

# Oral Health Population Needs Assessment

**January 30, 2026**

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## Executive Summary

This population needs assessment was prepared by the California Dental Network (CDN), a subsidiary of DentaQuest, LLC, as part of our contractual commitment to the Medi-Cal Dental Managed Care (DMC) Plan. The assessment combines two contracts – Los Angeles County Department of Health Care Services Prepaid Health Plan (DHCS PHP) and Sacramento County Department of Health Care Services Geographic Managed Care (DHCS GMC) – into one document for ease of comparison. The measurement period for this report is July 1 through December 31, 2025, representing six months of data from the onset of the contract effective date. In this document, we may also refer to CDN as DentaQuest.

The CDN's Population Needs Assessment (PNA) aim is to improve oral health services in two California counties, Los Angeles and Sacramento, by identifying areas with the highest oral health needs and addressing access barriers, particularly for underserved and vulnerable populations. The health status of members is considered, including children and adults with special health care needs, members with Limited English Proficiency (LEP), and members from diverse cultural and ethnic backgrounds. The CDN PNA process was designed to gather and synthesize data from multiple sources to advise the development of action plans to improve member outcomes and experiences.

Through this process, we identified several key areas of opportunity:

1. Improving use of preventive services in age groups 19-20 and adults 21-64.
2. Increasing sealants in age groups 6-9 and 10-14 as they are underutilized.
3. Improving fluoride application in age groups 10-14, 15-18, 19-20.
4. Increasing utilization of the caries risk documentation and education bundle.
5. Increasing opportunities for medical-dental education and targeted outreach for pregnant women and adults with chronic health conditions

## Purpose and Scope

The purpose of this population needs assessment is to evaluate and improve the delivery of oral health services within Los Angeles and Sacramento counties under the Medi-Cal Dental Managed Care (DMC) Plan. By systematically identifying the areas and populations with the greatest oral health needs, the assessment seeks to reduce barriers to care and enhance access, especially for underserved and vulnerable groups such as children, adults with special health care needs, individuals with Limited English Proficiency (LEP), and members from diverse cultural backgrounds.

The scope of this assessment encompasses a comprehensive review of demographic, utilization, and performance data from both internal and external sources during the measurement period of July 1 through December 31, 2025. It integrates findings from two major contracts—Los Angeles County Department of Health Care Services Prepaid Health Plan (DHCS PHP) and Sacramento County Department of Health Care Services Geographic Managed Care (DHCS GMC)—to enable direct comparison and inform targeted action plans. The assessment is designed to guide the development of strategies that improve member outcomes, ensure equitable access to care, and support the overall quality and effectiveness of dental services provided to Medi-Cal beneficiaries in the covered regions. The scope of the assessment aligns with the California Oral Health Plan (2018-2028) as well as other County-led oral health evaluations.

## Methods and Data Sources

Both internal and external data sources were consulted in the development of the PNA. Data sources offer insight into membership, member-based needs, gaps in care, and offer opportunities to inform a care plan.

Internal data sources reference data from Measurement Period July 1 to December 31, 2025. They include:

### **Enrollment data containing member demographic information**

The membership profile includes both active and termed members for the six-month reporting period.

### **Claims and encounter data**

Claims and encounter data as well as utilization management were key components in evaluating service delivery patterns, assessing member engagement with dental care, and identifying trends in both preventive and restorative service utilization. These internal insights informed the overall analysis by highlighting potential gaps in care, such as missed appointments or underutilization of available benefits, and enabled the PNA team to align findings with the performance and quality metrics required by the DHCS.

### **Performance and quality metrics**

The performance and quality measures reported are based on technical specifications outlined in the October 10, 2025, memorandum “APL 25-009 Performance Measures for Dental Managed Care Contracts Effective July 1, 2025” and “Attachment A: Performance Measures and Benchmarks”. The performance measures were selected by the DHCS to monitor and evaluate the quality and accessibility of care and services extended by Medi-Cal DMC Plans.

### **Network performance and access measures**

Monthly network performance and access measures are managed and optimized, leveraging a third-party vendor, Quest Analytics, ensuring dental providers are accurately listed and accessible to members.

### **Self-reported health and special needs requirements**

DentaQuest administers an Oral Health Information Form (OHIF) to new members to gather data about their health status and any special needs. Survey responses are systematically reviewed, analyzed, and, when necessary, referred to Outreach for further support.

### **External data**

External data sources were selected to supplement internal findings by providing broader context on population health, community characteristics, and social determinants that impact oral health outcomes in the target counties. These sources help to identify disparities, monitor public health trends, and support strategic planning for program interventions.

External data sources included surveillance reports from:

- American Community Survey
- California Department of Health Care Services
- California Department of Public Health
- California Health Information Survey (CHIS)

- Centers for Disease Control (CDC)
- County Health Rankings
- Los Angeles County Department of Public Health
- Sacramento County Department of Health Services
- US Census Bureau
- US Department of Agriculture

## Population Profiles

### General Population Characteristics

Los Angeles County and Sacramento County represent two distinct Medi-Cal population contexts within California, each with important implications for oral health needs, access and delivery of services. Los Angeles County is the most populous county in the nation<sup>1</sup> and enrolls the largest number of Medi-Cal beneficiaries in California, reflecting substantial racial, ethnic, and linguistic diversity. **See Table 1.** High Medi-Cal penetration, combined with geographic scale and neighborhood-level disparities, contributes to uneven access to oral health services and varying oral health outcomes across communities. Sacramento County, while considerably smaller, also has a significant Medi-Cal population and serves as a regional hub for healthcare delivery in Northern California, with a mix of urban, suburban, and surrounding rural communities. Differences in age distribution, language needs, and patterns of Medi-Cal utilization between the two counties influence oral health service demand, provider participation, and care continuity. Comparing these counties highlights how demographic and Medi-Cal enrollment characteristics shape oral health needs and inform targeted strategies to improve access and equity for publicly insured populations.

**Table 1** contrasts Medi-Cal enrollee demographics for California overall and two large counties—Los Angeles and Sacramento. Coverage rates are broadly similar: roughly 37–39% of the total population is enrolled in Medi-Cal across the three geographies. Gender distribution is balanced, with women slightly outnumbering men everywhere.

Age patterns vary. Los Angeles has a comparatively younger enrollee mix, with a smaller share ages 0–18 and 65+, and a larger share in the 19–44 age band. Sacramento skews younger at the low end, showing the highest 0–18 share, while California statewide has the largest proportion ages 65+.

Ethnic composition differs markedly. Los Angeles' Medi-Cal population is predominantly Hispanic (≈59%), with notable Asian/Pacific Islander representation and a smaller proportion identifying as White. Sacramento shows a more diverse balance, including higher African American and White proportion relative to Los Angeles, and the highest Asian/Pacific Islander proportion among the three. The state overall reflects a blended mix, with Hispanic as the largest group.

Language preferences mirror these patterns. English is the top preferred language everywhere, highest in Sacramento (≈73%). Spanish preference is strongest in Los Angeles (≈33%), while Asian language preferences (e.g., Mandarin, Korean, Vietnamese, Cantonese) appear more prominently in Los Angeles; Farsi is noted in Sacramento. These distinctions highlight the need for county-specific outreach and multilingual services tailored to each community's profile.

Table 1. Medi-Cal Demographic Profiles	State	County	
	California	Los Angeles	Sacramento
	<b>Overall population<sup>1</sup></b>	39,538,223	10,014,009
Medi-Cal coverage, % of population <sup>2</sup>	37.43%	39.13%	39.40%
Medi-Cal coverage, % gender <sup>2</sup>			
Male	47.10%	46.90%	48.00%
Female	52.90%	53.10%	52.00%
Medi-Cal, % age band <sup>2</sup>			
0-18	33.34%	29.63%	35.19%
19-44	35.43%	35.67%	36.54%
45-64	19.15%	20.68%	18.14%
65+	12.08%	14.02%	10.13%
Total	100%	100%	100%
Medi-Cal population, % ethnicity <sup>2</sup>			
African-American	6.77%	9.80%	12.06%
American Indian/Alaskan Native	0.33%	0.15%	0.45%
Asian/Pacific Islander	9.70%	9.50%	14.05%
Hispanic	51.70%	59.70%	25.01%
White	15.80%	13.40%	19.49%
Not reported	15.70%	7.43%	28.85%
Total	100%	100%	100%
Language, preferred, top 5 <sup>2</sup>			
English	64.75%	58.74%	72.57%
Spanish	28.00%	32.70%	10.90%
Vietnamese	1.39%		1.71%
Cantonese	0.96%		
Mandarin	0.77%	1.33%	
Korean		0.80%	4.15%
Armenian		2.44%	
Farsi			1.37%
<b>Sources</b>			
<sup>1</sup> U.S. Census Bureau. <a href="https://data.census.gov/profile/California?g=040XX00US06">https://data.census.gov/profile/California?g=040XX00US06</a>			
<sup>2</sup> California Department of Health Care Services. <a href="https://www.dhcs.ca.gov">https://www.dhcs.ca.gov</a> as of 11/25 enrollment period			

## California Dental Network (CDN) Membership Profile

As of December 31, 2025, CDN had 83,070 members in Los Angeles and Sacramento counties. **See Table 2.** The CDN membership profile differs from the state and county population profile, shown in **Table 1.** Because the insured population is relatively small compared to the county's overall size, the resulting sample may not fully capture the broader demographic variation present in the community. For example, the CDN membership in Los Angeles County has a lower proportion of Hispanic and higher proportion of English than the general population. Sacramento County membership, by contrast, has a more balanced ethnic distribution. Across both counties, the CDN membership skews older, with fewer children compared to the proportion of the total population.

California has identified threshold languages as state priorities by county. In Los Angeles they include Arabic, Armenian, Cambodian, Chinese, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese. Sacramento County includes Arabic, Chinese, English, Farsi, Hmong, Russian, and Spanish.<sup>2</sup>

**Table 2. California Dental Network Membership Profile**

CDN membership	County	
	Los Angeles	Sacramento
CDN membership	11,487	71,583
CDN, % gender		
Male	46%	50%
Female	54%	50%
CDN, % age band		
0-18	20%	26%
19-44	46%	48%
45-64	23%	21%
65+	10%	4%
Total	100%	100%
CDN, % ethnicity		
African American	11%	15%
American Indian/Alaskan Native	0%	0%
Asian/Pacific Islander	17%	14%
Hispanic	43%	27%
White	17%	22%
All other	12%	23%
Total	100%	100%
Language, preferred	Los Angeles	Sacramento
English	75%	81%
Spanish	18%	12%
Vietnamese	0%	1%
Cantonese	1%	1%
Mandarin	2%	0%
Korean	1%	0%
Armenian	1%	0%
Farsi	0%	0%
Other	1%	4%
Total	100%	100%

**Figures 1. and 2. Languages spoken in Los Angeles (PHP) and Sacramento (GMC) Counties**



## Oral Health Status and Outcomes

While demographic characteristics provide important context for understanding population risk, they do not capture the extent of oral disease experienced by residents. The following section examines key indicators of oral health burden in Los Angeles and Sacramento Counties, including the prevalence of dental caries among children, adolescents, tooth loss and oral disease among adults, and other population-level measures of oral health status.

In this section, select indicative state-wide and county level oral health statistics are provided based on the most recent, reliable data available from external data sources. While there are many aspects of oral health status that may be relevant to residents' overall health outcomes, the datapoints below have been chosen to align with Medi-Cal performance measures, where available, for comparability. External data is followed by CDN member data later in this Needs Assessment. CDN member oral health status is based on claim encounter data metrics, using measurement period July 1 through December 31, 2025.

*Note on children and adolescents:* external data sources vary considerably in how age bands are defined for tracking oral health status in children and adolescents. Ages are noted below where relevant and have been chosen to align as closely as possible to Medi-Cal age bands.

## California Oral Health Status

### Children

- In California, the majority of children ages 3-11 (and under 3 who have teeth) have been to a dentist within the last 6 months (73.5%), though 13.5% have never been to a dentist.<sup>3</sup>
- 54% of children, aged 3-5, and 71% of third graders (ages 8-9) have experienced dental caries (tooth decay), and nearly one-third of children have untreated tooth decay.<sup>4</sup>
- The prevalence of oral health problems (defined as toothaches, bleeding gums or decayed teeth or cavities) was 14.8%, 19.1%, 25.4%, and 37.9% among White non-Hispanic, other non-Hispanic, Hispanic, and Black non-Hispanic children respectively. Approximately 10.4% of parents described the condition of their children's teeth as fair or poor.<sup>5</sup>
- Note: We do not have reliable data from DHCS regarding emergency room visits for non-traumatic dental conditions and are relying on the literature and other external data sources.

### Adolescents/teens

- Adolescents (ages 12-17) in California are doing well on self-reported dental visits within the last year (87%), similar to the US overall (89%), with no variation across races/ethnicities, income levels, or languages spoken at home. Less than half, however, report the condition of their teeth as excellent or very good (48%), with 15% reporting the condition as fair/poor compared to the US rate of 6%.<sup>6</sup>
- 11% of Californian adolescents reported missing school due to dental problems (not including cleanings or check-ups) in 2022-2023.<sup>6</sup> Missing school days also affect the entire family – caregivers nationwide reported missing an estimated 38.5 million hours of productivity due to their children’s oral pain or unplanned dental visit.<sup>7</sup>

### Adults

- California currently outperforms the US in the percentage of adults with a dental visit in the last 12 months (71.1% versus 67.5%).<sup>8</sup> The majority of those adults (58.4%) in California visited a dentist within the last 6 months.<sup>3</sup> However, 19.5% report a dental visit between 1 and 5 years ago, with 7% more than 5 years ago and 2.4% having never been to a dentist. This translates to nearly 9 million adults (ages 18+, estimated) not making at least one recommended annual visit to a dentist.<sup>9</sup> This trend is highest among Latino and Black adults and lowest among White adults.<sup>3</sup>
- While annual visit trends are similar for men and women, fewer than half of pregnant women in California are receiving dental care during their pregnancies.<sup>9</sup> Women whose health care providers recommended a dental visit during pregnancy are nearly twice as likely to have dental care as women who did not get this recommendation.<sup>10,11</sup>
- The prevalence of permanent tooth loss ranged from 13% among those aged 18-24 years to 68% among adults aged 65 or older in California.<sup>4</sup>
- Less than 1% of adults in California reported receiving dental service at a hospital in the past year.<sup>3</sup>

## Los Angeles County Oral Health Status and Outcomes

### Children

- Though the proportion of children in LA County who have been to a dentist more than a year ago or never has trended downward from 2021, many are still not getting regular and preventive dental care. 11% of children ages 3-11 (and under 3 who have teeth) have never been to a dentist as of 2024, with minimal variation across races/ethnicities and genders.<sup>3</sup> Approximately 50% of children enrolled in Medi-Cal Dental did not have an annual dental visit.<sup>12</sup>
- Kindergartners and third graders in LA County have higher prevalence of untreated decay (19% and 21%, respectively) compared to the US benchmark (16% and 18%, respectively).<sup>6</sup> The Smile Survey (county data) indicates a high prevalence (65%) of tooth decay, especially before Kindergarten.<sup>13</sup> Disadvantaged and minority children experience substantially worse outcomes (64% versus 34%).<sup>13</sup> Latinx, Black/African American and Asian children have significantly higher rates of decay and untreated decay than White children.<sup>13</sup> Only 31% of third graders have dental sealants, well below the national average (42%).<sup>13</sup>
- Among all age groups in LA County, children aged 1-2 have the highest rate of emergency department visits for non-traumatic dental conditions (439 per 100,000 patients).<sup>12</sup>

