Dental Care Coordination and Access to Care

How Local Dental Pilot Projects Connect Children to Dental Care in California's State Medicaid Program

Katie Andrew
Rhoda Gonzales, RDHAP
Robyn Alongi

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Executive Summary

This brief highlights the successful elements of care coordination within 12 of California's Local Dental Pilot Projects (LDPPs), part of the state's Dental Transformation Initiative (DTI) and Section 1115(a) Medicaid Waiver, Medi-Cal 2020. Medi-Cal 2020 is a five-year initiative that has allowed California to embark on multiple demonstration projects to "improve the quality of care, access, and efficiency of health care services."

In California, 1 out of 2 children or 53.6 percent of California's 9.1 million children are enrolled in Medi-Cal, the state's Medicaid program. The Medi-Cal Dental Program has historically experienced poor rates of utilization. A 2014 report from the California State Auditor cited that only 44 percent of children enrolled in the program received an annual dental visit. The Medi-Cal system is complex and difficult to navigate, making dental care coordinators critical to overcoming the barriers of accessing care because of an overstretched, and in some cases, thin or non-existent dental provider network, members not knowing they have dental benefits, and varying degrees of investment in oral health based on culture, income, and competing priorities. Care coordination and case management within the LDPPs demonstrates a value-based method for ensuring individuals are provided with support, connecting them to the care they need. Key Findings include:

1. Partnerships with community organizations, providers, dental plans, and university and government entities are critical to success.

2. Care coordination reduces no-shows, improves patient experience, and increases provider participation and satisfaction.

3. System-level changes focused on medical-dental integration and data sharing systems to facilitate a bridge between medical and dental providers are needed to increase access to dental care.

4. Care coordination services offered in community settings such as schools, hospitals, WIC and Head Start sites eliminates one barrier to obtaining care.

The investment and momentum the Medi-Cal Dental Program has gained through community and public health partnerships should guide state efforts in reimagining the Medi-Cal system. The increased trust with Medi-Cal members at the local level aided in higher utilization of preventive services and access to dental care. The State of California must work with the Medi-Cal dental Administrative Services Organization (ASO), Medi-Cal medical and dental managed care plans, county public health departments, and other stakeholders to develop and adopt a comprehensive statewide plan for robust, community-based dental care coordination, utilizing local care coordinators and establishing metrics to monitor and track outcomes.

Effective and robust dental care coordination is facilitated by trusted, community-rooted resources where relationship building with families and providers alike is paramount. Care coordination must go beyond a referral to a provider and include supports tailored to patients' needs that remove barriers to care, including but not limited to appointment assistance, transportation assistance, translation assistance, reminder calls, day-of appointment support, and post-appointment follow-up.

The following recommendations are based on the findings in this brief:

Recommendation 1: Leverage Local Oral Health Programs & Existing Partnerships

Local Oral Health Programs (LOHPs), established through Proposition 56 funding, should leverage the community partnerships developed by the LDPPs and strategize how to continue the established community-based, robust dental care coordination efforts. Additionally, the LOHPs should work with the Department of Health Care Services (DHCS) to ensure that the local dental care coordination groundwork established by the LDPPs is incorporated into DHCS' annual provider and member outreach plan. Furthermore, DHCS could leverage the Smile, California Campaign[1] to bolster and fund some of these community-based dental care coordination partnerships.

Recommendation 2: Use Medi-Cal Managed Care Plan & Dental Administrative Services Organization (ASO) Procurement Processes to Ensure Robust Dental Care Coordination Services

DHCS should leverage the procurement processes for the Medi-Cal managed care plans and the Dental ASO to ensure that dental care coordination services are included and explicitly defined in forthcoming contracts, including measures to track and monitor dental care coordination efforts. Additionally, through the procurement process, the state should require the Dental ASO to establish and fund community-based organizations to provide dental care coordination services.

Recommendation 3: Ensure Full Implementation of AB 2207

To demonstrate compliance with AB 2207, the state needs to make publicly available a list of health plan dental liaisons by county and develop a way to track the activities of these dental liaisons. If a Medi-Cal managed care plan is unable to provide dental care coordination services via a dental liaison, DHCS should provide guidance to the plans on how to allocate funding and establish MOUs with local entities familiar with the Medi-Cal dental benefit and the local dental provider network to provide these services.

Recommendation 4: Leverage County-Based Child Health and Disability Prevention (CHDP) Programs

Most children enrolled in Medi-Cal receive their medical care through a Managed Care Organization (MCO). MCO's are often unfamiliar with the Medi-Cal Dental Program, benefits, and provider network, whereas, county-based CHDP programs have a long history of being responsible for ensuring the delivery of the Early Periodic Screening and Diagnostic Testing (EPSDT) benefit in the Medi-Cal program, including connecting children to dental care. The state should require MCO's who do not have the capacity to provide dental care coordination to establish a MOU with the local CHDP program to provide these services to children in Medi-Cal managed care.

Recommendation 5: CalAIM (California Advancing and Innovating Medi-Cal)

The state's multi-year initiative to restructure the state Medicaid program, CalAIM, has been put on hold as a result of the COVID-19 pandemic and the ensuing state budgetary restraints. The state intends to resume CalAIM once the public health crisis is resolved and the state finds itself on more solid financial footing. However, the proposal in its current form fails to prioritize children. When the CalAIM effort is reintroduced, DHCS will need to address how CalAIM can strengthen services for children within Medi-Cal and should explicitly include robust, community-based dental care coordination in the proposal.

Introduction

Oral health directly impacts a child's overall health, well-being, and development. Poor oral health affects a child's ability to eat, smile, play, and learn. In California, over 50 percent of kindergartners have experienced tooth decay and over 25 percent have untreated tooth decay,[2] meaning that a large portion of the state's children move through their day with dental pain. The social determinants of oral health are complex, with deeply rooted systemic issues and long-held cultural beliefs around dental care and hygiene further complicating the quest for all children to be cavity-free. Effective and robust dental care coordination services provide children and their families with the support necessary to access the dental care that they need and also presents an opportunity to educate families about why oral health care is important.

This brief examines the elements of the dental care coordination embedded within 12 of California's Dental Transformation Initiative (DTI) Local Dental Pilot Projects (LDPPs), part of the state's Section 1115(a) Medicaid Waiver. Through the analysis of LDPP program data and key informant interviews with LDPP staff, this brief aims to answer the following five research questions:

1. How are LDPPs defining care coordination?
2. How are LDPPs defining the effectiveness of care coordination?
3. What challenges do LDPPs face when providing care coordination?
4. What are the facilitator factors for providing care coordination?
5. What are the challenges and facilitators to sustainability and replicability of care coordination efforts?

A detailed project plan and key informant interview protocol can be found in Appendix A.

Background

Impact of COVID-19 on Dental Benefit Utilization among Children: On March 19, 2020 the State of California declared a public health emergency due to the COVID-19 pandemic and ordered all Californians to shelter in place to slow the spread of the virus. Fear, confusion, reduced availability of services, lack of proper personal protective equipment at dental offices, and the temporary or permanent closing of dental offices resulted in a decline in the utilization of the Medicaid dental benefits across the United States. In September 2020, the Centers for Medicare & Medicaid Services (CMS) released a preliminary data snapshot on the impact of the COVID-19 pandemic on preventive services utilization for children ages 18 and under, revealing a 69 percent decrease in dental services utilization from March through May of 2020.[3] While state-level data on the impact of COVID-19 on dental utilization was not available at the time of this brief, we know the pandemic impacted the services LDPPs were able to offer to Medi-Cal children and their families for a significant period of 2020.

In California, 5.5 million children receive their dental care through the state's Medicaid program, Medi-Cal. The Medi-Cal Dental Program has historically experienced disappointingly low rates of utilization. A 2014 report from the California State Auditor cited that almost 56 percent of children enrolled in the program did not receive dental services. It also cited the lack of pediatric providers, lack of any providers in some counties, low provider reimbursement rates, and inadequacy of Department of Health Care Services' (DHCS) monitoring of the program and compliance with reporting requirements.[4] The persistent problems within the program prompted the state's independent oversight agency, The Little Hoover Commission, to examine the program and the root causes of its shortcomings through public hearings and research. The findings of the Little Hoover Commission were released in a 2016 report, "Fixing Denti-Cal".[5] The report stated that in its "dysfunction" the Medi-Cal Dental Program had consistently failed to provide dental care to the majority of its members that represent one-third of the state's adult population and half of the state's child population, noting bureaucratic headaches, an insufficient number

of providers and specialists, and focus on restorative versus preventive care. The searing findings within the report led to legislation in 2016 to set a 60 percent utilization target for children within the Medi-Cal Dental Program; however, utilization of the Medi-Cal Dental benefit among child members remains well below this target. **Figure 1** below shows the utilization of the Medi-Cal dental benefit for children ages 0 to 20 for calendar years 2017-2019, demonstrating that utilization is well below the 60 percent utilization target. If structured and utilized properly, dental care coordination could ensure that a larger number of children receive dental care, thereby assisting the state in meeting its utilization target.

