brown, and Indigenous communities with low-incomes who rely on Medi-Cal for their oral health needs. Given that a majority of adults eligible for Medi-Cal services come from communities of color with low incomes and that a third of those eligible do not consider English their primary language, many of the following community evidence and recommendations are focused on the Medi-Cal dental delivery system, but can certainly be applied to commercial health insurance plans as well.

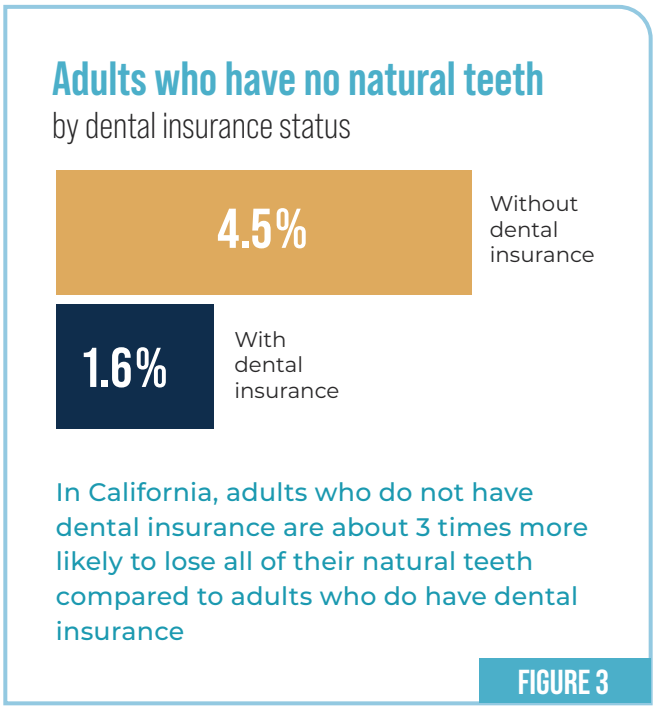
# Coverage Barriers

**RECOMMENDATION:**

**California and the federal government should work together to establish permanent, full-scope dental coverage for adults in Medi-Cal.**

One of the most significant barriers to accessing oral health care for low-income communities of color is the lack of stable preventive and restorative dental coverage for adults. While California currently has comprehensive adult dental benefits for adults enrolled in Medi-Cal, this has not always been the case. In the last fifteen years, California has eliminated and restored dental benefits for adult recipients of Medi-Cal multiple times. This year-to-year change in coverage has caused many providers enrolled in Medi-Cal to leave the program,[20] causing great confusion among Medi-Cal members who are affected by these sudden policy changes and left wondering whether or not they will have access to a dental check-up in a given year. Changes to dental benefits for adults enrolled in Medi-Cal also lead to the inability to continue ongoing treatment, interruptions in access to preventive services, and use of the emergency room for preventable dental conditions.

Establishing permanent, comprehensive coverage for all adults who rely on Medi-Cal will advance health, economic, and racial justice. Among adults with low-incomes in California, almost 50% of Latino adults did not have dental insurance in 2020, compared to 28% of White adults with low-incomes.[21] Adults who did not have dental insurance were also about 3 times more likely to have no natural teeth compared to adults who did have dental insurance.[22]




***Source: California Health Interview Survey, 2019***

Californians should not have to worry about their access to dental care changing from year to year simply because they are enrolled in Medi-Cal. Dental should be a permanent adult Medi-Cal benefit that is no longer subject to the volatility of the state budget.

## RECOMMENDATION:

### Integrate oral health with primary health care and improve accountability.

Oral health care has historically been separated from other physical health care, resulting in particularly unequal access as oral health care is considered more of a privilege than a right, and consumers are left to navigate dental coverage and care on their own. Dental problems disproportionately affect low-income communities of color, who often face the most challenges in accessing equitable oral health and primary care.[23] Therefore, integrating dental care as an essential component of physical and primary care is key to advancing health equity. This includes integration at all levels, including the payer and the point of care.

Many Federally Qualified Health Centers (FQHCs), such as Oral Health Equity Core Group member, Ravenswood Family Health Network in San Mateo County, offer both medical and dental services in the same location or in close proximity to one another, and have a unified electronic health record, where medical and dental health records are in the same system. The co-location of services under one roof along with a unified health record allows for opportunities for providers to partner with each other and with patients to provide care and coordinate services that patients need. The co-location of services under one roof has been a very successful model, as it allows for a warm handoff of patients from the medical provider to the dental provider. It also allows a collaborative approach on the part of clinicians to approach whole-person care, and ensures patients have access to all services to address their health care needs.

However, co-location of primary care and dental care is not a requirement for a good integration plan. Several clinics that do not have co-located services have successfully leveraged the integrated care model using telehealth technology as well as information sharing via electronic health records to integrate medical and dental services, provide care coordination, and improve their patients' health outcomes. One such example is Oral Health Equity Core Group member, Asian Health Services, which has multiple clinics across Alameda County. They have prioritized collaboration, resulting in better coordinated care and overall better health outcomes for their patients.