### *Adolescents/teens*

- Adolescents (ages 12-17) have a higher prevalence of dental visits within the last year than other age groups in LA County (86%).<sup>6</sup> The overall rate of dental visits among adolescents has fallen since 2019 (96%), however, and adolescents on Medi-Cal report much lower prevalence of dental visits (57% for 10-14 years old and 44% for 15-20 years old) than the total for all LA county adolescents.<sup>6</sup>
- Less than half (44%) of LA County adolescents report that their teeth are in excellent or very good condition, compared to 78% nationwide, and the percentage reporting excellent or very good condition has declined overall since 2019,<sup>6</sup> potentially due to continuing effects of delayed care during the COVID-19 pandemic.
- A similar proportion of LA County adolescents (10%) as in California overall reported missing school due to dental problems in 2022-2023.<sup>6</sup>

### *Adults*

- Approximately 75% of adults enrolled in Medi-Cal Dental in LA County did not have an annual dental visit.<sup>12</sup>
- Tooth loss due to tooth decay or gum disease is an important health issue among adults; 40% of adults in LA County have had permanent teeth removed (pulled) due to tooth decay or gum disease.<sup>6</sup>
- Less than 40% of women in LA County visited a dentist while they were pregnant, with a lower proportion of visits among pregnant women on Medi-Cal (31%) than those with private insurance (41%).<sup>6</sup>
- Black/African Americans and LA County residents who identify as multiracial are most likely to visit an emergency room for a non-traumatic dental problem (656 and 541 visits per 100,000 people, respectively).<sup>3</sup>
- There are opportunities to integrate and coordinate oral health care with other health, social, and environmental services. There were 4,762 cases of oral cavity (mouth) and pharynx (throat) cancer (9 cases per 100,000 people) in LA County between 2012-2016. The proportion of oropharyngeal cancers detected at the earliest stage (Stage 1) was 17% in LA County.<sup>11</sup>

## **Sacramento County Oral Health Status and Outcomes**

### *Children*

- Nearly 11% of Sacramento County children ages 3-11 (and under 3 who have teeth) have never been to a dentist, with another 9% having their last visit more than six months prior.<sup>3</sup>
- Sacramento County third graders have fewer experiences with dental caries and untreated decay than California third graders as a whole (46.2% to 60.6% for caries; 17.2% to 21.9% for decay in 2018-2019).<sup>14</sup>
- There are significant disparities across demographic factors within Sacramento County, however – for example, 72.2% of Hispanic third graders experienced caries compared to 40% of White third graders the same age. Third graders considered socioeconomically disadvantaged also experience higher incidence of both caries and untreated decay than their counterparts (those not socioeconomically disadvantaged).<sup>14</sup>
- Data from 2019 and 2021 shows that while the total number of emergency department (ED) dental visits for Sacramento County residents was declining, the percentage of visits that were considered preventable was rising among children ages 0-20, from 28.5% (ages 0-5) and 56.3% (ages 6-20) in 2019 to 30.3% (0-5) and 60.9% (6-20) in 2021.<sup>15</sup>

### Adolescents/teens

- It is difficult to assess adolescent oral health in Sacramento County due to the lack of specific health surveillance data on adolescent/teens. School-based programs such as Early Smiles Sacramento state that they include ages 0-20 in the program due to the school-oriented structure but do not separately report data on utilization or health outcomes by children versus teens. Most data from the California Health Interview Survey (CHIS) on oral health in teens is flagged as statistically unstable for multiple years or the sample sizes are small enough that data are excluded.<sup>16</sup>
- Usable CHIS datapoints suggest about half of Sacramento County teens rated their teeth in “good” condition in 2022, a steady increase since 2019. At the same time there has been an equivalent decrease in reported “very good” conditions within the same time period.

### Adults

- The number of Sacramento County adults reporting their last dental visit as 5+ years ago has been declining post-COVID, though it remains slightly higher at 6.0% in 2024 than in 2019 (5.5%). In total, an estimated 27% of adults have not had at least the recommended annual visit as of 2024.<sup>3</sup>
- 23.6% of Sacramento County adults rated the condition of their teeth as “fair” or “poor” in 2022, which nearly doubles at 0-200% of the Federal Poverty Line. Larger percentages of Black adults (37.4% for 2021) and Asian adults (29.2% for 2022) rate the condition of their teeth as “fair” or “poor” than other races.<sup>3</sup>
- The number of emergency department (ED) dental visits among adults over age 21 that were considered preventable was relatively consistent from 2019 to 2021, with a large majority of visits in the age 21-64 cohort considered preventable (76.9% in 2019 and 77.1% in 2021).<sup>3</sup> This is higher than the proportion of ED visits considered preventable statewide (all ages) for the same time periods (59.5%).<sup>15</sup>

## Oral Health Education and Cultural and Linguistic Needs

At a national level, 91% of adults believe oral health is integral to overall health, but understanding of the correlation between oral health and specific health conditions such as heart disease is declining.<sup>17</sup> CHIS reports for 2024 that 71.1% of Californian adults received oral health educational information in the last 12 months, though only 61.6% report receiving that from a dental office.

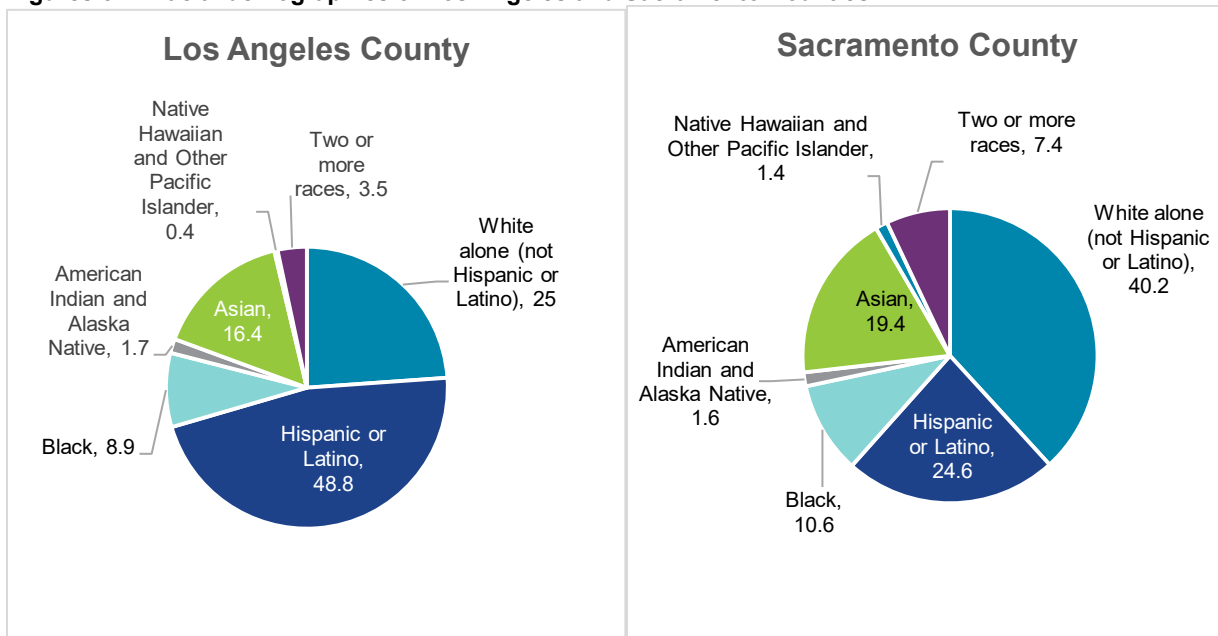
Oral health educational information is also only one aspect of oral health literacy (OHL), which is inclusive of information but recognizes broader factors such as a person’s ability to understand, engage in, and access oral health care for themselves and those they care for.<sup>18</sup> This section briefly outlines some of the key barriers to understanding and engaging in oral health care; access challenges are addressed in a subsequent section.

- *Educational attainment:* the effect of educational attainment on oral health and dental utilization has been well documented; one study estimates lower educational attainment is associated with being about one-third less likely to visit a dentist in the last 12 months and about 23% more likely to receive emergency and treatment services versus routine dental care.<sup>19</sup>
- *Diversity of the dental workforce:* 45% of adults report it is very or somewhat important to them that their dentist has a diverse workforce, with importance increasing inversely to income, and adults who identify as Black were at least twice as likely as those identifying as Hispanic, White, or Asian to report experiencing discrimination in oral health care.<sup>20</sup>

- Linguistic and cultural sensitivity:** just over a third of adults say that having translation services available at their dentist is very or somewhat important to them, with much higher proportions among Black, Hispanic, and Asian adults (59%, 54%, and 44%, respectively).<sup>21</sup> A higher proportion of adults (47%) say it is very or somewhat important for their dentist to embrace their cultural values, beliefs, and norms in making treatment recommendations, with increasing importance among younger adults (57% for ages 18-29 and 56% for ages 30-44).<sup>21</sup>

These barriers to increasing oral health literacy are highly relevant to California and the two selected counties. California as a whole ranked second on the US Census Bureau’s racial and ethnic diversity index based on the 2020 Census, which measures the probability that two people chosen at random from the state will be from different race and ethnicity groups (a 69.7% probability for the state).<sup>22</sup> Educational attainment also varies significantly across the state, with attainment of at least a bachelor’s degree ranging from as low as 13% of adults to as high as 60%, and trending much lower for Black, Latino, Native American, and Pacific Islander adults than for Asian and White adults.<sup>23</sup>

**Figures 3-4. Racial demographics of Los Angeles and Sacramento Counties<sup>24,25</sup>**



Racial demographics for both counties are provided in Figures 3-4. The counties are similarly diverse despite Sacramento County having less than a quarter of the population size of LA County.

Approximately one-third of LA County residents are also foreign-born, which is more than the proportion of foreign-born California residents as a whole, and over half of LA County residents ages 5+ report speaking a language other than English at home. While over 80% of its residents are at least a high school graduate, only 35.5% have attained a bachelor’s degree or higher.<sup>25</sup> When viewing only the Medi-Cal enrollee population, there are higher percentages of Black and Latino residents than in the county as a whole. **See Table 1.**

Sacramento County is home to a smaller proportion (21.4%) of foreign-born residents than LA County, though still well over the national percentage of 13.9%, and close to one third of its residents ages 5+ report speaking a language other than English at home. Sacramento County has a higher proportion of residents than LA County and California with at least a high school degree (88.4%), but a slightly lower

percentage with at least a bachelor's (33.3%).<sup>24</sup> When viewing only the Medi-Cal enrollee population, there are higher percentages of Black residents than in the county as a whole. **See Table 1.**

## Risk and Protective Factors

### Risk Factors

Oral health is deeply connected with chronic health conditions and health behaviors across the lifespan.<sup>26</sup> Poor oral health, including untreated dental caries, periodontal disease, and tooth loss shares many common risk factors with chronic health conditions such as diabetes, cardiovascular diseases and respiratory illnesses, and is exacerbated by tobacco use. Tobacco use is strongly linked to oral cancers, periodontal disease and poor oral treatment outcomes. Smoking not only increases the risk of oral disease but also compounds risks for systemic conditions that further degrade overall health status.

### Tobacco and Drug Use and Oral Health Risks in California Adults

Recent findings from the California Health Interview Survey (CHIS) indicate that approximately 5.0% of adults in California currently use tobacco products in 2024.<sup>3</sup> This figure highlights notable variations in tobacco use across different counties and demographic groups. These patterns of tobacco use are significant contributors to chronic health burdens, including those impacting oral health.

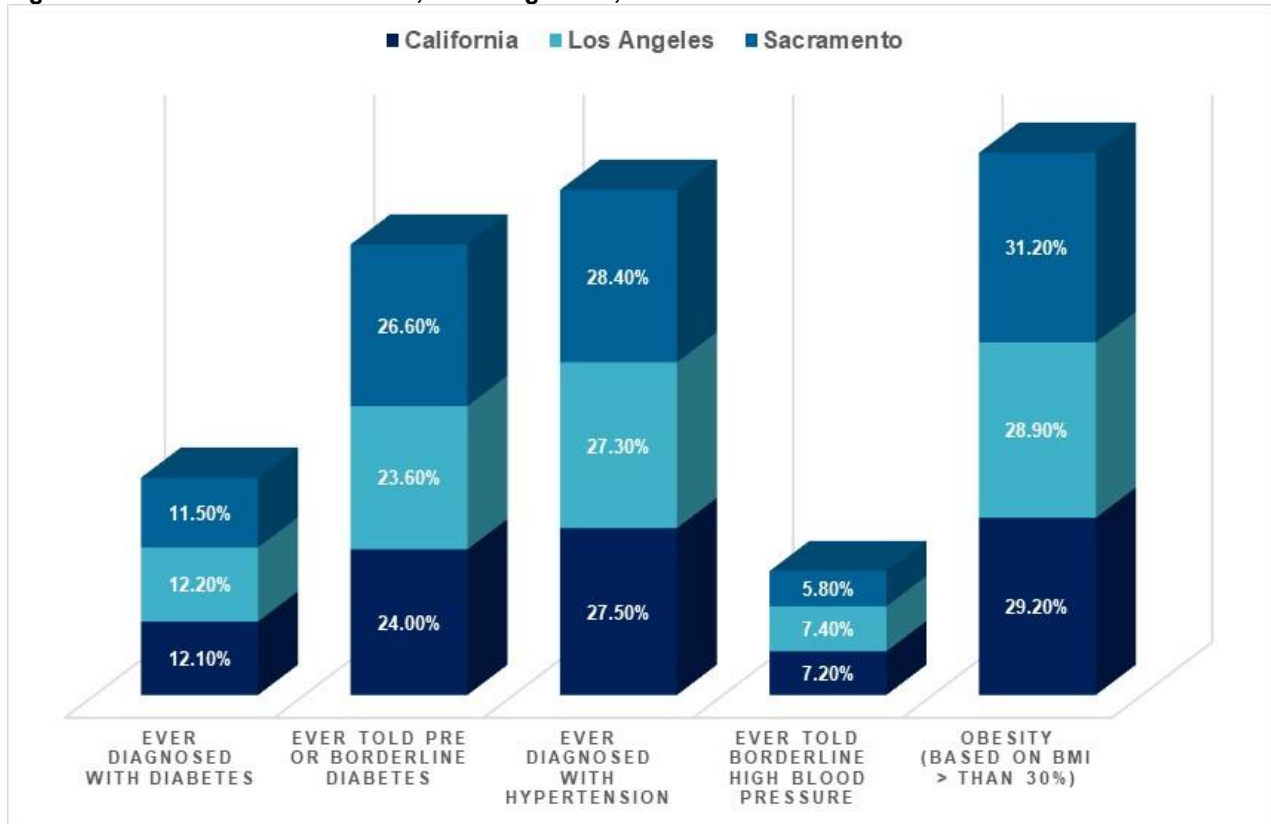
Specifically, adults residing in Los Angeles County report a smoking rate of 5.1%, while Sacramento County adults report a slightly lower rate of 4.0%. Currently, 21.1% of Sacramento County teens use e-cigarettes compared to 2.8% in Los Angeles. E-cigarette use among teens has risen annually since 2022 (0.70% in 2022, 3.20% in 2023, 5.70% in 2024).<sup>3</sup> These differences highlight behavioral risk factors linked to oral health and chronic disease disparities.