Figure 1. Child Dental Utilization by Service, Calendar Years 2017-2019[6]

Dental Service Ages 0-20	Reporting Year		
	2017	2018	2019
Annual Dental Visit (ADV)	47.16%	47.62%	49.65%
Preventive Service	43.51%	44.00%	46.30%
Sealants*	13.49%	13.11%	13.62%

*For children ages 6-14 only

In addition to an insufficient number of providers within the program, the majority of those providers that see Medi-Cal members do not reflect the diversity of the patients that they serve. Many families struggle to find a dentist who looks like them, speaks their language, and/or is familiar with their cultural norms. Furthermore, due to inconsistent benefits among the adult population, many families are not aware that dental coverage is a core benefit for children in Medi-Cal. Similarly, families are often not aware that they are entitled to transportation and translation assistance benefits through Medi-Cal. These challenges make accessing dental care for Medi-Cal members difficult and validate the need for dental care coordination.

Care coordination is recognized as a value-based method for ensuring individuals are provided with support to connect them to the care they need across multiple systems such as health care providers in different settings, schools, and community-based organizations, with the ultimate goals of improving patient experience, ensuring better patient outcomes, and containing costs. Care coordination increases appointment compliance, resulting in increased provider satisfaction. The Institute of Medicine has noted that well-designed care coordination can "improve the effectiveness, safety, and efficiency" of the health care system while improving outcomes for patients, providers, and payers alike.[7] The Agency for Healthcare Research and Quality defines care coordination as:

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.[8]

For children living in poverty, care coordination is crucial to ensuring they receive the care they are entitled to through Medi-Cal under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Care coordination services can include, but are not limited to scheduling appointments, managing referrals, arranging transportation and translation services, appointment reminders and follow-up, and accompanying patients and their families to initial appointments.

While the elements of care coordination differ from entity to entity and patient to patient depending on a patient's needs, the central characteristic of impactful care coordination is effective communication with the patient and amongst all parties responsible for the care of a patient.

Approximately 91 percent of children under the age of 21 enrolled in Medi-Cal receive their care through a risk-based managed care organization (MCO) with only 9 percent receiving their care through the state's Fee-for-Service (FFS) system.[9],[10] In April of 2016, a final rule on managed care released by the Centers for Medicare & Medicaid Services (CMS) broadened the care coordination requirements for MCOs to ensure that patients had access to all necessary and appropriate care. Specifically, the rule expanded federal standards for care coordination to include:

- Coordination between settings
- Coordination with services provided outside the plan by a different plan or through FFS
- Coordination with community and social support providers
- Required plans to provide enrollees with the contact information for an assigned care coordinator
- Conduct health risk assessments within 90 days of enrollment for all new enrollees[11]

Given the federal requirements for MCOs with respect to care coordination, most Medi-Cal children should receive care coordination services, including dental care coordination, through their Medi-Cal managed care plan. However, anecdotal evidence from multiple stakeholder agencies suggests that this may not be the case, and DHCS has not provided evidence to prove otherwise.

While California contracts with MCOs include the requirement for plans to provide care coordination services for dental care, the California legislature felt it necessary to solidify this requirement in statute via AB 2207 (Wood, Chapter 613, Statutes 2016).[12] AB 2207 expands dental data transparency and reporting requirements for DHCS and establishes in statute dental-specific requirements for Medi-Cal managed care plans. Specifically, it requires Medi-Cal managed care plans to:

1. Provide dental screenings for every eligible beneficiary as a part of the beneficiary's initial health assessment.
2. Ensure that an eligible beneficiary is referred to an appropriate Medi-Cal dental provider.
3. Identify plan liaisons available to dental managed care contractors and dental fee-for-service contractors to assist with referrals to health plan covered services.[13]

Although in place since 2016, it remains unclear if or how the state is tracking and monitoring the requirements of AB 2207.

Recognizing the benefits of dental care coordination, DHCS undertook a Care Coordination Assessment Project in 2018 to evaluate what care coordination looked like in Medi-Cal across all delivery systems.[14] At the time, DHCS did not have a comprehensive set of standards to guide care coordination services within Medi-Cal, save broad contractual requirements and statutes relevant to Medi-Cal managed care.[15] As a result, DHCS established a care coordination unit within their Telephone Service Center (TSC), first referencing the services in a July 2019 Provider Bulletin.[16] To access dental care coordination services Medi-Cal members call and speak with a representative who can provide the name and phone number of dentists accepting patients in their zip code. The representative can coordinate additional services by referring members to their respective health plans to access translation and transportation when needed. Members can also access information regarding care coordination services offered through the TSC via the member service website. While the state does not produce reports specific to the care coordination unit, for this study, DHCS provided statewide data on requests made to the TSC by Medi-Cal Dental fee-for-service members. From January 2019 to December 2019, DHCS reports receiving 15,302 provider referral requests where the TSC assisted in scheduling an appointment for the member and 3,360 interpreter services requests through the DHCS Language Line.[17] DHCS did not report how many of these points of contact resulted in a successful dental visit.

Medi-Cal members who have special healthcare needs, meaning the member has a significant medical, physical and/or behavioral diagnosis, may be eligible for dental case management. Dental case management services must be requested by a provider through a referral process. Requests for dental case management often require that a provider or Medi-Cal member provide additional documentation beyond what was initially included in the request. This can elongate the timeline for DHCS's decision to approve/deny the request for case management beyond the initial 24 to 48-hour window, leaving providers frustrated and patients without the care they need. If it is determined that the member does not meet established criteria for dental case management, they will be referred to the TSC for care coordination support. During the first six months of 2020 (January 2020 to June 2020), the case management program serviced a mere 45 individual cases,[18] an exceptionally low number given there are 13 million people enrolled in the Medi-Cal program with dental benefits. For a comparison of the DHCS care coordination program, DHCS case management program, and LDPP care coordination services please see Appendix A. For a comparison of the DHCS TSC care coordination program, DHCS case management program, and LDPP care coordination services please see Appendix B.

Medi-Cal 2020 & The Dental Transformation Initiative (DTI)

In December 2015, California received approval from the Centers for Medicare & Medicaid Services (CMS) for the state's Section 1115(a) Medicaid Waiver, Medi-Cal 2020. Medi-Cal 2020, a five-year initiative slated to expire at the end of December 2020, allowed the state to embark on multiple demonstration projects to "improve the quality of care, access, and efficiency of health care services."[19] As part of Medi-Cal 2020, California prioritized improving the Medi-Cal Dental Program by investing up to $740 million to increase access to dental care and preventive dental services for children ages 0-20.

The Dental Transformation Initiative (DTI), the dental-focused demonstration project resulting from the Medi-Cal 2020 Waiver, contains four Domains. According to DHCS, each Domain aims to do the following:

- **Domain 1:** Increase the statewide proportion of children ages 1 through 20 enrolled in Medi-Cal who receive a preventive dental service by 10 percentage points over a five-year period.
- **Domain 2:** Diagnose early childhood caries by utilizing Caries Risk Assessments (The CRA tool can be found in Appendix C) to treat childhood caries as a chronic disease and to introduce a model that proactively prevents and mitigates oral disease.
- **Domain 3:** Increase continuity of care for beneficiaries ages 20 and under for 2, 3, 4, 5, and 6 continuous periods.
- **Domain 4:** Address one or more of the three domains through alternative programs, potentially using strategies focused on rural areas, including local case management initiatives and partnerships.

Through Domain 4, 13 Local Dental Pilot Projects (LDPPs) have been implemented across the state. See Appendix D: Child Utilization Data Over time by LDPP County. Figure 2 below provides a brief snapshot of each LDPP.

According to the American Academy of Pediatric Dentistry, a dental home is an "ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way. The dental home should be established no later than 12 months of age to help children and their families institute a lifetime of good oral health. A dental home addresses anticipatory guidance and preventive, acute, and comprehensive oral health care and includes referral to dental specialists when appropriate."[20]