Another model that could set an example for primary care integration in the Medi-Cal program is Sacramento County's implementation and establishment of the Medical Dental Referral and Navigation (MDRAN) model, which encourages medical providers to make dental referrals, and care coordinators to ensure that appropriate support is provided where needed to patients so that resulting dental appointments are kept. This helped to create an electronic system whereby not just a primary care provider, but also a Women, Infants, and Children (WIC) site or anyone who works with a child could make a referral to a dental provider if a child's record showed that they had not visited a dentist.

After MDRAN's success in Sacramento County, Children Now, a non-partisan, whole-child research, policy development, and advocacy organization, is working with San Joaquin County to launch a similar initiative, which would look slightly different due to San Joaquin being a fee-for-service county. In this model, there will be a similar data sharing agreement between Medi-Cal managed care plans and Medi-Cal dental for care coordinators and community health workers to identify and refer children who have not been to the dentist in the last year to a dental provider. This will allow providers to track and refer children to a dentist, as well as determine why a child may not have visited a dentist despite being referred (lack of transportation, cultural/linguistic access issues, etc.). This improves care coordination and helps target specific barriers to dental care.

Lastly, bringing care directly to the community is an effective strategy for integrating oral health and primary care, thereby improving oral health equity. The Los Angeles Trust for Children's Health, a nonprofit affiliated with the Los Angeles Unified School District (LAUSD), utilized a public health model to establish a District Oral Health Nurse position to coordinate oral health services across LAUSD, and implemented a school-based oral health program across six elementary schools.[24] This initiative included community-wide oral health education for children and parents on topics including dental care habits, importance of the use of fluoride toothpaste, tobacco use prevention, and a "Drink the Water" fluoride campaign. The initiative also included full-scope preventive care in the form of screenings and assessments, fluoride varnishes, sealants for students on school campuses, and referrals to community providers for restorative care as needed.[25]

As a result of this initiative, there has been an improvement of oral health in children who initially had a high burden of untreated dental diseases – most of whom came from Latino families with low-incomes – demonstrating that a school-based fluoride-varnishing program coupled with identifying unmet dental needs, and providing dental referrals to community-based dental providers, can significantly reduce untreated dental disease.[26]

# Cultural and Linguistic Access Barriers

## RECOMMENDATION:

**Approach care with both cultural competence *and* cultural humility.**

California is the most culturally diverse state in the country, and is often referred to as a "majority-minority" state as no single race or ethnic group forms a majority of California's population.[27] In addition, California has more immigrants than any other state, with almost 11 million immigrants calling California home.[28] Due to the cultural and linguistic diversity of the state, we must ensure that our health care delivery systems are addressing the diverse needs of Californians in a culturally and linguistically appropriate manner, and with cultural humility.

Cultural humility is often compared to cultural competence. Cultural competence means that one is aware of the culturally diverse backgrounds of the individuals and communities they work with and that they provide care, assistance, or resources in a way that considers that individual's or communities' identities. But, when taking into consideration intersectionality[29] – the acknowledgment that one person is shaped by many intersections of different characteristics such as race, class, gender, and sexual orientation – it becomes clear that it's impossible to put people into

one specific identity category because not everyone has identical backgrounds and experiences.

While cultural competence suggests that one has all the knowledge about a person and their background, cultural humility takes a more interpersonal approach – understanding that each individual has a unique identity and that one can learn from them about their experiences to better assist them, and provide quality, tailored care for individuals, while simultaneously being aware of one's own biases. Understanding the cultural backgrounds of Californians will help to understand their cultural oral health needs.

For example, the Oral Health Equity Core Group shared that some community members with low-incomes have expressed the challenges of going to a dental appointment with children. ***"There are folks who have said that when they show up to the dental office waiting room with their children after a long day, the children are hungry, tired, and might be a little rambunctious, and because they don't have access to affordable childcare, they feel ashamed for being there with all their children because they know there are assumptions made about their parenting skills."*** To avoid these challenges, they may stop visiting the dentist altogether. To an outsider who does not know the situation, it may seem as if the patient does not care about their oral health and therefore is no longer scheduling dental appointments. However, someone practicing cultural humility will take the time to understand why the patient can no longer visit the dentist. Another issue that has surfaced more recently due to COVID-19 precautions is that clinics do not allow family members to accompany the patient, making it even more challenging for parents to visit the dentist. Lack of childcare is an ongoing issue that may prevent patients from seeking care.

The Oral Health Equity Core Group also noted that immigrants, in particular, face several barriers to receiving oral health care when arriving in California. Many immigrants migrating from Mexico and other Latin American counties, especially Indigenous communities, ***"understand the importance of oral health, but there are so many barriers when arriving to the UnitedStates and other needs they need to provide for their family, so knowing that oral health care is very expensive leads to them not receiving the treatment or receiving the oral health service that they may need."*** Many immigrants also hesitate to seek dental coverage, despite being eligible for programs such as Medi-Cal. Due to complications in the system, they face challenges navigating eligibility requirements, enrollment, coverage options, and finding a provider, among other things. For others, costly oral health care leads to using home remedies to treat symptoms, which can worsen their oral health. When dental providers meet with patients who have migrated to the United States, it would be important to note their specific hesitancies and preferences to deliver the type of care that is right for them.

