2025 Oral Health Needs Assessment

San Bernardino County Department of Public Health,
Local Oral Health Program – Smile SBC

Prepared by
Dr. Bahar Amanzadeh, DDS, MPH
Mayte Cruz, Senior Associate, MP

Table of Contents

Executive Summary

San Bernardino County – the largest county in the country by total area – combines urban valleys, mountain communities, and the high desert. This vast geography and population diversity give rise to both innovative dental partnerships and persistent barriers for socially and economically disadvantaged residents. The needs assessment revealed several key patterns:

- **High early childhood caries:** 63% of the county's kindergartners have experienced tooth decay, versus 54% statewide, with the East Valley region topping out at 69% (see Appendix C for a list of cities by region).
- **Untreated decay and urgent needs in kindergarteners:** 27% of kindergarteners in San Bernardino County experience untreated decay, comparable to 28% in California (with California's target of 22% calculated proportionally based on Healthy People 2020). The screening results revealed differences in caries experience and untreated decay among kindergarten students by geographical region. Kindergarten children from the East Valley region had the highest prevalence of caries experience (69%) compared to the West Valley (60%) and Desert (54%) regions. However, the desert region had the highest prevalence of untreated decay, with 33% of kindergarten children having untreated decay compared to 26% in the East Valley region and 22% in the West Valley region. The Desert region also had the highest rate of urgent dental needs when compared to the East Valley and West Valley regions.
- **Caries experience among third grade students:** Among third graders, the prevalence of caries experience was 74%, or three out of four third graders in San Bernardino had tooth decay, slightly higher than the statewide rate. Both San Bernardino County and California rates exceed California's 2028 target of 57%. Third-grade students in the Desert region had a higher prevalence of untreated tooth decay (36%) when compared to third graders in the West Valley (28%) and East Valley (24%) regions. Similar to trends observed among kindergarten students, third graders in the Desert region were slightly more likely than their peers in the East Valley and West Valley to have an urgent dental need.
- **Low sealant coverage for third grader students:** The prevalence of dental sealants among third graders in San Bernardino County is lower than that of their peers across California. Less than one-third (31%) of third graders in the county had dental sealants, compared to 37% of third graders in California. The Desert region has the lowest sealant use in the County when compared to the East Valley and West Valley. About 21% of third graders in the Desert had a sealant on at least one molar compared to 33% in the East Valley and 37% in the West Valley.
- **Declining adult tooth loss:** The percentage of older adults reporting loss of six or more teeth decreased from 20.9% in 2020 to 12.4% in 2022, edging closer to the California average of 9.4%.
- **Rising Medi-Cal preventive use:** Utilization among children aged 0–2 increased between 2018 and 2022. Preventive-service use for 0–5-year-olds grew from 31% to 38%, narrowing the gap with the state average (~42%).

- **Improved prenatal dental visits:** The share of pregnant women reporting dental visits rose from 29% (2018–2020) to 36% (2020–2022), approaching the statewide rate of 42%.
- **Dental Workforce Shortages:** In San Bernardino County, the population-to-dentist ratio for 2024 is 2,214,281:1,480, meaning there is one dentist for almost 1,500 people in San Bernardino County. In contrast, for the Medi-Cal population, this ratio for Medi-Cal enrollees to Medi-Cal dental providers is 856,910:475. The ratio of Medi-Cal dentists to all dentists in the County is 475:1,480, meaning only 3 out of 10 providers accept Medi-Cal. When this ratio is broken down by specialty, only 0.1 (10%) or 1 out of 10 specialists accept Medi-Cal. It is important to note that many of these dentists do not see Medi-Cal patients full-time. Geographically, there are significant disparities in dentist availability in areas of the county with known access barriers. Dentist-to-population ratios are highest in the southwestern valley (from Chino to Rancho Cucamonga to Fontana), while High Desert areas, from Phelan to Barstow and across to the eastern Morongo Basin, fall below 16 per 100,000, resulting in long travel times and disrupted care. Medi-Cal safety-net clinics are scarce in remote regions like Lucerne Valley and Needles, despite high poverty rates. Countywide, pediatric dentists, endodontists, and oral surgeons remain in very short supply.

Qualitative interviews and focus groups underscored both strengths and challenges. Stakeholders praised strong collaborations among managed-care plans, school dental programs, and community organizations, yet noted that many Medi-Cal families struggle to find local dentists, and that rural residents face multi-hour bus rides, canceled mobile clinics, and weather-related disruptions. Specific populations—children with special health care needs, foster and unhoused youth, and perinatal women and immigrant families—encounter unique obstacles ranging from sedation waitlists to language barriers and repeatedly lost records.

School-based screenings, sealants, and fluoride-varnish services provide a robust preventive foundation, but referral pathways and follow-up coordination often falter. Emerging efforts by managed-care organizations and other organizations to integrate oral health into primary and prenatal care offer promising, sustainable models for addressing both upstream prevention and the county's ongoing access-to-care and workforce challenges.

Introduction

Oral health is a fundamental pillar of overall health and well-being throughout the lifespan. Poor oral health not only causes pain and infection but also contributes to chronic conditions such as cardiovascular disease, diabetes, and adverse pregnancy outcomes. Beyond physical health, dental disease carries social, educational, and economic consequences: individuals with untreated decay may experience difficulty eating, speaking, and concentrating at school or work, which can, in turn, undermine academic achievement and productivity. Like other chronic diseases, oral health inequities have deep socio-ecological roots, disproportionately affecting socially and economically disadvantaged communities.

Tooth decay remains the most common chronic childhood condition, far exceeding the prevalence of asthma or hay fever. In California alone, children missed an estimated 869,202 school days in a year due to dental problems, resulting in a loss of approximately $60 million to school districts. Three hundred and fifty-one thousand (351,000) children and teens missed at least one or more days of school due to dental problems in the past year (asked in 2022), and 87% of these children missed more than one day of school. [1] Early intervention is critical: the first dental visit by age one, combined with oral health education during pregnancy, establishes a strong foundation for lifelong healthy habits. Because the consequences of poor oral health can persist into adulthood, targeting pregnant women, infants, and young children with preventive services is among the highest-impact strategies.[234]

Oral diseases are largely preventable through timely, evidence-based interventions. Yet many San Bernardino County residents face significant barriers to both preventive care and treatment – barriers that are especially acute in rural, mountainous, and high-desert communities. The 2018-2019 California Third Grade Smile Survey found that 61% of third graders statewide had experienced tooth decay—a marked increase from 40% in 2005–2006—and reported an average 22% rate of untreated decay. In San Bernardino County, third-grade decay rates exceed the state average, reflecting gaps in access and utilization of care. Although the county benefits from committed local partners, diverse school-based dental providers, and programs like the San Bernardino County Department of Public Health Local Oral Health Program (Smile SBC), persistent social and geographic inequalities continue to deepen oral health disparities.

Understanding the oral health needs of these communities, as presented in this report, lays the groundwork for community-informed, collaborative, and innovative strategies. When possible, this report also examines any changes from the previous Oral Health Needs Assessment Report, published in 2018. By leveraging this needs assessment, stakeholders can develop an Oral Health Strategic Plan that builds on the strengths of communities and community partners, incorporating upstream prevention approaches while addressing access-to-care challenges and provider shortage obstacles.