Figure 2. Funded LDPPs by Grantee and County

Grantee Name	County	Program Name	Program Elements
Alameda County Department of Public Health	Alameda County	Healthy Teeth, Healthy Communities (HTHC)	• Recruit dentists into a community of practice • Coordinate care
California State University, Los Angeles	Los Angeles County	Educational Community Health Outreach (ECHO)	• Provide oral health screenings and oral health education • Provide individualized oral health plans, recommendations for and connections to vetted dental homes • Conduct interdisciplinary training about oral health and its social determinants for dental and health care providers, health and human service practitioners, and students
Fresno County Department of Public Health	Fresno County	Free Medi-Cal Dental Youth Services (FDYS)	• Recruit dentists • Coordinate care • Case manage and provide wrap-around services
Humboldt County Department of Public Health	Humboldt County	--	• Coordinate care • Track caries risk assessment and oral health services provided in the medical setting
First 5 Orange County	Orange County	--	• Coordinate care • Create and implement call center (Smile Connect) • Recruit and credential dentists into their network • Provide Virtual Dental Home services
Sacramento County Department of Public Health	Sacramento County & Amador County	Every Smile Counts! (ESC!)	• Coordinate care • Provide Virtual Dental Home services • Improve medical-dental integration • Provide community outreach and parent education
San Francisco County Department of Public Health	San Francisco City and County	--	• Dentist training • Care coordination services provided by health department & school district • Community outreach messaging • Improve medical-dental integration
First 5 San Joaquin	San Joaquin County	SJ TEETH	• Coordinate care • Organize and lead monthly interdisciplinary training • Provide Virtual Dental Home services
San Luis Obispo County Department of Public Health	San Luis Obispo County	--	• Fund community dentists in school settings • Coordinate care • Support/fund training of assistants and RDHAPs
First 5 San Bernardino/ Riverside	San Bernardino/Riverside County	Early Childhood Oral Health Assessment (ECOHA)	• Coordinate care • Provide Virtual Dental Home services
Sonoma County Department of Public Health	Sonoma County	Cavity Free Sonoma	• Coordinate care through CDHWs who receive a certificate at local junior college • Provide caries risk assessment in primary care sites • Develop Sonoma Smiles App to track case management
University of California, Los Angeles	Los Angeles County	More LA Smiles	• Coordinate care through electronic database LADDRS- Pediatricians place referral into LADDRS and a dentist retrieves referral for care • Provide education and training to primary care sites
California Rural Indian Health Board (CRIHB)[21]	Indian Health Program	--	• Improve medical-dental integration • Coordinate care in 17 sites statewide • Provide caries risk assessment during primary care visits

Due to contracting delays at both the state and local levels, implementation of the LDPPs did not begin until 2017, with the majority of LDPPs not starting in earnest until mid-2018, leaving only 2.5 to 3 years to test pilot strategies. The LDPPs are set to sunset with the Medi-Cal 2020 Waiver on December 31, 2020.

CalAIM & DTI: California Advancing and Innovating Medi-Cal (CalAIM) is a new multi-year initiative that DHCS initially proposed in October of 2019. The CalAIM proposal builds upon the successes of various pilots from previous federal waivers and strives to overhaul the Medi-Cal program to include whole person care approaches that address the social determinants of health; creating a more consistent, integrated, and flexible system; and improving quality outcomes by reducing health disparities and transitioning to a value-based system. Only Domains 1 through 3 of the DTI were included in the CalAIM proposal. However, due to the impact of COVID-19 on the state's systems and budget, the CalAIM initiative has been postponed, resulting in the state requesting a one-year extension of the state's Section 1115(a) Medicaid Waiver. Domains 1 through 3 were included in the extension request submitted to CMS in September of 2020. Domain 4 was not included and, therefore, will sunset at the end of December 2020.

Dental Care Coordination Within the LDPPs

Each LDPP is uniquely designed to capitalize on the assets of their respective communities. Although each LDPP has unique elements and partnerships in place to support the individual goals of each pilot project, care coordination emerged as a common strategy to connect children to dental care across all LDPPs.

While care coordinators may be referred to by another name depending on the LDPP (e.g., Outreach Health Educator (OHE), Community Dental Care Coordinator (CDCC), Community Health Worker (CHW), Health Education Specialist (HES), Community Dental Health Worker (CDHW), etc.), each pilot project has individuals that are responsible for assisting children and their families to access dental care. Care coordinators are employed by different entities, including but not limited to Federally Qualified Health Centers (FQHCs), community-based organizations (CBOs), county public health departments, school districts, and independent physicians' associations. The number of care coordinators utilized within each LDPP varies, ranging from three to as many as 32 care coordinators, with 20 being the average.

Below we discuss in more detail the elements of the different care coordination efforts within each LDPP. We attempt to define care coordination based on the experiences of the LDPPs and highlight the facilitators for and challenges of implementing care coordination at the local level.

Elements of Dental Care Coordination

To determine common elements and goals of care coordination across the LDPPs, the participating 12 pilot projects were asked during key informant interviews to offer their own definition of care coordination. Definitions ranged widely from citing a federal definition from the Agency for Health Care Quality, to articulating the tasks and services offered by care coordinators, to naming the desired outcomes resulting from care coordination. The definitions offered, as well as how care coordination is defined and carried out varies widely across the LDPPs. Examples of different elements of care coordination definitions include:

- Community-based care coordination services provided by trusted community partners and resources.
- Dental appointment scheduling and follow-up.
- Identifying and addressing underlying barriers to care by coordinating necessary support services to ensure the completion of a successful dental visit, such as arranging transportation and/or translation services.
- Working with families to understand and address previous experiences, beliefs, and attitudes that may act as barriers to accessing dental care.

- Accompanying a family to their first dental appointment.
- Increasing oral health literacy among children and their families.
- Family-centered capacity building to establish long-term healthy oral health behaviors.
- Ensuring continuity of care.
- Extensive hands-on case management that moves beyond coordinating dental care to first address basic needs related to the social determinants of oral health.
- Reaching children and families where they are, including through schools, community sites, medical offices, community health clinics, emergency departments, community-based events, and social marketing campaigns.

The Virtual Dental Home (VDH) is a community-based oral health care delivery system that provides dental care directly in the community where people live, work, play, attend school and receive social services. VDH utilizes telehealth technology to link specially trained hygienists in the community with dentists at remote office sites.

Figure 3 shows the age range of the children served through the LDPPs and the care coordination elements offered by grantee. Based on interview and program data, all 12 LDPPs provide case management services, with four of those providing care coordination services through a VDH. The following services were provided across the 12 participating LDPPs:

- 11 provided appointment assistance
- 6 assisted with arranging transportation and/or translations services
- 4 provided reminder calls
- 6 provided day-of-appointment support, including attending initial dental appointments with children and their families
- 12 provided follow-up to ensure a successful dental visit

Figure 3 Care Coordination Efforts

Grantee Name	Target Age	Virtual Dental Home*	Case Management**	Schedule Appts	Coordinate Translation/ Transportation	Reminder Calls	Day-of Patient Support	Quality/ Visit Experience Follow-Up
Alameda County Department of Public Health	0-20 yrs. (50% 0-5 yrs.)		√	√	√	√	√	√***
California State University, Los Angeles	0-20 yrs.		√	√	√			√
Fresno County Department of Public Health	0-20 yrs.		√	√	√	√	√	√
Humboldt County Department of Public Health	0-12 yrs.		√	√				√
First 5 Orange County	0-20 yrs.	√	√	√			√	√
Sacramento County Department of Public Health	0-20 yrs.	√	√	√	√	√	√	√
San Francisco County Department of Public Health	0-20 yrs. (focus 0-5 yrs.)		√	√	√	√		√
First 5 San Joaquin	0-20 yrs. (focus 0-5 yrs.)	√	√	√	√	√	√	√
San Luis Obispo County Department of Public Health	0-12 yrs.		√	√			√	√
First 5 San Bernardino/ Riverside	0-12 yrs.****	√	√	√	√			√
Sonoma County Department of Public Health	0-6 yrs.		√	√				√
University of California, Los Angeles	0-5 yrs.		√					√

*Each Virtual Dental Home program has at least 1 dental care coordinator, case managing identified referral needs.

**Case management addresses disparities, and social determinants of health providing resources including but not limited to food insecurity, housing, weatherization, Head Start, and WIC, etc.

***Alameda receives a written report from the dental provider as part of an incentive program for dental encounter data.

**** Early Childhood Oral Health Assessment (ECOHA) focuses on ages 0-5 while VDH focuses on ages 6-12

Dental Care Coordination Challenges

Contract Delays. The LDPPs faced challenges during implementation. The first challenge identified across the LDPPs was the delay in state contracting processes resulting in pilot projects having to push back their timelines multiple times. The original award date was February 2017; however, project scope and budget negotiations at the state level delayed the finalizing of contracts until May 2017. Due to these delays, several LDPPs did not receive funding until late 2017, with one project not receiving funding until January 2018. The delays at the state level trickled down to the local level. Once funded, slow county contracting processes, including the requirement to obtain Board of Supervisors' approval to receive and expend funds and issue contracts, delayed implementation further.

Planning and Start-Up Challenges. Once LDPPs had contracts with subcontractors in place, work to develop and establish critical community partnerships, workflow processes, data collection tools and processes, and training and educational materials began. These planning activities and subsequent implementation strategies also brought challenges. Many LDPPs encountered significant challenges in the development of data tracking and reporting tools due to their complexity, including the need to have multiple partners reporting activities and metrics, the need to establish data-sharing agreements with subcontractors, and ensuring the security of the data housed within these systems.

Client-Related Challenges. Across the LDPPs, dental care coordinators encountered challenges determining how best to engage clients. Building trust with children and families required creativity, time, and commitment. Care coordinators found that outreach in community settings was difficult but learned that leveraging partners with existing community relationships allowed for a higher level of engagement. For some LDPPs, enrolling Medi-Cal child members and their families as clients in pilot projects presented some challenges. For example, Humboldt County's LDPP realized that the answer choices on their client enrollment form were too restrictive, discouraging Medi-Cal member participation. To address this issue, Humboldt County revised the form to allow responses to be more open-ended.

