OPEN Oral Health Progress and Equity Network CALIFORNIA

Hanging By a Thread

Current Threats to California's Progress on Oral Health Equity

Background

Oral health access is a considerable challenge for communities of color in California. Only 48.7% of low-income Californians had a dental visit in the past year. Similarly, fewer than 50% enrolled in Medi-Cal had an annual dental checkup last year. These concerns fall disproportionately on low-income communities of color, in no small part due to major weaknesses in Medi-Cal's dental services and infrastructure.

To better understand the key issues, in 2015, the California Pan-Ethnic Health Network (CPEHN) completed a landscape assessment of the oral health challenges facing communities of color across California.

Since that time, California has taken substantial strides toward oral health equity:

- Established the California State Dental Director and the Office of Oral Health
- Provided $30 million annually to local public health departments to conduct oral health literacy and prevention work
- Raised the payment levels for dentists serving Medi-Cal members to equal commercial payment rates
- Provided additional incentive payments to dentists to provide preventive dental care to children
- Provided $30 million in student loan forgiveness to dentists who agreed to serve Medi-Cal beneficiaries
- Funded 15 pilot projects across the state to develop methods of improving oral health in low-income communities (LDPPs)
- Conducted a statewide public education campaign to make families aware of the dental care available to them through Medi-Cal
- Expanded eligibility for Medi-Cal to include all children and young adults up to age 26, providing access to dental care for these Californians
- Fully restored the Medi-Cal dental benefit for adults to include gum treatment, partial dentures, root canals on the back teeth and labratory processed crowns.

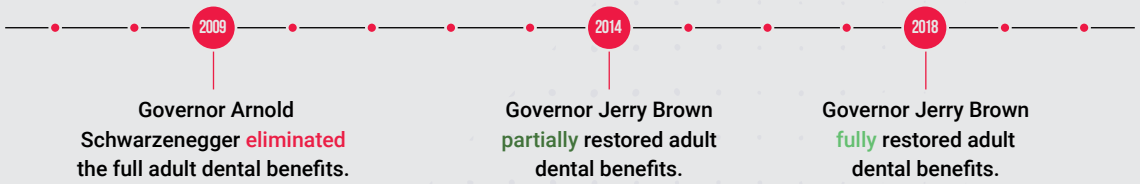
Taken together, these actions have had a significant positive impact on the oral health of low-income Californians. Most importantly, the restoration of the adult dental benefit in Medi-Cal allowed beneficiaries to access sorely needed services. A recent analysis showed that gum treatments are one of the most frequently utilized services, keeping consumers out of emergency rooms by treating periodontal disease before it progresses to an urgent concern.

*To learn more about Medi-cal dental benefits please click here or visit the link below:
https://cpehn.org/sites/default/files/resource_files/medi-cal_dental_gum_treatments_one-pager.pdf

However, California is now proposing to reduce adult dental benefits down to 2014 levels due to the unprecedented impact of COVID-19 on our economy. In addition, California is proposing to reduce dental provider rates back to previous levels. This report provides a stark reminder of what is at stake if we walk back the progress California has made on oral health equity. By reviewing the community concerns expressed in 2015, we are able to fully understand the devastation that these proposed policy changes would cause.

California has changed the scope of Medi-Cal adult dental benefits three times in the past decade, causing incredible confusion and variability in the program.

Timeline of Medi-Cal adult dental benefit changes:



In the May revision, Governor Gavin Newsom proposed to reduce adult dental benefits back to 2014 levels. Should California reduce adult dental benefits back to 2014 levels, we will again see the worsening of barriers to oral health care faced by communities of color, as illustrated in the landscape assessment- including access to quality, affordable and culturally appropriate dental care providers, a lack of culturally appropriate consumer education programs and materials, and a lack of integration between oral health and the wider health system. These benefit cuts would also have a significant impact on Medi-Cal consumers' overall health – particularly for those populations at most risk of disease and death from COVID-19.

