

The San Francisco Foundation
Community Health

Oral Health Briefing Paper
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INTRODUCTION

This briefing paper outlines dental health issues within the Foundation's five-county Bay Area service area, namely Alameda, Contra Costa, Marin, San Francisco and San Mateo counties. Its purpose is to serve as an informational tool for evaluating the feasibility of implementing a strategic initiative focusing on oral health within the Foundation's Community Health program area.

The paper provides State and national information that is important to understanding local and regional dental health issues in the Bay Area. Information for the briefing paper was obtained from one-on-one interviews with individuals in the dental field in the five-county area and from various reports and research. It should be noted that dental health and oral health are not the same. Dental health (which pertains to the teeth) is a subset of oral health (which pertains to the mouth). The words are sometimes used interchangeably. This briefing paper generally uses the term oral health because it is the term generally used in the provider, advocate, research and philanthropic communities.

According to the Centers for Disease Control, more Americans lack dental coverage (108 million) than medical coverage (46 million). In many ways, improved access to oral health services and improved oral health status is no different from general health. It can be improved by having dental insurance, engaging in prevention and having access to quality dentists. Without access to regular preventive dental services, many children and adults, postpone dental care until symptoms appear and become too painful to ignore.

In general, improvements in the provision of dental care and services have enabled most Americans to have much better oral health than in previous generations and in that past decade.¹ Nevertheless, there is striking evidence that disparities in oral health status exist -- not all Americans have the same level of oral health and well-being. Oral diseases and conditions can be critical impediments to growth, function, self-image and employability. It is increasingly understood that dental and oral diseases compromise general health.

ORAL HEALTH IN AMERICA

Oral health care has historically not received the same level of priority as other health care fields. This is in large part because untreated dental disease and decay does not lead to a fatality. However, when various focus groups are asked to identify their top health priorities, dental care and dental services are consistently among the top priorities. It constitutes one of the greatest unmet needs in the health care system.

The 2000 release of *Oral Health in America: A Report of the Surgeon General* brought about increased interest in addressing the unmet dental health needs of vulnerable populations. The report noted that oral health disease disproportionately affects children, disabled, elderly, low-income persons, individuals in rural communities and people of color. In addition, the report stressed that "oral health means more than healthy teeth" and that "oral health is integral to

¹ Surveillance for Dental Caries, Dental Sealants, Tooth Retention, Edentulism and Enamel Fluorosis – United States, 1988 – 1994 and 1999 – 2002. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control (2005).

general health.” Since the release of the report, national, state, regional and local efforts have been undertaken, with varying degrees of success, to address the framework for action outlined by the Surgeon General. The principal components of the framework are:

- Change perceptions (i.e., public, policymakers and health providers) regarding oral health and disease so that oral health becomes an accepted component of general health.
- Accelerate the building of the science and evidence base and apply science effectively to improve oral health.
- Build an effective health infrastructure that meets the oral health needs of all Americans and integrates oral health effectively into overall health.
- Remove known barriers between people and oral health services.
- Use public-private partnerships to improve the oral health of those who still suffer disproportionately from oral diseases.

This framework, along with the Healthy People 2010 objectives for oral health, constitutes the strategies that states should undertake to improve oral health. These strategies are undertaken with the active involvement of localities, advocates, policymakers, consumers and the public.

ORAL HEALTH IN CALIFORNIA

California is not meeting the oral health needs of its population. In Oral Health America’s 2003 Oral Health Report Card, California received a “C” grade in advancing oral health and oral health care for its residents. The report card provides a snapshot of oral health in America and provides comparative data on each state using state level data. California’s grade mirrored the national grade, which was also “C.” **Attachment A** provides the specific grades for California in the five categories.

California is particularly weak in the area of prevention. As with any health-related field, the focus on improving oral health outcomes begins with prevention, health promotion, and health education. However, in this area, the State of California received a “D-” grade from Oral Health America. Specifically, it received a failing grade in the area of community water fluoridation and below average grade in school-based dental sealant programs. While the State has a fluoridation program designed to adjust the naturally occurring fluoride level in water to the optimum level that prevents tooth decay, less than 26% of the State’s population is served by fluoridated community water supplies.² The five-county Bay Area is somewhat fortunate in that all communities, except the Bay Point community of Contra Costa County, have optimally fluoridated water. The California Department of Health Services states that for every \$1 spent on fluoridation, \$120 is saved in dental treatment costs. Dental sealants are another effective prevention strategy for tooth decay. The sealant is a plastic coating applied to the chewing surface of molar teeth. While the State is good in collecting and reporting data on sealant prevalence, its sealant program served only 15,201 children in 2004. There were 6.9 million school-aged children in California in 2004.³

² Synopses of State and Territorial Dental Public Health Programs – California, 2004. National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control (2005).

³ Ibid.

ORAL HEALTH IN THE FIVE-COUNTY BAY AREA

Community Health examined the 2003 California Health Interview Survey (CHIS) to obtain information on dental health coverage and access in the five-county Bay Area region that TSFF serves. CHIS data indicates that more residents in this area lack dental coverage than health care coverage -- 1,156,000 individuals (28%) lack dental insurance while only 420,000 individuals (10.1%) lack health insurance (i.e., was uninsured at the time the survey was administered).

The data indicate that a general cross-section of the population lack dental care coverage when examined by age, ethnicity and income. By age distribution, the number and percentage of residents without dental insurance is the following. Table 1 indicates that adults (including seniors) comprise almost 84% of those without dental care coverage. A slightly higher percentage of seniors (19%) lack dental coverage than children and youth (16%).

Table 1
Residents without Dental Insurance by Age
(Alameda, Contra Costa, Marin, San Francisco and San Mateo)

Age	Number	Percentage
0 -18 years	190,000	16.4%
19 – 64 years	747,000	64.6%
65 +	220,000	19.0%

When states or the federal government, implement efforts to expand dental coverage, the resources focus primarily on providing dental health services to children. These expansions have occurred through either publicly-funded insurance programs or school-linked dental prevention programs. In addition, several California counties have implemented Children's Health Initiatives in an effort to expand health and dental coverage to uninsured children ineligible for any state or federally-funded program. These efforts are pursued, in part, because of society's long-standing approach to ensuring that children have basic services. In addition, there is the belief that by working with children, the dental community can help reinforce the principles of dental care and prevention early in life.