Another challenge was ensuring that project enrollment forms were completed and signed by clients, and that LDPPs had current and accurate client contact information. For example, a school-based screening and navigation program in Sacramento County collects current contact information for the children that are screened. Because Sacramento County has mandatory dental managed care for all Medi-Cal members, children identified as needing care are routed to their assigned dental plan for care coordination services. The dental plans receive the updated member contact information but are not able to update the information within their system because member information is provided by the state and can only be changed by the member contacting Medi-Cal member services.

Many LDPPs conduct and track caries risk assessment (CRA) scores with the intention of observing a reduction in those scores over time. This, however, is exceptionally difficult because a reduction in CRA scores requires behavior change that is supported and driven by the entire family. Using CRA scores as a conversation starter, pilots utilize motivational interviewing to inspire children and their families to change unhealthy behaviors that affect the health of the mouth. This enterprise is intensive and requires multiple conversations with clients. Many LDPPs concluded that they would not be able to realize a significant change in patient CRA scores within the project timeframe.

Staff Hiring and Retention Challenges. Some LDPP's encountered challenges in their human resources departments resulting in delays in hiring care coordination staff. Staff retention issues existed at both the state and grantee level. Several LDPPs noted that staffing turnover within DHCS made it difficult to receive timely guidance during pilot project implementation. For LDPPs, care coordinator turnover amongst pilot projects varied significantly. Some LDPPs experienced a 50 percent turnover while others had virtually no turnover, retaining 97 percent of their original care coordination team.

Provider-Related Challenges. The Medi-Cal Dental Program has long struggled to have enough dental providers and specialists; some California counties do not have any Medi-Cal dental providers. Recognizing the impact that a strong Medi-Cal Dental provider network has on a child's ability to receive care, the majority of LDPPs set out to vet existing dental providers to ensure they were actively serving Medi-Cal members and recruit new ones into the Medi-Cal Dental Program within their county. Six LDPPs had designated provider teams that provided dental care and dental care coordination (i.e., VDH), others had a designated person to recruit and maintain the provider network, and five LDPPs had an explicit focus on recruiting providers into the Medi-Cal Dental Program within their counties. For example, San Joaquin County's SJ TEETH recruits non-Medi-Cal providers into the Medi-Cal Dental Program by providing enrollment assistance to providers who commit to caring for at least 10 Medi-Cal enrolled children. As a result, the number of Medi-Cal dental providers within the county has increased over the course of the pilot project.

Other provider-related challenges include a high rate of staff turnover, particularly within partner FQHCs, long wait times for appointments and long waits while at dental offices, inconsistency in the care received, and billing issues. In most LDPPs, care coordinators act as liaisons between families and the dental provider, often helping to coordinate care for the entire family. Some care coordinators embedded within the dental clinic noted initial reluctance among providers to delegate certain aspects of care coordination to the care coordinator. To overcome these barriers, care coordinators have to identify the challenges that exist for the client and the provider and build trust among both parties. As providers began to recognize the benefits of dental care coordinators (e.g., reduction in the "no-show" rate), trust and a better working relationship developed between dental providers and care coordinators. LDPPs reported that as trust developed, dental providers became more willing to see Medi-Cal members because they knew the care coordination services provided to the patient would result in a successful dental visit.

Challenges Related to the COVID-19 Public Health Emergency. With the onset of the COVID-19 pandemic and the subsequent public health emergency declaration in March 2020, dentistry came to a halt. As scientists and public health officials worked to better understand the disease and establish guidelines to keep patients and providers safe, access to preventive and restorative care ceased. Similarly, many LDPP activities that had traditionally taken place in-person, such as outreach through community events and school-based services stopped. Many dental provider offices and FQHCs furloughed and laid off staff. Community-based VDH activities at WICs, Head Starts, preschools, and elementary schools significantly slowed or stopped due to shelter-in-place directives and school closures.

As shelter-in-place directives relaxed, dental offices began to re-open. However, providers remain challenged to navigate the barriers related to reduced dental office hours, closures of dental offices, lack of personal protective equipment (PPE) supplies, new protocols and guidance from Centers for Disease Control (CDC) and California Department of Public Health (CDPH). LDPPs that are led by county public health departments also experienced staffing challenges as many county employees were and continue to be deployed to assist with the emergency response. However, by utilizing the relationships developed with trusted and consistent community partners, LDPPs have been able to resume many pilot activities while re-strategizing how best to serve their communities during the public health crisis. Most LDPPs have resumed care coordination activities and oral health education. Some have expanded the care coordination services to help address the hard-hitting secondary effects of the pandemic such as food security and housing. Care coordinators are also addressing new billing practices related to PPE, missed appointments, and navigating the reduced provider network with fewer dental appointments available. During the pandemic, LDPPs believe that community-based care coordinators are needed more than ever to provide oral health education, appointment assistance, and to help reduce fears around obtaining dental care.

Facilitators of Care Coordination

Many strategies employed across the LDPPs demonstrate the strength of community-based dental care coordination. LDPPs cited that the dental care coordinators helped reduce the dental appointment "no-show" rate in their counties, thereby improving dental providers' experience and opinion of the Medi-Cal Dental Program resulting in an increased number of children with an established dental home. Below are the facilitators of impactful dental care coordination, as identified by LDPPs.

Partnerships

Partnerships with organizations that understand the strengths, challenges, and culture of the community in which they work is critical to establishing a trusting relationship with clients. Often these partners have already established credibility within the community and can leverage community resources, identify and address underlying barriers such as transportation services, translation services, and billing issues.[22] The relationships established with community-based organizations, medical and dental providers, and university and community partners is crucial to ensuring families have the care coordination support necessary to establish a dental home. Several types of partnerships that provide the capacity and community-experiential knowledge are necessary to be effective.

Community Partnerships. LDPPs can gain access to Medi-Cal eligible children through community partnerships. These include WIC sites, local First 5 commissions, FQHCs/Community Health Clinics/Rural Health Clinics, non-profit community-based organizations, schools, foster care agencies, Boys and Girls Clubs, community libraries, and home visitation programs. Community stakeholders invest in the health and well-being of children and the opportunity to partner with a LDPP allows for the implementation of innovative strategies to support those goals.

Provider Partnerships. Establishing partnerships with dental providers, through local dental and hygiene societies or other organizations, is a key to the success of dental care coordination efforts. It allows LDPPs to establish a referral network, coordinate dental screening events, and ensure that VDH's were staffed.

Establishing relationships with medical and dental champions is another key facilitator in establishing important channels to coordinate dental care for children. Every year approximately 108 million people in the U.S. see a physician but do not visit a dentist, and approximately 27 million people in the U.S. have a dental visit but no medical visit.[23] Connecting these systems of care can reduce the burden of oral disease in children by providing preventive oral health services within the medical home and by establishing lines of referral, communication, and care coordination. Partnerships between medical and dental providers that go beyond a simple referral to include robust dental care coordination are critical. Sacramento, San Joaquin, and UCLA focused on medical-dental integration and systems change. Sacramento County integrated registered dental hygienists into primary care settings to provide oral health education, fluoride varnish application, caries risk assessment, and to refer and coordinate dental care. Sacramento County also convened a Medical-Dental Learning Collaborative, which brought together medical providers, dental providers, medical and dental plans, public health and policy experts, and other stakeholders to learn about different aspects of medical-dental integration. In San Joaquin County, a partnership with the Health Plan of San Joaquin was established to provide fluoride varnish training to primary care providers and to share the care coordination services available through the SJ TEETH program. UCLA engaged in a systems change approach by partnering with medical providers to implement Plan-Do-Study-Act cycles to educate primary care physicians on the importance of oral health.

Universities and Government Partners. Several LDPPs were led by universities and government partners, which allowed LDPPs to bring together a broad range of stakeholders and partners with many different strengths and levels of capacity to carry out dental care coordination activities. The University of Southern California (USC) integrated care coordination into the fieldwork requirement for the Master of Social Work program and California State University, Los Angeles (Cal State LA) developed an interdisciplinary field internship training program for students in health and human service fields. UCLA worked closely with primary care providers implementing medical provider training modules related to oral health and used Plan-Do-Study-Act cycles for continuous quality improvement. Additionally, the connection of many LDPPs to a county public health department created the ability to bring partners together from different branches and divisions within the public health department, as well as other programs outside of public health such as social services and mental health.

"UCLA's transformative work is being accomplished through multiple strategies in collaboration with local and national subcontractors and partners. The strategies include practice level and system-level improvements, professional education programs, information technology solutions and innovative performance measurements. The design and implementation of the Los Angeles Dental Registry and Referral System (LADRRS) allows the spirit of those partner collaborations to be realized through a referral management tool designed to increase access to oral health services through electronic referrals. LADDRS is improving care coordination and communication among dental providers, medical providers, and care management teams in LA County, ensuring consistent, high-quality oral health services for children in the county." - Dr. Jim Crall, UCLA School of Dentistry

Data Tracking and Care Coordination Systems

LDPPs instituted oversight measures and data tracking systems to ensure quality and consistency within each pilot project. Beginning with a year-end report in 2018, LDPPs are required to submit quarterly and year-end reports to DHCS. Progress towards the self-determined goals and objectives are monitored through data collection, recurring all-partner meetings and project-specific reporting requirements.