CPEHN, in collaboration with the California Oral Health Equity and Progress Network (CA-OPEN), a statewide network of policymakers, consumers, advocates and providers committed to ensuring good oral health care is a fundamental right for all Californians, is releasing this report to illustrate how cutting benefits again would have the same deleterious impact on the oral health of communities of color across California.

Introduction

In 2015, the California Pan-Ethnic Health Network (CPEHN) worked with nine community partners across California to complete an oral health assessment. The goal of the assessment was to explore the perspective and experiences of low-income communities of color.

- How do community members and health care providers understand the role of dental health?
- What is the existing quality of care in oral health?
- How do health disparities affect dental care?
- What solutions do the community and providers propose for increasing access and quality of oral health care?

The community discussions were rich with information about the challenges to obtaining good oral health. Access was the key theme related to the barriers for quality oral health care. Community members described multiple roadblocks in accessing quality care including cultural, geographic, and economic hurdles. The discussions with providers included findings about the impact of social and environmental determinants on oral health care.

Key findings from the provider interviews included the need for consumer education on oral hygiene and health care, the impacts of language barriers on access to care, the role of substance abuse on tooth decay, and the effects of high sugar intake. These discussions also emphasized the need for oral health providers to focus on prevention in addition to treatment.

Methodology

The landscape assessment was conducted through community discussions and provider interviews. Nine community partners, representative of California's geographic and ethnic diversity, assisted in conducting community discussions on the barriers to oral health care.

The community partners included:

- Centro Binacional para el Desarrollo Indígena Oaxaqueño - Central Valley
- Black Women for Wellness - South Los Angeles
- Inland Empire Immigrant Youth Collective - Inland Empire
- Korean Resource Center - Los Angeles Koreatown
- Nile Sisters Development Initiative - San Diego
- Latino Health Access - Orange County
- Sacramento Native American Health Center - Sacramento
- Roots Community Health Center - Bay Area
- Asian Health Services - Bay Area

Together, the community partners developed guidelines for the community discussions, a participant information form, and a key-informant interview question guide. Each community partner was provided a stipend to assist with the discussions and informant interviews. In addition, the community partners conducted key-informant interviews with their staff and providers at community health centers, and other local programmatic staff.

Snapshot of Community Members

- 75 community members participated in a total of 7 community discussions.
- The majority of community members were of adult age
- Community discussions were held in Spanish, French, Burmese, and Korean and English
- 24 key informant interviews were conducted
- Languages spoken among community members included English, Spanish, Mixtec, Tlapaneco, French, Korean, Creole and Burmese-Karen
- Community members were from a range of cultural groups, including Latino/Hispanic, Black/African American, American Indian/Alaska Native, Burmese, and Indigenous/ Indigenous Mixtec

Detailed Findings

High Cost of Care

One of the most consistent barriers community members cited is the high cost of care for dental services. Although many dental issues can impede physical health, many dental procedures are often considered optional and require additional payment from the consumer. For example, in the Central Valley, a community member talked about having to pull a tooth instead of paying $800 for a filling. A woman in Orange County no longer seeks dental care because she is still paying off $5000 from a treatment she had five years ago. These consumers are unable to justify paying the high co-pays for dental coverage or out-of-pocket costs because food, rent, and other costs are more urgent. One community member in the Inland Empire stated the dilemma very succinctly,

> *The problem is, their families would have to abstain from buying groceries for the week in order to pay for the services needed."* - Inland Empire Youth Immigrant Collective

For very low-income families the high cost of care, even when necessary, is the biggest barrier to treatment and has led to reduced utilization of dental care.