Similarly, the Oral Health Equity Core Group shared, ***"some East Asian and Southeast Asian patients may not ask for pain medication after a dental procedure, and they may go home and use a home remedy or herbs to help with their post-operation discomfort, because they believe that medication can bring more harm than good."*** These home remedies may help relieve pain and discomfort temporarily, but when the pain and discomfort returns and the patients seek care, dental conditions have worsened. The only solution then is to remove the offending tooth. This causes many patients to become partially or entirely edentulous at a young age – something that could be prevented if the intervention had taken place earlier through education.

Many individuals with low incomes also perceive oral health care as a luxury due to its high cost and therefore only seek care when they have an emergency. The delay of dental care until an emergency arises leads to increased dental care costs for both the state and the individuals, as the replacement of missing teeth to re-establish chewing functions is more expensive than prevention methods. For providers, this again means taking the time to understand each patient individually and determine what will and will not work for them.

Additionally, the Oral Health Equity Core Group reported, ***"several communities across California do not drink tap water due to distrust in the system,"*** despite several counties having fluoridated water in their public water systems, which is proven to reduce tooth decay.[30] ***"When communities hear news stories on topics such as the lead contaminated water in Flint, Michigan, coupled with the systemic racism they experience in their lives, it's hard to convince them that their water is safe."*** It is also challenging to convince immigrants that it is safe to drink from the public water system in their county if they immigrated from a place where the public water system is poor. These experiences can render county water fluoridation less effective, leading to higher incidences of tooth decay in these communities.

The Oral Health Equity Core Group felt that understanding that these nuances exist between different patients is essential for dental providers. As this community evidence demonstrates, there cannot be a one-size-fits-all approach to dental care, and providers must approach care with cultural humility. Doing so will help mitigate implicit biases and help providers deliver tailored treatment to their patients by creating a deeper understanding and connection between patients and providers. In turn, this can

Dental offices can ensure they meet diverse patients' needs by assessing their needs before the appointment. Ravenswood Family Health Network does this in their dental practice through an accommodation questionnaire, to assess the accommodations a patient would need for their appointment. What started with asking questions such as, "How long should the appointment be?" or "What time of day would be best?" to assess the needs of patients, has now expanded into a questionnaire that asks essentially, "What would make your visit go well?" Whether it's translation and interpretation, whether it's help with filling out forms, whether it's special needs accommodations for a wheelchair – all of these preferences are collected ahead of time, giving the clinic an opportunity to be better prepared for the patient's appointment. This helps patients feel heard as they are no longer treated as a number, builds trust between the patient and the provider, and makes patients more responsive to their treatment.

increase the level of satisfaction patients feel after their dental appointments, and ultimately improve their oral health outcomes.

## RECOMMENDATION:

**Improve timely access to quality interpretation and translation services.**

Both state and federal law require that people seeking dental care, and other medical care, be provided with interpretation and translation services.[31] Studies show that in-language communication increases positive health outcomes.[32] Despite this, timely access to language assistance is not a reality for many limited English proficient consumers, or the providers who serve them.

Many Medi-Cal members do not know they have the right to request an interpreter,[33] while others have noted a lack of interpreters in their preferred language when seeking oral health services. Often, when members do request an interpreter in advance, it is a long and complicated process, with members sometimes waiting more than three weeks to find the right interpreter. And if an interpreter cannot be found before their appointment, their appointment is canceled, significantly delaying their care.

Other times, when an interpreter is found on time, both patients and providers report dropped calls and having to call the interpretation line multiple times during a single appointment, which wastes the time of the patient, the interpreter, and the dentist. Sometimes these dropped calls and reconnections take up so much time that the appointment needs to be rescheduled, again delaying care. For some Indigenous communities, when an interpreter is found, it is often not the right dialect of their spoken language, as there is a lack of knowledge among service providers about Indigenous languages.

These issues deter some members with limited English proficiency from receiving oral health care services. For members who do decide to seek oral health care services despite not having an interpreter, they may find themselves confused and unable to fully understand their care plan, which can often lead to uninformed decisions made about their oral health.

On June 10, 2019, advocates from 28 statewide organizations submitted a **joint letter** to the Department of Health Care Services regarding language access within DHCS Medi-Cal Dental Division. Since the submission of the letter, DHCS has undertaken additional efforts to make substantial improvements in response to the concerns raised in the advocates' letter. At the request of stakeholders, DHCS has also launched a Medi-Cal Language Access Workgroup. The Department of Health Care Services has also launched and implemented the Smile, California Campaign in the top Medi-Cal threshold languages. Despite the existence of explicit state law and these achievements by DHCS, cultural and linguistic access remains a barrier to receiving quality oral health care.