The most critical elements to monitoring progress and milestones within each LDPP are the data tracking systems developed independently by each pilot project. Like the design of each LDPP, the sophistication of these data tracking systems varied widely. For example, Fresno County's LDPP data system has geo-mapping capabilities to identify dental providers, while others are simple databases used to track quality metrics including reminder calls, patient appointments, and necessary follow-up. Examples of LDPP data tracking and care coordination systems are described below.

Alameda County's Healthy Teeth, Healthy Communities (HTHC) Pilot. The HTHC developed a cloud-based Care Coordination Management System, which collects demographic and dental encounter data. HTHC offers dental providers an incentive for completing a dental encounter form for HTHC clients, noting treatment recommended and/or completed, and submitting through the HTHC system. To be eligible for the incentive[24] dentists participate in HTHC's dental provider community of practice and provide family oral health education, which is also noted on the dental encounter form. HTHC found that dental providers were not utilizing the cloud-based system, so they called on their care coordinators to collect and input the data into the system manually. The care coordinators provide appointment assistance, arrange for transportation/translation, attend a client's first dental appointment, complete the dental encounter form, input that data into the system, and answer any questions the family has before and/or after the appointment. Through this strategy, the care coordinators enrolled approximately 11,000 children of which about 5,500 are under 5 years of age.

Sacramento County's Medical-Dental Partnership (MDP) Pilot. The MDP pilot integrates preventive oral health services, such as caries risk assessment, fluoride varnish application, visual oral health assessment, and oral health education in the pediatric medical setting and connects children to dental care via a referral and care coordination support. Sacramento County has mandatory dental managed care[25], where Medi-Cal members receive their dental benefits through one of three dental managed care plans. In order to facilitate referrals to a child's assigned dental provider and track those referrals, it was necessary to develop a secure, HIPAA-compliant database for health and dental plans to share member and encounter data. The database has a provider interface that allows medical providers to 1) identify a child's assigned dental plan and dental provider, 2) determine if the child has seen a dentist within the past 12 months, 3) make and track a referral; and 4) auto-populate a printable referral form with all necessary dental and medical provider information. Business Associate Agreements are in place with all three dental plans and many health plans, who upload encounter data into the database on a monthly basis. This allows medical providers to track whether a dental visit occurred following the referral and note what procedures were completed during the visit. Aggregate referral and tracking data is reported from a data system developer to Sacramento County on a monthly basis.

UCLA's More LA Smiles Pilot. UCLA utilizes a cloud-based referral system called Los Angeles Dental Registry and Referral System (LADRRS). LADDRS is a tool designed to increase access to oral health services through electronic referrals. UCLA's LADDRS program allows a primary care provider to upload a dental referral into the LADDRS database when they note a child does not have a dental home or has oral health needs. A dental provider can log-in to the LADDRS database to view and accept a patient. The LADDRS system can track whether a referral was accepted, if an appointment was made, and what transpired within the appointment.

Across the state, no matter the complexity of the system, there are common data elements that are collected and tracked by care coordinators. These data elements include but are not limited to the number of clients enrolled, number of completed dental appointments, number of fluoride varnish applications, and number of individuals that participate in community events. Many of the data collection efforts require the participation of those not directly involved with the pilot projects, requiring LDPPs to think creatively about how to encourage participation in the data collection effort. For example, Alameda County recognized the administrative burden required by asking dental providers to complete dental encounter forms and responded by providing data entry support and incentives to providers who submitted completed forms through their data system. Figure 4 below describes common data elements collected by grantee.

"Alameda County's Care Coordination Management System (CCMS) was designed to capture client appointment data provided by our partner dental offices and FQHCs. The Community Dental Care Coordinators (CDCCs) were instrumental in entering this appointment data which allowed Alameda County to perform data analysis and generate data reports." –Arash Aslami, Alameda County Public Health Department

Figure 4. Data Collection Elements by Grantee

Grantee	# of Clients Enrolled (Target #)	Caries Risk	Dental	Fluoride Varnish Application	Follow-up of Completed Appt	No. of Providers Recruited into Medi-Cal Program	No. of Outreach Events
Alameda County Department of Public Health	√		√	√	√	√	√
California State University, Los Angeles	√		√		√	√	√
Fresno County Department of Public Health	√		√	√	√	√	√
Humboldt County Department of Public Health	√	√	√	√	√		√
First 5 Orange County	√		√	√	√	√	√
Sacramento County Department of Public Health	√	√	√	√	√	√	√
San Francisco County Department of Public Health	√		√	√	√	√	√
First 5 San Joaquin	√		√		√	√	√
San Luis Obispo County Department of Public Health	√		√	√	√	√	√
First 5 San Bernardino/ Riverside	√	√	√	√	√	√	√
Sonoma County Department of Public Health	√	√	√	√	√		√
University of California, Los Angeles	√					√	√

Care Coordination Education & Training

Robust community level education and training was an essential element in each project, as revealed through key informant interviews. Various key stakeholders including dental professionals, medical professionals, and university and government agencies, provided formal education and training. Continuing education and training opportunities were provided internally and externally and were often led by the lead LDPP agency. Education and training were provided at a local level, allowing for a deeper understanding of the barriers and cultural context that exists within each LDPP's unique community.

- In the Cal State LA pilot project, health educators are current or former students/interns of the Educational Community Health Outreach (ECHO) program whose primary function is to provide oral health education in community-based sites. Resource navigators and social work interns at USC assist the health educators and other staff in the field in connecting children and their families to dental care. Training consists of understanding and application of program processes, cultural humility, and relational-skills building. The care coordinators are trained to build trust with clients by gaining an understand of where reluctance or resistance may be rooted. They are also trained to troubleshoot and resolve identified root causes and barriers. Data is stored in a USC database hosted on secure, HIPAA compliant servers. Resource navigators or USC social work interns provide follow-up calls. Cal State LA recently began educating partner agencies on a how to perform a psychosocial assessment.

- In Sonoma, a registered dental hygienist at the local community college provides 6-8 weeks of formal training to students working towards a Community Dental Health Worker certificate.

- In Sacramento, the medical-dental partnership pilot hosts quarterly learning collaboratives. Having medical and dental professionals attend and learn in the same space provides the opportunity to build professional comradery. Various topics and esteemed presenters throughout the state have contributed to the success of the professional education provided. Dental Providers are incentivized with free continuing education units.

- San Joaquin County's SJ TEETH provides initial and ongoing training with all new agencies. The pilot program incentivizes medical providers to complete The Smiles for Life National Oral Health Curriculum to promote the integration of oral health preventive practices into primary care. Additionally, ongoing training is provided by partners and guest speakers. A designated dental professional provides oral health training and recommendations to care coordinators, and coordinators are able to share resources and best practices with one another based on their work with clients.

The LDPP at California State University Los Angeles cultivated partnerships and relationships with a broad network of community-based agencies, school districts and educational entities, local elected officials, and organizations serving the American Indian / Alaska Native community and families with children who have developmental disabilities. "These unique partnerships and our values-based service delivery system strengthened capacities to address oral health disparities and to connect families with essential oral health services. We offer three pillars of service: 1) screening; 2) oral health education; and 3) a field training program for students that reflect program values, including strengths-based, culturally informed, community-based practice that address the social determinants of oral health. Coordination and continuity of care is advanced as program staff forge caring, trusted relationships with families and organizations to disseminate and connect families to vital resources.

"Our oral health education curricula and the training model for the field education program can be modified and implemented by other agencies. We plan to disseminate oral health and field education curricula and a field training manual in December 2020 to support replication." --Rita Ledesma, PhD, LCSW, California State University Los Angeles

Recommendations for Sustainability

Based on the experiences and learnings gleaned from the work of the LDPPs, outlined below are recommendations and opportunities to continue the conversation and advance efforts to invest in community-based, robust care coordination.

Recommendation 1: Leverage Local Oral Health Programs & Existing Partnerships

In 2016, California passed the California Healthcare, Research, and Prevention Tobacco Tax Act (Proposition 56), which increased the excise tax rate on tobacco products. This additional tax revenue has been used to support several state efforts, including the State Office of Oral Health and the establishment of Local Oral Health Programs (LOHPs). The LOHPs are tasked with implementing a locally developed strategic plan for their county and local health jurisdiction that helps to move the needle on the priorities identified in the California Oral Health Plan, developed by the State Office of Oral Health. One of these priorities is building infrastructure to assure linkages to dental care. To help meet this priority, the LOHPs should leverage the community partnerships developed by the LDPPs and strategize how to continue the established community-based, robust dental care coordination efforts. Additionally, the LOHPs could partner with DHCS to ensure that the local dental care coordination groundwork established by the LDPPs could be incorporated into DHCS' annual provider and member outreach plan to ensure these partnerships could continue beyond the LDPP grant period. Furthermore, DHCS could leverage the Smile, California Campaign[26] to bolster these community-based dental care coordination partnerships.