> *"Community members, the elder community members … all struggled without care, because there are no dentist[s] willing to use Medi-Cal Dental system due to proper reimbursement. So these community members had to pay dental costs from their own pocket, with either savings (if any), or loans from family members, or taxing [requesting] their adult children to help them when things were dire."* - Korean Resource Center

Lack of Comprehensive Coverage

The lack of comprehensive dental insurance coverage was another consistent finding from the discussions. Often when an individual has dental coverage it does not cover more than basic cleanings and checkups. When consumers needed dental procedures, such as fillings, crowns or bridges, they were disappointed and frustrated to learn that their coverage does not pay for such procedures. Many consumers pay for insurance only to learn that the high co-pays for procedures force them to suffer through conditions that make eating difficult and cause chronic pain. As a result, many consumers often stop paying for coverage and skip routine cleanings and checkups.

Many of the community members with Medi-Cal Dental coverage expressed frustration and confusion about the adult benefits covered. Often coverage includes minimal services and does not include many services they actually need. One provider gave the following example: if a consumer needs a root canal and a crown, the root canal is covered but the crown is not. Covering only part of the work that is needed prevents consumers who are suffering from painful conditions to access the complete care they need to prevent a further decline in their oral health.

> *"They are able to receive general services such as teeth cleaning and cavity filling but cannot get other services such as dentures especially for the elderly population. Many elders …have inquired about this service because they have failing teeth."* - Nile Sisters Development Initiative

This theme was also illustrated through a story told by an older adult in Koreatown who needed a partial denture. Medi-Cal only covers full dentures, and he could not afford to pay for the partial denture. Therefore, a dental lab employee constructed a poorly made partial denture for him under-the-table for $500. He stated that even though it does not fit his mouth completely and causes painful mouth sores, he continues to use it in order to eat.

Lack of Accessibility

Community members also discussed a lack of affordable, local dental providers and the long wait times at free clinics. As a result, some community members sought alternative care at underground clinics/dentists and free health fairs.

Community members also noted that many local providers do not accept Medi-Cal Dental, forcing those who had coverage to either travel long distances to find a provider or to wait months to access care from the limited local providers who accept Medi-Cal Dental. Additional barriers cited by community members included difficulties in procuring transportation when they needed to travel outside their local communities for services and difficulty taking time off work during normal clinic operating hours.

In times of emergencies, many community members, particularly undocumented community members, reported using underground clinics and providers. These "clinicas clandestinas" or clandestine clinics are thought of both positively and negatively. For example, a community member in the Inland Empire shared that a local, non-licensed dental provider was much more trusted and affordable compared to the local licensed dentists. However, other community members were leery of these services because of questionable hygiene practices, the inability to have follow-up care, and the risk that the services will not work. One community member explained that individuals feel vulnerable because they are not able to find affordable and trustworthy providers.

> *"[Some] take advantage of [a] 'dentist' coming from Mexico [who] travel[s] to individuals' houses to provide dental services. Some that have used this service are not satisfied with it…For instance, a person was given [a] dental plaque that did not fit her mouth and was not able to use it."* - El Centro Binacional para el Desarrollo Indígena Oaxaqueño

Lack of Funding for Clinics

Many of the providers interviewed offer health and dental services for communities at lower costs or a sliding scale, but all providers interviewed felt they needed greater resources in order to improve oral health in their communities. Without adequate resources, these providers are unable to serve their communities in a comprehensive way because they lack funding for staff, physical space, and dental equipment.

> *"There are just not enough dental clinics or existing clinics…to accommodate all patients. The limited capacities have kept many patients from accessing…dental services and consequently not receiving care."* - Asian Health Services

Lack of Diversity in Providers

Many monolingual community members discussed the importance of having culturally competent providers who speak their language and understand their cultural context and traditions. Numerous participants chose not to seek oral care because they found it difficult to go to a provider that did not speak their language or understand their community. In San Diego, participants noted that when a Burmese dentist serving the majority of his community retired there was a marked decline in utilization. Others noted how they did not feel comfortable asking questions or filling out forms when the dental office does not speak their language. Communities in the Central Valley and Orange County shared that many people traveled to Mexico for culturally and linguistically appropriate oral care that is much more affordable, even when considering the time and costs associated with travel.