Geography and Demographics of San Bernardino County

San Bernardino County is the largest county in the contiguous United States, spanning 20,105 square miles and encompassing 24 incorporated cities. Approximately 88% of the land area is outside the control of San Bernardino County or city government, with 82% of it federally owned. Its geography is defined by four distinct geographical regions with unique characteristics and land use patterns. The valley, encompassing just 2% of the county's total land area, is the most densely populated and urbanized, home to major cities such as San Bernardino, Ontario, Chino, Fontana, Loma Linda, and Yucaipa. The mountains, comprising 4% of the land, are home to the San Bernardino Mountains and part of the San Gabriel Mountains and communities such as Lake Arrowhead and Big Bear Lake. The eastern desert geographic area, accounting for 17% of the county, includes areas such as Joshua Tree and Twentynine Palms. The largest geographic region is the north desert region, which covers 77% of the county and communities such as Victorville, Apple Valley, Barstow, and Needles.

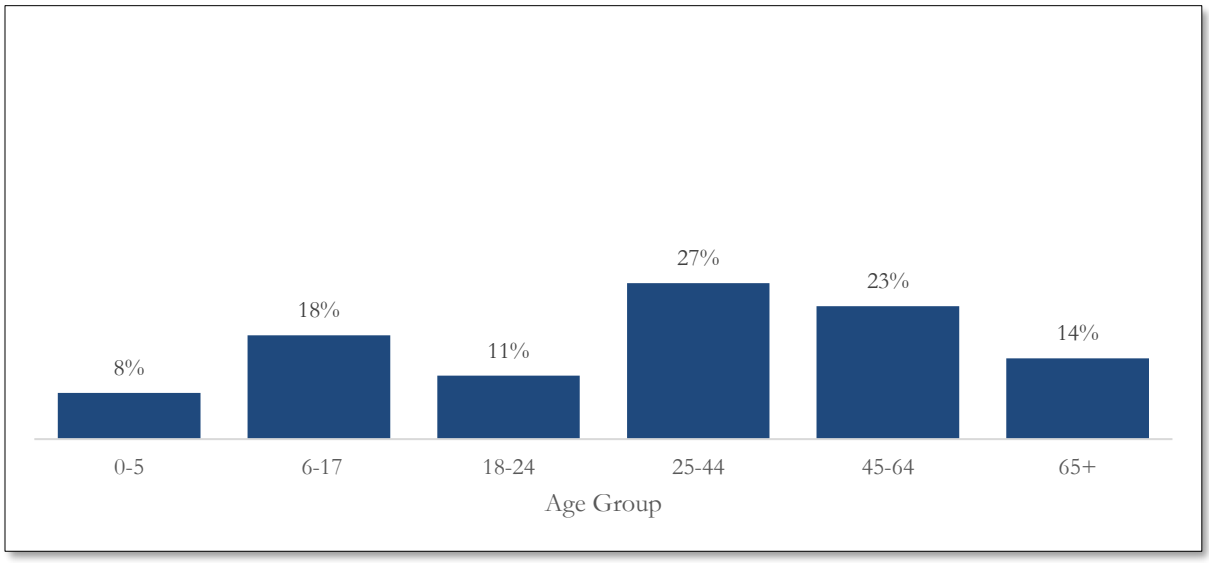
San Bernardino County Demographics

San Bernardino County had an estimated total population of 2,187,665 in 2022. The projected growth between 2022 and 2045 is 18%.

Age

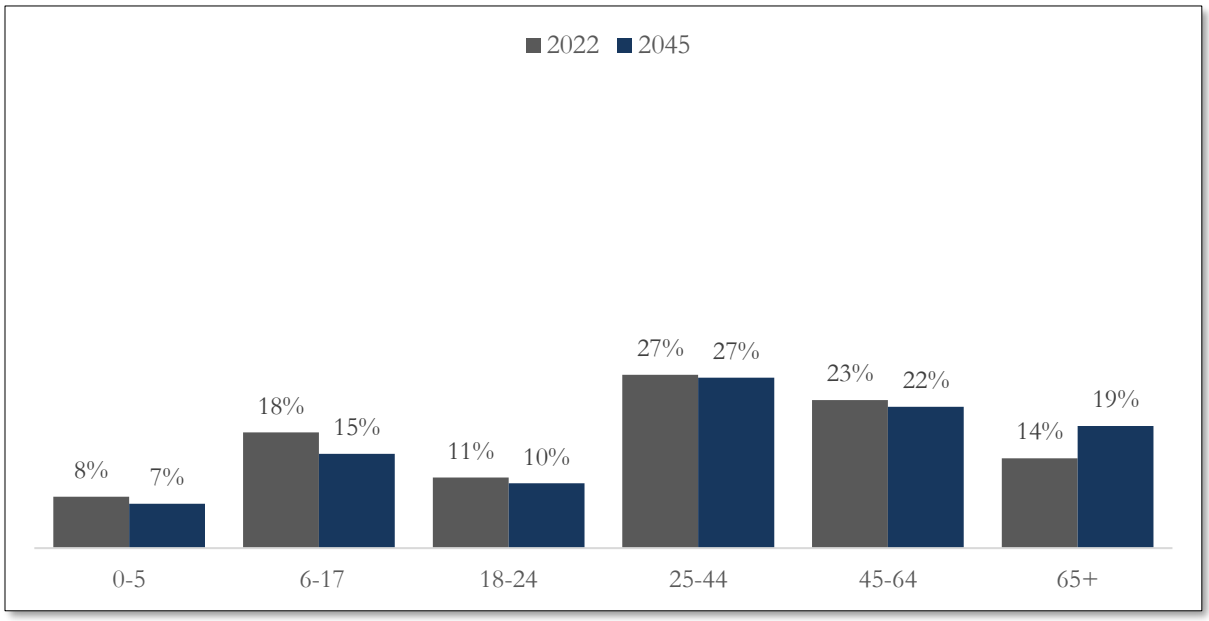
In San Bernardino County, in 2022, the largest segment of the population was adults aged 25–44, while the youngest group (0–5) made up the smallest share. Older adults aged 65 and older represented 14% of the population, as shown in Figure 1. The County's population is projected to undergo significant demographic shifts between 2022 and 2045, mainly driven by an aging population. The percentage of young children (ages 0-5) and school-aged youth (6-17) is projected to decrease from 8% to 7% and from 18% to 15%, respectively. Likewise, the share of young adults (18-24) will decline from 11% to 10%. In contrast, the proportion of older adults, particularly those aged 65 and over, is anticipated to rise sharply from 14% in 2022 to 19% by 2045. The working-age groups (25-44 and 45-64) will remain relatively stable, with only slight decreases in the 45-64 age group (Figure 2).

Figure 1: Percent of Population by Age Groups in San Bernardino County, 2022



Source: San Bernardino County Community Indicators https://indicators.sbcounty.gov/county-profile/

Figure 2: Projected Change in Age Group Proportions of the San Bernardino County Population, 2022 and 2045

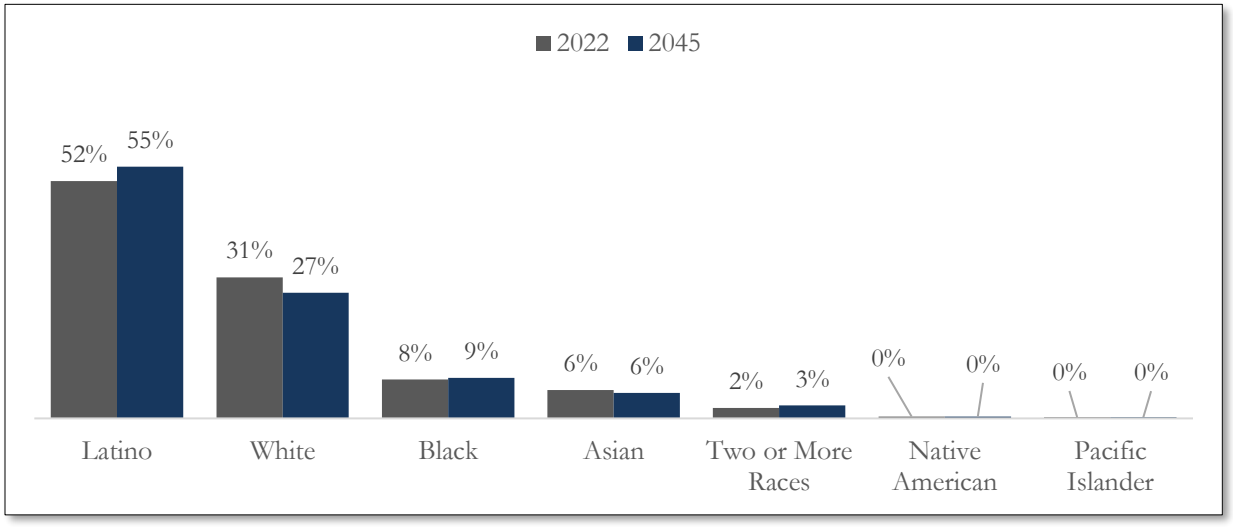


Source: San Bernardino County Community Indicators https://indicators.sbcounty.gov/county-profile/