With respect to ethnicity, in absolute terms, whites have the highest number and therefore the highest percentage of residents lacking dental coverage. However, as Table 2 reveals, when the number of residents without dental coverage by ethnicity is compared to the total population of that ethnic group, it becomes apparent that persons of color are disproportionately affected by the lack of dental coverage. For example, over 30% of Latinos lack dental coverage but they are less than 18% of the population. More disturbing is that 70% of Native Americans lack dental insurance and this population constitutes less than one percent of the population.

Table 2
Residents without Dental Insurance by Ethnicity and
Estimated Total Population by Ethnicity
 (Alameda, Contra Costa, Marin, San Francisco and San Mateo)

Ethnicity	Population Without Dental Coverage		Estimated Total Population⁴		
	Number	Percent	Number	Percent of Population	Percent in Ethnicity w/o Dental Coverage
African Amer.	62,000	5.4%	406,079	9.5%	15.3%
Native Amer.	10,000	.09%	13,979	.3%	71.5%
Asian	235,000	20.3%	846,154	19.9%	27.8%
Latino	231,000	20.0%	757,212	17.8%	30.5%
White	573,000	49.6%	2,126,822	50%	26.9%
Multi-Ethnic	45,000	3.9%	106,640	2.5%	4.2%

Table 3 indicates that income is a factor in access to dental insurance. In the five-county Bay Area, over one-third of all households earning less than 300% of the Federal Poverty Level (FPL) lack dental insurance. This percentage falls to 24% for households with income in excess of 300% FPL.

Table 3
Dental Insurance by Income Level
 (Alameda, Contra Costa, Marin, San Francisco and San Mateo)

Income Level	Has Coverage	No Coverage
0-99% FPL	67.6%	32.4%
100-199% FPL	61.9%	38.1%
200% - 299% FPL	66.0%	34.0%
300% FPL +	75.9%	24.1%

However, a higher family income does not necessarily make a household immune from having difficulty accessing dental insurance. As Table 4 reveals, more than 50% of those without dental coverage have family incomes in excess of 300% FPL (roughly \$44,000 for a family of three in 2003, when the survey was taken). The significant percentage of higher income households without dental insurance is most probably a reflection of the fact that these individuals do not have access to employer-sponsored dental coverage.

⁴ State of California, Department of Finance, California County Race/Ethnic Population Estimates and Components of Change by year July 1, 200 – 2003. Sacramento, California, June 2005.

Table 4
Percentage of Population w/o Dental Insurance by Income Level
 (Alameda, Contra Costa, Marin, San Francisco and San Mateo)

Income Level	Number	Percentage
0-99% FPL	140,000	12.1%
100-199% FPL	203,000	17.5%
200% - 299% FPL	166,000	14.3%
300% FPL +	648,000	56.0%
Total	1,157,000	100.0%

In addition to examining dental insurance coverage, TSFF reviewed comparative data on oral health for California and the five Bay Area counties. **Attachment B** provides this information and shows that, in general, residents in the five Bay Area counties fare slightly better than State residents overall, in access to dental health services. Specifically, Bay Area residents are more likely to have dental coverage and more likely to have seen a dentist in the last year. However, the data also reveals disparities across racial and ethnic groupings. For example, Bay Area adults of color (ages 19 to 64) were less likely, than their white counterparts, to have visited a dentist in the last year. Specifically, the rates were as follows: Latino (55.5%), American Indian (56.4%), African-American (69.2%), Asian/Pacific Islander (73%) and Caucasians (79.3%). The overall rate for this population in the five Bay Area counties was 73%.

IDENTIFIED BARRIERS TO OBTAINING ORAL HEALTH CARE AND SERVICES

Access to care is essentially a patient’s ability to obtain dental services. Several barriers exist to obtaining oral health care and to promoting good oral health care. They include lack of access to dental insurance, insufficient reimbursement for publicly-funded dental care, an inadequate dental safety net, shortage of dentists in certain communities, a less ethnically representative dentist workforce, current practice model for dentistry, and cultural values and practices regarding dental care.

Limited access to oral health services can have long-term affects. Children with limited access to dental care may be forced to miss school much more frequently with dental pain. This could impact their learning. Older individuals with edentulism (i.e., having no teeth) may be unable to maintain a balanced and nutritious diet, which can comprise their health. Low-income individuals who have not had adequate oral health and may have lost teeth, could find their employment prospects limited if when talking or smiling it is readily apparent that they have lost teeth. For a variety of factors, access to oral health care has become a marker in determining a person’s socio-economic status.

This paper groups the barriers into the following categories and summarizes the issues in more detail: access, financial, workforce, systems and cultural.

Access Issues

Lack of access to dental insurance: Dental insurance is critical to accessing appropriate preventative and treatment services. As noted above, 28% of all residents in the five-county Bay Area region lack dental insurance. Dental coverage is particularly limited for

the elderly (e.g., Medicare does not provide preventative dental coverage; only dental coverage provided within the context of hospitalization and a particular condition is provided) and low-income persons (e.g., adults, immigrants, etc). As noted previously, while publicly funded expansion of dental coverage to children has occurred, little has been done to expand coverage for adults on the local, state or federal levels. As a result, working uninsured and indigent persons have limited access to dental services and dental insurance.

An inadequate dental safety net: The dental “safety net,” is system by which communities without dental coverage obtain access to needed services. It is made up of dental and dental hygiene schools, community-based clinics, school-based programs, hospital clinics, nursing homes and mobile vans. Because the dental safety net is significantly smaller than the medical safety net, individuals have fewer opportunities to obtain affordable dental care. In addition, because the dental safety net is smaller, patients often face long lines and lengthy wait times for services. **Attachment C** provides a summary of the number of county and community clinics that provide dental services in TSFF’s five-county service area. It also provides information on any special collaborations or projects undertaken in the county. As the attachment indicates, there are a total of 38 safety net clinic sites for children and 34 safety net clinic sites for adults in the five counties for the over 1.1 million residents lacking dental coverage.

Financial Issues

Insufficient reimbursement for publicly-funded dental care: Denti-Cal is California’s Medi-Cal dental services program which provides dental treatment and services to those individuals who qualify for Medi-Cal. Denti-Cal, like Medi-Cal, does not fully reimburse providers for the cost of providing care. In 2000, the General Accounting Office reported that Denti-Cal rates varied from 17% to 68% of average regional dental fees.⁵ Denti-Cal reimbursement affects a provider’s willingness to accept Denti-Cal patients. A recent survey of the San Mateo Children’s Health Initiative found that dentists were less likely to participate in Dent-Cal and other public programs due to low reimbursement and cumbersome treatment authorization processes.⁶ As a result, while 35% of California dentist may be listed with the State as Denti-Cal providers (11,631 out of 32,846 licensed dentists as of fiscal year 2003-04), in actuality, the percentage of dentists willing to accept Denti-Cal patients is much smaller.