Illicit drug use is also a challenge in California, with 9.5% of Californian adults reporting using illicit drugs other than opioids and cannabis in the last 12 months.<sup>2</sup> Many illicit drugs are strongly linked to oral health problems such as caries, periodontal disease, and dry mouth. This is especially true for methamphetamines, which have a significant impact on tooth decay (sometimes referred to as “meth mouth”).<sup>27,28</sup> The proportion of adults in both Los Angeles and Sacramento Counties that report using methamphetamines in the last 12 months are higher than in the state as a whole for 2024, translating to approximately 95,000 people.<sup>3</sup> California is also seeing increasing rates of polysubstance abuse among people who use fentanyl, mostly involving methamphetamines.<sup>29</sup>

### Chronic Health Conditions (Adults)

Oral health is a fundamental component of overall health, yet it is deeply influenced by broader health chronic health conditions and health behaviors that affect Californians. Conditions such as diabetes, hypertension, obesity and asthma are not only among the most common chronic diseases in California but also share common risk factors with oral diseases such as periodontal diseases and tooth loss. These chronic conditions can exacerbate oral health problems and complicate dental treatment outcomes underscoring the need to view oral health within the broader health status. **See Table 3.**

Figure 5. Chronic Health Conditions, Adults aged 20+, 2024

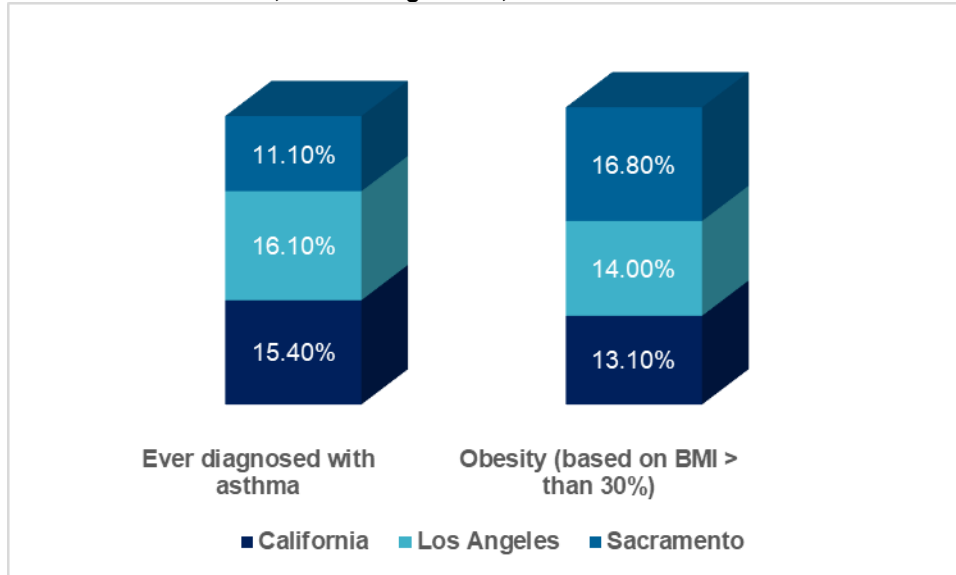


According to CHIS, approximately 23.60% of adults in Los Angeles County reported ever being diagnosed with diabetes, 27.30% with hypertension, and 28.90% classified as obese. Comparable estimates for Sacramento County were 26.60% for diabetes, 28.40% for hypertension, and 31.20% for obesity. State-level estimates were provided as a benchmark. These county level figures highlight the significant burden of chronic health conditions and risk behaviors that are strongly linked to poor oral health outcomes, including periodontal disease and delayed healing after dental procedures and underscore the needed for integrated chronic disease and oral health efforts.

### Chronic Health Conditions (Children)

Oral health in childhood is both a marker and a determinant of overall health, closely intertwined with chronic conditions and health behaviors that emerge early in life and often persist in childhood. Children with chronic illnesses such as asthma, obesity, diabetes, developmental or behavioral conditions and activity-limiting health needs face elevated risks for oral disease due to medication effects, dietary patterns, functional limitations and barriers to routine care. These same conditions are associated with higher rates of school absenteeism, emergency department use and unmet health needs. In 2022, 351,000 children and teens missed at least one or more days of school due to dental problems.<sup>30</sup> These are factors that also predict delayed or foregone dental care. The CHIS survey provides population-based, county-level data on children’s health status, chronic conditions making it a critical source for understanding how pediatric health burdens intersect with oral health risk in Los Angeles and Sacramento counties.

Figure 6. Chronic Health Conditions, Children ages 0-19, 2024



Asthma, obesity and dietary behaviors such as sugar sweetened beverage consumption are among the most consequential pediatric health factors shaping oral health risk. Children with asthma experience higher rates of dental caries and enamel erosion, in part due to the drying effects of inhaled medication, increased mouth breathing, and the acidic pH of some inhalers, all of which reduce saliva’s protective roles against tooth decay.<sup>31</sup> Obesity is closely related to oral disease through shared behavioral pathways, particularly high intake of added sugars and ultra-processed foods which fuel both excess weight gain and cariogenic bacterial growth. Frequent consumption of sugar-sweetened beverages is one of the strongest predictors of childhood caries; repeated exposure to sugar and acid creates a sustained environment for demineralization, even in children who brush regularly. CHIS reports that teens in Los Angeles County consume two or more sugary drinks per day (19.3%), higher than the state average of 18.2%. Sacramento County is well below the state average at a reported rate of 12.2%.<sup>3</sup> Together, these conditions reflect a convergence of biological vulnerability and modifiable behaviors that elevate oral health risk early in life. Using CHIS indicators for asthma, obesity, and sugar drink consumption allows DentaQuest to understand the dynamics of the pediatric population in Los Angeles and Sacramento counties who are at heightened risk for preventable oral disease and to frame oral health interventions within broader pediatric chronic disease and nutrition prevention strategies.

### Protective Factors: Community Water Fluoridation

Fluoridation remains an important local oral health strategy. The CDC and state health authorities identify community water fluoridation as an effective, low-cost way to reduce dental decay across populations.<sup>32</sup> However, not all cities within the county add fluoride, and decisions about fluoridation are made at the municipal or water authority level.<sup>33</sup>

At the state level, about 57–60% of Californians served by community water systems receive optimally fluoridated water, according to CDC summaries of fluoridation data.<sup>34</sup> This rate is below the national average of about 72% of people on community water systems receiving fluoridated water.<sup>35</sup> Both Los Angeles and Sacramento counties’ fluoridation status is above California’s average.

### Los Angeles County

Los Angeles County’s fluoridation landscape is mixed because water service comes from many different municipal systems and agencies. As of year-end 2025, CDC water fluoridation reports indicate that 77%

of Los Angeles County residents have access to optimally fluoridated drinking water, based on mapping of water systems and their fluoride levels.<sup>34</sup> This percentage reflects the share of the county's population served by water systems that adjust fluoride to recommended levels for cavity prevention.

## Sacramento County

Sacramento County's water supply situation is somewhat easier to characterize because a key local provider, the Sacramento County Water Agency, fluoridates its water for most of its service area. CDC water fluoridation reports suggest that a substantial majority of Sacramento County residents receive fluoridated drinking water, historically estimated around 65% or higher.<sup>34</sup> These estimates include areas served by systems that add fluoride, though fluoridation is partial or not present in 35% of the Sacramento's public water systems.<sup>34</sup>

Sacramento County agencies, like many in California, monitor fluoride levels and maintain them around the optimal 0.7 mg/L to help prevent tooth decay, aligning with state and federal public-health recommendations. Community water fluoridation is endorsed by major health bodies (CDC, ADA, state dental directors) as one of the most effective population-based measures to reduce tooth decay. Where fluoridated water coverage is incomplete or unavailable, individuals and health programs often emphasize supplementary strategies, such as professional fluoride treatments, fluoridated toothpaste, or fluoride varnishes to protect oral health.

## Access to Care and Utilization

### Persistent Barriers to Oral Health Care Access

Despite the strength of the dental safety net in both Los Angeles and Sacramento counties, as outlined in **Table 5**, and DentaQuest's inclusion of dentists who accept Medi-Cal, significant barriers to timely and effective oral health care remain for many residents. While coverage is an important factor, it does not fully resolve access challenges experienced throughout the region.

High demand for dental services, in conjunction with workforce shortages in certain neighborhoods, contributes to limited appointment availability. As a result, patients—particularly new ones—can encounter long wait times before securing necessary care. These access limitations persist even within robust dental networks, demonstrating that coverage alone is insufficient to eliminate obstacles.

In California, these workforce issues are further highlighted by the existence of 565 Dental Care Health Professional Shortage Areas (HPSAs). Approximately 7.5% of Californians (2,976,924 people) live in a Dental HPSA.<sup>36,37</sup> This shortage exacerbates challenges in securing timely dental care for affected communities.

Across both counties, these structural barriers are compounded by linguistic, cultural, and informational challenges that hinder navigation of the dental system and reduce preventative services. A fear among immigrant populations, for example, may hinder certain communities from seeking care. As a result, even with comprehensive coverage in place, many residents experience delayed treatment and rely on emergency settings for conditions that are largely preventable.

In this Population Needs Assessment, we are providing data on access with the current information we have available for the first six months of the contract. Other data, such as the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey results will be available in late summer 2026. Further, we intend to seek community input which will further inform barriers to oral health care. The qualitative plan, which describes our approach to seeking community input is described later in the document.

## Access for Special Populations

For members with special health care needs, DentaQuest applies a person-centered case management model designed to reduce barriers to care and ensure continuity across medical, behavioral and dental services. In Los Angeles and Sacramento counties where 49 and 134 members respectively, have identified special needs, each identified individual is assigned a dedicated care coordinator (or manager, depending upon risk) who conducts proactive outreach, assesses clinical and social needs and develops an individualized care plan in partnership with the member, family and providers. Case coordinators support appointment scheduling, transportation and provider matching, including specialists experienced in treating individuals with complex conditions.

## Provider Network and Workforce

### Los Angeles DHCS PHP and Sacramento DHCS GMC Dental Providers and Access to Care

Monthly Network Analysis reports are shared with DHCS regarding the strength of the provider network as well as other access metrics. As of 12.31.2025, Dentaquest's network in both **Los Angeles and Sacramento Counties** demonstrates strong provider availability and excellent geographic access for both adults and children. **See Table 5.**

In Los Angeles County, the network is supported by a strong supply of contracted general dentists and primary care dentists which include 1,427 general providers and 1,518 primary care providers across 665 to 688 unique locations. Members benefit from an extensive number of access points, totaling 9,972 for adults and 10,568 for children, which ensures that care is dispersed geographically throughout the county. Access points are defined by the number of providers that may practice at different locations.

DentaQuest maintains close proximity to care. Average travel distances are low, with members reaching their closest provider within 1.1 miles, and the second and third closest providers within 1.3 to 1.5 miles. Average drive times are equally favorable, ranging from 2.0 to 2.6 minutes.

Overall, the Los Angeles network is robust, offering near-total access compliance and a densely distributed provider base that minimizes transportation barriers for members.

**Sacramento County** maintains 100% access compliance with an adequate supply of contracted providers relative to the member population.

With a significantly larger membership of 64,100 total members, provider supply includes 546 general dentists and 586 primary care dentists, representing a broad network of 191 to 197 unique locations. Members have access to 3,188 adult access points and 3,381 child access points, indicating wide distribution across the county. (Note that the population may differ due to the timing of the enrollment file from the CDN population profile on page 8).

Despite the larger member population, access remains strong. The average distance to the first available provider is 1.3 miles, and all three closest provider distances remain tightly clustered between 1.3 and 1.4 miles. Drive times also remain low, averaging 2.2 to 2.5 minutes, demonstrating consistent physical accessibility across the county.

The member-to-provider ratios—26.8 for general dentists and 11.3 for primary care dentists—indicate sufficient provider capacity to meet member needs within the GMC model. Sacramento County's network structure supports excellent geographic access, strong provider supply, and effective coverage for the dental needs of the population.

**Table 3. Los Angeles DHCS PHP and Sacramento DHCS GMC dental provider networks (as of 12/31/2025)**

<b>Los Angeles County DHCS PHP 99.9% access</b>	<b>Total CDN Members</b>	<b>Adults</b>	<b>Children</b>
	<b>12,708</b>	<b>9,843</b>	<b>2,865</b>
	<b>Type of dentist</b>	<b>General</b>	<b>Primary care</b>
	<b>Member: Provider ratio</b>		
	<b>Unique locations</b>	665	688
	<b>Access Points</b>	9,972	10,568
	<b>Providers</b>	1,427	1,518
	<b>Average distance (miles)</b>		
	to 1st provider	1.1	1.1
	to 2cd closest provider	1.3	1.3
	to 3rd closest provider	1.4	1.5
	<b>Average drive time (minutes)</b>		
	to 1st provider	2.0	2.0
	to 2cd closest provider	2.4	2.4
	to 3rd closest provider	2.6	2.6
	<b>Sacramento County DHCS GMC 100% access</b>	<b>Total CDN Members</b>	<b>Adults</b>
<b>64,100</b>		<b>44,218</b>	<b>19,882</b>
<b>Type of dentist</b>		<b>General</b>	<b>Primary care</b>
<b>Member: Provider ratio</b>		26.8	11.3
<b>Unique locations</b>		191	197
<b>Access Points</b>		3,188	3,381
<b>Providers</b>		546	586
<b>Average distance (miles)</b>			
to 1st provider		1.3	1.3
to 2cd closest provider		1.4	1.4
to 3rd closest provider		1.4	1.4
<b>Average drive time (minutes)</b>			
to 1st provider		2.2	2.3
to 2cd closest provider		2.4	2.4
to 3rd closest provider		2.4	2.5

## **Preliminary Findings for Access and Availability (Q3 2025)**

Each quarter, access and availability surveys are conducted on 25% of providers' office locations in-network. These service office locations are randomly selected. By year end 2026, 100% of the provider office locations will have been surveyed. Surveys are conducted at the office location level (not on an individual provider level).

- DentaQuest utilizes a call vendor to complete the quarterly access and availability of calls. The call vendor uses an approved call script that identifies the caller as someone calling on behalf of DentaQuest to confirm appointment availability.
- Survey results are shared with the DentaQuest Provider Engagement (PE) team. The PE team contacts offices that were non-compliant and educates them on the required access and availability standards.
- Below is a summary of the results of the Q3 2025 access and availability survey:
  - 95% of offices surveyed indicated that they schedule members for emergency services within 24 hours.
  - 97% of offices surveyed indicated that they schedule members for routine appointments within 4 weeks.
  - 97% of offices surveyed indicated that they schedule members for follow-up appointments with a specialist within 30 business days.
  - 100% of offices surveyed indicated that they schedule new patients for an initial visit within 4 weeks.
  - 97% of offices surveyed indicated that they schedule existing patients for preventive appointments within 4 weeks.
  - 82% of offices surveyed indicated that they have after-hours availability.
- Access and availability standards are readily available for providers via various methods including our online provider web portal, provider training materials, and in our provider Office Reference Manual (ORM).

### **Process Improvement Measures**

Beginning in Q4 2025, our call vendor implemented call spoofing technology, which is when the caller uses a tool to alter the caller ID, so that it appears as if the call is coming from a different number. Call spoofing is done using an in-state phone number to help increase call completion rates, as provider offices are more likely to answer a call from a phone number within the state.

In Q1 2026, DentaQuest began sending providers a quarterly communication, in advance of the access and availability surveys, to remind them of the required standards.

### **Availability of Other Supportive Community Dental Services**

For both counties, we provide a listing of safety-net and low-cost dental service providers in Sacramento County, including community clinics and organizations that typically offer Medi-Cal, sliding scale, or reduced cost for underserved populations.