## RECOMMENDATION:

### Conduct effective community outreach and education through trusted messengers and use of multiple mediums, including visual materials.

In 2018, the Department of Health Care Services (DHCS) launched the Smile, California campaign to increase awareness and utilization of the Medi-Cal Dental benefit among Medi-Cal members.[34] The campaign's website and materials provide facts about the dental benefits available to members through Medi-Cal, including the importance of regular dental visits, which services are covered by age group, and a quick link to help members find a dentist near them.[35]

The Smile, California campaign website is available in English (smilecalifornia.org) and Spanish (sonriecalifornia.org), and has landing pages in 15 other threshold languages. It was developed to be user-friendly and easy to navigate to help members take full advantage of their Medi-Cal dental benefits. This campaign seems to have helped improve Medi-Cal members' awareness of their dental benefits, however, there are still gaps that Medi-Cal should address. One glaring gap is among those who have low literacy and those who do not read or write, and therefore cannot understand written information relayed through the Smile, California campaign or other member-facing materials.

The Oral Health Equity Core Group specifically highlighted Indigenous community members whose native languages are only spoken – not written or read. One recommended way to increase outreach and education to those communities, as well as other communities whose native languages are not written or read is through the use of images and other visuals.


FIGURE 4

Oral Health Equity Core Group member, Centro Binacional para el Desarrollo Indígena Oaxaqueño (CBDIO), provides "I Speak" cards to Indigenous community members to help them assert their right to an interpreter at health clinics, hospitals, social service agencies, law enforcement agencies, courts, public schools, and other government agencies. These cards were designed by California Rural Legal Assistance, Inc. in collaboration with CBDIO.

FIGURE 5

Centro Binacional para el Desarrollo Indígena Oaxaqueño hosts health education events across Central Valley and Central Coast of California to facilitate access to health and social services for Indigenous community members.

Currently, most member-facing materials are text-heavy, making it almost impossible for members who speak a language not part of the threshold languages to understand the materials that Medi-Cal dental sends. Employing more images and other visuals in member-facing materials will help make information more concrete for those who do not understand written language, ultimately clarifying meaning and promoting understanding. Given that Indigenous populations experience poorer oral health outcomes compared to non-Indigenous populations,[36] Medi-Cal must pay particular attention to ensuring that Indigenous communities are being reached through Medi-Cal's education and outreach campaigns and other member-facing materials and notices.

Another way to increase outreach and education to communities who have low literacy is through one-on-one conversations at community health events or other places where the community gathers. Outreach should be done in person through partnerships with community-based organizations (CBOs). These partnerships are critical, as trust between CBOs and the community has been built over the years. In addition to the unique expertise CBOs possess, CBOs know the most effective strategies to reach out to their communities. And now, with the recent approval of the community health worker benefit in Medi-Cal, community health workers can help to conduct oral health outreach, provide education, and connect patients to resources that make oral health care more accessible as they have deep, trusting relationships with their communities.

Dental providers can also collaborate with CBOs by providing presentations at community gatherings or building partnerships to offer services onsite at the CBO. For example, FQHCs have provided dental services at elementary schools, libraries, and senior centers. By partnering with CBOs, dental providers can help provide both education and dental services to more community members in a location that the community members feel comfortable.

# Workforce Barriers

**RECOMMENDATION:**

**Support efforts to expand the oral health care team to include dental therapists and community health workers.**

To address inequities in access and quality of care, while simultaneously building trust between communities of color and providers, it is necessary to expand the oral health care team to include providers such as dental therapists and community health workers – providers who come from the communities they serve.

Expansion of the dental workforce to include dental therapists and community health workers creates more opportunities for members of historically underrepresented populations to become involved in the oral health care workforce and improves access to preventive and restorative care for those disparately affected by oral health service barriers.[37] When members

In July 2022, California added community health worker services, including oral health education and outreach, as a Medi-Cal benefit. Additionally, the 2022-2023 state budget included a one-time allocation of $10 million to create new and enhanced community-based clinical education rotations for dental students to improve the oral health of underserved population groups in California.[38]

of the health care team and patients share the same race, ethnicity, or language, patient satisfaction, participation in care, and level of trust all increase.[39] When patients have trust in their oral health team, they are more likely to seek out and maintain oral health care regularly.

Trust is a crucial factor in a patient-provider relationship, including trust in the provider, and the system in which the provider practices. Unfortunately, due to a history of abuse, distrust of our health care delivery systems and distrust of providers is prevalent among communities of color and serves as a barrier, preventing communities from receiving the care they need.

The Oral Health Equity Core Group shared that this distrust extends tremendously into Black communities, who have faced significant barriers due to systemic racism. A history of discrimination and racism by researchers, medical professionals, and the government has led to a rightful skepticism among Black communities. This reality, coupled with the fact that only 2% of dentists in California are Black,[40] further contributes to oral health disparities and inequities in access to care, utilization of dental services, and oral disease burden, and demonstrates the need for the expansion of the oral health care team.