Workforce Issues

Shortage/mal-distribution of dentists in certain communities and a declining number of individuals in dentistry as a profession: The federal Health Resources and Services Administration (HRSA) has outlined a process by which certain populations and facilities can request designation as areas with a shortage of health professionals. Under HRSA guidelines, any area with less than one full-time dentist to every 5,000 residents (or a ratio of 1:5,000) is considered a professional shortage area. The designation and its

⁵ Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations. Washington, DC:US General Accounting Office (September 2000).

⁶ E. Howell, D. Hughes, G. Kenney, J. Sullivan, J. Rubenstein (2005) Evaluation of the San Mateo County Children’s Health Initiative: Second Annual Report.

associated score are used by various federal health agencies in determining allocation of resources. Scores range from one to 26 for dental services and the higher the score, the greater the priority. It is important to recognize that shortage designations, while determined by HRSA, are not, initiated by HRSA. As a result, many areas that might qualify for designation, but the population or facility has not started the designation process.

With that caveat in mind, **Attachment D** provides the Dental Health Professional Shortage Areas for the five Bay Area counties. The data indicates that there are 20 shortage areas in the five counties. The data also reveals that a majority of the shortage scores are 'five' on the 1 to 26-point scale. There were two shortage areas based on population, one in the Fruitvale area of Oakland (Alameda County) with a score of 15 and one in the South of Market area of San Francisco with a score of eight (8). Alameda County had the largest number of designated shortage areas for dentists. It is also home to the facility with the largest shortage score – the women's Federal Correctional Institution in Dublin with a score of 21.

It is important to note that in many ways, the shortage areas document the potential mal-distribution of dentists within our communities. Research has shown that communities with a fewer dentists have higher percentages of persons of color, children and low-income individuals.⁷ This is certainly the case for the 20 shortage areas in our region.

Compounding the shortage/mal-distribution of dentist is that fact that fewer people are entering dental school. The Bay Area is home to two of California's five dental schools – University of California at San Francisco and University of the Pacific. Nationally 4,000 students graduate from dental schools on an annual basis. Twenty years ago, 6,000 students graduated from dental schools annually. The shortage in dental school graduates nationally is primarily due to the closure of seven dental schools from 1986 to 2001 and a reduction in enrollment in the remaining dental schools. At the same time, the workforce continues to age with the average age of a California dentist at 48.⁸ The decrease in the number of dental graduates coupled with the aging of the dental workforce places tremendous strain on a system that is already not meeting the dental health needs of many in the community.

A less ethnically representative dentist workforce: Another component of the shortage is that fewer dental professionals practice in low-income communities in California, are persons of color, and/or bilingual dentists who can deliver services in a culturally competent manner that could lead to improved dental health outcomes. In many ways, this issue highlights one aspect of the demographic composition of the dental workforce – the composition of the dental workforce has an impact on access for low-income communities. Specifically, research undertaken by The California Endowment notes that the dental workforce “is among the least racially and ethnically diverse of the health

⁷ Mertz E, Grumbach K. (2001) Identifying communities with low dentist supply in California. Journal of Public Health Dentistry.

⁸ Mertz E, Manuel-Barkin C, Isman B, O'Neil E. (2000) Improving Oral Health Care Systems in California. San Francisco, CA: San Francisco, Center for the Health Professions.

professions.”⁹ The most recent information on California dentist reporting race and ethnicity indicates that 75% are White, 18% are Asian/Pacific Islander, 4% are Latino, 2% are African-American and 0.2% are American Indian/Native American. This is in stark contrast to the demographics of the State in which almost one-third of residents are Latinos and 8% are African-American. Research indicates that dentists from communities of color are more likely to practice in those communities thereby improving access to care.

Systems Issues

Current practice model for dentistry: The current practice model for dentistry has not changed or adapted to changing demographics, family lifestyles, and other factors. Dentistry is essentially a highly technical surgical profession. Almost 90% of all dentists are in private practice and own their dental businesses – this service delivery model severely hampers the ability of dentists to serve uninsured or low-income individuals. Research conducted by the Center for the Health Professions at the University of California at San Francisco found that 60% to 75% of a dentist’s gross revenue is set aside to cover fixed overhead costs that are generally quite high because of the nature of solo practice settings. These high fixed costs effectively limit a dentist’s ability to provide services to underserved communities. Additional service delivery and practice models (outside the dental office model) are needed to care for low-income individuals. Such models would be particularly helpful for individuals who require less complex dental services and/or procedures. Many in the community may simply need preventative dental treatment (i.e., sealants, fluoride varnish, dental education, etc.). There may be opportunities to provide some of services in a more community-oriented setting.

Cultural Issues

Cultural values and practices regarding dental care: For most, a trip to the dentist is not a welcomed excursion. In some communities of color, dental visits may be feared and avoided at all cost, even if it results in the person unwittingly setting the stage for advanced dental disease and decay. In addition, in some immigrant communities there may be the belief tooth loss is a natural process of aging. For example in some communities, dental decay of a child’s primary teeth is not cause for alarm because these teeth will fall out anyway to make room the child’s permanent teeth. These parents may not realize that dental disease is bacterial and that decaying primary teeth set the stage for how a child’s permanent grow and is a predictor for future tooth decay. In addition, some communities may avoid drinking tap water, preferring bottled water for its perceived safety. However, tap water in the Bay Area is fluoridated and as a result is a significant tool in reducing dental disease. Bottled water, for the most part, is not fluoridated.

Cultural and Linguistic Capacity in Providers: Language differences between providers and clients can be a significant barrier in accessing oral health services and in appropriately promoting good oral health education and prevention. This is a particularly important issue given the ethnic and linguistic diversity of the Bay Area.

⁹ George Zamora memorandum entitled “Overview of Dentistry,” dated August 5, 2005.

IDENTIFIED ORAL HEALTH PROBLEMS BY POPULATION

The following section summarizes some of the oral health problems encountered by those who lack appropriate access to oral health services – those with and without coverage.