**Table 4. Los Angeles County safety net services as of December 31, 2025**

Organization	Address	Description of Services
St. Johns Community Health 50th Street Dental Clinic at Boys & Girls Club	1000 W 50th St, Los Angeles, CA 90037	Provides comprehensive dental care including preventive exams, cleanings, fillings, extractions, periodontal therapy, sealants, x-rays, and emergency dental care. Offers services to all ages with sliding-scale fees and Medi-Cal acceptance.
Los Angeles Christian Health Centers - Joshua House Clinic	325 E 7th St, Los Angeles, CA 90014	Community health center offering dental and other health services focused on underserved populations; services may include preventive and restorative care.
UCLA Dental Clinics	714 Tiverton Dr, Los Angeles, CA 90095	Academic dental clinic providing general dentistry, pediatric dentistry, oral surgery, and specialty care at typically at reduced costs due to supervised training.
West Los Angeles College Dental Clinic	9000 Overland Ave (MSB-100), Culver City, CA 90230	Dental training clinic offering low-cost services provided by students under supervision.
Kids Community Dental Clinic of Burbank	400 W Elmwood Ave, Burbank, CA 91502	Pediatric-focused low-cost dental care including exams, cleanings, x-rays, and basic restorative services.
El Proyecto del Barrio	22250 Elkwood St, Canoga Park, CA 91303	Community clinic offering general dental services for low-income patients.
Northeast Valley Health Corporation Dental	26974 Rainbow Glen Dr, Canyon Country, CA 91351	Offers general dental care including preventive and basic restorative services for all ages.
Valley Community Healthcare Dental	6801 Coldwater Cyn Ave, North Hollywood, CA 91605	Community health center with dental care as part of comprehensive services.
Mission City Community Network Dental	15206 Parthenia St, North Hills, CA 91343	Provides general dental care for low-income and uninsured residents; may include preventive and restorative services.
Antelope Valley Community Clinic Dental	45104 10th St W, Lancaster, CA 93534	Community clinic offering general dental services; supports underserved and low-income clients.
AltaMed Health Services Dental	13005 Sunset Ave, West Covina, CA 91790	FQHC network offering dental care including exams, cleanings, fillings, and more on a sliding scale; accepts Medi-Cal.
Arroyo Vista Family Health Center Dental	6000 N Figueroa St, Los Angeles, CA 90042	Dental services including general care and prosthodontics (dentures, crowns, etc.) for low-income patients.
Buddhist Tzu Chi Clinic (nominal fee) Dental	1000 S Garfield Ave, Alhambra, CA 91803	Offers general dental care on a low-cost or donation basis to community members.
Chinatown Service Center Dental	850 S Atlantic Blvd, Monterey Park, CA 91754	Community dental services with a focus on accessible care for diverse populations.
Community Health Alliance of Pasadena Dental	1855 N Fair Oaks Ave, Pasadena, CA 91103	Low-cost dental care including restorative and preventive services; check for current treatments offered.

**Table 5. Sacramento County safety net services as of December 31, 2025**

Organization / Website	Website or Address	Description of Services
Asian Health Services	<a href="http://www.asianhealthservices.org">www.asianhealthservices.org</a>	The AHS Dental Clinic provides a full range of primary oral health care. Patients receive care from skilled general dentists, board certified specialists, dental residents and top dental students. The dental care staff place a strong emphasis on prevention and education, and the clinic is equipped with state-of-the-art digital X-Ray technology.
CA Northstate College of Dental Medicine	<a href="http://www.dentalmedicine.cnsu.edu">www.dentalmedicine.cnsu.edu</a>	Operates a Comprehensive Family Care Clinic that provides dental care for children and adults. All care is provided by a dental student team under the direct supervision of faculty who are California-licensed dental professionals.
Carrington College Dental Hygiene Student Services	8909 Folsom Blvd, Sacramento, CA 95826	Free or low-cost hygiene services (cleanings, x-rays, fluoride) provided by students under supervision (availability varies).
Community Health Centers of America	<a href="http://www.chcahealth.org">www.chcahealth.org</a>	Community Health Center where dental services are offered. See Eastern Dental.
Elica Health Centers - Franklin	5385 Franklin Blvd, Ste K, Sacramento, CA 95820	Part of Elica Health Centers providing comprehensive dental care to Medi-Cal, Denti-Cal, uninsured, and sliding fee patients.
Sacramento City College Dental Hygiene Clinic	3835 Freeport Ave, Sacramento, CA 95822	Offers low-cost preventive care (cleanings, exams, x-rays, sealants) often at very low fees; services provided by supervised students.
Sacramento Department of Health Services	<a href="http://www.dhs.saccounty.gov">www.dhs.saccounty.gov</a>	Connects people to dental care, provides oral health education and resources for the community
Sacramento Community Clinic - Dental	7215 55th St, Sacramento, CA 95823	Dental care through Sacramento Community Clinics network with sliding scale payment; general dental services
Sacramento Community Medical Clinic & Sacramento Community Dental Clinic	965 El Camino Ave, Sacramento, CA 95815	Community health center offering dental services on a sliding fee scale; preventive and basic restorative care and referrals.
Sacramento Native American Health Center, Inc.	2020 J St, Sacramento, CA 95811	Comprehensive preventive and general dental services for adults and children including exams, cleanings, fillings, extractions, sealants, and emergency care; accepts Medi-Cal, sliding scale, and some insurance.
Salud Clinic (West Sacramento)	500 B Jefferson Blvd, West Sacramento, CA 95605	Offers dental exams, cleanings, sealants, fillings, root canals, dentures, and emergency care on a sliding fee basis including Medi-Cal acceptance.
South Valley Community Health Center (WellSpace)	8233 E Stockton Blvd, Sacramento, CA 95828	Preventive and general dental care with Medi-Cal and sliding scale options; services include exams, cleanings, fillings, and extractions.
Univ of the Pacific - Pacific Health Care Collaborative	<a href="http://www.pacific.edu/PHCC">www.pacific.edu/PHCC</a>	Integrative dental and medical training campus accepting new patients.

### Emergency Department Locations (Los Angeles and Sacramento Counties)

According to recent statewide health care data, Los Angeles County has approximately 76 licensed hospital emergency room departments, supported by 15 fully accredited trauma centers, collectively serving a population of nearly 10 million residents across the county. These emergency departments provide 24/7 acute, trauma and medical dental care to one of the most populous and densely urbanized regions of the US.<sup>38</sup> In contrast, the Sacramento region has about 15 licensed emergency departments operating within its hospital system.<sup>39</sup> This region services Sacramento County and surrounding communities, where the county population is approximately 1.6 million people under the most recent US census estimates.<sup>40</sup>

### Access to Hospital and Surgery Center-Dental Care for Special Needs Populations

Despite having upwards of 76 hospitals in Los Angeles and 15 hospitals in the Sacramento vicinity, the availability of hospital operating room (OR) for dental procedures is difficult to assess. Many providers have attested to OR wait times for member OR dental care procedures up to one or more years. Due in

part to the shortage of Anesthesiologists, high demand, limited availability, as well as low Medicaid rates this is a concerning situation for Members with special health care needs that are unable to receive dental care in a typical outpatient setting.

## 2025 Q3-Q4 Utilization: California Dental Network PHP and GMC

Figure 7. 2025 GMC and PMP Dental Utilization Rates – Q3 and Q4

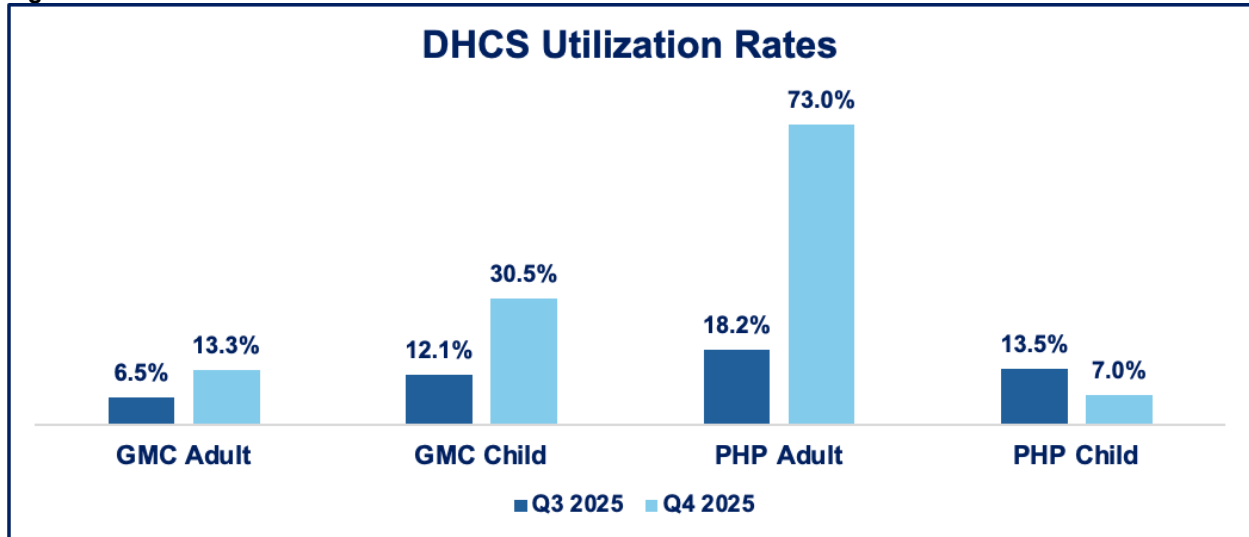


Table 6. Q3 and Q4 2025 Child Claim and Procedure Utilization Rates and Details

Metric	GMC - Child			PHP - Child		
	Q3	Q4	Trend	Q3	Q4	Trend
Total Encounters	6304	4103	▼	314	1479	▲
Avg Monthly Members	20451	20680	▲	2061	2357	▲
Unique Members Seen	4656	3247	▼	152	1447	▲
Total Procedures	16862	21517	▲	1030	2410	▲
Claims per thousand	308.2	198.4	▼	152.4	627.5	▲
Procedures per Thousand	825	1040	▲	499.8	1022.5	▲
Procedures per Member	3.6	6.6	▲	6.8	1.7	▼
Exams (D0120-D0180)	10.3%	48.1%	▲	11.4%	9.5%	▼
Preventive Care (D1110-D1208)	16.7%	78.3%	▲	19.8%	17.1%	▼
Sealants (D1351, D1352, D1353)	9.0%	44.3%	▲	11.5%	10.6%	▼
Fillings (D2140-2395)	4.6%	26.3%	▲	3.7%	5.7%	▲
Ratio Fillings to Sealants	0	0.6	▲	0	0.5	▲

**Table 7. Q3 and Q4 2025 Adult Claim and Procedure Utilization Rates and Details**

Metric	GMC - Adult			PHP - Adult		
	Q3	Q4	Trend	Q3	Q4	Trend
Total Encounters	8782	10328	▲	1320	2108	▲
Avg Monthly Members	51126	51070	▼	7875	7883	▲
Unique Members Seen	6796	7390	▲	867	1385	▲
Total Procedures	27012	25750	▼	4840	6988	▲
Claims per thousand	171.8	202.2	▲	167.6	267.4	▲
Procedures per Thousand	528	504	▼	614.6	886	▲
Procedures per Member	4.0	3.5	▼	5.6	5.0	▼
Exams (D0120-D0180)	12.1%	8%	▼	12.7%	11%	▼
Preventive Care (D1110-D1208)	9.5%	7%	▼	13.0%	10%	▼
Fillings (D2140-D2395)	9.2%	5.8%	▼	11.4%	14.0%	▲
Crowns - Stainless Steel (D2930-D2931)	0.000%	0.002%	▲	0.000%	0.000%	No Change
Perio - SRP (D4341-D4342)	6.7%	4.2%	▼	10%	15.3%	▲
Dentures (D5110-D5120)	0.2%	0.00	▼	0.1%	0.00	▲
Endodontics (D3310-D3348)	1.2%	1%	▼	1%	2%	▲
Extractions - Simple (D7111-D7140)	1.9%	1%	▼	0%	1%	▲
Extractions - Surgical (D7210-D7251)	3.7%	3%	▼	3%	3%	▲

Overall Medi-CAL dental utilization rates have increased for both the GMC/Sacramento and PHP/Los Angeles County Plans. Q3 to Q4 utilization rates have risen as members transition to DentaQuest, a new plan in the California market. As members gain familiarity with DentaQuest through continued outreach efforts, utilization will continue to gain momentum.

## PHP Utilization – Los Angeles County

A total of 3,851 unique members were treated in the child and adult populations for a total of 15,268 total procedures. From Q3 to Q4, PHP (Child plan) shows expansion and broader reach. **See Tables 10 and 11.** Encounters surged from 314 → 1,479 and unique members seen from 152 → 1,447, alongside growth in average membership (2,061 → 2,357). Utilization intensified at the population level—claims/1,000 increased from 152.4 → 627.5 and procedures/1,000 499.8 → 1,022.5, but procedures per member dropped sharply (6.8 → 1.7), indicating more children touched with fewer services per child. The service mix tilted slightly away from prevention: exams eased (11.4% → 9.5%), preventive care slipped (19.8% → 17.1%), and sealants edged down (11.5% → 10.6%), while fillings rose modestly (3.7% → 5.7%). Overall, PHP prioritized access and scale in Q4, with a relative softening in preventive share per encounter.

PHP shows favorable growth in access and reach from Q3 to Q4. Encounters, unique children seen, and overall membership all increased. These are strong indicators of expanding capacity and engagement, which is directionally appropriate given a new plan. Utilization at the population level (claims and procedures per thousand) also rose, which is expected when a plan rapidly increases the number of engaged members.

PHP experienced a decline in preventive care proportions (exams, preventive visits, sealants). While not necessarily alarming in isolation, it is an area DentaQuest will monitor.

## GMC Utilization – Sacramento County

A total of 22,089 unique members in the child and adult populations were seen for a total of 91,141 total procedures. The GMC (Child) plan contracted in breadth but intensified care per child. **See Tables 10 and 11.** Encounters fell (6,304 → 4,103) and unique members seen declined (4,656 → 3,247) despite a steady membership base (20,451 → 20,680). Yet utilization deepened: total procedures rose (16,862 → 21,517), procedures/1,000 climbed (825 → 1,040), and procedures per member nearly doubled (3.6 → 6.6), even as claims/1,000 decreased (308.2 → 198.4). The clinical mix pivoted strongly toward prevention and assessments: exams (10.3% → 48.1%), preventive care (16.7% → 78.3%), and sealants (9.0% → 44.3%) all increased markedly, while fillings also rose (4.6% → 26.3%) with the fillings□to□sealants ratio moving from 0 to 0.6. Net: GMC delivered more service intensity per child with a pronounced preventive emphasis in Q4.

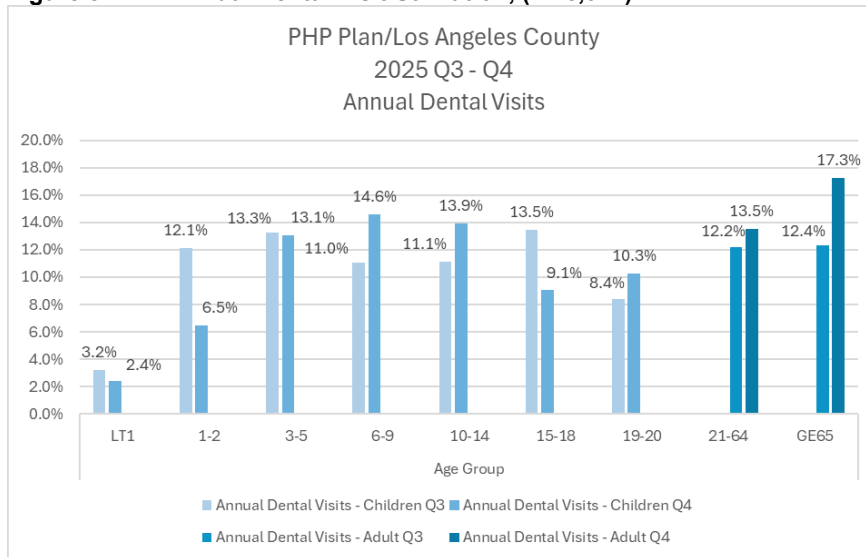
GMC shows a different pattern: even though total encounters and unique children seen declined, the plan delivered more procedures and significantly more preventive services per child. Preventive care percentages (exams, cleanings/fluoride, sealants) all increased steeply—an extremely favorable shift, especially for child oral health outcomes. Procedures per member and procedures per thousand both increased as well, a trend we anticipate will continue.