Dental therapists can increase trust by expanding access to cost-efficient routine, preventive care, improving the oral health outcomes of underserved communities.[41] Dental therapy in other states has provided an accessible training program and career pathway in the oral health care sector for Black, Brown, and Indigenous communities with low-incomes. When community residents have dental providers from the community who understand the culture and history of the community, trust in the oral health system increases due to community members receiving reliable oral health care and the overall health of the community improves by:

- Ensuring continuous oral health care, since dental therapists from the community are invested in staying in the community and serving the community.
- Spurring economic investment, since dental therapists live and spend money in the community.
- Creating savings in health care costs for patients through the provision of cost-efficient care, which allow for patients to use the savings for other necessities such as food, housing, and other health care needs.

## RECOMMENDATION:

**Establish incentives to increase the number of diverse dental providers.**

Dental schools should increase opportunities for applicants from low-income, underrepresented, and rural populations. One way to do this is to increase the number of pipeline education programs, which aim to remove barriers to careers in dentistry for students of color, thereby increasing the number of dentists from communities of color. A 2019 study evaluated the Boston University Oral Health Sciences pipe-

The California 2022-23 state budget included significant investments to improve the dental pipeline, including $45 million to provide training and career-ladder opportunities for workers like dental assistants. The budget also included $175 million to expand nontraditional apprenticeships, possibly including dental assisting apprenticeships.[42]

line program, established in 2005, to increase the level of academic preparedness of students from "underrepresented minority groups" for dental school.[43] After assessing 10 years of data, the study found that the pipeline program not only increased the number of socioeconomically disadvantaged first-generation college students who would then go on to serve rural areas, but also increased the racial diversity among dentists as a whole.[44]

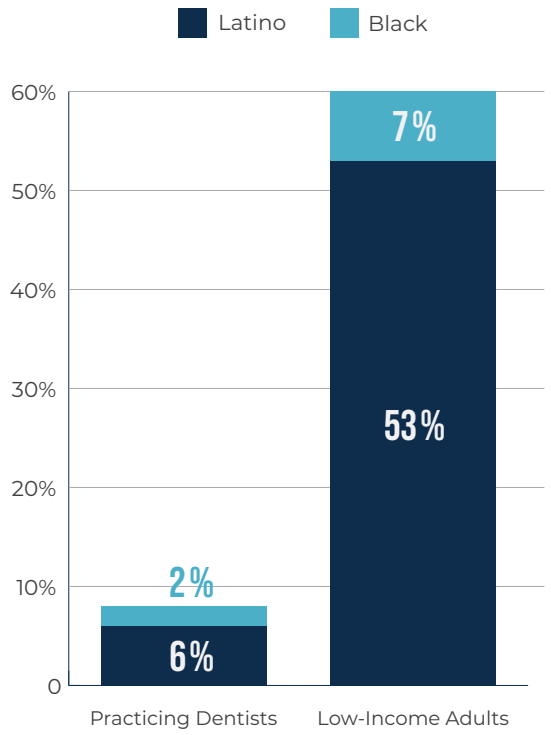
Currently, the lack of dental providers in Medi-Cal is an additional barrier to obtaining care, which is even more striking in underserved areas. Medi-Cal covers about 35% of the state's population;[45] however, in 2021, only 21% of dentists in California participated in Medi-Cal, one of the lowest rates of participation in the country.[46] [47] Additionally, although 53% of the state's adults with low income are Latino, only 6% of practicing dentists are Latino, and while 7% of the state's adults with low income are Black, only 2% of practicing dentists are Black.[48] These numbers are even lower for American Indian/Alaska Native and Native Hawaiian/Pacific Islander groups. This can be a barrier for adults with low incomes in receiving dental care, as Black and Latino dentists are more likely to practice in areas with more low-income populations and communities of color, and are more willing to participate in Medi-Cal compared to their White counterparts.[49]

Increasing the number of Black, Latino, and Indigenous dental providers is crucial to achieving racial equity in oral health, as researchers have found that patient-provider race concordance improves patient experience.[50] Studies also show that dentists' decision-making, at times, is affected based on a patient's race, where dentists will opt for more invasive procedures for Black patients compared to their White counterparts.[51] Supporting initiatives that aim to increase the number of diverse dental providers can ultimately help prevent racial bias and racism, leading to overall improved patient experiences and oral health outcomes.

The state has made investments through legislation in the form of Proposition 56 to develop a loan repayment program to incentivize dentists to increase participation in Medi-Cal.[52] As part of the eligibility requirements for the program,

## Latino and Black Dentists

Compared to their Racial/Ethnic Distribution in California




Note: Low-income Adults are those with incomes of 0-199% FPL.

FIGURE 6

*Source: California Health Interview Survey, 2019; American Dental Association Health Policy Institute*

dentists are required to maintain a Medi-Cal patient caseload of 30% or more and agree to serve in California for five years.[53] However, there is no explicit requirement to address racial and ethnic disparities. While this program may encourage more dentists to enroll as Medi-Cal providers, it does not guarantee that more racially and ethnically diverse dentists will join the workforce. Furthermore, loan forgiveness is not a good option for students who cannot afford to pay at the outset. A Medi-Cal caseload of 30% is also too low to address existing shortages. These program funds should be better targeted to address the identified needs of people with low incomes who do not attend dental school due to high costs. Policies incentivizing oral health care delivery to adults with low incomes should continue to be refined and operate in tandem with pipeline programs.