Tooth decay is the single most common chronic disease of childhood—five to eight times more common than asthma. Eighty percent of tooth decay is found in 25% of all children. Children of color are less likely, than white children, to see a dentist in a year (29% versus 49%). As a result, many efforts have been developed to expand dental coverage to children, either through publicly funded insurance programs or through school-linked dental prevention programs. For example, all but one of the local First 5 Children and Families Commissions has identified dental/oral health as a health issue for children aged 0 – 5 in either their strategic plan or assessments. A majority of the five First 5 Commissions has funded expansion of dental services, particularly preventive dental screening services, for this population. However, even with these public efforts not all children have access to needed dental services and treatment. For example, the California Children’s Dental Disease Prevention Program, which is designed to promote and protect the oral health of children through school-based/linked oral health education and services, serves only 300,000 of the estimated 3 million eligible children.

As noted previously, little, if anything, has been done to ensure dental services and treatment for adults. Elderly individuals and persons with special needs are particularly vulnerable. Medicare does not provide dental coverage—less than 20% of Americans over the age of 75 have any form of private dental insurance. The lack of dental coverage for this population is of growing concern as people live longer and the incidence of edentulous (having no teeth) declines—estimated at under 19% of the State’s population over 65 from a high of 50% four to five decades ago.¹⁰ As a result, there will be increased demand and need for dental coverage among the elderly. This population also faces a shortage of geriatric dental care providers. With respect to persons with special needs, they often face some of the same hurdles as elderly persons in accessing appropriate dental providers. Many dental providers lack the training to address the complex medical, physical and/or psychological problems of this population. As a result, dental access is severely limited to these individuals.

The following table provides summary information on the oral health access problems plaguing certain communities.

**Table 5
Summary of Oral Health Concerns by Population**

Population	Identified Concern
Adults	<ul style="list-style-type: none"> • Lack of health care coverage – inability to purchase dental health coverage and/or receive publicly-funded dental health care • Limited access to dental care services and providers • Shortage of dentists willing to accept Denti-Cal (for those eligible adults) due to low reimbursement

¹⁰ California Oral Health Profile. National Oral Health Surveillance System, Center for Disease Control.

Population	Identified Concern
Children	<ul style="list-style-type: none"> • Tooth decay is the single most common chronic disease of childhood – five to eight times more common than asthma. Eighty percent of tooth decay is found in 25% of all children. • Asian/Pacific Islanders suffer the most tooth decay, followed by Latinos, African-American and Caucasian children. • Children of color are less likely to see a dentist in a year than white children (29% to 49%). • Inadequate access to sealants which prevent cavities and reduce associated dental treatment costs • Shortage of pediatric dentists
General Population	<ul style="list-style-type: none"> • General fear of dentists and dentistry • Limited access to fluoridated water, which is proven to reduce dental caries. The CDC reports that for every \$1 invested in fluoridation, \$38 in dental treatment costs area saved.
Immigrants	<ul style="list-style-type: none"> • Lack of dental providers able to work with diverse communities • Cultural differences regarding natural aging of teeth – particularly as it relates to preschoolers and older adults • Need for public education regarding the role nutrition and fluoride play in healthy dental care • Lack of health care coverage – inability to purchase dental health coverage and/or receive publicly-funded dental health care
Low-income	<ul style="list-style-type: none"> • Lack of health care coverage – inability to purchase dental health coverage and/or receive publicly-funded dental health care • Shortage of dentists willing to accept Denti-Cal (for those eligible adults) due to low reimbursement • Limited access to dental care services and providers
Older Adults/Seniors	<ul style="list-style-type: none"> • Medicare does not provide dental coverage/benefits except in the case of hospitalization – less than 20% of Americans over the age of 75 have any form of private dental insurance • Fewer numbers of adults aged 65 and over who have edentulous – estimated at under 19% from a high of 50% fifty years ago; results in increased need for dental coverage • Medications may have an adverse effect on oral health • Shortage of geriatric dental care providers • California reimburses for one dental screening for skilled nursing residents on Medi-Cal; limited opportunities to obtain reimbursement for recall examinations
Special Needs Populations	<ul style="list-style-type: none"> • Lack of adequate provider training to address the complex medical, physical and psychological problems of persons with special needs • Inadequate reimbursement and incentives to serve population

In a continued effort to publicize the state of oral health among children, the Dental Health Foundation will release the 2005 Oral Health Needs Assessment in February 2006. This assessment is undertaken to create a statewide surveillance system that will provide information on the oral health status of California children in kindergarten and third grade.

DESCRIPTION OF CURRENT LOCAL, REGIONAL AND STATEWIDE WORK IN ORAL HEALTH

Work has been undertaken by philanthropic entities, government (local and state) and community-based organizations forming collaboratives to improve dental health services. **Attachment E** provides a summary of selected state-wide activities. In general, the activities focus on prevention, access and workforce. Not surprisingly, the focus of these activities is disproportionately on children. This is in part a reflection of funding availability (what limited public funding there is for dental services, is generally allocated to children) and the focus of early prevention and intervention (reducing the incidence of tooth decay in preschoolers and children, which can reduce the incidence of dental disease in adolescence and adulthood). In addition to collaborative activities noted in Attachment E, Community Health has conducted a preliminary scan of philanthropic entities funding in oral health. The current list is in **Attachment F**.

A COMMUNITY HEALTH INITIATIVE – ORAL HEALTH

Developing and implementing a strategic initiative in the area of oral health would not be in conflict with TSFF's mission and would help address four of Community Health's program objectives. Specifically, more substantive work in the area of oral health could:

1. *Improve access to healthcare, services, and treatment for those who are low-income, uninsured, or underinsured:* As the background information makes clear, limited access to dental coverage severely compromises oral health. As noted above, an estimated 1.1 million residents in the five-county Bay Area region lack dental coverage. One of the access strategies supported by Community Health is to increase the number of people who participate (enrolled and retained) in publicly funded health insurance programs.
2. *Foster efforts to prevent poor health status, disease, and disability through investments in health promotion and health education:* It is also clear that prevention is critical to improving dental health status – from fluoridating community water supplies, to expanding dental sealant programs to promoting sound dental health practices to improving access to and workforce diversity of dentists. One of the prevention strategies supported by Community Health is to increase opportunities for residents to promote and protect the health and well-being of their communities.
3. *Support local efforts designed to reduce or eliminate disparities in health status due to poverty, disproportionate exposure to environmental agents/hazards, and/or race:* The data clearly document the prevalence of racial and ethnic disparities in oral health. African-Americans, American Indians/Native Americans, Asian/Pacific Islanders and Latinos generally have poorer oral health than Caucasians. One of the health disparity strategies supported by Community Health is to address the underlying socio-economic causes of reduced health status. In addition to oral health disparities due to race, disparities in oral health status have also been documented for elderly persons and persons with disabilities/special needs populations.