Race/Ethnicity

The County's population is notably diverse with 52% identifying as Latino. This share is expected to grow to 55% by 2045. In contrast, the proportion of White residents is projected to decline, while the percentage of Black residents is expected to slightly increase. On the other hand, Asian, Native American, and Pacific Islander populations are projected to remain stable by 2045, as shown in Figure 3.

Figure 3: Projected Change in Racial and Ethnic Proportions of San Bernardino County Population, 2022 and 2045



Source: San Bernardino County Community Indicators https://indicators.sbcounty.gov/county-profile/

Language

According to the recent census data, nearly 44% of residents aged 5 and older speak a language other than English at home. This rate is almost equal to the state and more than double the national average of around 22%.[1] While the exact breakdown of all spoken languages is not detailed in the latest census data QuickFacts, in the 2017 American Community Survey, 33.4% spoke Spanish and 9.2% spoke other languages.

Poverty

San Bernardino County has 13.2% persons in poverty in the recent census data compared to 16.2% in 2017 ACS 1-year estimate. The U.S. Census Bureau determines poverty status by using the Official Poverty Measure (OPM) and the Supplemental Poverty Measure (SPM). In 2023, the OPM poverty threshold for a family of four (two adults and two related children under 18 years old) was $30,900.

The 2023 median household income is $82,184 compared to the state average of $96,334. The 2023 per capita income is $33,180 compared to the state average of $47,977.

Employment

The average unemployment rate in San Bernardino County in 2024 was approximately 5.1%, higher than the rate in 2019 at 3.9%. However, compared to the 13.5% rate in 2010, the county demonstrates continued economic resilience and improvement in the job market. San Bernardino County's unemployment rate was also nearly equal to the state average of 5.3%.[2]

[1] San Bernardino County Community Indicators. *County profile.* Retrieved June 26, 2025, from https://indicators.sbcounty.gov/county-profile/

[2] Bureau of Labor Statistics. (n.d.). *Local Area Unemployment Statistics: Tables and Maps*. Retrieved June 26, 2025, from https://www.bls.gov/lau/tables.htm

Individuals with Intellectual and Developmental Disabilities

The most recent census data for 2019-2023 show that in San Bernardino County, 8.3% of the population under age 65 lives with a disability, compared with the state average of 7.3%.[3]

History of Smile SBC and the Smile SBC Advisory Committee

The San Bernardino County Department of Public Health's Local Oral Health, Smile San Bernardino County (Smile SBC) program, established in January 2018, aims to work in alignment with and towards achieving the goals and objectives outlined in the California State Oral Health Plan 2018-2028. Smile SBC and local oral health programs like it across the state are funded by the California Department of Public Health, Office of Oral Health, through funds generated as a result of the passage of the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56). Smile SBC is tasked with improving oral health, especially of vulnerable and high-risk populations, through assessment, planning, health promotion and education, population-level disease control and prevention, and capacity-building. The program also focuses on coordinating countywide efforts and building partnerships to ensure county residents have equitable opportunities and resources to achieve and maintain optimal oral health.

Over its first seven years, Smile SBC and its network of partners have achieved several impactful milestones:

- **Strong Foundation**. During the first couple of years, Smile SBC established essential program infrastructure, completed the county's first-ever oral health needs assessment, and developed stakeholder-driven strategic and evaluation plans, all of which have guided the program's approach to improving oral health.
- **Network of Committed Partners**. Forty (40) leading organizations have officially pledged their commitment to the program's mission. Beyond this, nearly 150 organizations have engaged with Smile SBC and integrated oral health elements into their work. The network continues to grow each year.
- **Advisory Committee**. Smile SBC established an Advisory Committee (AC) composed of diverse stakeholders including representatives from universities and dental schools, community-based organizations, San Bernardino Department of Public Health (SBDPH) leadership, other public health and social support programs, home visiting programs, Federally Qualified Health Centers (FQHCs) and community clinics, individual dental and medical providers, mobile dental providers, school districts, hospital systems and managed care plans among several others. Since its inception, AC participation has grown from a few dozen partners to more than 100 individuals who engage in meetings and collaborative activities throughout the year. The AC meets quarterly to exchange best practices, provide strategic direction, and stay informed about program progress.
- **School Programs Work Group.** A specialized subgroup of the AC, the School Programs Work Group, meets approximately four times a year to strengthen and expand school-based oral health efforts. This group comprised largely of mobile dental providers, FQHCs, and school or district staff, works to make oral health

[3]U.S. Census Bureau. (n.d.). *QuickFacts: San Bernardino County, California; California; United States* [Data table]. Retrieved June 26, 2025, from https://www.census.gov/quickfacts/fact/table/CA,sanbernardinocountycalifornia,US/POP815223

education, assessments, and services more accessible to underserved children and families in San Bernardino County. The group also collaborates regionally with Riverside County's oral health program as a Regional Work Group. Currently, the work group is leading the creation of a Kindergarten Oral Health Assessment (KOHA) Toolkit to support school nurses and staff in implementing KOHA programs. The toolkit will include practical guidance and a video demonstration of a school-based KOHA event, showcasing how the process is simple, non-invasive, and engaging for the students.

- **Branding and Recognition**. Smile SBC's easily recognizable branding, developed with input from the Advisory Committee, combined with years of consistent engagement with local leaders, service providers, and the community, has established a strong and positive program identity. County Supervisors and other community leaders now regularly request Smile SBC by name and advocate for its inclusion in public events. The program is widely recognized for elevating the visibility and importance of oral health and has become the go-to resource for oral health education and solutions in San Bernardino County.
- **SmileSBC.org**. The program's community-built oral health website, www.SmileSBC.org, went live in April 2020 and was officially launched in September 2021. It serves as the central hub for up-to-date oral health information, downloadable resources, community partner tools, and referral materials. Partners frequently use the site to connect community members to care and oral health resources.
- **Development of Educational Materials**. Smile SBC continues to produce a wide array of educational materials to raise awareness, support community learning, and promote access to care. These include toolkits, flyers, curricula, and infographics on topics like pregnancy and oral health, smoking, nutrition, insurance enrollment, and school-based dental programs. Materials are shared at community events, in partner presentations, and through social media.
- **School Program Provider Survey**. In 2023, Smile SBC developed and launched its first comprehensive survey of school oral health programs to gather detailed information to support program planning and reporting. A slightly revised version was distributed in 2024 to collect a second year of data. All mobile dental professionals participating in school programs have consistently responded, providing valuable insights. The survey results are now used in annual progress reports and play a key role in guiding the refinement and strategic expansion of school oral health programs.
- **Expansion of School Oral Health Programs**. School-based programs have expanded significantly. During the 2023–2024 school year, 23 of the county's 32 school districts (72%) had signed Memoranda of Understanding (MOUs) for dental services—up from 59% the year prior. As a result, KOHA completion rates rose from 39% to 58% of enrolled kindergarten students, bringing the county rate higher than ever previously recorded (43% in 2013-2014) and close to California's Office of Oral Health 2027 goal of 60% (California Oral Health Plan 2018-2028). Contributing factors include: the use of the Results-Based Accountability (RBA) framework, the execution of contracts to provide stipends for KOHA performed in school settings, the purchase and distribution of mobile dental equipment for

school programs, data-driven strategies informed by the provider survey, and, most importantly, the dedication of the mobile dental providers serving school districts .