# Data Barriers

## RECOMMENDATION:

**Collect and report utilization, quality, and outcome data that is disaggregated by race, ethnicity, preferred language, gender identity, sexual orientation, age, disability status, and county.**

In order to improve the delivery of dental care and advance oral health equity, both communities and decision-makers must have access to data that is actionable and fully reflective of California's diverse communities. Data is not neutral. How data is collected, reported, and used can either exacerbate or ameliorate disparities. Aggregated data often masks true inequities. Data that is disaggregated by race, ethnicity, preferred language, gender identity, sexual orientation, age, disability status, and county can be used to identify inequities and help close gaps.

Currently, the Medi-Cal program collects and reports some information with demographic indicators, although the data is limited. For example, the Department of Health Care Services collects and reports language data for members who call the state for assistance accessing dental care. Recent data from January to June 2022 shows that of those callers who received language assistance, most spoke Spanish (30%), followed by Mandarin (13%) and Russian (13%), Vietnamese (8%), Cantonese (7%), Farsi (6%), Arabic (5%), Dari (5%), Korean (3%), and Oth-

er Languages (10%).[54] This information allows the state to set policy and allocate resources according to language assistance needs. In addition, utilization data for annual dental visits, exams/oral health evaluations, diagnostic services, dental treatment services, preventive services, restorative services, and treatment/prevention of caries is collected and reported by age, county, and race.

While this information is publicly posted on the Department of Health Care Services website and the California Health and Human Services Open Data Portal, respectively, the format of the data on both sites is not easy to access nor is it presented in a user-friendly manner. DHCS should work to publish the data in a way that is more user-friendly, filterable, and easily accessible to a wider audience. DHCS should also work to represent the data in a meaningful way using dashboards and reports, in addition to any raw data that is published.

Additionally, existing publicly available data is not fully disaggregated for some communities. For example, currently, "Asian" or "Asian American and Pacific Islander" (AAPI) is considered a single racial/ethnic category in most data and reports. This often conceals persistent inequities among individuals of at least 50 distinct ethnic groups who fall into this category, each with their own historical, linguistic, and cultural differences that influence their outcomes.[55] In the same vein, in Mexico, while there are 68 unique Indigenous spoken languages, and 364 variations of those languages, Indigenous communities from Southern Mexico are categorized as a single racial/ethnic category – Latino/Hispanic – which erases their Indigenous background and does not capture the linguistic and cultural diversity among the Mexican immigrant population.

In addition to accurately representing the diversity of consumers, oral health data must provide actionable information. Existing public data sets focus on utilization measures such as visit types and service counts, which bring visibility to inequities in consumer access and navigation through the oral health system. However, this data does not answer questions about potential inequities in care quality and outcomes, which should also be collected and made publicly available. Outcome data for oral health includes measures such as presence or absence of periodontal disease, permanent teeth extractions, edentulous status, replacement of missing teeth, and emergency room visits for oral health-related issues.

# Closing

Structural racism is the reinforcement of centuries of racist rhetoric, public policies, and institutional practices in our current political, economic, and social systems and is present in every facet of our society, including our oral health delivery systems. To effectively dismantle racism in oral health, we must move beyond individual education and action, and address systemic barriers and social norms that engage in institutional racism.

Advancing racial equity in oral health should be a multi-pronged approach that requires addressing multiple existing systemic barriers that contribute to the poor oral health of Black communities, Brown communities, Indigenous communities, and other communities of color with low incomes. Addressing barriers by focusing on systemic change includes establishing comprehensive dental coverage for all, improving access to culturally and linguistically responsive care, supporting efforts to increase the number of diverse dental providers, and improving the process of data collection and reporting, among others.

These recommendations are important first steps towards achieving a more racially equitable oral health system in California, where everyone achieves the best possible oral health outcomes, regardless of their race, ethnicity, income, spoken language, gender identity, sexual orientation, age, immigration status, disability status, or zip code.

# Endnotes


1 "The Many Costs (Financial and Well-Being) of Poor Oral Health," University of Illinois Chicago, accessed August 31, 2022, https://dentistry.uic.edu/news-stories/the-many-costs-financial-and-well-being-of-poor-oral-health/.

2 "Oral Health Conditions," Centers for Disease Control and Prevention, April 6, 2022, https://www.cdc.gov/oralhealth/conditions/index.html.

3 "Cardiovascular Disease and Race: Causes," Medical News Today, August 23, 2021, https://www.medicalnewstoday.com/articles/cardiovascular-disease-and-race.

4 Jonathon Timothy Newton, Neeta Prabhu, and Peter G. Robinson, "The Impact of Dental Appearance on the Appraisal of Personal Characteristics," *The International Journal of Prosthodontics* 16, no. 4 (August 2003): 429–34.