## Performance Measures

Multiple performance measures were considered for both children and adults to calculate the baseline determination process for plans in both Sacramento (GMC) and Los Angeles (PHP). The cohorts were further stratified to gain additional perspective and insight on age, gender, race/ethnicity, language, residential area and Service Planning Areas. Stratifying data can be challenging when the population for a specific cohort is small. As a result, we evaluated the data in proportion to the population and made notations.

## Los Angeles County Performance Measures (PHP) ADV Age and Gender

Figure 8. PHP Annual Dental Visit Utilization, (n= 8,944)

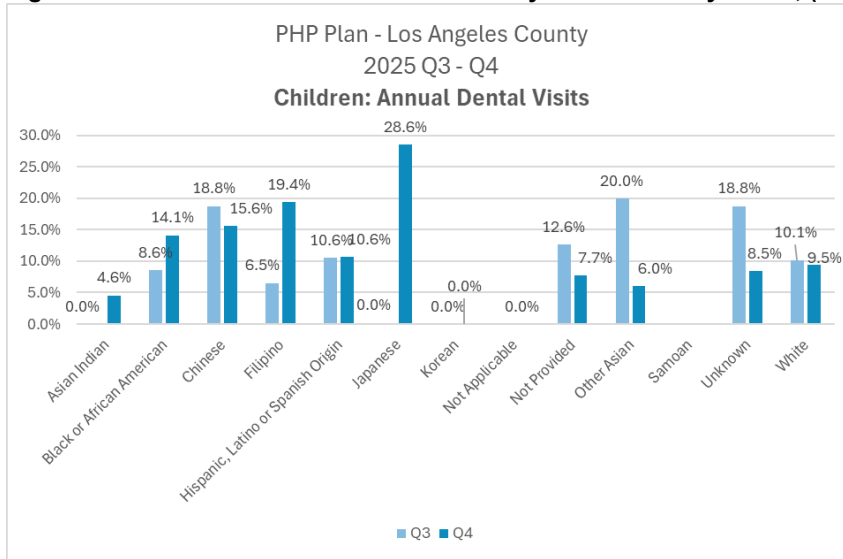


In the Child cohort, the highest utilization by population size was the 6-9 and 10-14 age groups followed by the 15-18 age group. In the teenage groups, ADV utilization decreased. The increased amount of ADV in the 3-5 age group may coincide with the CA pre-school and kindergarten requirements for Oral Health evaluations prior to enrollment. As mentioned in the GMC section, children are experiencing oral changes that can precipitate a dental visit during the years that the percentages are remaining consistent within one to two percentage points. Age 1-5 is a targeted high-risk period for dental caries in children.<sup>41</sup>

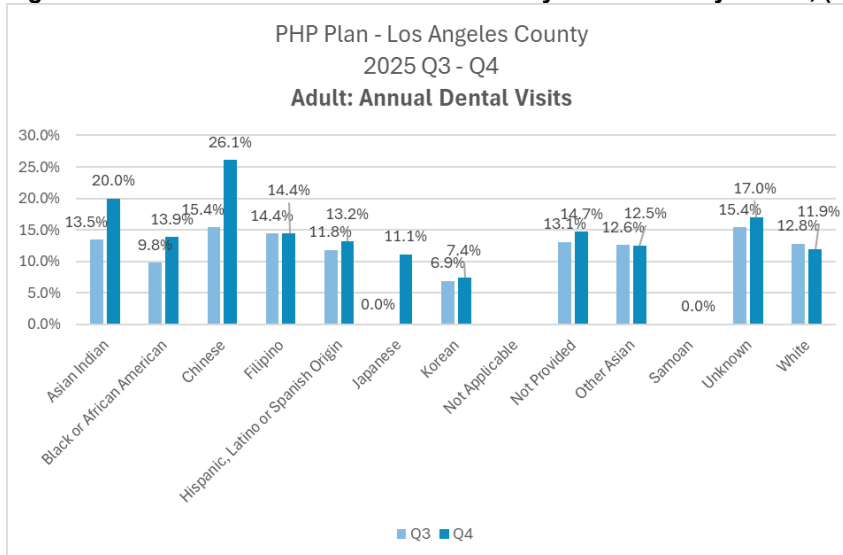
In the Adult cohort the ADV utilization increased in both adult groups from Q3 to Q4. The Senior group (age 65 +) exhibited a higher proportional utilization rate than the 21-64 age group. Senior citizens often have more complex oral health needs and may not have alternative options for dental care due to cost. The pattern of higher proportional utilization by the 65+ group has been well documented in Medicaid populations.<sup>42</sup> In the Child cohort the proportion of females to males is similar at 18.2% to 18.3%. In the Adult cohort, the proportion of females was 1.5% higher than the proportion of males for the ADV measure.

## ADV by Race and Ethnicity

**Figure 9. PHP Annual Dental Visit Utilization by Race/ Ethnicity- Child, (n= 2,038)**



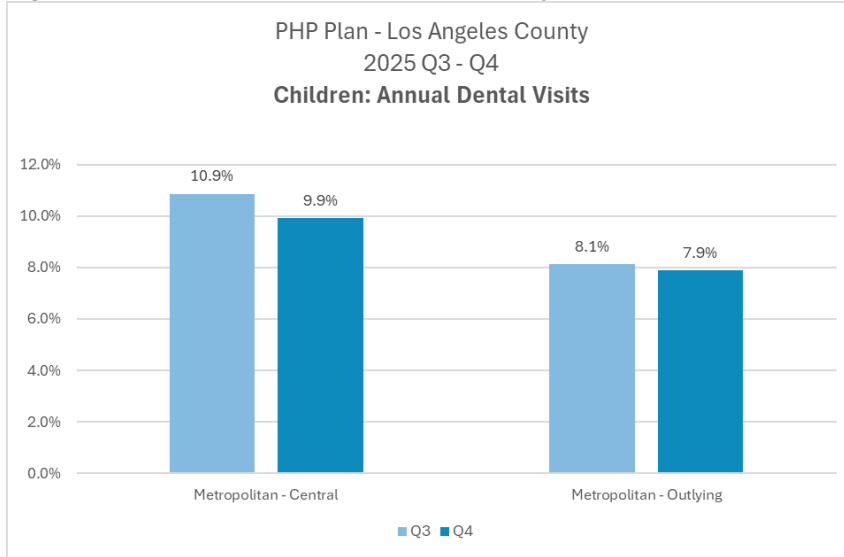
**Figure 10. PHP Annual Dental Visit Utilization by Race/Ethnicity - Adult, (n= 6,906)**



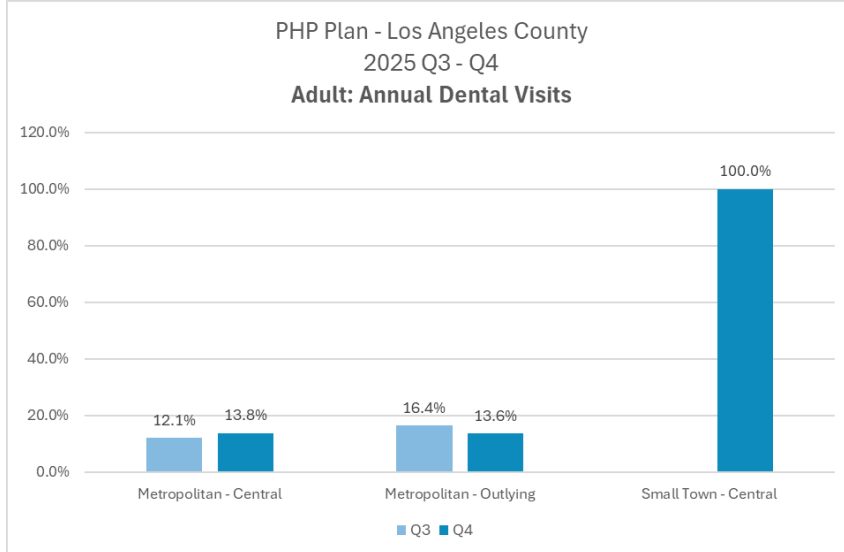
Analysis indicated that the Japanese group within the Child cohort and the Chinese group within the Adult cohort exhibited the highest proportion of ADV utilization relative to their population sizes. This observation was derived from comparing each group's patient count with their actual utilization rates. Despite the small overall numbers in these groups, the proportion of utilizers was notably high—a trend also present among the Chinese group in the Adult cohort. The application of this intra-group metric offers valuable insights for identifying target populations and developing programs focused on enhancing intra-group utilization outcomes.

## ADV and Rural/Urban Area

**Figure 11. PHP Annual Dental Visit Utilization by Rural-Urban Area (RUA)- Child, (n= 2,038)**



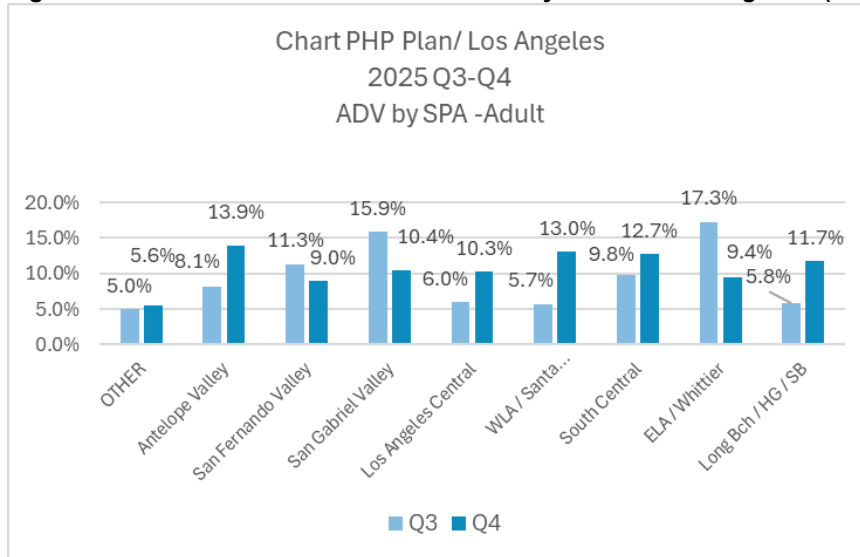
**Figure 12. PHP Annual Dental Visit Utilization by Rural- Urban Area (RUA)- Adult, (n= 6,906)**



In the child and adult cohorts the greatest, overall proportion of members receiving care reside in the central and outlying areas of the larger cities. In child cohort, the largest proportion of the population of members receiving ADV resided in the Metropolitan -Central (17.9%), followed by members residing in Metropolitan-Outlying areas with the fewest members residing in Micropolitan-Central areas. In the Adult cohort, the largest proportion of the population of members receiving ADV resided in the Metropolitan - Central areas (20.6%), followed by the Metropolitan- Outlying areas (20.1%) with minimal members residing in the Micropolitan Central areas (50%). The data for the children and adult residences is consistent with the documented Medicaid claims apart from the Micropolitan area.

## ADV and Service Planning Area

**Figure 13. PHP Annual Dental Visit Utilization by Service Planning Area (SPA)- Adult, n= 6,906**

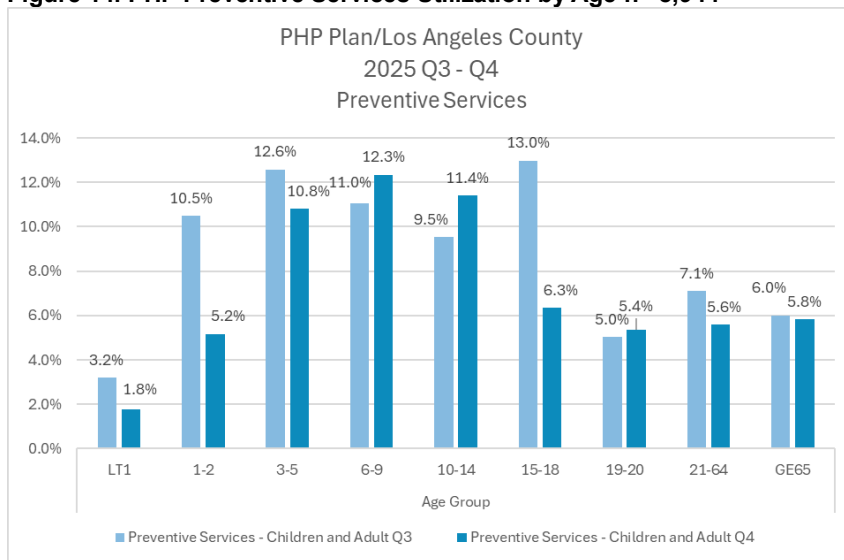


The highest utilization by child population size was exhibited in the following Service Planning Areas: SanGabriel Valley (21.8%) followed by San Fernando Valley (16.5%), Long Beach/Harbor Gateway/South Bay (17.7%), East Los Angeles/Whittier (17.7%). The Los Angeles Central Service Planning Area exhibited the lowest amount of resident utilization.

The Adult ADV utilization proportions were highest among members residing in San Fernando Valley (17.6%) followed by San Gabriel Valley (24.9%), Long Beach/ Harbor/Gateway (20.6%), Los Angeles Central (21.0%) and lastly South Central (18.7). The Service Planning areas are geographic areas designed to enhance equity, efficiency, and community- specific health care. Collaboration with ongoing programs within each SPA to strengthen access and care will benefit our member base.

## Preventive Services Utilization

**Figure 14. PHP Preventive Services Utilization by Age n= 8,944**



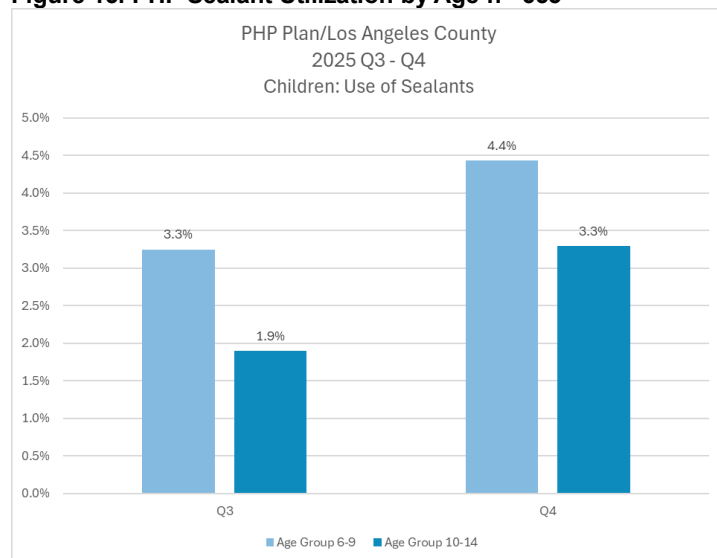
## Preventive Services Age and Gender

Figure 14 shows that in the Child cohort, the highest proportion of preventive services utilization by population size was in the 10-14 age group followed by the 15-18 age group and the 6-9 age group. The adolescent group exhibited a decrease in preventive services utilization with advancing age. In the Adult cohort, the 65+ age group exhibited a higher utilization than the 21-64 adult age group exhibited. The proportion of females to males was greater by 1.9%. The highest group by population size for the proportion of preventive services utilization by racial/ethnic group in children and adults combined was the Hispanic/Latino/Spanish group (11%) followed by the White group at 12%. The lowest group by population size for the proportion of racial/ethnic groups to each other was Japanese group at 14.3 % and the Asian/Indian group at 14.9%. In the child and adult cohorts, the greatest, overall proportion of members' residence in descending order was Metropolitan-Central, Metropolitan Outlying and Micropolitan-Central. The largest proportion of members resided in band on the outskirts of large cities and in small cities. In order of population, the highest proportion of members residing in the various Service Planning Areas was San Fernando Valley (11.2%), Long Beach Harbor Gateway/South Bay (12.3%), East Los Angeles/ Whittier (11.8%) and Los Angeles Central 10.6%.