Recommendation 2: Use Medi-Cal Managed Care Plan & Dental Administrative Services Organization (ASO) Procurement Processes to Ensure Robust Dental Care Coordination Services

DHCS began the process of procurement for Medi-Cal managed care plan partners through the release of a Request for Information (RFI) on September 1, 2020 and is expected to release the Request for Proposals (RFP) during 2021.[27] DHCS also began the process of procurement of a new Dental ASO through the release of an RFI on October 19, 2020.[28] Both procurement processes provide an opportunity to revise the contract language, and therefore, the responsibilities Medi-Cal managed care plans and the Dental ASO have in ensuring the delivery of health and dental care services to Medi-Cal members. DHCS needs to ensure not only that dental care coordination services are included and explicitly defined in both processes, but that measures to track this service and hold plans and the Dental ASO accountable are also included. Additionally, through the procurement process, the state should require plans that do not have the capacity to carry out dental care coordination to carve out funding and establish memorandums of understanding (MOUs) with local entities and organizations that have the expertise and capacity to effectively provide robust dental care coordination services. Similarly, DHCS should ensure that the Dental ASO leverages funded partnerships with community-based organizations to provide care coordination services.

Recommendation 3: Ensure Full Implementation of AB 2207

AB 2207 (2016) requires that Medi-Cal managed care plans "identify plan liaisons available to dental managed care contractors and dental fee-for-service contractors to assist with referrals to health plan covered services".[29] However, DHCS has not established a way to monitor and track 1) whether health plans utilize dental liaisons, and 2) if dental liaisons are in place, what dental care coordination services they provide to Medi-Cal members. The state needs to make publicly available a list of health plan dental liaisons by county and develop a way to track the activities of these dental liaisons to hold Medi-Cal managed care plans accountable for their contractual responsibilities. If a Medi-Cal managed care plan is unable to provide dental care coordination services via a dental liaison, DHCS should provide guidance and require the plans to allocate funding and establish MOUs with local entities familiar with the Medi-Cal dental benefit and the local dental provider network to provide these services.

Recommendation 4: Leverage County-Based Child Health and Disability Prevention (CHDP) Programs

The California CHDP Program[30] is a state-federal partnership that oversees the screening and follow-up portions of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children and youth under age 21 eligible for the Medi-Cal program. The program is operated at the county-level by local health departments and within three cities throughout the state. One of the cornerstones of local CHDP programs is to provide client support services, including linkages to medical, dental, and mental health care providers and ensuring continuity of care.

As the Medi-Cal program has progressively moved from a fee-for-service (FFS) program to a majority managed care system, the role of CHDP in providing Medi-Cal member support services, facilitating linkages to care, and monitoring continuity of care for children has shifted away from the CHDP program to managed care organizations (MCO). In terms of dental care, the CHDP program is now tasked with helping children in the fee-for-service Medi-Cal program access dental care and maintain continuity of dental care. While CHDP plays an important role in the care of Medi-Cal FFS children, this represents only a small portion of the Medi-Cal population. Most children enrolled in Medi-Cal receive their medical care through a MCO. MCO's are often unfamiliar with the Medi-Cal Dental Program, benefits, and provider network. The state should require MCO's who do not have the capacity to provide dental care coordination to establish a MOU with the local CHDP program to provide these services to children in Medi-Cal managed care.

Recommendation 5: CalAIM (California Advancing and Innovating Medi-Cal)

The state's multi-year initiative to restructure the state Medicaid program, CalAIM, has been put on hold as a result of the COVID-19 pandemic and the ensuing state budgetary restraints. The state intends to resume CalAIM once the public health crisis is resolved and the state finds itself on more solid financial footing. However, the proposal in its current form fails to prioritize children, and while the proposal does specify that Medi-Cal managed care plans "shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance…[and] information shall include assistance in arranging for referrals, including…dental referrals..." it does not indicate what support services will be provided to help facilitate care beyond the referral. When the CalAIM effort is reintroduced, it will be important for DHCS to address 1) how CalAIM can strengthen services for children within Medi-Cal and 2) how robust, community-based dental care coordination can explicitly be included in the initiative. For instance, DHCS should consider including all Medi-Cal children in the enhanced care model within the CalAIM proposal. This would allow all children to receive robust care coordination services where they are, ensuring they obtain access to all of the services they are entitled to under the EPSDT benefit, including oral health services.

Sustainability has been a priority from the onset of Sacramento County's Every Smile Counts! Program. The different strategies were developed using systems thinking and were framed with the intent of changing how people access dental services, keeping sustainability central. The Medical-Dental Partnership Pilot developed a unique data system that allows medical providers to identify a child's assigned dental plan and provider. The system flags whether a child has seen a dentist in the past 12-months, auto-populates a referral form, tracks the referral, any resulting dental encounter, and the care coordination efforts. Because this system supports medical to dental provider referral, the Sacramento managed care dental plans are very interested in sustainability and the scalability of the system across the county. The pilot also embedded dental hygienists into pediatric medical offices. To ensure sustainability of this piece of the larger model, ESC! worked with the dental plans to enroll the Registered Dental Hygienists in Alternative Practice as standalone providers so they can bill for their services following the end of the grant. – Robyn Alongi, Sacramento County Public Health

Conclusion

The state needs to continue to build upon the investment, momentum, and learnings from recent efforts to increase access to dental care. The partnerships the LDPPs developed to increase access to dental care and the local lessons learned about how best to connect and build trust with Medi-Cal members and providers should guide state efforts in reimagining the Medi-Cal program and how the dental benefit is situated within the next iteration of the program. The State of California must work with Medi-Cal medical and dental managed care plans, county public health departments, and other stakeholders to develop and adopt a comprehensive statewide plan for robust, community-based dental care coordination, utilizing local care coordinators, that includes measurable outcomes and accountability.

The Medi-Cal system is complex and difficult to navigate. Dental care coordinators are critical to overcoming the barriers of accessing care because of the overstretched, and in some cases, thin or non-existent dental provider network, members not knowing they have dental benefits, and varying degrees of investment in oral health based on culture, income, and competing priorities. COVID-19 forced the permanent closure of many dental practices and reduced the number of dental appointments available due to social distancing requirements. Now more than ever, dental care coordination that goes beyond offering a referral and a phone number is necessary to support Medi-Cal children and families. California is diverse and a one-size-fits-all care coordination system will not work. Local care coordinators need the ability to assist each Medi-Cal member and eligible individual uniquely.

LDPP care coordination lessons from which a comprehensive statewide dental care coordination effort could be launched include:

1. The level of care coordination needed varies among Medi-Cal members. Flexibility is essential so that care coordination can be tailored to the needs of individual members.
2. Partnerships with local organizations that understand the strengths, challenges, and culture of the community in which they work is critical to establishing trusted relationships with clients.
3. System changes such as medical dental integration and databases to bridge medical and dental providers are needed to increase access to dental care.
4. Care coordination services offered in community settings such as schools, hospitals, WIC and Head Start sites eliminates barriers by facilitating that connection to care where children and families are.
5. Comprehensive care coordination increases patient and provider satisfaction.
6. Dental care coordinators need community-level education and training.

To drive that effort, the State of California should adopt the following experiential-based definition of dental care coordination:

Effective and robust dental care coordination is facilitated by trusted, community-rooted resources where relationship building with families and providers alike is paramount. Care coordination must go beyond a referral to a provider and include supports tailored to patients' needs that remove barriers to care, including but not limited to appointment assistance, transportation assistance, translation assistance, reminder calls, day-of appointment support, and post-appointment follow-up.

Appendix A: Methodology

This project utilized LDPP program data and key informant interviews with LDPP program staff to answer five research questions detailed below. Program data included but was not limited to year-end reports, self-reports, provider feedback surveys, and patient surveys. The key informant interviews occurred with 12 of the 13 LDPPs and lasted approximately 60-90 minutes. The interview protocol is below. Data was analyzed within and across projects to gain a deeper understanding of the facilitators, barriers, training, outreach, and outcomes within the local dental care coordination efforts. Findings suggest that dental care coordination helped to improve oral health literacy and assisted in increased utilization and the establishment of a dental home among Medi-Cal children and their families.

LDPP Care Coordination Meta-Analysis

Goal: Examine the Local Dental Pilot Projects (LDPP) care coordination efforts, including strategies to increasing access to dental care, the cost associated with each level of care coordination, sustainability and replicability. Make recommendation(s) for the future use of care coordination.