5 American Dental Association. *Oral Health and Well-Being in California*. Health Policy Institute. 2015, https://bit.ly/3cuwgLb.

6 Ibid.

7 "Taking a Bite Out of Oral Health Inequities: Promoting Equitable Oral Health Policies for Communities of Color" (California Pan-Ethnic Health Network, n.d.), https://cpehn.org/assets/uploads/archive/resource_files/cpehn_oral_health_brief_01_16.pdf.

8 UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2020. Condition of teeth – Adults compared by Race.

9 UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2020. Condition of teeth – Adults compared by Type of current health insurance coverage.

10 Sarah Zhang, "A Long-Lost Data Trove Uncovers California's Sterilization Program," *The Atlantic*, January 3, 2017, sec. Health, https://www.theatlantic.com/health/archive/2017/01/california-sterilization-records/511718/.

11 Newell G. Bringhurst, "The Ku Klux Klan in a Central California Community: Tulare County During the 1920s and 1930s," *Southern California Quarterly* 82, no. 4 (December 1, 2000): 365–96, https://doi.org/10.2307/41172036.

12 Shilpa Jindia, "Belly of the Beast: California's Dark History of Forced Sterilizations," *The Guardian*, June 30, 2020, sec. US news, https://www.theguardian.com/us-news/2020/jun/30/california-prisons-forced-sterilizations-belly-beast.

13 Richard Delgado and Jean Stefancic, *Critical Race Theory: An Introduction*, 2nd ed (New York: New York University Press, 2012).

14 Julissa Arce, "Racial Segregation of Latino Students Continues with English-Only Laws," UnidosUS, September 29, 2021, https://www.unidosus.org/blog/2021/09/29/racial-segregation-of-latino-students-continues-with-english-only-laws/.

15 "California Law Prohibits Asian Immigrants from Owning Land," Equal Justice Initiative, accessed August 31, 2022, https://calendar.eji.org/racial-injustice/may/03.

16 "Jim Crow Laws: California, Colorado, Connecticut and Delaware," Americans All, accessed August 31, 2022, https://americansall.org/legacy-story-group/jim-crow-laws-california-colorado-connecticut-and-delaware.

17 "Medicaid Adult Dental Coverage Checker," CareQuest Institute for Oral Health, accessed August 31, 2022, https://www.carequest.org/Medicaid-Adult-Dental-Coverage-Checker.

18 Pamela K. Johnson, "Disparities Persist in Tooth Decay, Preventive Care," *California Health Report*, April 15, 2015, https://www.calhealthreport.org/2015/04/14/disparities-persist-in-tooth-decay-preventive-care/.

19 Myechia Minter-Jordan and Kiran Savage-Sangwan, "For Seniors' Dental Care, Medicare Needs to Step Up," *Capitol Weekly*, October 11, 2021, https://capitolweekly.net/for-seniors-dental-care-medicare-needs-to-step-up/.

20 Ron Shinkman, "Number of Dentists Who Accept Denti-Cal Declined over Last Five Years," *The Mercury News,* April 10, 2018, https://www.mercurynews.com/2018/04/10/number-of-dentists-who-accept-denti-cal-declined-over-last-five-years/.

21 UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2020. Dental Insurance – Adult compared by Race UCLA CHPR, limited by FPL 0-138%, age 21-64.

22 UCLA Center for Health Policy Research, Los Angeles, CA. AskCHIS 2019. Condition of teeth – Adults compared by Dental Insurance – Adult.

23 Jane Koppelman and Rebecca Singer Cohen, "Dental Health Is Worse in Communities of Color," *Pew Charitable Trusts*, May 12, 2016, http://pew.org/1XlO2z6.

24 Rebecca N. Dudovitz et al., "A School-Based Public Health Model to Reduce Oral Health Disparities," *Journal of Public Health Dentistry* 78, no. 1 (March 8, 2017): 9–16, https://doi.org/10.1111/jphd.12216.

25 Ibid.

26 Ibid.

27 Hans Johnson, Eric McGhee, and Marisol Cuellar Mejia, "California's Population," Public Policy Institute of California, January 2022, https://www.ppic.org/publication/californias-population/.

28 Ibid.

29 Kimberle Crenshaw, 1989. Demarginalizing the intersection of race and sex: a Black feminist critique of anti-discrimination doctrine, feminist theory and anti-racist politics. *University of Chicago Legal Forum*, 1989(1), pp.139-167.

30 "Fluoridation by Public Water Systems," The California Water Boards, accessed August 31, 2022, https://www.waterboards.ca.gov/drinking_water/certlic/drinkingwater/Fluoridation.html.

31 "SB 853 Senate Bill," California Legislative Information, February 21, 2003, 8, http://www.leginfo.ca.gov/pub/03-04/bill/sen/sb_0851-0900/sb_853_bill_20031009_chaptered.html.