4. *Advance policy reform efforts that improve access to health services:* There are several policy reforms needed to improve dental health in the areas of:
- expanding and strengthening the dental health safety net,
 - eliminating barriers to care,
 - addressing inadequate reimbursement rates and cumbersome administrative processes for publicly-funded dental coverage,
 - exploring opportunities to more effectively tier the oral health care delivery system by type of dental professional and needed dental procedure in order to effectively and efficiently meet client needs and
 - diversifying the dental services workforce.

Community Health is committed to advancing policy reform efforts that improve access to oral health services. It recognizes that advancing efforts in this area will require changing the public's perception and increasing overall awareness of oral health.

Assessment of the Oral Health Initiative Against Initiative Criteria

The current assessment is that an oral health strategic grant making area meets eight of the ten primary criteria, both of the secondary criteria and the single tertiary criteria (see **Attachment G**). At this point, it is difficult to ascertain: (1) whether work in this area could be sustained after TSFF terminates funding or (2) if there will be a long-term impact of focusing on this area over a three-year period.

Potential Areas for TSFF Investment

It should be stressed that the most significant investment needed in oral health is to pay for direct services. This is principally due to inadequate Denti-Cal and/or Healthy Families reimbursement rates that discourage dentists from seeing patients with this payor source. Improving reimbursement rates could vastly improve access and greatly reduce some of the barriers to access identified by dental health providers and advocates in the five counties. While Community Health believes that this should be a component of any effort to improve access to dental services, it also believes that this strategy would require a much more significant resource investment (both financial and time) than that currently envisioned for the three-year strategic grant making period. As a result, Community Health believes that it is vital to work with other philanthropic entities, advocates and policy makers to effectively identify and advocate for a long-term strategy solution to inadequate reimbursement levels.

Community Health has identified the following areas for potential TSFF investment in the area of oral health:

- Program (Service Expansion)
 - Fund efforts targeted at dental education, prevention and treatment communities with access to dental coverage
 - Fund efforts that work to expand the oral health safety net – either in community, public or dental school clinic settings
 - Fund efforts targeted at older and disabled adults who are either home-bound or residing in skilled nursing facilities

- Work with the dental societies in each county to determine the feasibility of and potential mechanisms needed to enable private practice dentist to provide services to uninsured individuals
- Practice (Delivery System)
 - Fund efforts targeted at expanding opportunities to obtain dental services outside the traditional dental office setting, particularly preventive dental care
 - Work with the dental community to further explore opportunities to more effectively tier the oral health care delivery system by type of dental professional and needed dental procedure
 - Analyze and assess the feasibility of developing an Operation Access-type model of care for adults without dental insurance or approach Operation Access to determine the feasibility of expanding the current model for providing outpatient surgical services for uninsured individuals
 - Work with the medical societies in each county to train physicians to detect dental disease and make appropriate referrals to dentists – effort could focus on children aged 0 – 18 years of age. This effort would actively solicit the involvement of dental societies in this training.
- Policy (Advocacy and System Reform Opportunities)
 - Support the development and implementation of an oral health policy agenda
 - Work to support and participate in the Oral Health Access Council
 - Work with the dental community and advocates for the State of California to provide annual reimbursement for dental services provided to residents of skilled nursing facilities
 - Work with Dental Health Foundation, California Primary Care Association, local health departments, California School Health Centers Association and others to advocate for the expansion of dental sealant programs in schools (public and private)
 - Work with the dental community and advocates to expand access to and funding for Denti-Cal and Healthy Families

Community Health does not propose to address the work force issues noted in the barriers section of this report. This is principally because of the existence of the California Dental Pipeline Initiative funded by The California Endowment. This effort is in its third year and is successfully working with California's dental schools to address work force diversity and expand clinical practice model used in dental school curriculum.

At this point, the preliminary outcomes of work in this area are:

- documented increase in the number of individuals who have access to diagnostic, preventative and restorative dental services,
- expansion of the dental health safety net through development of alternative delivery models (such as an Operation Access type model of care, mobile dental vans, etc.),
- increased understanding and recognition of the importance of oral health among consumers, the general public and policy makers, and
- noticeable advancement on the identified policy and advocacy issues.

The outcomes will be informed by further discussions with potential key partners in the oral health community.

As part of this Initiative, Community Health would undertake two levels of evaluation. First, it will evaluate the success of any effort funded under the initiative as part of its customary assessment of grantees and programmatic work. Second, Community Health will periodically assess the Foundation's experience in implementing and managing this component of its work to ensure that it documents the strengths, weaknesses, and/or needed revisions.

Recommendation

It is recommended that Community Health develop and implement a strategic initiative focused on oral health. Doing so would be consistent with the Community Health's goal, strategic grant making criteria and increased focus on proactive work. It is further recommended that Community Health hold a focus group/convening with those individuals who were interviewed as part of the development of this briefing paper. **Attachment H** provides the list of individuals who were interviewed. In addition, it recommended that Community Health explore the appropriateness and feasibility of creating an advisory committee for this effort.

ATTACHMENT A
2003 Oral Health America Assessment of California's Oral Health Activities

Category	Grade	Meaning
Prevention	D-	An almost failing grade in the combined areas of community water fluoridation (F) and school-based or linked dental sealant programs (D+).
Access	B	Above average grade in the combined areas of dentist availability (B), Medicaid providers (C), dental insurance status of elderly (A),
Infrastructure	D+	Below average grade in the combined areas of leadership (F), improvement plan (C), State budget (C), data use (D)
Health Status	B-	Above average grade in the combined areas of adult tooth decay (B), edentulous among the elderly (B), youth tobacco use (C), oral cancer mortality rates (B)
Policies	B-	Above average grade in the combined areas of fluoridation laws (C), competitive food policies (B), tobacco taxes, (C), Medicaid adult dental policies (A), State dental board policies (B)
Overall	C	

ATTACHMENT B
Dental Health Data from California Health Interview Survey
2003

Time Since Last Dental Visit

Category	California	Alameda, Contra Costa, Marin, San Francisco, San Mateo
Never been to dentist	6.3% (2,194,000)	5.6% (230,000)
1 – 6 months	48.6% (16,899,000)	55% (2,275,000)
7 – 12 months	20.5% (7,119,000)	18.7% (775,000)
1 – 2 years	10.6% (3,694,000)	8.7% (361,000)
2 – 5 years	8.6% (3,002,000)	7.3% (302,000)
More than 5 years	5.4% (1,893,000)	4.6% (192,000)
Total	100% (34,802,000)	100% (4,136,000)