Research Questions

- RQ1: How are LDPPs defining care coordination?
- RQ2: How are LDPPs defining the effectiveness of care coordination?
- RQ3: What challenges do LDPPs face when providing care coordination?
- RQ4: What are the facilitators for providing care coordination?
  - RQ4.1: What partnerships exist?
  - RQ4.2: What are care coordination promising practices identified by LDPPs?
  - RQ4.3: How are managed care plans supporting and tracking care coordination at the local level?
- RQ5: What are the challenges and facilitators to sustainability and replicability of care coordination efforts?
  - RQ5.1: What are the cost-benefit trade-offs to providing care coordination?
  - RQ5.2: What is the estimated per-person cost of providing care coordination services?

Data Collection

Activity	Action	Responsible Person	Measure	RQ Addressed	Timeline
1. Collect LDPP administrative data related to care coordination efforts	1.1 Request LDPP Y3 2019 final reports and the most current report available. 1.2 Request one-page summary of LDPP pilot programs. 1.3 Request information regarding overall and per person cost of providing care coordination.	Lani Schiff-Ross, San Joaquin County Robyn Alongi, Sacramento County	Materials received from the LDPPs that have care coordination uploaded to shared file.	RQ1, RQ2, RQ4.1, RQ5.2	April 2020-May 2020

2. Conduct key informant interviews with each LDPP	2.1 Develop interview protocol. 2.2 Schedule phone interviews with representative(s) of each LDPP. 2.3 Conduct interviews.	Rhoda Gonzales	8-10 Interview questions formulated. 60% or greater of LDPPs representatives will participate in Key informant interview. Results of interview questions uploaded.	RQ1, RQ2, RQ3, RQ4.1, RQ4.2, RQ4.3 RQ5.1, RQ5.2	April 15-June 2020
3. Identify All Plan Letters (APL) relevant to care coordination for dental care coordination	3.1 Scan relevant APLs. 3.2 Compile identified APLs.	Rhoda Gonzales	Materials received and uploaded.	RQ4.3	April 2020-May 2020
Data Analysis					
4. Analyze LDPP administrative data	5.1 Extract, clean, and synthesize care coordination data. 5.2 Identify key themes related to care coordination.	Rhoda Gonzales	Data compiled and materials uploaded.	RQ1, RQ2, RQ4.1, RQ4.2, RQ5.1, RQ5.2	April 2020-June 2020
5. Analyze LDPP Key Informant qualitative data	6.1 Clean qualitative data. 6.2 Analyze qualitative data for key themes.	Rhoda Gonzales	Materials uploaded.	RQ1, RQ2, RQ3, RQ4.1.RQ4.2, RQ4.3, RQ5.1, RQ5.2	May 2020-July 2020
Reporting					
6. Draft report	8.1 Write report and solicit feedback from key stakeholders. 8.2 Revise report based on feedback received.	Rhoda Gonzales	Draft report uploaded to shared file.	RQ1, RQ2, RQ3, RQ4.1, RQ4.2, RQ4.3 RQ5.1, RQ5.2	June 2020-October 2020
7. Finalize report	9.1 Finalize the report based on review feedback. 9.2 Develop report dissemination plan. 9.3 Package report for dissemination.	Rhoda Gonzales	Final report uploaded to shared file.	RQ1, RQ2, RQ3, RQ4.1, RQ4.2, RQ4.3 RQ5.1, RQ5.2	July 2020-December 2020

Key Informant Interview

Exploration of Care Coordination in Local Dental Pilot Projects

General Information:
These interviews will be conducted with each LDPP's point of contact to further understand the care coordination efforts and outcomes.

Title:	
Contact phone number:	
Role in project:	
Time interview started:	
Time interview ended:	

Role in project and implementation experiences

1. Can you please tell us more about your Pilot Project?
    - What is your role?
    - Have you been there since the inception?
    - How close to the initial proposal have you followed?
    - Have you changed strategies throughout the implementation of the LDPP?

Assessing key outcomes and impact of care coordination

2. (RQ1) How are you defining care coordination?
3. (RQ2) How do you define the effectiveness of care coordination?
    - Who oversees/employs the care coordinators?
    - Who is responsible for delivery of care coordination?
        i. Do you have more than one care coordination team?
        ii. What name is given to the team members that coordinate care? (I.e. CHWs, OHEs etc)
        iii. How many care coordinators are employed?
        iv. Have additional care coordinators been approved/added as time went on?
        v. Do care coordinators have a target number of families/children that they aim to engage with?
        vi. If so, what is that number?
        vii. Is there a data base that they input the engaged individual's information into?
        viii. What does it take to make these connections and get children into dental care?
        ix. Who is responsible for the fidelity of the care coordination model?
        x. How is reporting accomplished and who is this reported to?
4. (RQ3) What challenges have you faced in providing care coordination?
5. (RQ4) What are the facilitators for providing care coordination?
    - RQ4.1 What additional partnerships exist?
        i. Where do activities related to care coordination and recruitment take place?
        ii. Has there been additional services that care coordinators refer to?
            - If yes, what other services have been coordinated?
    - RQ4.2 What care coordination promising practices have been identified?
    - RQ4.3 How are managed care plans supporting and tracking care coordination at the local level?

Final thoughts and promising elements of care coordination

5. (RQ5) What are the challenges and facilitators to sustainability and replicability of care coordination efforts?
    - (RQ5.1) What are the cost-benefit trade-offs to providing care coordination?
    - (RQ5.2) What is the estimated per-person cost of providing care coordination services?
        i. Anything else we should know about the overview of your LDPP?

Appendix B

Comparison of DHCS Case Management vs. TSC Care Coordination vs. LDPP Care Coordination			
	Case Management	TSC Care Coordination	LDPP Care Coordination
Outreach/Referral Source	Requires referral from Medi-Cal provider, case manager, social worker, or nurse.	Self-referral by calling Telephone Service Center (TSC) *	Care Coordinators outreach in community directly and through community partnerships.
Year implemented	2019	2019	2017
Services provided overview	Complex case management across multiple providers and specialties. Eligibility requires a current, comprehensive evaluation and treatment plan.	Care Coordination support depends on the degree of complexity for coordinating appointment(s). Locating a general dentist, specialist dentist or a clinic that offers dental services.	Provides education, ongoing support and follow up of referral, enhancing oral health outcomes. **
Age Requirement	No age limit	No age limit	0-20 years
Special healthcare needs requirement	√		
Identifying providers	√	√	√
Scheduling appointments	√		√
Tracking and follow up of referrals (managing referrals)	√		√
Coordination of ASL (American Sign Language Services)	√	√	√
Arranging transportation/ translation	√***	√***	√***
Appt. reminders and follow up	√		√
Assistance with TAR (treatment authorization request) status	√	√	√
Accompanying pt.'s and families to first appt.			√****
Connecting care across multiple systems	√		√
Tracking data and outcomes	√		√
*	Website states that there are member outreach events. The reach of these events is unknown.		
**	Scheduling, reminding, and following up after appointments. Tracking outcomes through a data system. Connection to wrap around services. Addressing SDOH. Care coordination teams are reflective of the diverse community they serve and are provided education on cultural humility.		
***	Coordinates with health plan for transportation and translation needs.		
****	Select counties attend first appointments.		

Appendix C: DTI Caries Risk Assessment

California Department of Health Care Services
Domain #2 Caries Risk Assessment Form for Children <6 Years of Age

Patient Name:

ID# Age: Date of Birth:

Assessment Date:

Please indicate whether this is a BASELINE assessment or a FOLLOW-UP VISIT
Provide follow-up visit #)

RISK ASSESSMENT

Assessment through interview and clinical examination	High Risk	Moderate Risk	Low risk	Priority for Self-management goal
	Check All That Apply			
1. Risk factors (Biological and Behavioral Predisposing factors)				
(a) Child sleeps with a bottle containing a liquid other than water, or nurses on demand		Yes ☐	No risk factors	
(b) Frequent use beverages other than water including sugary beverages, soda or juice		Yes ☐		
(c) Frequent (>3 times/day) between-meal snacks of packaged or processed sugary foods including dried fruit		Yes ☐		
(d) Frequent or regular use of asthma inhalers or other medications which reduce salivary flow		Yes ☐		
(e) Child has developmental disability /CSHCN (child with special health care needs)		Yes ☐		
(f) Child's teeth not brushed with fluoride toothpaste by an adult twice per day		Yes ☐		
(g) Child's exposure to other sources of fluoride (fluoridation or fluoride tablets) is inadequate		Yes ☐		
2. Disease indicators/risk factors – clinical examination of child				
(a) Obvious white spots, decalcifications, enamel defects or obvious decay present on the child's teeth	Yes ☐	No disease indicators	No disease indicators	
(b) Restorations in the past 12 months (past caries experience for the child)	Yes ☐			
(c) Plaque is obvious on the teeth and/or gums bleed easily		Yes ☐		
OVERALL ASSESSMENT OF RISK* (Check)	**HIGH ☐ Code 0603**	**MODERATE ☐ Code 0602**	**LOW ☐ Code 0601**	

*YES to any one indicator in the HIGH RISK COLUMN = **HIGH RISK** [Presence of disease or recent disease experience]. YES, to one or more factors/indicators in the MODERATE RISK COLUMN in the absence of any HIGH RISK indicators = MODERATE **RISK** [Presence of a risk indicator; no disease]. Absence of factors in either high or moderate risk categories = **LOW RISK**