- **Little Teeth, Big Responsibility Campaign**. In collaboration with First 5 San Bernardino, Smile SBC launched the award-winning, annual *Little Teeth, Big Responsibility* campaign, which promotes early childhood oral health and the importance of establishing a dental home early in life. The campaign received national recognition with a National Association of Counties (NACo) Achievement Award in 2023.
- **Oral Health Integration**. Numerous local agencies and collaboratives have integrated oral health objectives in their planning efforts and/or infused oral health education, tools, and referral resources in the work they do with the community. Some of these include: Maternal Health Network, Whole Child Collaborative, High Desert Wellness Network, San Bernardino County Nutrition Action Partnership, Inland Empire Health Plan (IEHP) Community Resource Centers, Black Infant Health, Arrowhead Regional Medical Center Mobile Medical Units, CA Home Visiting Program, Preschool Services Department, Department of Children's Support Services, California Association of Health and Education Linked Professions, Rx4Kids Foster Home Visiting, Childhood Lead Poisoning Prevention, Rainbow Pride Youth Alliance, and California Children's Services.
- **Sustainability**. Smile SBC is committed to building long-term sustainability by connecting event organizers with local dental professionals who can continue serving communities beyond individual outreach events. These efforts have grown significantly; in the second half of 2024, 64% of more than 9,000 community encounters were conducted by Smile SBC partners, with Smile SBC providing educational materials and support as needed. Sustainability will continue to be an important aspect of future planning.

Best Practices in Community Oral Health

Effective community oral health initiatives adopt a "whole-system approach", addressing upstream determinants of disease and ensuring equitable access to prevention and care. The following evidence-based strategies illustrate how local policies and programs can build on the best practices in dental public health:

1. **School-Based Dental Programs.** Delivering preventive services directly in schools removes transportation and scheduling barriers for families. Programs offering periodic oral health screenings, fluoride varnish applications, and dental sealant placement on-site have demonstrated significant reductions in caries incidence among elementary-aged children. A 2016 review by the Community Preventive Services Task Force found that school-based sealant programs reduce tooth decay by an average of 88% in permanent molars of participating children and adolescents.
2. **Early Dental Visits and Prenatal Oral Health.** Initiating dental care by a child's first birthday—and incorporating oral health assessments and education into prenatal care—lays the foundation for lifelong healthy practices. The American Academy of Pediatric Dentistry recommends the "Age One" dental visit, which

facilitates timely risk assessment, anticipatory guidance, and early intervention for high-risk infants. Integrating oral health into prenatal programs has been shown to improve maternal periodontal health outcomes and reduce adverse birth outcomes associated with poor oral health.

3. **Fluoride Varnish and Dental Sealants.** Topical fluoride varnish, applied two to four times per year, can reduce early childhood caries by approximately 50%. Sealant placements on first and second permanent molars yield up to an 88% reduction in decay over a two-year period. These interventions are cost-effective and can be administered by trained allied health personnel in non-dental settings, such as Women, Infants, and Children (WIC) clinics and preschools.
4. **Bringing Services to the Community.** Embedding preventive services within existing community-based programs—such as WIC, Head Start, First 5, faith-based organizations, and senior centers—leverages trusted community touchpoints. Mobile dental vans and portable equipment expand reach into remote or underserved neighborhoods, overcoming geographic and socioeconomic barriers.
5. **Systematic Care Coordination and Linkage to Services.** Utilizing care coordinators and peer educators helps families navigate complex eligibility requirements and insurance networks. Community Dental Health Coordinators (CDHCs), as defined by the American Dental Association, serve as liaisons between clinical providers and community members—scheduling appointments, arranging transportation, and providing culturally tailored health education.
6. **Integration of Primary Care and Dental Services.** Co-located or integrated oral health within medical settings—pediatric well-child visits and OB/GYN clinics—enables early screening and application of fluoride varnish by medical staff, along with seamless referral to dental providers. The Centers for Medicare & Medicaid Services has promoted Oral Health in Primary Care settings as a best practice to expand preventive care for Medicaid-eligible children.
7. **Community Health Centers Providing Comprehensive Care.** FQHCs and Rural Health Clinics offering both medical and dental services address the needs of low-income, uninsured, and migrant worker populations. These centers often employ sliding-scale fees and outreach programs, ensuring continuity of care for hard-to-reach groups.
8. **Community and Individual Health Education.** Sustained public education campaigns—focusing on the importance of twice-daily brushing, tobacco cessation, and limiting sugar-sweetened beverage consumption—reinforce clinical interventions. Tailoring messages to local cultural contexts and languages maximizes engagement and behavior change.

By leveraging these evidence-based approaches and tailoring them to the specific demographics and needs of San Bernardino County, community stakeholders and partnerships can strengthen prevention efforts, enhance access to care, and ultimately improve oral health outcomes across the community (see Appendix A for a list of best practice resources).

Methodology

Data Collection and Analysis Framework and Process

This needs assessment was structured around the American Association of State and Territorial Dental Directors (ASTDD) Seven-Step Model for Oral Health Needs Assessment, ensuring a systematic and comprehensive examination of oral health in San Bernardino County. The work unfolded in five interconnected phases:

1. Secondary Data Review
   The process began with the assembly and analysis of existing, publicly available data to establish baseline oral health indicators and to identify information gaps. Key sources included:
   - California Health Interview Survey (CHIS)
   - California Oral Health Report (COHR)
   - Department of Health Care Services (DHCS)
   - Maternal and Infant Health Assessment (MIHA) Survey
   - Office of Statewide Health Planning and Development (OSHPD) (now California Health Care Access and Information, HCAI)
   - San Bernardino County Dental Provider Data (2023)

2. Gap Analysis & Priority Setting
   Using secondary data, a gap analysis was conducted to pinpoint areas where surveillance or research was insufficient. These priorities guided the design of primary data collection instruments and informed the selection of key informants and focus-group participants.

3. Primary Data Collection
   To capture local perspectives and lived experiences, two complementary approaches were implemented:
   - Key Informant Interviews: Semi-structured interviews with health administrators, program directors, community leaders, and subject-matter experts.
   - Community Focus Groups: Facilitated discussions with residents from diverse geographic and demographic subgroups, including rural, mountain, and high-desert communities, both in-person and virtually.

   A full list of interviewees and focus-group sites is provided in Appendix B.

4. Qualitative Analysis
   All interviews and focus-group sessions were audio-recorded, transcribed verbatim, and coded in the qualitative and mixed-methods data analysis software, NVivo. A combined content and thematic analysis approach was applied—iteratively developing a codebook, coding transcripts, and synthesizing emergent themes to shape the findings.

5. Environmental Scan & Strengths, Weaknesses, Opportunities, Threats (SWOT) Analysis
   An interactive workshop with the Advisory Committee—and input from the Smile SBC Core Team—served to:
   - Conduct an environmental scan of local policies, programs, and resources
   - Develop a SWOT analysis

This collaborative exercise validated insights from both secondary and primary data and directly informed the strategic recommendations presented in this report.