Use of Alternative Medicine

When community members were unable to access affordable dental care, some turned to cultural remedies to treat dental pain or for general hygiene practices. For example, within the Burmese community in San Diego, members used a traditional remedy of swishing hot water and salt in their mouths to soothe toothaches. In the Somali community, older generations reported not using toothbrushes and preferred to use a traditional teeth cleaning twig called a "miswak." In South Los Angeles, participants discussed using a coconut oil rinse as an oral hygiene method. In Koreatown in Los Angeles, seniors used an herbal medication from Korean pharmacies and bamboo salt to brush their teeth. Central Valley participants spoke about a treatment from Mexico that only seemed to take away pain temporarily, but was used in their community as a remedy. Often providers are not aware of these cultural practices and do not understand how to integrate them with standard practices of care.

Lack of Culturally Appropriate Consumer Education and Language Access Services

Without a fundamental understanding of the impact of oral health on overall health, providers acknowledged that their consumers were already several steps behind in achieving good oral health. Providers noted that culturally appropriate oral health materials or programs are not generally available. In addition to lacking access to dental health education materials community members often also do not know where to sign up for dental insurance, what services are covered under their dental insurance, and that supplemental coverage is available through Covered California. Overall providers feel that families are poorly informed about dental health and how to enroll in coverage.

> *"Toothache was a recurring theme which suggests that it is prevalent in the Burmese community. [A] majority of the participants responded that they are not familiar with dental hygiene issues such as brushing, flossing, or using antiseptic oral rinse."* - Nile Sisters Development Initiative

As a result of the lack of health education materials and diverse partners to emphasize the importance of oral health, consumers often have misperceptions and misunderstandings about oral health. For example, many consumers believed that oral health at younger ages was not important because baby teeth are replaced by permanent teeth. Pregnant women often do not understand that periodontal disease can lead to low birth weight and early deliveries. Generally, providers felt that consumers do not correlate the relationship between oral health and physical health, self-esteem, and employability until it is too late. Providers also cited the impact of language barriers on oral health care and noted the severe lack of linguistically appropriate providers who can serve their communities.

> *"I was surprised to find out how many extremely tragic stories people had with dentists or oral care service providers that were not even related to the dental work. A few people shared stories on how they were overcharged for procedures that were done incorrectly and unfinished…. Despite the stigma and fear associated with oral care, everyone in the group was genuinely concerned with their oral health and willing to seek any available resources."* - Black Women for Wellness

The issues contributing to the prevalence of oral health disparities among low-income communities of color, immigrants, and limited-English proficient communities are broad and complex but this should not dissuade us from working towards the needed changes. Oral health is imperative to quality of life and overall health and should be readily available to all Californians. Change will require a multi-faceted approach including working with community members directly while also advocating for greater resources to expand quality, affordable dental coverage and services. CA-OPEN will continue partnering with community-based organizations, providers, health advocates, and policymakers to develop a robust policy agenda in order to move towards the goal of advancing oral health equity throughout the state.

Summary

The above stories from community members and providers highlight the impact of a fragmented oral health system on the quality of oral health care for California's low-income communities of color. Not enough culturally and linguistically appropriate dentists participate in the Medi-Cal Dental program. Many community members do not know that their Medi-Cal benefit covers oral health services, don't understand how to access these services, or lack culturally and linguistically appropriate education about safe and appropriate oral health care.

California is still recovering from the lack of investments in oral health care. However, California's recent investments to Medi-Cal's dental program have yielded a reduction in emergency room (ER) visits and a steady increase in the utilization of services among Medi-Cal consumers over the past two years. California must protect the progress made over the last two years by rejecting any proposals or decisions to cut benefits and services, which will only hurt an already fragile system of care for community members and the providers that serve them.