Dental Insurance

Category	California	Alameda, Contra Costa, Marin, San Francisco, San Mateo
Has dental insurance	69.4% (24,165,000)	72.0% (2,979,000)
Doesn't have dental insurance	30.6% (10,637,000)	28% (1,156,000)
Total	100% (34,802,000)	100% (4,136,000)

Missed Work/School Because of Dental Problem

Category	California	Alameda, Contra Costa, Marin, San Francisco, San Mateo
Missed work/school	6.1% (1,794,000)	6.4% (221,000)
Did not miss work/school	93.9% (27,428,000)	93.6% (3,250,000)
Total	100% (29,222,000)	100% (3,471,000)

Reason for Visiting a Dentist or Dental Clinic

Category	California	Alameda, Contra Costa, Marin, San Francisco, San Mateo
Regular check-up	42.4% (229,000)	49.1% (23,000)
Had dental problem	47.8% (258,000)	34.1% (16,000)
Regular check-up & dental problem	9.8% (53,000)	16.8% (8,000)
Total	100% (539,000)	100% (47,000)

Could Not Afford Dental Care that was Needed

Category	California	Alameda, Contra Costa, Marin, San Francisco, San Mateo
Could not afford dental care	17.3% (6,024,000)	14.5% (600,000)
Could afford dental care	82.7% (28,778,000)	85.5% (3,536,000)
Total	100% (34,802,000)	100% (4,136,000)

ATTACHMENT C
Summary of Dental Health Services Safety Net by County

County Clinics Providing Dental Services

County	Children	Adults	Collaborations or Special Projects
Alameda	6 – 7 clinical sites	<ul style="list-style-type: none"> • No clinical sites • Adults referred to Highland Hospital, LifeLong Medical, La Clinica de la Raza 	Office of Dental Health programs have a particular focus on children: <ul style="list-style-type: none"> • Healthy Smiles Children’s Dental Program • Healthy Kids, Healthy Teeth • School Dental Sealant Program
Contra Costa	4 clinical sites	4 clinical sites	Maintains a Children’s Oral Health Program: <ul style="list-style-type: none"> • Screening and Sealant Program (Save Our Smiles) • First 5 California Oral Health Education and Training Project • Has a Comprehensive Oral Health Strategic Plan • Formed a Dental Health Action Group (a community oral health advisory committee) to oversee implementation of strategic plan
Marin	1 clinical site	1 clinical site	<ul style="list-style-type: none"> • First 5 California Oral Health Education and Training Project – day care centers
San Francisco	4 clinical sites	2 clinical sites	None noted
San Mateo	3 clinical site	3 clinical site	Released a Profile of Children’s Oral Health in San Mateo County (2000)

Community Clinics Providing Dental Services (per California Primary Care Association)

County	Children	Adults	Collaborations or Special Projects
Alameda	8 clinical sites	8 clinical sites	Alameda Health Consortium is member of Oral Health Access Council
Contra Costa	3 clinical sites	3 clinical sites	Community Clinic Consortium of Contra Costa is a member of the Contra Costa Dental Health Action Group
Marin	No clinical sites	No clinical sites	Redwood Community Health Coalition is member of Oral Health Access Council
San Francisco	6 clinical sites	6 clinical sites	San Francisco Community Clinic Consortium is member of Oral Health Access Council
San Mateo	2 clinical sites	2 clinical sites	Community Health Partnership is member of Oral Health Access Council

Dental Schools

County	School	Activities
San Francisco	University of California San Francisco	Participates in Dental Pipeline Project
San Francisco	University of the Pacific	Participates in Dental Pipeline Project

ATTACHMENT D
Health Professional Shortage Area – Dental Designation

<i>County</i>	<i>Type¹¹</i>	<i>Score</i>
Alameda		
Low-Inc: Fruitvale	Population Group	15
Albert Thomas	Comprehensive Health Center	6
Fairmount Hospital	Comprehensive Health Center	6
Mountain Valley Health Center	Comprehensive Health Center	9
Children's Hospital	Comprehensive Health Center	6
Over 60 Health	Comprehensive Health Center	5
Asian Health Services	Comprehensive Health Center	5
FCI - Dublin	Correctional Institution	21
Contra Costa		
Low-Inc: Antioch/Pittsburgh North	Population Group	8
Brookside CHC	Comprehensive Health Center	5
Contra Costa Co. Health Dept.	Comprehensive Health Center	0
Marin		
Mental Health/P	Comprehensive Health Center	5
Bolinas Family	Comprehensive Health Center	5
San Francisco		
San Francisco Medical Center	Comprehensive Health Center	5
Mission Area Health	Comprehensive Health Center	5
Northeast Medical Services	Comprehensive Health Center	5
San Francisco General Health Center	Comprehensive Health Center	5
Low-Inc: South of Market	Population Group	8
San Mateo		
South County CHC	Comprehensive Health Center	5
San Mateo Dept. of Health	Comprehensive Health Center	5

¹¹ A Population Group is a population within an area that is designated by HRSA. A Comprehensive Health Center is an entity receiving Section 330 funds to operate a comprehensive health center. A Correctional Institution is a federal and state prison and youth detention center.

ATTACHMENT E
Summary of State-wide Dental Health Activities

Prevention Activities

<i>Entity</i>	<i>Activity</i>	<i>Local Participation</i>
First 5 California	<p><i>Oral Health Education And Training Project</i> is a joint venture of the California Dental Association Foundation and the Dental Health Foundation. Aims:</p> <ul style="list-style-type: none"> • Dental and medical provider education and training to further increase preventive oral health services for young children • Parent, caregiver and general community education to have a better understanding of the importance of oral health for young children <p>(Funder: First 5 California)</p>	<ul style="list-style-type: none"> • Alameda County Public Health Department • Contra Costa Health Services • Univ. of Pacific • UCSF
State of California	<p><i>Children's Dental Disease Prevention Program</i> promotes and protects the oral health of California's children through by a offering community dental diseases prevention program to public and private school children in preschool through sixth grade and in classes for children with exceptional needs. Program was created via Senate Bill 111. (Funder: State Department of Health Services)</p> <p><i>Community Water Fluoridation Program</i> provides scientific and technical expertise to communities interested in fluoridating their drinking water. California's fluoridated drinking water act, Assembly Bill 733, became law in 1995, authorizing water systems with 10,000 or more service connections to fluoridate once money from an outside source is provided. (Funder: Non-State funding; California is responsible for securing funds to purchase and install fluoridation equipment for public water systems.)</p>	<ul style="list-style-type: none"> • Alameda • Contra Costa • Marin • San Francisco • San Mateo <p>All zips in the five counties have optimally fluoridated areas except Bay Point in Contra Costa</p>