Role of the Advisory Committee

The Smile SBC Advisory Committee has been instrumental in guiding the process of the Oral Health Needs Assessment, as well as the implementation of the previous plan through the following roles:

- Development and modification of the Smile SBC Vision and Goals
- Support Needs Assessment and ongoing planning/program development efforts by sharing expertise, data (as needed and available) and building partnerships
- Provide feedback and input regarding the overall issues to be addressed and populations to be served by Smile SBC and its partners
- Participate in the implementation of program strategies and activities, including providing information and education to staff, members and clients related to oral health efforts
- Endorse efforts by sharing information through various communication outlets
- Support and participate in collaborative efforts

Advisory Committee members have contributed to the needs assessment process by:

- Reviewing and giving feedback on the goals and overall plan for data collection and needs assessment
- Identifying priority populations
- Identifying Key Informant Interviewees (KIIs) and Focus Groups
- Participating as KIIs or community liaison for Focus Groups when applicable
- Contributing to a SWOT analysis

Priority Population for the Needs Assessment

Below is the list of the priority population that the Smile SBC Advisory Committee identified for this needs assessment:

- Children Ages 0-5
- School-aged Children
- Pregnant Individuals
- Individuals enrolled in Medi-Cal
- Rural and Tribal Communities
- Spanish-Speaking and/or Immigrant Communities
- Special Healthcare Needs
- Homeless Individuals
- Foster Youth
- Justice-Involved Youth
- Older Adults (Ages 65+)

Oral Health Status

This section examines available data on the status of oral health in San Bernardino County, drawing on Kindergarten Oral Health Assessment data, Basic Screening Survey results for Kindergarten and Third Grade students, and findings on the condition of adult teeth and tooth loss among county residents.

Kindergarten Oral Health Assessment

In 2005, the California legislature passed the Kindergarten Oral Health Assessment (KOHA) Requirement. This law was enacted to help schools identify kindergarten children with untreated tooth decay and assist parents/caregivers with establishing dental care for their children.[4] Every public school district is required to enter KOHA data into the state's System for California Oral Health Reporting (SCOHR) each year. This data includes the number of students who were assessed, the number of families who opted out of the requirement, and the number of assessed students with caries experience and urgent dental needs.

The data uploaded into SCOHR only reflects what was reported. They should not be used to draw meaningful conclusions about the oral health status of all kindergarten students in the county. For the 2023-2024 school year, KOHA data entered into SCOHR revealed that caries experience rates varied widely by school district. Needles Unified (88%) and Upland Unified (63%) reported the highest rates of caries experience among kindergarteners.

Although the majority of school districts entered KOHA data into SCOHR during the 2023-2024 school year, more than one-quarter (28%) entered no data. The school districts that did not enter data in SCOHR were Alta Loma Elementary, Barstow Unified, Helendale Elementary, Mt. Baldy Joint Elementary, Oro Grande Elementary, Redlands Unified, San Bernardino County Office of Education, Trona Joint Unified, and Yucaipa-Calimesa Joint Unified. To have a more complete picture of KOHA assessment rates at the county level, all school districts should collect KOHA assessments (as required by legislative mandate) and enter the data into SCOHR. The lack of data entry among these school districts presents an opportunity for the Smile SBC program to connect with these districts and identify ways that could help them enter data.

Basic Screening Survey Results: Students in Kindergarten and Third Grade

During the 2018-2019 school year, the San Bernardino County Local Oral Health Program (LOHP) conducted the Smile Survey that included a representative sample of kindergarten and third-grade students in San Bernardino County public schools.[5] All public schools with kindergarten and third-grade enrollments during the 2017-2018 school year were included in the sampling frame.

[4] The KOHA requirement also applies to first-grade students who had not previously enrolled in kindergarten in a public school.

[5] The California Department of Public Health will conduct an update of the Smile Survey in the 2025-2026 school year.

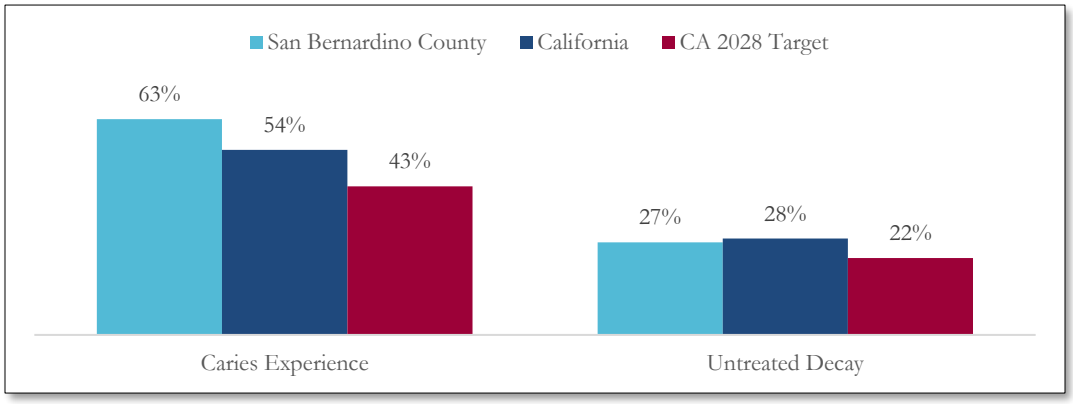
The final sample included 21 participating schools out of the 36 invited schools, representing a 58% response rate at the school level. Overall, 2,773 students were screened, a 36% response rate at the student level. The sample included 1,306 third-grade students, 1,341 kindergarten students, and 123 students with missing information on grades. The average age of the sample was 6.8 years. The age of kindergarten children ranged from four to six years (mean = 5.4 years). Third-grade children were between the ages of seven and ten years (mean = 8.4 years). This section elevates some of the key findings from the survey results.

Kindergarten Students

The prevalence of caries experience among kindergarten students in San Bernardino County was 63% (Figure 4). This suggests that about 2 out of 3 kindergarten students in San Bernardino County have had tooth decay. The share of kindergarten students with caries experience is higher than the statewide rate (63% compared to 54%), and much higher than the California 2028 Target Goal of 43%. This finding emphasizes the need for San Bernardino County and California to consider strengthening efforts aimed at reducing the incidence of dental caries among kindergarten students. As for untreated tooth decay, the rates were similar in both the County and California – at 27% and 28%, respectively. While these rates are lower than the caries experience rates, they are still higher than the California 2028 Target Goal of 22%.

A student whose screening reveals an urgent dental need requires dental care within 24 to 48 hours due to signs or symptoms that include pain, infection or swelling. The survey data showed that of the kindergarten students screened, 5% had an urgent dental need requiring treatment.

Figure 4: Percentage of Kindergarten Children with Caries Experience and Untreated Tooth Decay in San Bernardino County 2018-19



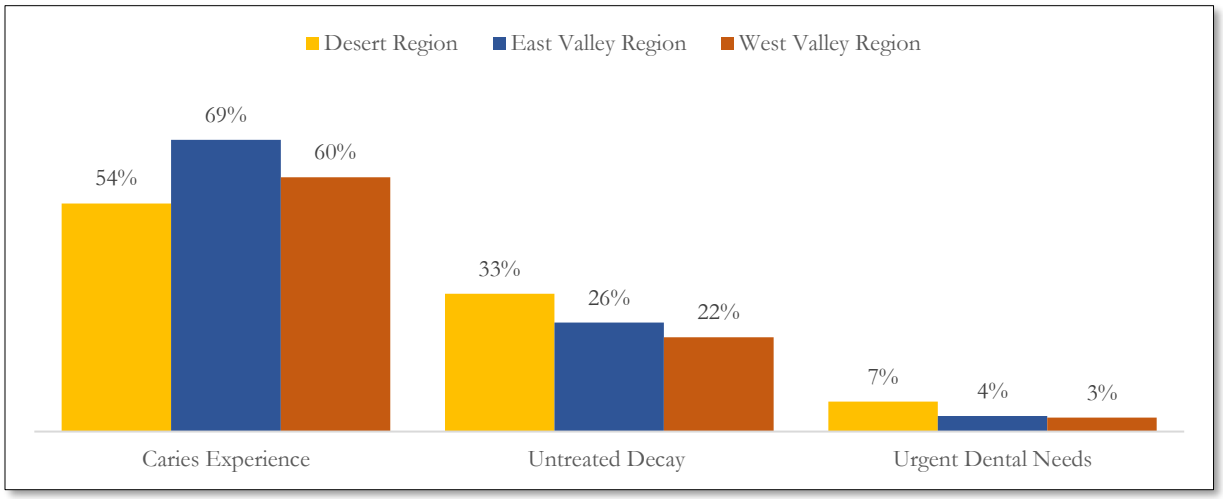
Source: San Bernardino County Basic Screening Survey (BSS) 2018-2019 Data