32 Alicia Fernandez et al., "Language Barriers, Physician-Patient Language Concordance, and Glycemic Control Among Insured Latinos with Diabetes," *Journal of General Internal Medicine* 26, no. 2 (February 2011): 170–76, https://doi.org/10.1007/s11606-010-1507-6.

33 "Centering Equity in Health Care Delivery and Payment Reform: A Guide for California Policymakers" (California Pan-Ethnic Health Network, December 2020),

34 "Campaign Backgrounder," Smile, California, January 2020, https://smilecalifornia.org/wp-content/uploads/2020/02/Campaign-Backgrounder-01-2020.pdf.

35 "Medi-Cal Dental Program," Smile, California, accessed August 31, 2022, https://smilecalifornia.org/.

36 "The Oral Health Crisis Among Native Americans," *Pew Charitable Trusts*, July 23, 2015, http://bit.ly/1HqI74a.

37 Albert Yee, Kristen McGlaston, and Robert Restuccia, "How Dental Therapists Can Address the Social and Racial Disparities in Access to Care," *American Journal of Public Health* 107, no. Suppl 1 (June 2017): S28–29, https://doi.org/10.2105/AJPH.2016.303641.

38 CDA Secures Historic State Budget Wins for Dentistry, Oral Health Access," CDA, accessed August 31, 2022, https://www.cda.org/Home/News-and-Events/Newsroom/Article-Details/cda-secures-historic-state-budget-wins-for-dentistry-oral-health-access.

39 Lisa A. Cooper, and Neil R. Powe, *Disparities in Patient Experiences, Health Care Processes, and Outcomes : the Role of Patient-Provider Racial, Ethnic, and Language Concordance*. (New York, NY: Commonwealth Fund, 2004).

40 American Dental Association. *Dentist Profile Snapshot by State: 2016*. Health Policy Institute. January 2018, https://bit.ly/3AYeklo

41 Donald L. Chi et al., "Dental Therapists Linked to Improved Dental Outcomes for Alaska Native Communities in the Yukon-Kuskokwim Delta," *Journal of Public Health Dentistry* 78, no. 2 (March 2018): 175–82, https://doi.org/10.1111/jphd.12263.

42 CDA Secures Historic State Budget Wins for Dentistry, Oral Health Access," CDA, accessed August 31, 2022, https://www.cda.org/Home/News-and-Events/Newsroom/Article-Details/cda-secures-historic-state-budget-wins-for-dentistry-oral-health-access.

43 Theresa A. Davies et al., "Improving Diversity of Dental Students Through the Boston University Master's of Oral Health Sciences Postbaccalaureate Program," *Journal of Dental Education* 83, no. 3 (March 2019): 287–95, https://doi.org/10.21815/JDE.019.024.

44 Ibid.

45 "Medi-Cal Eligibility Statistics," Department of Health Care Services, accessed August 31, 2022, https://www.dhcs.ca.gov/dataandstats/Pages/Medi-Cal-Eligibility-Statistics.aspx.

46 "Enrolled Medi-Cal Fee For Service Provider," California Health and Human Services Open Data Portal, accessed August 31, 2022, https://data.chhs.ca.gov/dataset/enrolled-medi-cal-fee-for-service-provider.

47 American Dental Association. *Dentist Profile Snapshot by State: 2016*. Health Policy Institute. January 2018, https://bit.ly/3AYeklo

48 Pourat N, Ortega-Verdugo P, Ditter M. 2021. The Challenge of Meeting the Dental Care Needs of Low-Income California Adults With the Current Dental Workforce. Los Angeles, CA: UCLA Center for Health Policy Research, https://bit.ly/3B39h2U

49 American Dental Association. *Racial and Ethnic Mix of the Dentist Workforce in the U.S.* Health Policy Institute. January 2018, https://bit.ly/3Ty3KIY

50 Junko Takeshita et al., "Association of Racial/Ethnic and Gender Concordance Between Patients and Physicians With Patient Experience Ratings," *JAMA Network Open* 3, no. 11 (November 9, 2020): e2024583, https://doi.org/10.1001/jamanetworkopen.2020.24583.

51 N. Patel et al., "Unconscious Racial Bias May Affect Dentists' Clinical Decisions on Tooth Restorability: A Randomized Clinical Trial," *JDR Clinical & Translational Research* 4, no. 1 (January 2019): 19–28, https://doi.org/10.1177/2380084418812886.

52 "AB-882 Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program.," California Legislative Information, February 17, 2021, https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB882.

53 Ibid.

54 "Medi-Cal Dental Services Division Statewide Fact Sheet," Department of Health Care Services, August 2022, https://www.dhcs.ca.gov/provgovpart/denti-cal/Documents/Statewide-Fact-Sheet-Aug2022.pdf.

55 Christian Edlagan and Kavya Vaghul, "How Data Disaggregation Matters for Asian Americans and Pacific Islanders," Equitable Growth (blog), December 14, 2016, http://www.equitablegrowth.org/how-data-disaggregation-matters-for-asian-americans-and-pacific-islanders/.

CareQuest Institute for Oral Health™