Preventive Services utilization increased throughout childhood and began to decrease after age 18. The early years of childhood are typically the years when parents seek the greatest amount of preventive care for their children. Dental caries is the most prevalent disease of childhood and parents seek dental care for their children to combat tooth decay, teach good oral hygiene habits and prevent problems before they occur. The Adult cohort demonstrated a slight decrease in utilization from Q3 to Q4. Adults traditionally do not experience as much preventive care as children due in part to the permanent tooth structure being more resistant to decay than primary teeth. Additionally, the adult preventive benefit allows for fewer cleanings and fluoride treatments for adults than for children. Hence, it follows that we should see more child utilization than adult utilization for preventive procedures. The slight decrease in utilization from Q3 to Q4 may have been due to members navigating and acclimating to the change in coverage, because DentaQuest is new to the CA market. Members were and possibly also navigating and acclimating to a change in provider.

## Sealant Utilization

**Figure 15. PHP Sealant Utilization by Age n= 655**

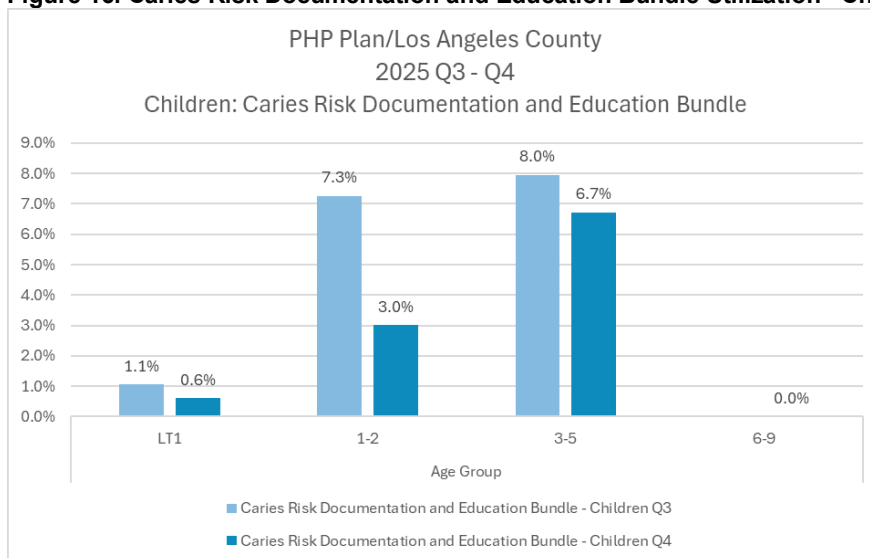


### Sealant Utilization Age and Gender

Although sealants have been administered in the PHP plan, sealant utilization is extremely low based on prior DHCS benchmarks. Gender differences are unable to be discerned at the current utilization level. The highest utilization proportion by population size is exhibited by the Hispanic/Latino/Spanish group, followed by the White group. The highest proportion of sealant utilization by population residence location is demonstrated in the center of larger cities and in the outlying areas of larger cities. The following Service Planning Areas demonstrated the highest proportion of sealant utilization: San Gabriel Valley, San Fernando Valley, Long Beach/Harbor Gateway/South Bay, East Los Angeles/Whittier and Los Angeles Central. Sealant utilization levels are a concern in Medicaid programs nationwide. Programs to address this and utilization of other preventive procedures are essential.

### Caries Risk Documentation and Education Bundle

**Figure 16. Caries Risk Documentation and Education Bundle Utilization –Child n =711**



The Caries Risk Documentation and Education Bundle reflects the greater proportions of utilization in the 3-5 year and 1–2-year age groups. Based on population (chart not shown), the groups with the highest proportional utilization include the Hispanic/Latin/Spanish group (10.2%) and the White group (4.8%). This pattern of utilization is well documented in Medicaid populations.<sup>43</sup> Utilizers primarily resided in the center of large cities (8.8%) and in the outlying areas of large cities (9.7%) (not shown). The highest utilizers resided in San Gabriel Valley (11.2), San Fernando Valley (8.9%), Long Beach/Harbor Gateway/South Bay (8.3%). Lowest utilizers reside in East Los Angeles (10.0%) and Central Los Angeles (6.5%). This limited benefit applies to a limited category of patients. Due to this issue, average utilization rates may correspond to the data percentages reflected.

## Fluoride Application Utilization

Figure 17. PHP Fluoride Utilization- Child n = 397

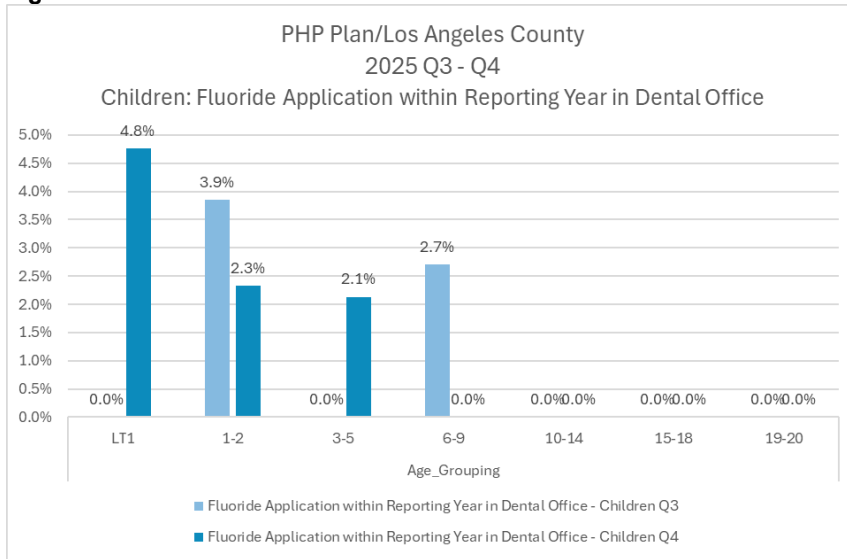


Figure 18. PHP Fluoride Utilization- Adult n=1519

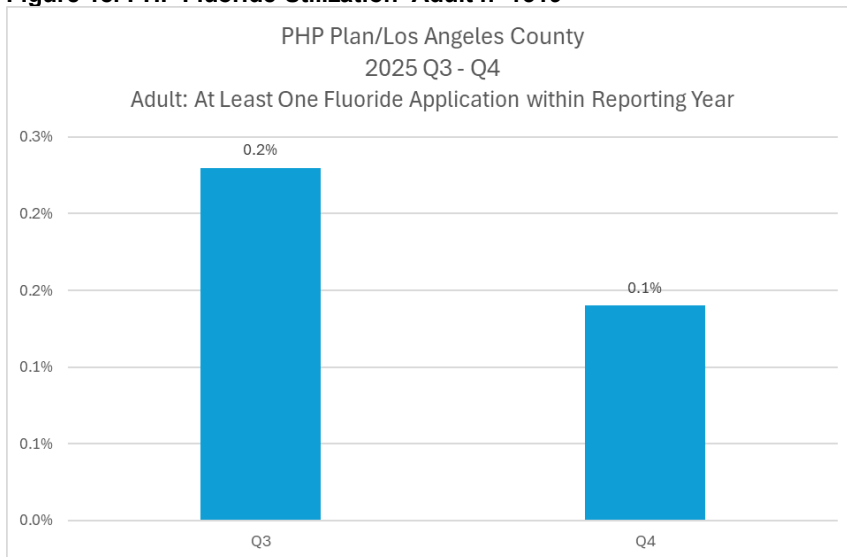


Figure 18. shows that fluoride utilization was proportionally higher in the youngest age groups. Q3 demonstrated the highest levels of utilization. Q3/Q4 exhibited highest utilization in the 0-2,6-9 and 3-5 age groups. Minimal utilization was demonstrated in the adult cohort. Utilization of fluoride application in children was inconsistent from Q3 to Q4. Adolescent utilization was zero, followed by low adult utilization levels. In Q4, the fluoride applications decreased for children and adults as utilization of other procedures increased. Utilization in children focused on the high-risk age groups, but it is alarming that 2 age groups reported zero utilization in Q3 / Q4. Taking into consideration the small PHP child population this will be an area of further investigation.

## Sacramento County Performance Measures (GMC)

### ADV Age and Gender

Figure 19. Annual Dental Visit by Age – Q3/Q4 (n=73,180)

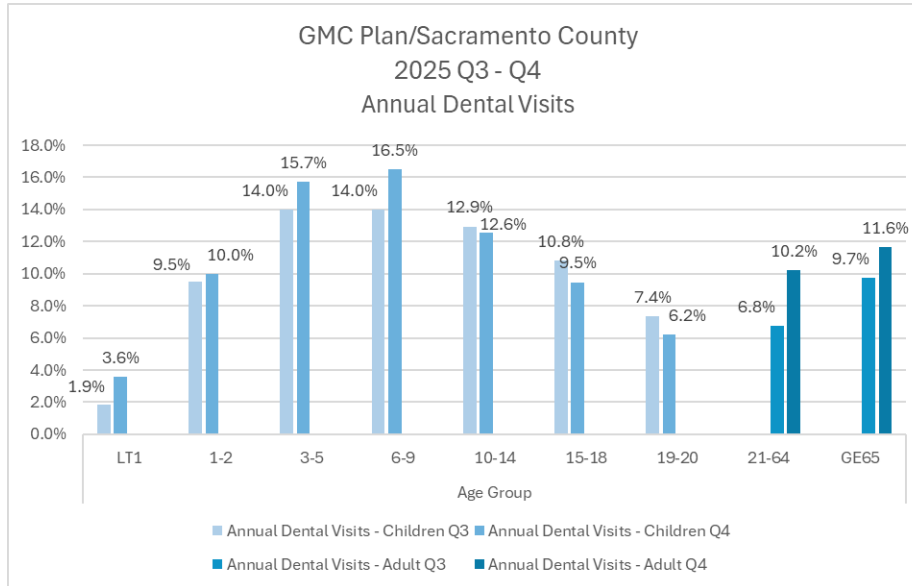
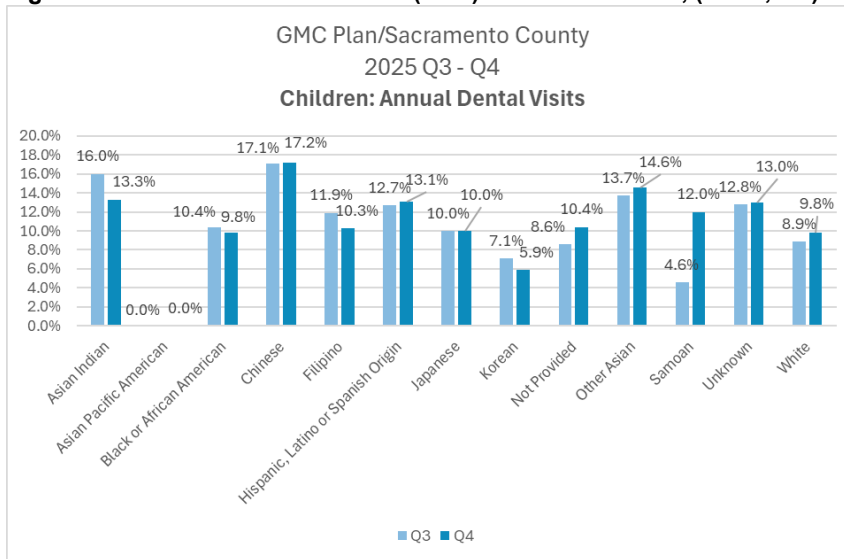


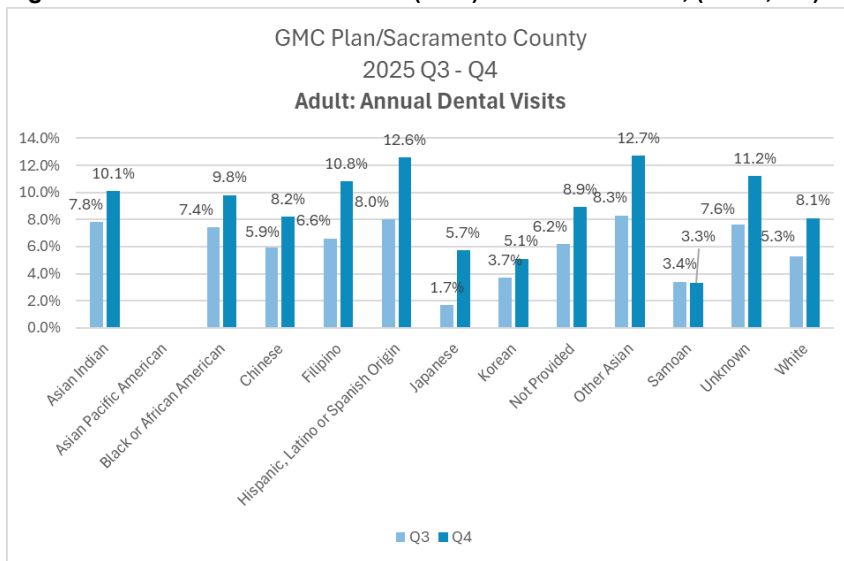
Figure 19 shows that the highest level of utilization by age group and overall population size was achieved by the 3-5, 6-9, 10-14 and 15-18 age groups. Although we have only two quarters of data, the current utilization across age groups appears to follow child, adolescent, and adult usage patterns.<sup>44</sup> In the adult cohort, the 65+ utilization levels were higher than the 21-64 age group. The proportion of males to females in the child cohort was similar with females (20.7%) over males (19.7%) (not shown). In the adult cohort, female utilization (15.7%) of ADV was higher than the proportion of male utilization (12.0%) by over 3 percentage points (not shown).