There was no difference in caries experience between male and female kindergarten students, with 63% of male and female kindergarten students having experienced tooth decay at the time of the screening (Figure 5). Female students had a higher prevalence of untreated tooth decay than their male peers (29% vs 24%, respectively). However, this difference was not found to be statistically significant at P>0.05. Similar to caries

experience, the prevalence of urgent dental needs among kindergarten students was essentially the same for male and female students, at 4% and 5%, respectively.

The screening results revealed differences in caries experience and tooth decay experience among kindergarten students by geographical region (Figure 5). Kindergarten children from the East Valley region had the highest prevalence of caries experience (69%) compared to the West Valley (60%) and Desert (54%) regions.[6] However, the Desert region had the highest prevalence of untreated decay, with 33% of kindergarten children having untreated decay compared to 26% in the East Valley region and 22% in the West Valley region. The Desert region also had the highest rate of urgent dental needs among the East Valley and West Valley regions.

Figure 5: Percentage of Kindergarten Children with Caries Experience, Untreated Tooth Decay, and Urgent Dental Needs in San Bernardino County 2018-19, by Geographical Region



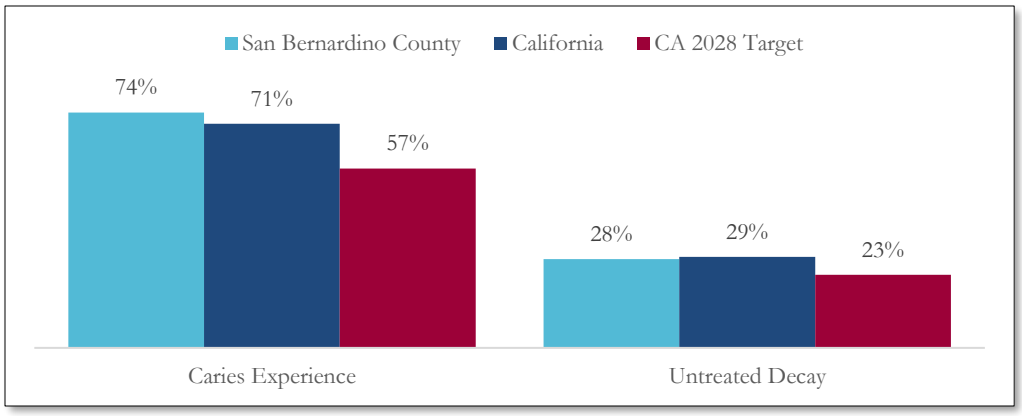
Source: San Bernardino County Basic Screening Survey (BSS) 2018-2019 Data

Third Grade Students

Among third graders, the prevalence of caries experience was 74%, or three out of four third graders in San Bernardino had had tooth decay, slightly higher than the statewide rate (Figure 6). Both San Bernardino County and California rates exceed the California 2028 target goal of 57%. In terms of untreated tooth decay, third-grade and kindergarten students had similar rates. Less than one-third (28%) of third graders had untreated decay at the time of screening.

Figure 6: Percentage of Third Grade Children with Caries Experience and Untreated Tooth Decay in San Bernardino County 2018-19

[6] See Appendix C for a list of cities/ communities by geographic region. The East Valley region includes cities such as Big Bear, San Bernardino, and Yucaipa. The West Valley region includes cities such as Alta Loma, Fontana, and Ontario. The High Desert region includes cities such as Apple Valley, Barstow, and Lucerne Valley.



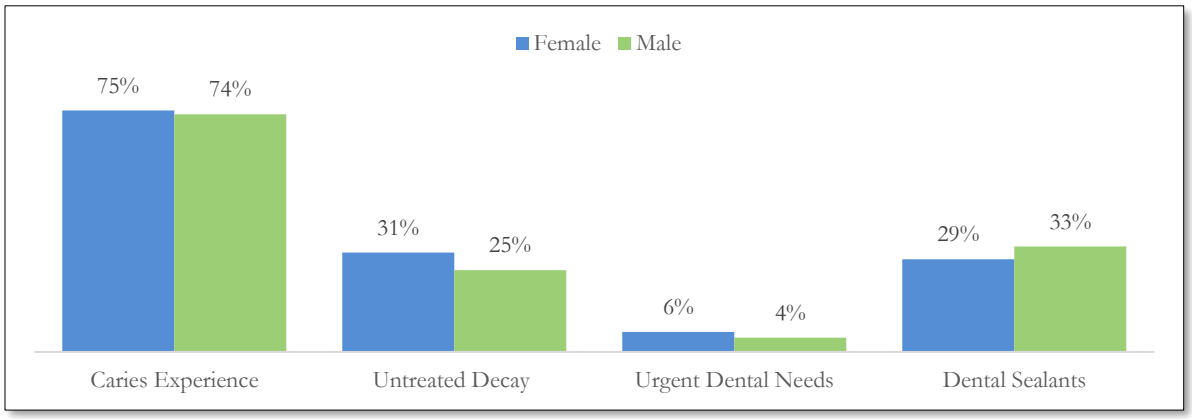
Source: San Bernardino County Basic Screening Survey (BSS) 2018-2019 Data

Although the prevalence of caries experience was similar for male and female students, there were differences in untreated tooth decay and the urgency of dental needs by sex. Figure 7 shows that female students were more likely than their male peers to have untreated tooth decay. They were also slightly more likely than male students to have an urgent dental need at the time of screening.

Dental sealants are thin plastic coatings applied to the chewing surfaces of the back teeth by trained dental professionals. Health care providers recommend that dental sealants be placed on permanent molars as soon as they come in (first molars at 5-7 years and second molars at 11-14 years) as the placement of sealants reduces the risk of tooth decay by 80% (National Center for Chronic Disease Prevention and Health Promotion; CDC Division of Oral Health). School-age children (ages 6-11) without sealants have almost 3 times as many first-molar cavities as those with sealants.

The screening results also showed a difference in dental sealant placement by sex. Even though females had a higher prevalence of urgent tooth decay, they were less likely than their male peers to have a dental sealant on at least one permanent molar (29% and 33%, respectively).