RISK ASSESSMENT CODE THIS VISIT D060_____ RISK ASSESSMENT CODE LAST VISIT D 060_____

SELF MANAGEMENT GOALS AND PLANS

3. (a) Identify one or two Self-Management Goals for parent/caregiver
(b) Counsel the mother or primary caregiver to seek dental care — Yes ☐ No ☐

Plan for next visit:

Signature: Date:

Note: Adapted from CAMBRA risk assessment, CDA Journal, October 2011, vol 139, no 10

Example of a Caries Management Protocol for Children <6 years of Age

Risk Category	Visit	Fluoride	Counseling (age appropriate)	Sealants on permanent teeth	Treatment [2]
High Risk	Every 3 months	Topical fluoride Supplements in non-fluoridated areas	Twice daily brushing with fluoride toothpaste Feeding habits Diet	Yes	Active surveillance of incipient lesions Silver diamine fluoride Restoration of cavitated lesions with Interim Therapeutic Restoration (ITR) or definitive treatment
Moderate Risk	Every 4 months	Topical fluoride Supplements in non-fluoridated areas	Twice daily brushing with fluoride toothpaste Feeding habits Diet	Yes	Active surveillance of incipient lesions Silver diamine fluoride Restoration of cavitated lesions with ITR or definitive treatment
Low Risk	Every 6 months	Topical fluoride	Twice daily brushing with fluoride toothpaste Feeding habits Diet	Indicated for teeth with deep pits and fissures.	Surveillance

2. Management of dental caries should take into consideration a more conservative approach that includes age of the individual, risk for caries progression, active surveillance, application of preventive measures, potential for arresting the disease process, and restoration of lesions with interim therapeutic restorations.

Note: Adapted from Guideline of Caries-risk Assessment and Management for Infants, Children and Adolescents. AAPD Reference Manual 2014.

Appendix D: Child Utilization Data Over Time by LDPP County

Alameda County ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
28.25%	27.04%	26.34%	38.71%	41.14%	41.82%	12.89%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
44.42%	43.97%	42.82%	42.01%	44.78%	44.99%	0.57%

Fresno County ADV Utilization Over Time (Ages 0-20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
36.02%	35.65%	35.39%	39.02%	41.60%	41.81%	5.79%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
43.79%	43.61%	43.30%	43.60%	46.29%	46.42%	2.63%

Humboldt County ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
2.20%	2.37%	2.67%	26.92%	25.73%	31.24%	29.02%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
30.36%	34.18%	35.15%	35.49%	37.94%	38.40%	8.04%

Los Angeles County ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
42.06%	42.06%	41.44%	42.83%	46.62%	47.12%	5.06%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
46.65%	46.72%	46.21%	46.39%	50.04%	50.67%	4.02%

Orange County ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
46.12%	45.85%	46.09%	45.86%	48.82%	48.66%	2.54%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
50.91%	50.63%	49.87%	50.38%	51.98%	52.39%	1.48%

Sacramento County ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
23.82%	24.58%	23.06%	27.48%	30.15%	30.94%	7.12%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
30.65%	31.72%	29.80%	33.65%	35.94%	36.47%	5.82%

San Bernardino Co. ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
40.21%	39.53%	36.46%	41.54%	41.75%	42.12%	1.91%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
42.64%	43.45%	38.28%	43.10%	45.17%	45.07%	2.43%

San Francisco Co. ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
32.49%	30.28%	30.27%	44.99%	48.64%	48.91%	16.42%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
48.62%	48.78%	48.75%	49.85%	51.75%	51.91%	3.29%

San Joaquin Co. ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
34.68%	34.50%	34.41%	33.33%	21.09%	36.89%	2.21%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
38.21%	38.58%	39.00%	40.66%	40.60%	40.66%	2.45%

San Luis Obispo Co. ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
29.98%	31.74%	33.55%	43.78%	44.45%	46.52%	16.54%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
46.10%	45.75%	46.07%	45.61%	46.42%	47.97%	1.87%

Sonoma County ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
24.70%	25.01%	23.43%	45.51%	47.54%	47.29%	22.59%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
45.09%	47.77%	48.29%	46.85%	50.10%	50.32%	5.23%

Riverside County ADV Utilization Over Time (Ages 0 to 20)						
Use of Preventive Services						
2013	2014	2015	2016	2017	2018	% Increase
39.88%	36.79%	35.99%	40.31%	40.87%	41.38%	1.5%
Annual Dental Visit Utilization						
2013	2014	2015	2016	2017	2018	% Increase
43.03%	42.34%	42.18%	42.65%	39.39%	44.59%	1.56%

Endnotes

1 https://smilecalifornia.org/
2 Dental Health Foundation. "Mommy, It Hurts to Chew" The California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. Oakland: Dental Health Foundation, 2006.
3 Centers for Medicare & Medicaid Services. Fact Sheet: Service Use among Medicaid & CHIP Beneficiaries age 18 and Under during COVID-19 (September 2020). https://www.cms.gov/newsroom/fact-sheets/fact-sheet-service-use-among-medicaid-chip-beneficiaries-age-18-and-under-during-covid-19.
4 https://www.auditor.ca.gov/pdfs/reports/2013-125.pdf
5 Little Hoover Commission (April 2016). Fixing Dent-Cal, Report #230: https://lhc.ca.gov/report/fixing-denti-cal.
6 https://www.dhcs.ca.gov/services/Pages/Dental_Performance_Measures-High_Level.aspx
7 Agency for Healthcare Research and Quality, Care Coordination: https://www.ahrq.gov/ncepcr/care/coordination.html#:~:text=Care%20coordination%20involves%20deliberately%20organizing,safer%20and%20more%20effective%20care.
8 Agency for Healthcare Research and Quality, Care Coordination: https://www.ahrq.gov/ncepcr/care/coordination.html#:~:text=Care%20coordination%20involves%20deliberately%20organizing,safer%20and%20more%20effective%20care.
9 California Health and Human Services Open Data Portal, Individuals Under Age 21 Enrolled in Medi-Cal by Delivery System, June 2020: https://data.chhs.ca.gov/dataset/eligible-individuals-under-age-21-enrolled-in-medi-cal-by-county.
10 For the Medi-Cal dental benefit, the majority children ages 0 to 20 receive their care through the FFS service system (93 percent), with only two counties, Sacramento (mandatory) and Los Angeles (optional) delivering dental services through dental managed care plans (7%).
11 CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions, KFF Issue Brief (June 2016). https://www.kff.org/report-section/cmss-final-rule-on-medicaid-managed-care-issue-brief/.
12 https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2207
13 https://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Jan2020-StatusReport-Regs.pdf
14 https://www.dhcs.ca.gov/services/Pages/Care-Coordination-Assessment-Project.aspx
15 https://www.dhcs.ca.gov/services/Documents/CareCoordination.pdf
16 https://dental.dhcs.ca.gov/DC_documents/providers/provider_bulletins/Volume_35_Number_23.pdf
17 This information was provided to Children Now in an email from the Medi-Cal Dental Services Division on October 14, 2020.
18 https://www.dhcs.ca.gov/services/Documents/MDSD/Stakeholder-Meeting-Materials/Statewide-Fact-Sheet-Aug-2020.pdf
19 https://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx
20 https://www.aapd.org/research/oral-health-policies--recommendations/Dental-Home
21 Due to capacity and time constraints, the California Rural Indian Health Board opted to not participate in this study.
22 Care coordinators have received requests from families to assist with dental bills received, despite Medi-Cal members being protected from being billed for any covered services. Examples of charges include missed-appointment fees, personal protective equipment, deposits for nitrous, and Silver Diamine Fluoride. Care coordinators provide guidance to patients and work with the Medi-Cal Dental program on the behalf of member via Telephone Service Center (TSC) for further assistance in resolving issues.
23 Atchison, K., Rozier, R.G. & Weintraub, J.A. (2018). Integration of Oral Health and Primary Care: Communication, Coordination and Referral, National Academy of Medicine: https://nam.edu/integration-of-oral-health-and-primary-care-communication-coordination-and-referral/
24 Alameda County's HTHC Pilot provides an incentive of $10 per dental encounter form and $20 per child under 5 years of age up to two times a year for dental education helped in administrative barriers perceived by dentists treating Medi-Cal Dental children in program.
25 Sacramento County has mandatory dental managed care, meaning each Medi-Cal member receives their dental benefits through a dental plan and are assigned to a dental provider. Sacramento County has three dental plans, which include Access Dental Plan, HealthNet, and Liberty Dental Plan. Los Angeles County also has dental managed care but it is not mandatory; Medi-Cal members must opt.
26 https://smilecalifornia.org/
27 https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Documents/MCOD_RFP_Schedule_v20200227.pdf
28 https://caleprocure.ca.gov/event/4260/20-002
29 https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160AB2207
30 https://www.dhcs.ca.gov/services/chdp/Pages/ProgramOverview.aspx

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