## ADV by Race and Ethnicity

**Figure 20. GMC Annual Dental Visit (ADV) Utilization –Child, (n= 20,629)**



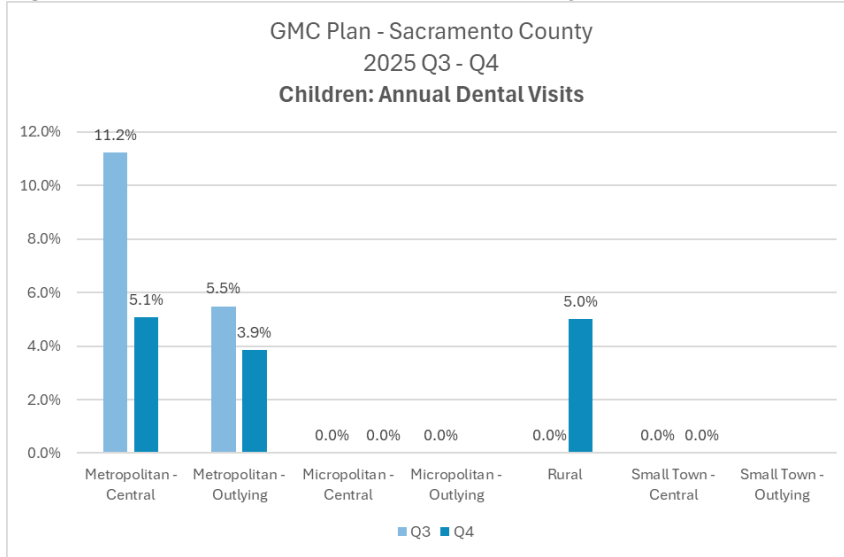
**Figure 21. GMC Annual Dental Visit (ADV) Utilization –Adult, (n= 52,551)**



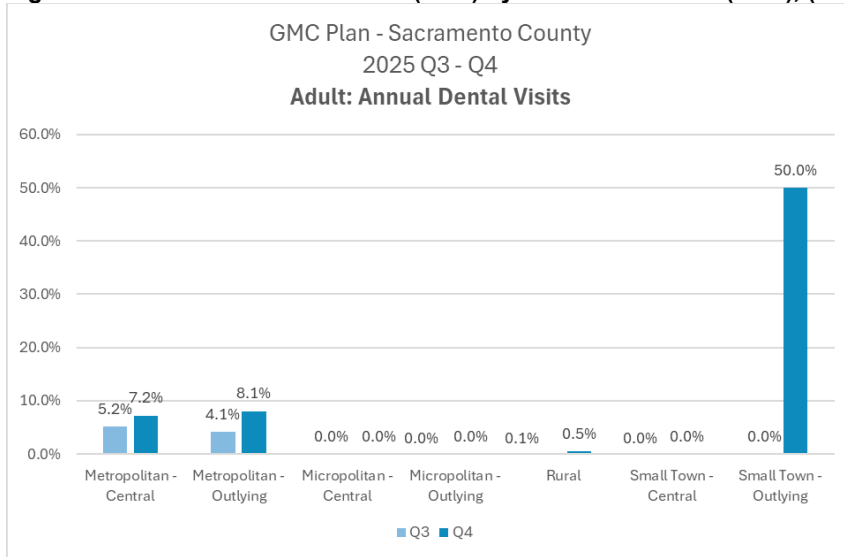
In the child and adult cohorts, the highest ADV utilization percentage by the proportion of the population was the Chinese, Asian Indian and other Asian groups, as well as the Hispanic/Latino/Spanish group (in the adult group only). The lowest utilization group by proportion of population size was the Samoan and Japanese groups. Medicaid claims research by the Kaiser Family Foundation identified Hispanic (56%) and Asian (50%) children have higher rates of dental service compared to other groups.<sup>43</sup>

## ADV by Rural/ Urban Area

**Figure 22. GMC Child Annual Dental Visit (ADV) by Rural-Urban Area (RUA), n= 20,629**



**Figure 23. GMC Annual Dental Visit (ADV) by Rural-Urban Area (RUA), (n= 52,551)**



In the child cohort, the members' home addresses were used to identify their location in central and outlying metropolitan areas as having the greatest ADV utilization. The provider network sufficiency is accessible for members to walk to their appointments due to < 2- mile average geo –access to dental offices for members in the Sacramento area. High adult ADV utilization was also demonstrated in both metropolitan, outlying, and additionally in rural areas. According to Kaiser Family Foundation research, the proportion of children and adults who received at least one ADV during the year is marginally lower in rural regions than in urban settings.<sup>43</sup>

## Preventative Services Utilization - Child and Adult

**Figure 24. GMC Preventive Services- Children and Adult (Measure #3) ( n= 73,180)**

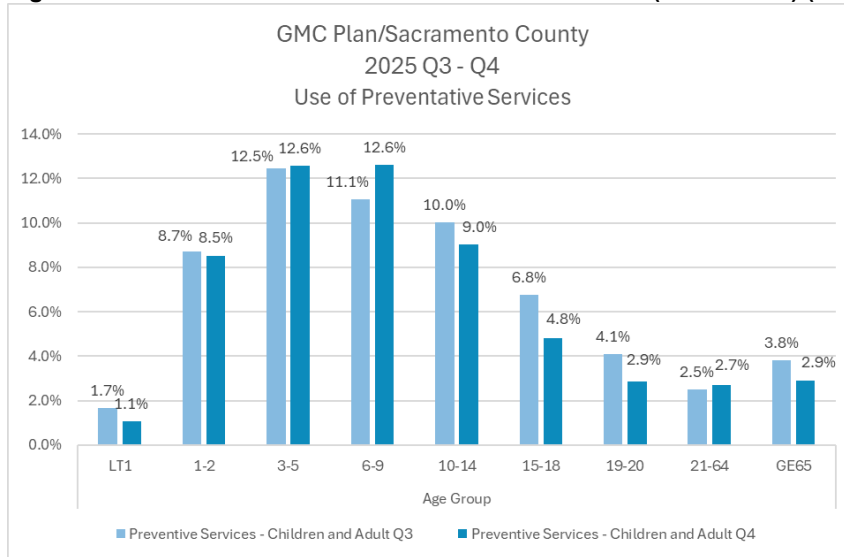


Figure 24 demonstrates that the increased utilization of preventative services continues throughout childhood 6-9 years but decreased throughout the teenage years and the remainder of childhood. The early years of childhood are typically the years when parents seek the greatest amount of preventative care for their children. This finding is consistent in the literature.<sup>44</sup> The adults demonstrated an increase from Q3 to Q4 with the 65+ age group exhibiting higher utilization than the 21-64 age group. Children led adults in the proportion to preventative services utilization. Lastly, the increase in utilization from Q3 to Q4 may have been due to members navigating and acclimating to the change in coverage, because DentaQuest is new to the CA market. Members were and possibly also navigating and acclimating to a change in provider. {Citation}

## Sealant Utilization

**Figure 25. GMC Sealant Utilization by Age, n= 6,867**

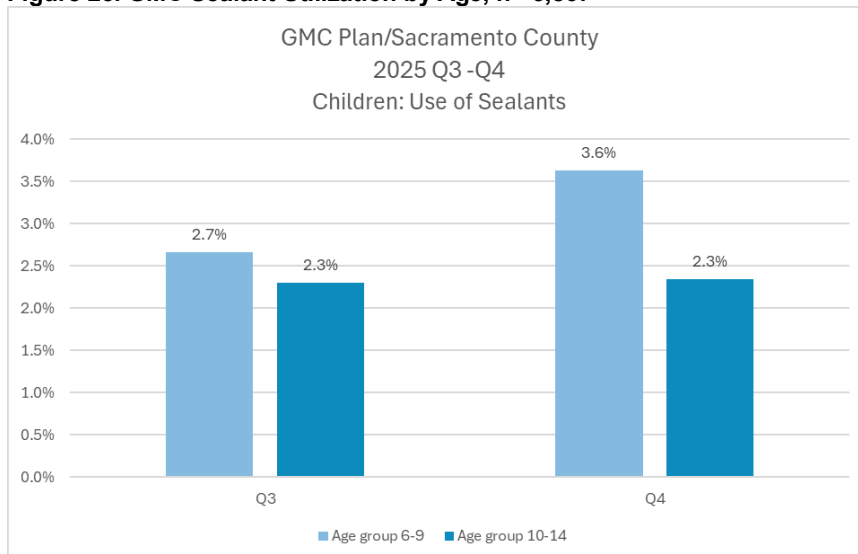
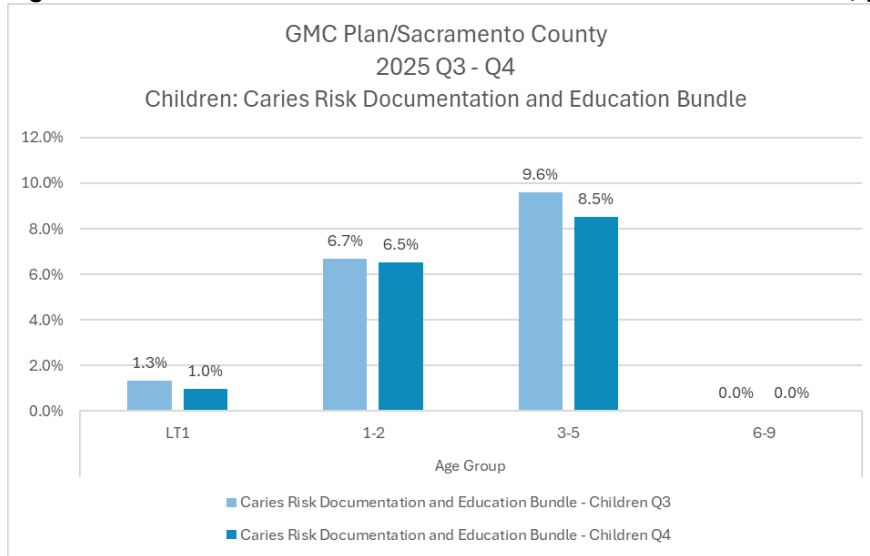


Figure 25 shows that sealant utilization increased in the 6-9 year age group from 2.7% to 3.6% and remained stable in Q3 and Q4 in the 10-14 age group at 2.3%. Hispanic/Latino Spanish and White groups were among the highest utilizers, while the Japanese and Asian Indian groups were among the lowest utilizers (not shown). This pattern of utilization is consistent with the Medicaid utilization data regarding highest utilizing groups.

### Utilization of Caries Risk Documentation Bundle- Children

**Figure 26. Utilization of Caries Risk Documentation and Education Bundle, (n= 7,948)**

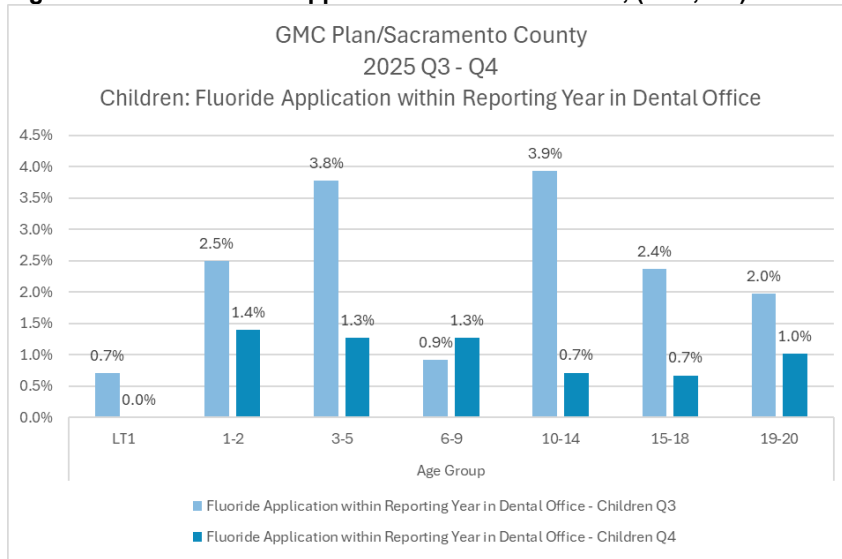


The highest utilization was demonstrated in the 3-5 age group. Utilization remained stable within 1% from Q3 to Q4. This performance measure coincides with the ages of Headstart and CA Public School oral health exam enrollment requirements. These mandatory requirements typically impact dental utilization in this age group.

Gender alignment is demonstrated by the nearly equal utilization percentages between male and female groups. Hispanic/Latino/Spanish and White groups exhibited the highest utilization while the Asian Indian group exhibited the lowest utilization. However, many groups exhibited zero utilization; additional analyses with a larger population over a longer time period is necessary. Utilization was primarily from members residing in the center and outlying area of large cities and additionally from smaller towns on a much lower level.

## Fluoride Application Utilization

**Figure 27. GMC Fluoride Application Utilization –Child, (n= 3,143)**



**Figure 28. GMC Fluoride Application Utilization Adult, (n = 8,796 )**

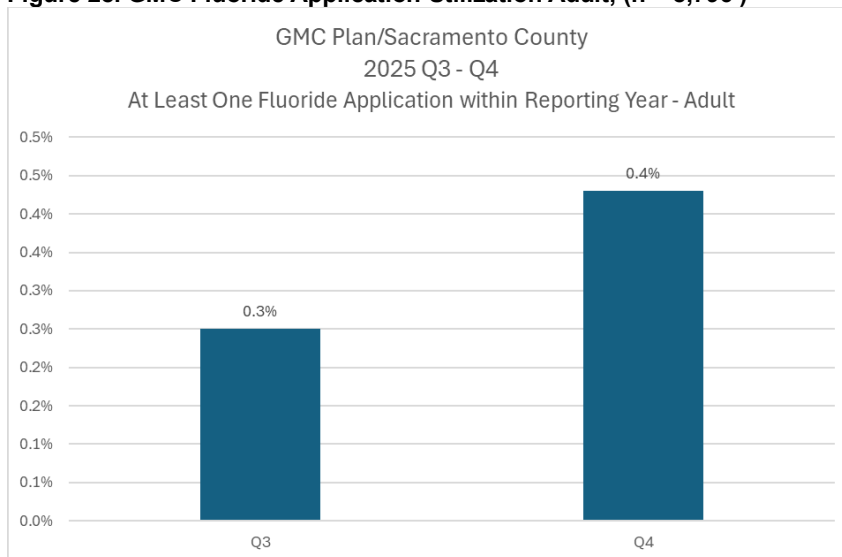


Figure 27 demonstrates that fluoride application utilization was initially highest among the 3-5 and 10-14 age groups in Q3, as members began engaging in dental care with the new Dental Benefits Manager. In Q4, fluoride applications for children declined while utilization of other procedures increased, which may be due to how members advance through their treatment plans. As members further determine how and where to utilize their dental benefits—potentially with new providers—we anticipate an eventual increase in utilization rates. DentaQuest will continue to monitor these trends in the coming quarters.

Figure 28 represents the adult cohort. It shows that fluoride applications rose from Q3 to Q4, representing another key area for ongoing observation by DentaQuest. It is important to note that fluoride application is covered twice annually for children and once annually for adults; this benefit structure may affect observed utilization differences between pediatric and adult populations throughout the year.

## Social Determinants of Oral Health (SDOH)

Social determinants of oral health are the non-clinical factors that shape individuals' ability to achieve and maintain good oral health, including socioeconomic conditions, access to care, education, and environment. These determinants influence not only access to dental services but also underlying risk exposures and behaviors. In California broadly, lower household income, lack of dental insurance or coverage that is accepted by many providers, lower educational attainment, limited English proficiency, and food insecurity are all correlated with higher prevalence of poor oral health outcomes, including untreated decay and periodontal disease.<sup>45</sup> These patterns reflect broader structural inequalities: residents without private insurance or with low-income report significantly worse oral health than their higher-income or privately insured counterparts, and immigrant status and language barriers further exacerbate disparities in use of preventive services.<sup>46</sup> These determinants affect populations across age groups and ethnicities, with communities of color often disproportionately impacted.<sup>47</sup>

### Los Angeles County

Extensive socioeconomic diversity and a high proportion of low-income families contribute to marked oral health inequities. Approximately 36% of children in Los Angeles County rely on Medi-Cal.<sup>48</sup> Children living in households below 200 percent of the federal poverty level in LA County (51%) demonstrate significantly higher rates of dental caries than their higher-income peers, indicating the strong influence of poverty on oral health outcomes.<sup>12</sup> Racial/ethnic disparities also emerge: Latino and Black children exhibit higher caries prevalence, reflecting how social and economic disadvantage intersects with oral health risk in one of the nation's largest and most diverse counties.<sup>12</sup>

### Sacramento County

In Sacramento County, similar social determinants shape oral health outcomes, though local demographics and service patterns influence the specifics. A substantial portion (47.5%)<sup>48</sup> of the county's children rely on Medi-Cal, and many live below the 200 percent federal poverty level (33.5%)<sup>49</sup>, which affects both preventive service use and access to routine dental care. Limited English proficiency among residents also poses communication barriers that can deter utilization of dental services and health information.<sup>46</sup> These county-level determinants underscore how economic, linguistic, and systemic factors intersect to shape oral health disparities across Sacramento.