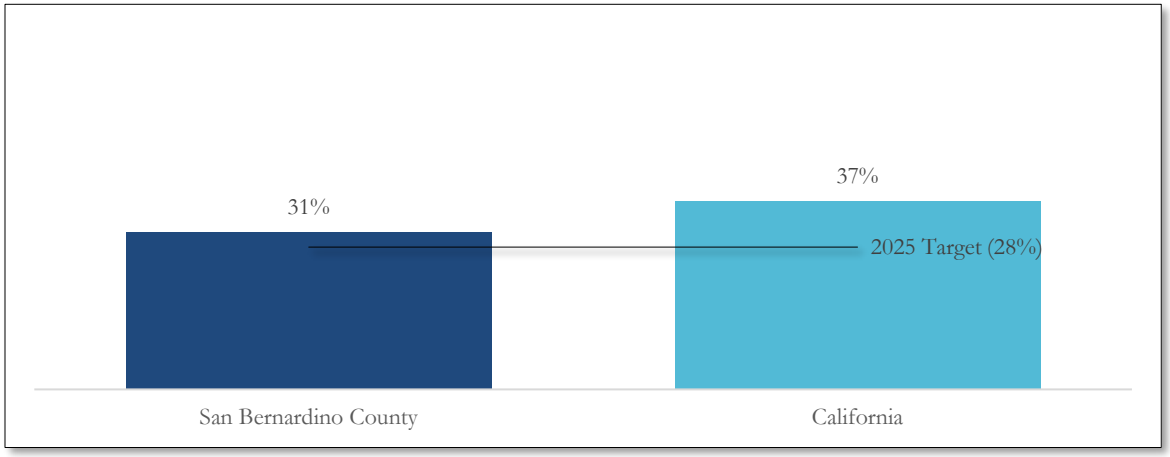
Figure 7: Percentage of Third Grade Children with Tooth Decay, Urgent Dental Needs, and Dental Sealants in San Bernardino County 2018-19, by Sex



Source: San Bernardino County Basic Screening Survey (BSS) 2018-2019 Data

The prevalence of dental sealants among third graders in San Bernardino County is lower than that of their peers across California. Less than one-third (31%) of third graders in the county had dental sealants, compared to 37% of third graders in California (Figure 8). Both the county and the state have met the 2025 California target of 28%.

Figure 8: Percentage of Third Grades with Dental Sealants in San Bernardino County and California 2018-19

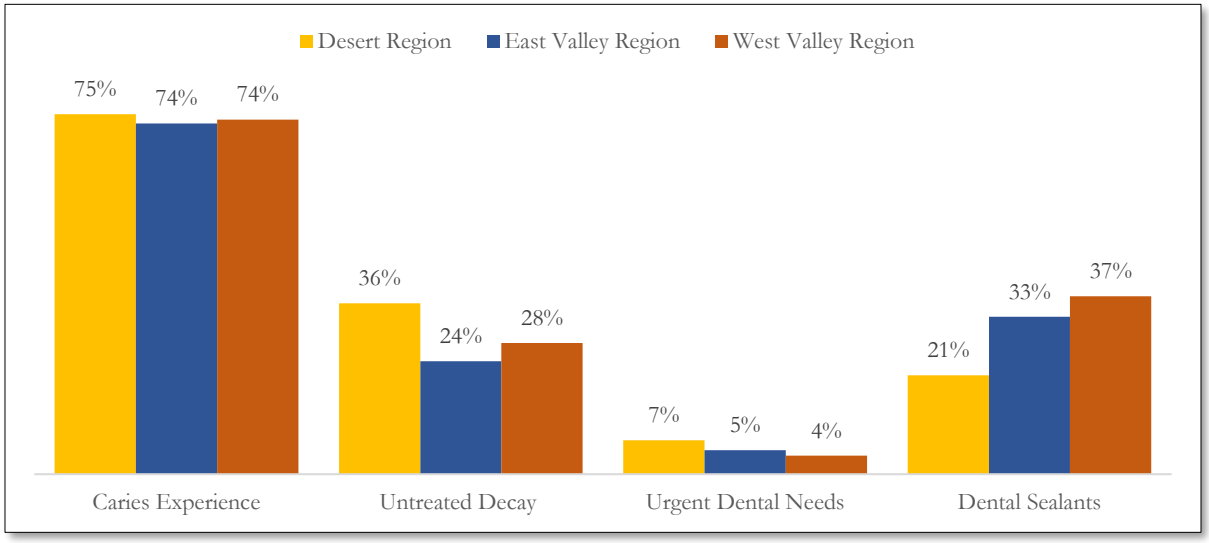


Source: San Bernardino County Basic Screening Survey (BSS) 2018-2019 Data; California 2019 3rd Grade Smile Survey

Screening results showed no differences in caries experience across county regions, with 75% of third graders in the Desert region, 74% in the East Valley, and 74% in the West Valley having had tooth decay. However, there were differences when looking at untreated decay and urgent dental needs by county region (Figure 9). Third-grade students in the Desert region had a higher prevalence of untreated tooth decay (36%) than third graders in the West Valley (28%) and East Valley (24%) regions. Similar to the trends observed for kindergarten students, third graders from the Desert region were slightly more likely than their peers in the East Valley and West Valley to have an urgent dental need.

Analysis showed differences in sealant use across regions, with the Desert region having the lowest sealant use in the County despite having the highest rate of untreated decay and urgent dental needs when compared to the East Valley and West Valley. About 21% of third graders in the Desert had a sealant on at least one molar compared to 33% in the East Valley and 37% in the West Valley.

Figure 9: Percentage of Third Grade Children with Tooth Decay, Urgent Dental Needs, and Dental Sealants in San Bernardino County 2018-19, by Geographical Region



Source: San Bernardino County Basic Screening Survey (BSS) 2018-2019 Data

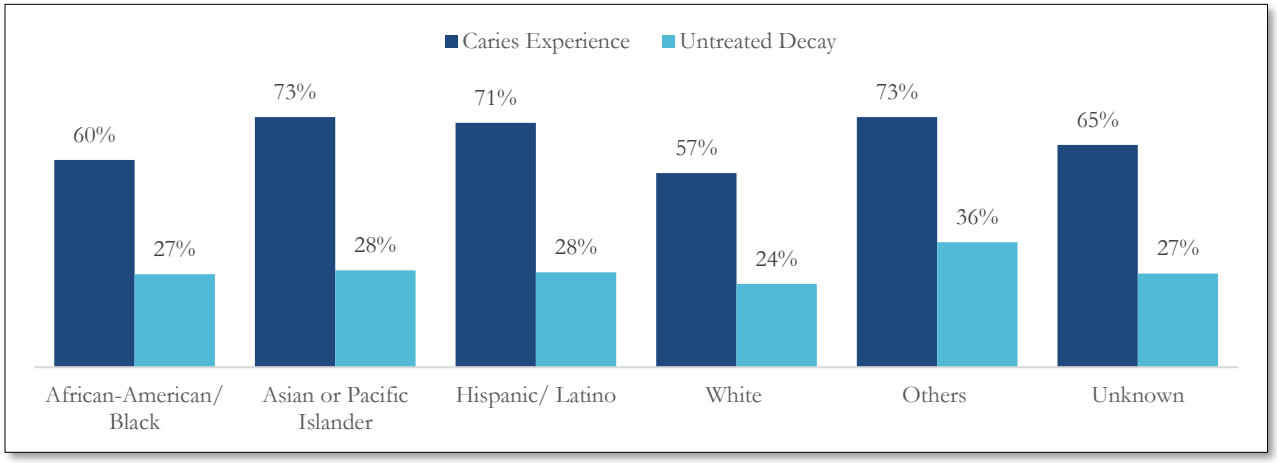
Race/Ethnicity (Kindergarten and Third Grade)

Analysis of caries experience and untreated decay revealed disparities by race/ethnicity (Figure 10).[7] Due to small cell frequencies in some categories of race/ethnicity, data for kindergarten and third-grade students were combined. Thus, the results should be interpreted with caution.

Caries experience was found to be higher among non-White ethnicities, 71% of Hispanic/ Latino(a) students, 60% of Black/African American students, 73% of Asian/Pacific Islander students, and 73% of students of other race/ethnicity have had tooth decay compared to 57% of White students. The results also showed that fewer White students had untreated tooth decay compared to all other categories of race/ethnicity. About 24% of White students were found to have untreated tooth decay compared to 28% of Hispanic/Latino(a) students, 27% of Black/African American students, 28% of Asian/Pacific Islander students, and 36% of students of other race/ethnicity.