Access Activities

<i>Entity</i>	<i>Activity</i>	<i>Local Participation</i>
California Managed Risk Medical Insurance Board	<p><i>Insurance-based Oral Health Demonstration Project (IOHDP)</i> is part of a larger oral health initiative designed to significantly reduce the incidence of dental decay in young children and children with disabilities and other special needs. The IOHDP uses the existing dental and health plans participating in the Healthy Families Program to administer approaches designed to increase the utilization of preventive dental services in young children. (Funder: First 5 California)</p>	<ul style="list-style-type: none"> • Alameda Alliance • Contra Costa Health Plan • San Francisco Health Plan • Health Plan of San Mateo • Delta Dental

Entity	Activity	Local Participation
Dental Health Foundation	<p><i>Oral Health Access Initiative (OHAI)</i> is co-facilitated by the Dental Health Foundation (DHF) and the California Primary Care Association (CPCA). OHAI, a multi-lateral, non-partisan initiative directed towards improving the oral health status of the state's traditionally underserved and vulnerable populations. That goal is being pursued through a variety of objectives directed towards achieving a substantial increase in the primary safety net system's overall capacity to provide those populations with access to necessary preventive and restorative primary oral health care. (Funders are The California Wellness Foundation and WK Kellogg Foundation.)</p> <p><i>2005 Oral Health Needs Assessment (OHNA)</i> is intended to create a statewide surveillance system that will provide information about the oral health status of California children in kindergarten and third grade. The sample will consist of 12,000 kindergarten and third grade students selected from 200 schools in the six regions defined by the California Department of Social Services. Assessment will be released in November 2005. (Funders are HRSA and the California Dental Association Foundation.)</p>	<ul style="list-style-type: none"> • Alameda Health Consortium • Community Health Partnership • Redwood Community Health Coalition • SF Community Clinic Cons. • UCSF • Univ. of Pacific <p>Schools from each county participate in the assessment</p>

Workforce Activities

Entity	Activity	Local Participation
The California Endowment	<p><i>The California Dental Pipeline Program</i> is designed to address the oral health needs of California's underserved communities. All five dental schools in California receive funding to: (1) recruit and retain an increased number of underrepresented minority students, (2) reform the dental school curricula to integrate community-based practice experience and cultural competence, (3) change a portion of clinical programs to patient-centered and community-based sources of care for disadvantaged populations and (4) create a state and national policy agenda that will increase the number of under-represented minorities in the dental work force. (Funders: The California Endowment and the Robert Wood Johnson Foundation (initiative is Pipeline Profession and Practice: Community-Based Dental Education). The W.K. Kellogg Fndn. provides funding for financial aid to underrepresented minority and low-income students.)</p>	<ul style="list-style-type: none"> • UCSF • Univ. of Pacific

**ATTACHMENT F
LIST OF ORAL HEALTH FUNDERS**

Oral Health Initiatives in California

Foundation	Oral Health Initiative	Geographic Focus
California Community Foundation	A five-year, \$25 million initiative aimed at enabling low-income individuals to improve their own lives through jobs, education, good health and enhanced neighborhood leadership. Health component focuses on enhanced access to primary health care for the working poor and those living in poverty. Basic care includes primary medical care, vision, dental and prenatal services.	Located within and primarily serving residents of Los Angeles County.
Sierra Health Foundation	With the support and cooperation of the Dental Health Foundation and the California Dental Association, Sierra Health Foundation developed a Oral Health Grant making Program. The primary purpose of this grant making program is to expand the availability of oral health services within Sierra Health Foundation's funding region.	26 counties in northern California (north of Sacramento County)
The California Endowment	A \$6.3 million grant to fund the efforts of up to four California dental schools to increase the enrollment of minority and low-income students. The initiative also aims to improve access to dental care for underserved populations through dental resident and student rotations in community clinics as well as practices that provide care to disadvantaged patients. Dental schools eligible to apply for these \$1.3 million grants are Loma Linda University, University of the Pacific, University of California at Los Angeles, and University of Southern California.	Statewide
The Health Trust	Children's Dental Health Initiative: This initiative addresses the oral health needs of Santa Clara County's at-risk children through the following programs: <ul style="list-style-type: none"> • Mobile Dental Clinic, • Franklin McKinley School District (two operatory clinics at the district office) and • Dental Sealant Program. 	Santa Clara County
The Health Trust	Dentists With a Heart Initiative: Coinciding with National Children's Dental Health Month in February, The Health Trust, in collaboration with Santa Clara County Dental Society, held a Dentists with a Heart program that addresses the dental needs of children who otherwise would not have access to dental care. Offices throughout Santa Clara County open their doors and hearts to needy children on February 14th. The Health Trust will identify, triage, schedule and direct the most needy children to participating practitioners. The children are then referred back to Dentistry With Heart, at The Health Trust, to initiate comprehensive care. Transportation is provided to families that require it.	Santa Clara County

Foundation	Oral Health Initiative	Geographic Focus
The Health Trust	FIRST 5 Oral Health Education and Training Program: The Health Trust is one of several community healthcare organizations in California to receive a grant for educating dental and medical professionals on the newest scientific information about dental disease prevention in young children. The funding comes from FIRST 5 California-Santa Clara County. Over a three year period, Santa Clara County pediatricians, obstetricians, primary care physicians and dentists are trained on how to recognize the early warning signs of dental disease in children from birth to 5 years old.	Santa Clara County

Grant Funders in the larger Bay Area

Alliance Healthcare Foundation	McKesson Corporation
California HealthCare Foundation	John Muir/Mt. Diablo Community Health Fund
California Endowment	David and Lucille Packard Foundation
California Wellness Foundation	Peninsula Community Foundation
Health Trust	San Francisco Foundation

Grant Funders in the U.S. (courtesy The California Endowment)