## Gaps and Opportunities

While the California Dental Network has been asked to document an action plan for Los Angeles and Sacramento counties, it is premature to define specific strategies at this stage as insights are still emerging through this assessment process. This report defers detailed planning until the data collection is complete, which is after the one-year anniversary of the contract, and requires synthesis and validation with stakeholders. However, we do share some insights from two quarters of available CDN data.

In the interim, we have incorporated preliminary action items drawn from the Los Angeles and Sacramento counties' oral health assessments to reflect known priorities. These early considerations are intended to inform future planning, not replace the collaborative, data-driven process required to develop effective and sustainable interventions.

## Los Angeles County

We reviewed the LA Chartbook<sup>6</sup> and the Los Angeles County Department of Public Oral Health Program “Community Oral Health Improvement Plan Implementation Report”<sup>20</sup> and the latest materials from the LAC DPH Community Oral Health Improvement Plan (COHIP) 2026 Advisory Committee. We also summarized the research presented in this document and identified the following priority populations:

1. Children enrolled in Medi-Cal DMC with low utilization, reflecting:
  - Low dental utilization rates (35.7–43.9%).
  - Low preventive visit rates (32–37.8%).
2. Kindergarteners and third graders with high caries burden, including:
  - 17.8% of kindergarteners with untreated decay and 32.5% with caries experience.
  - 19% of kindergarteners and 21% of third graders with untreated decay.
  - Disproportionately higher decay among Spanish-speaking households (70% vs. 47% in English-speaking households).
  - Higher burden among Black, Latino, and low-income children.
3. Adolescents with gaps in oral health education and preventive care, including:
  - Only 12.2% reporting receipt of oral health education in school.
  - Low HPV vaccination rates (36% completing the 2-dose series).
4. Adults with low preventive utilization, including:
  - Medi-CAL DMC adults with preventive dental care rates between 10.6–15.2%.

## Sacramento County

The literature identifies several populations experiencing disproportionate oral health challenges in Sacramento County:

1. Children with elevated emergency department (ED) use and caries burden, including:
  - Rising preventable ED dental visits among children ages 0–20 (2019–2021 data).
  - Need for improved reliability of Kindergarten Oral Health Assessment (KOHA) screening data.
  - Children needing increased sealant application, particularly those in high need school environments. Increasing the use of sealants was also a key finding in our own data.
2. Adults facing significant access challenges, including:
  - Adults requiring general anesthesia (GA) dental procedures amid insufficient hospital OR capacity.
  - Limited community health center capacity for adult dental services.
  - High rates of preventable ED dental visits among adults ages 21+.
3. Populations experiencing inequities in oral health, as identified in Sacramento County’s CHIP and oral health evaluation.
  - Includes low-income, LEP, and racially diverse communities facing structural and geographic barriers.
  - Individuals affected by substance use, where integration of oral health services with alcohol and drug programs is needed.

For both Los Angeles County and Sacramento County, these findings are consistent with our own observations and analysis of utilization management and performance measures, which include the following areas of need:

1. Improving use of preventive services in age groups 19-20 and adults 21-64.
2. Increasing sealants in age groups 6-9 and 10-14 as they are underutilized.
3. Improving fluoride application in age groups 10-14, 15-18, 19-20.
4. Increasing utilization of the caries risk documentation and education bundle.
5. Increasing opportunities for medical-dental education and targeted outreach for pregnant women and adults with chronic health conditions (e.g., cardiovascular conditions, diabetes).

## **Conclusion**

### **Implementation Support**

The implementation of strategies informed by the oral health needs assessment will require coordinated support across policy, programmatic, and operational levels. Key resource considerations include the availability and distribution of oral health providers and allied professionals, capacity for prevention-oriented and pediatric services, and the internal and external infrastructure needed to support data-sharing, monitoring and quality improvement.

Implementation support will focus on translating assessment findings into actionable guidance by aligning recommended strategies with existing delivery systems, funding mechanisms, and workforce capacity. This includes providing clear prioritization, identifying feasible points of integration within medical, dental, and community-based settings, and supporting stakeholders with data, technical assistance, and shared learning resources. Ongoing collaboration with public agencies, providers, schools, and community partners can help address implementation barriers, promote consistent adoption of evidence-informed practices, and ensure that strategies are adapted to local context while maintaining fidelity to equity and prevention goals.

### **Evaluation and Monitoring**

Evaluation and monitoring of the oral health needs assessment will be structured as an ongoing, iterative process that supports accountability, learning, and equity-informed decision-making. The assessment establishes a baseline against which changes in oral health status, access to care, and system performance can be tracked over time. A logic model or theory of change can serve as the organizing framework, linking identified needs to strategies, outputs, and short-, intermediate-, and long-term outcomes, and providing a clear structure for selecting indicators and interpreting progress.

Monitoring activities will draw on routinely available quantitative data sources, including dental and medical claims, public health surveillance systems, workforce datasets, and emergency department utilization for dental conditions. Indicators may be organized using a structure–process–outcome approach to assess system capacity (e.g., provider availability and benefit design), service delivery (e.g., preventive and restorative care utilization), and outcomes (e.g., untreated disease or preventable emergency department use). Where feasible, measures will be stratified by age, geography, and socioeconomic characteristics to assess whether improvements are occurring equitably, with attention to preventive care and early intervention for children and adults.

Evaluation extends beyond outcomes alone to examine the implementation of strategies informed by the needs assessment. Incorporating elements of an implementation-focused framework, such as RE-AIM/PRISM, can help assess whether priority populations are being reached, whether strategies are adopted across relevant settings (e.g., dental practices, schools, medical clinics), and whether

implementation is feasible and sustainable over time. This approach supports a more complete understanding of not only whether gaps are closing, but how and under what conditions progress is occurring.

Qualitative and contextual inputs will complement quantitative monitoring to ensure findings are interpreted within the broader social and delivery system context. Stakeholder feedback, insights from community-based and school-based programs, and information from medical–dental integration efforts can help explain observed trends and surface emerging barriers or facilitators of care. Applying a health equity–focused evaluation lens across both quantitative and qualitative components helps ensure that progress for the overall population does not obscure persistent disparities among high-need groups, including children and underserved communities.

To maintain relevance over time, the evaluation framework will be revisited periodically and refined to reflect changes in policy, funding, delivery models, or data availability. Findings from ongoing monitoring will inform mid-course adjustments to strategies and guide priorities for future analyses or updates to the needs assessment. By embedding evaluation and monitoring into routine planning and continuous improvement processes, the oral health needs assessment can function as a dynamic, learning-oriented tool to support sustained and equitable improvements in oral health.

## **Risks and Mitigations**

The preparation of an oral health needs assessment is subject to several inherent risks related to data availability, methodological limitations, and the dynamic policy and care delivery environment. One key risk is data incompleteness or lag, particularly for dental claims, utilization, and workforce data, which may not fully capture recent changes in coverage, service delivery models, or population needs. This risk is mitigated by our use of the most recent multi-year datasets available, clearly documenting data timeframes, and triangulating findings across multiple sources, including claims data (six months), public health surveillance, and secondary literature.

Another risk involves limited representation of vulnerable or underserved populations, such as children from low-income households, individuals experiencing housing instability, undocumented residents, or those relying on episodic or medical-based emergency care. These populations are often underrepresented in administrative datasets, which can lead to an underestimation of unmet need. For children, early childhood and health needs may be underestimated due to low utilization of preventive services prior to school entry. To mitigate this risk, future assessments will incorporate proxy indicators (e.g., emergency department utilization for dental conditions, community health center data) and apply a health equity lens when interpreting results, explicitly noting where gaps may exist.

Another risk is overreliance on quantitative indicators without sufficient contextual interpretation, which may obscure family-level, cultural, or system-level barriers to care. For pediatric populations, these barriers include caregiver knowledge and beliefs, language access, transportation challenges, and misalignment between identified needs and feasible points of access for families. This risk is mitigated by integrating qualitative insights from other county assessments, stakeholder reports, and policy analyses, and by situating findings within the broader oral-systemic health and healthcare delivery context. To ensure we capture these findings, the Needs Assessment includes the Qualitative Assessment Plan which we plan to execute at plan anniversary.

The assessment also faces risks related to delivery system capacity and fragmentation, including workforce shortages, uneven geographic distribution of providers, and limited integration between medical and dental systems. These challenges are salient for children and adults alike, who frequently interact with pediatric medical providers earlier and more consistently than dental providers. Mitigation

strategies include pairing needs assessment findings with workforce and access indicators, highlighting opportunities for medical-dental integration (such as preventive services in primary care and referral pathways), and framing recommendations that are aligned with existing delivery infrastructure.

Finally, there is a risk that findings may be interpreted as static, despite ongoing changes in Medicaid policy, reimbursement structures, and delivery system reforms. To mitigate this, we aim to include trends rather than point-in-time conclusions, acknowledge known upcoming policy or programmatic changes, and position results as a foundation for iterative planning rather than a definitive endpoint. We also recommend working in partnership with the health plans for an integrated plan, rather than in isolation, to optimize planning, execution, and process and outcome evaluation.

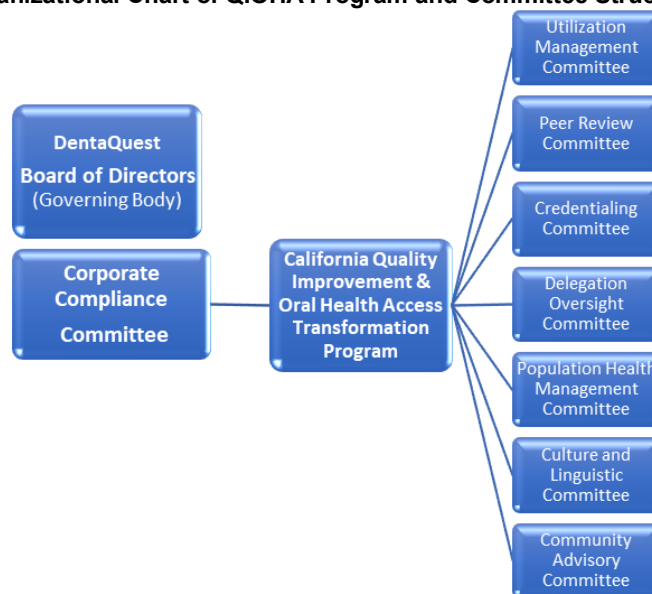
Collectively, these mitigation strategies strengthen the validity of the assessment while maintaining transparency about its limitations and appropriate use in planning and decision-making.

### Governance and Stakeholder Engagement

The QIOHAC convenes quarterly and is the governing body. It maintains oversight and accountability for the Oral health improvement plan and all member related clinical and administrative activity. The Population Health Management Committee, a subcommittee of the QIOHAC, establishes the Oral Health Improvement plan with essential input from the Community Advisory Committee that possesses cultural and regional insight as well as “lived experience”. These committees merge the quantitative and qualitative aspects of care to achieve data driven, culturally appropriate solutions to improve the oral health of the populations that we serve.

The Community Advisory Committee convenes Members, Providers, and community stakeholders to give feedback on the program, share ideas, concerns, and requests. The members have an opportunity to weigh in on ongoing programs as well as new programs. The results of these interactions inform the direction of decisions and provide context to member needs and constraints. Their input also informs improvements that meet the collective needs of our Members. Together, the Community Advisory Committee and the Population Health Management Committee focus on the specifics of various underserved groups, as well as the social determinants of health to improve care and access to care. The QIOHAC ensures that the Oral Health Program is carried out appropriately, responsibly, and consistently.

**Figure 29. Organizational Chart of QIOHA Program and Committee Structure**



## Phase II - Qualitative Assessment

The qualitative component of the population needs assessment will surface lived experiences, contextual barriers, cultural norms, and system-level frictions that are not visible in administrative or surveillance data. This approach ensures that findings are grounded in community reality and inform recommendations that are practical, equitable, and locally responsive.

To complete the qualitative assessment, we recommend a full year of quantitative data to contextualize and validate findings. This typically includes the development of a qualitative research plan, stakeholder engagement strategy, and structured instruments such as focus groups or interview guides. These qualitative tools are intentionally designed based on patterns observed in the quantitative data, such as geographic variation, service gaps, disparities among subpopulations, or provider access issues—to ensure that qualitative inquiry is targeted, relevant, and actionable. Developing focus group guides or interview protocols in advance of a stable data foundation increases the risk of misalignment between stakeholder input and actual population needs, limiting the usefulness of the findings. We present our qualitative plan below, for both Los Angeles and Sacramento counties.

The qualitative assessment is designed to capture perspectives across three levels:

1. Community and patient experience. How do residents perceive oral health, navigate care, and experience barriers?
2. Provider and workforce perspectives. How do dental and medical providers experience service delivery, capacity constraints, and referral pathways?
3. System and policy context. How do public health leaders, safety-net administrators, and community-based organizations understand gaps, coordination challenges, and opportunities for improvement?

## Methods

A mixed-method qualitative design is recommended, combining:

- *Key Informant Interviews (KIIs):*  
Semi-structured interviews with public health officials, dental directors at FQHCs, school-based oral health program leaders, dental practitioners, and leaders of community-based organizations. These interviews explore system-level issues such as workforce shortages, reimbursement challenges, integration with primary care, and regional differences in service delivery.
- *Focus Groups:*  
Facilitated discussions with residents from priority populations (e.g., Medi-Cal beneficiaries, parents of young children, older adults, immigrant communities, rural residents in Sacramento County, and urban underserved communities in Los Angeles County). Focus groups allow participants to build on each other's experiences, revealing shared norms, misconceptions, and practical barriers.
- *Community Listening Sessions or Town Halls (Optional):*  
Open forums hosted in partnership with trusted local organizations to broaden participation and validate emerging themes.
- *Environmental Scan and Document Review:*  
Review of community health improvement plans, oral health coalition reports, school district wellness policies, and local program evaluations to contextualize interview and focus group findings.

## Sampling Strategy

Participants would be purposefully selected to reflect:

- Geographic diversity (urban core, suburban, rural/peripheral areas)
- Demographic diversity (age, race/ethnicity, income, language)
- Care settings (private practices, FQHCs, mobile clinics, school-based programs)

This ensures that the assessment captures both shared challenges and county-specific dynamics, particularly the contrast between Los Angeles' scale and diversity and Sacramento's mix of urban and rural communities.

## Core domains of inquiry

The quantitative data will inform the domains of inquiry, which may explore the following:

- Perceptions of oral health
  - How residents define "good oral health"
- Cultural beliefs and norms related to dental care
- Preventive vs. crisis-driven care behaviors
- Access and navigation
  - Experience finding a dentist who accepts Medi-Cal
  - Wait times, transportation challenges, and appointment availability
  - Awareness of available programs and benefits
- Financial barriers
  - Out-of-pocket costs, coverage gaps, and perceived affordability
  - Impact of benefit limitations on care-seeking behavior
- Trust and experience of care
  - Prior negative experiences
  - Language and cultural concordance with providers
  - Perceived quality and respect in care settings
- System integration
  - Coordination between medical and dental care
  - Role of schools, WIC programs, and primary care in oral health
  - Referral pathways and breakdowns
- Provider constraints
  - Workforce shortages and burnout
  - Administrative burden and reimbursement issues
  - Capacity to serve high-need populations

## Analysis and Outputs

Qualitative data will be coded thematically using a structured framework aligned to the domains above. Analysis will:

- Identify cross-cutting themes shared by both counties
- Surface county-specific challenges and assets
- Highlight discrepancies between system intent and lived experience
- Illuminate root causes behind quantitative patterns (e.g., low utilization despite high provider density)

Key outputs will include:

- A narrative synthesis of major themes
- Direct quotes that humanize the data and illustrate barriers
- County-specific profiles of lived experience
- A set of actionable insights tied to policy and program levers

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