American Dental Association Foundation	Methodist Healthcare Ministries of South Texas, Inc.
Agency for Healthcare Research and Quality (AHRQ)	Metro Health Foundation
Berwick Health and Wellness Foundation	National Dental Association Foundation
California Dental Association Foundation	Pajaro Valley Community Health Trust
The California Endowment	John Rex Endowment
Carlisle Area Health & Wellness Foundation	Kate B. Reynolds Charitable Trust
Connecticut Health Foundation	St. Luke's Health Initiatives
Endowment for Health	Sisters of Charity Foundation of Canton
The Health Foundation of Greater Indianapolis, Inc.	United Methodist Health Ministry Fund
Health Resources and Services Administration (HRSA)	W.K. Kellogg Foundation
Irvine Health Foundation	

ATTACHMENT G
ASSESSMENT OF INITIATIVE CRITERIA

#	Criteria	Description/Rationale	Type	Assessment
1	Ability to evaluate ongoing progress	Evaluation is a fundamental component of Community Health's grant making, both responsive and strategic. Evaluation is essential to ensure the ongoing understanding of program goals and objectives, assess whether goals and objectives have been met, and measure the program's short and long-term impact. It is important to select a health area that can be sufficiently evaluated to determine impact.	Primary	Meets
2	Aligns with Community Health goals and objectives	This criteria guarantees that the chosen strategic area is in line with and connected to one of Community Health's priority areas of access, prevention, safety net services, disparities and policy. The chosen strategic area will support, rather than add to, existing Community Health goals and objectives.	Primary	Meets
3	Allows for appropriate exit strategy after completion of funding commitment	In selecting, implementing and terminating any strategic grant making work, Community Health must ensure that it leaves the field appropriately by purposefully planning for its departure. As a result, if Community Health engages in any strategic area, it must work to strengthen and sustain the capacity of its partners and ensure that there is continued community support for the work after TSFF's role in the effort diminishes.	Primary	Meets
4	Documented need for issue area is present in all 5 or a majority of the counties	Community Health should select a health area or population in which there is documented need (i.e., health data, need assessment, qualitative information from the community, etc.) on the local level. Likewise, community-based organizations, advocates, consumers and others should support TSFF's strategic work in the chosen health area. Given TSFF's regional scope, strategic grant making must focus on issue areas that impact all or the majority of the five counties served by TSFF. The strategic grant making work does not have to be done in all 5 counties, but the issue area must be present in similar levels of harm and impact the same populations in the majority of the counties.	Primary	Meets
5	Existence of capable non-profit organizations	With strategic grant making, Community Health seeks to engage non-profit organizations with experience in the chosen strategic area. With capable non-profits, the Foundation is assured that program strategies will be implemented by those with the most expertise/experience and that program activities can commence with minimum delay.	Primary	Meets

#	Criteria	Description/Rationale	Type	Assessment
6	Foundation and Community Health staff experience in area	Ensure Community Health staff's ability to: (1) design program scope taking maximum advantage of staff knowledge and experience base, (2) provide vision, leadership and project management and (3) work in partnership with funded agencies and others.	Primary	Meets in All Material Respects
7	Has potential to influence health policy and practices	TSFF, as a community foundation, seeks to create change at the community level. Community Health believes that one strategy to accomplish this is to support work that has the potential to influence health policy and practices. Funding policy and/or advocacy efforts that enable broader adoption of needed systems change reform can ultimately result in having a larger impact with the funding provided. Therefore, Community Health should select strategic grant making work that includes a policy component.	Primary	Meets
8	Project is sustainable after TSFF funding terminates and has the potential for long-term impact	As with its responsive grant making, Community Health strives to ensure that it supports efforts that are not solely dependent upon TSFF funding and are not likely to terminate when a TSFF grant ends. As a result work in the health area or population selected should be sustainable after TSFF funding ends. To achieve sustainability and long-term impact, the work should identify and build on the strengths and assets of the targeted/affected community and help build the capacity of the organizations funded.	Primary	Difficult to Ascertain
9	Results achievable in 3 – 5 years	Strategic grant making is designed to provide focused funding and attention on an issue for a discrete period of time with the expectation that results will be achievable in that time frame. Community Health believes that three to five years is sufficient time to document results on targeted funding efforts.	Primary	Meets
10	Unable to meet CH goals via responsive grant making	Responsive grant making is a community-driven funding approach whereas strategic grant making is a foundation-driven funding approach. Community Health will engage in strategic grant making when it is the most appropriate vehicle to meeting a particular goal or objective.	Primary	Meets
11	Has potential to leverage additional resources	Strategic grant making should provide the ability to identify funding and leverage resources that are both internal and external to TSFF. Leveraging provides collaborative opportunities with other funders and attracts resources to expand the work (broader, deeper, or for a longer period of time).	Secondary	Meets

#	Criteria	Description/Rationale	Type	Assessment
12	National and/or state activities on health area	Local and regional health data and issues are oftentimes reflected in state and national health policy and priorities. This is important because health services funding, regulatory reforms and delivery system practices emanate from the state and federal levels. The health issue(s) selected by Community Health should be one that has received either state or national attention or focus.	Secondary	Meets
13	Issue area resonates beyond TSFF geographic area	Strategic grant making offers Community Health the opportunity to delve deeper into a particular target population or health issue. Because many of the health issues facing individuals in TSFF's geographic region are similar to those experienced by residents in other communities, it is anticipated that the issue area selected by Community Health will resonate beyond TSFF's service area. Ideally, the lessons learned from any strategic grant making activity will result in best practices that can be replicated in other areas or for other populations and communities.	Tertiary	Meets

ATTACHMENT H
LIST OF INTERVIEWEES

Pamela Arbuckle Allston, DDS
Alameda County Medical Center

Derik Aoki, Senior Program Officer
San Francisco First 5 Commission

Rudy Blea, Chief, Office of Dental Health
State Department of Health Services

Aimee Chitayat, Executive Director
Community Clinic Consortium of Contra Costa County

Paul Glassman, DDS
University of the Pacific, School of Dentistry

Francisco Ramos Gomez, DDS
University of California, San Francisco

Mary Gregory, Interim Executive Director
Operation Access

Wynne Grossman, Executive Director
The Dental Health Foundation

Dana Hughes
UCSF Institute for Health Policy Studies

Louise McCarthy, Policy Analyst
California Primary Care Association

Beth Mertz, Program Director of California Dental Access Project
UCSF Center for Health Professions

Francina Lozada-Nur, DDS,
Professor of Clinical Oral Medicine
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Julia McKeon, Executive Director
Sonrisas Community Dental Clinic

Lynn Pilant, Children's Oral Health Program Manager
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Nadereh Pourat, PhD, Senior Research Scientist
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George Zamora, Program Associate
The California Endowment