[7] Race/ethnicity categories were combined for small groups, the final categories in the analysis were Hispanic/Latino(a), White, Black/African-American, Asian and Pacific Islander, others (including American Indian/Alaskan Native, Multiple races and others) and unknown.

Figure 10: Percentage of Kindergarten and Third Grade Students with Caries Experience and Untreated Tooth Decay in San Bernardino County 2018-19, by Race/Ethnicity



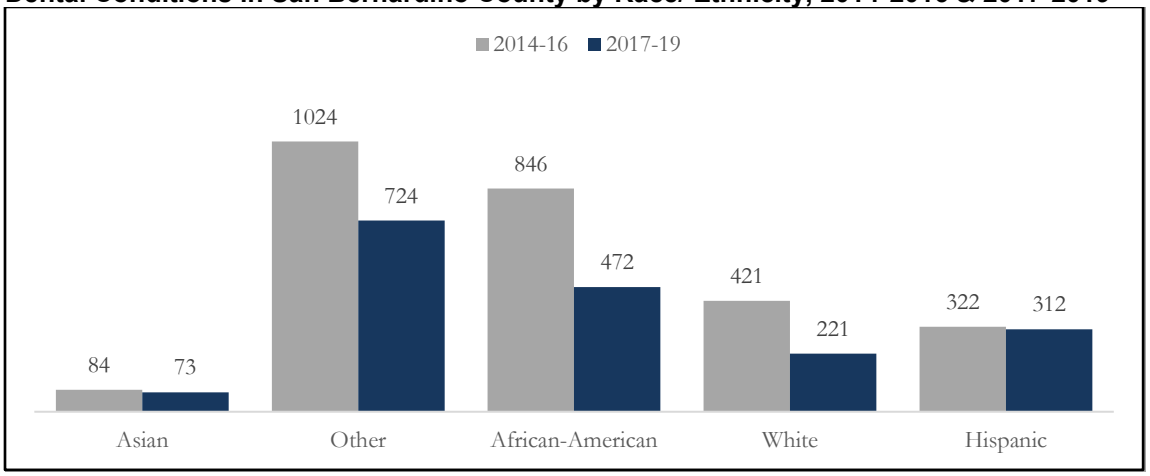
Source: San Bernardino County Basic Screening Survey (BSS) 2018-19 Data

Additional indicators

Trends in Emergency Department Visits for Non-Traumatic Dental Conditions

Poor access to preventive and routine dental care can result in years of oral neglect, leading to emergency department (ED) visits for non-traumatic dental conditions (NTDCs). Although the ED is not equipped to treat NTDCs, individuals without a dental home may resort to seeking care there. Analysis of data on ED visits for NTDCs per 100,000 revealed disparities by race/ethnicity in San Bernardino County. African Americans had the highest rates for both the 2014-2016 and 2017-2019 time periods (Figure 11). In stark contrast, Asian residents visit the ED for NTDCs at a much lower rate than all other race/ ethnic groups. Latinos/Hispanics also had high rates of seeking care for NTDCs at ED. Between 2014-2016 and 2017-2019, white residents had the biggest decrease (48%) in ED visits for NTDCs across all race/ethnicity groups.

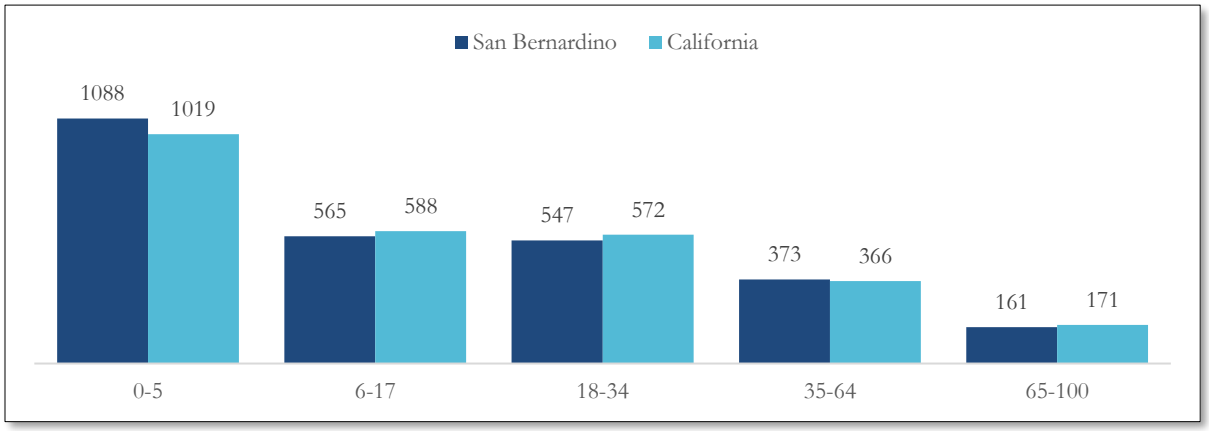
Figure 11: Number of Emergency Department Visits per 100,000 population for Non-traumatic Dental Conditions in San Bernardino County by Race/ Ethnicity, 2014-2016 & 2017-2019



Source: Office of Statewide Health Planning and Development. 2012-2016 Emergency Department Data.

The 2017-2019 rates of NTDCs by age group reveal comparable rates for the county and the state, with some differences (Figure 12). Children ages 0 to 5 in the county were more likely to seek care for a NTDC compared to their peers statewide. In contrast, children aged 6 to 17 and adults aged 18 to 34 in the county were slightly less likely to visit the emergency department for treatment of an NTDC compared to those in the state overall.

Figure 12: Number of Emergency Department Visits per 100,000 population for Non-traumatic Dental Conditions in San Bernardino County and California by Age Group, 2017-2019

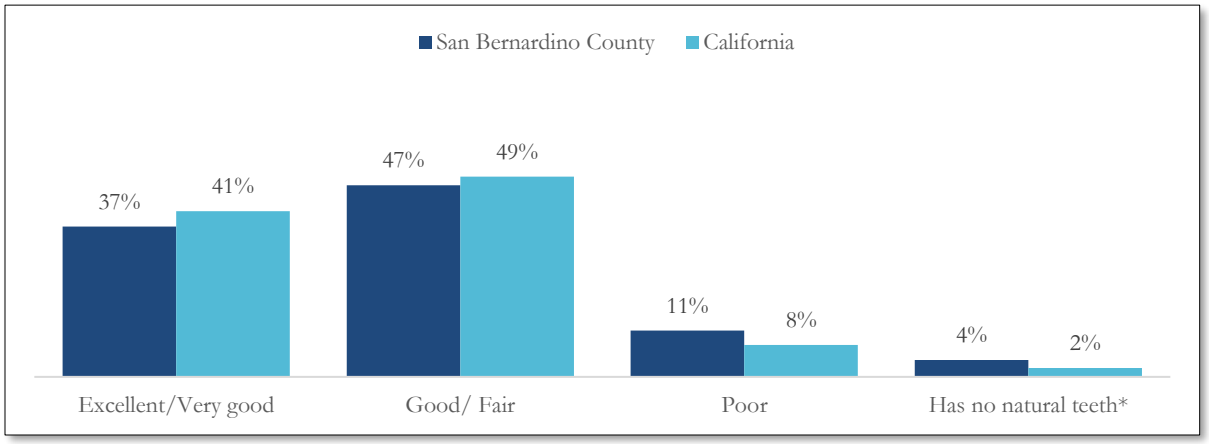


Source: Office of Statewide Health Planning and Development. 2012-2016 Emergency Department Data.

Condition of Adult Teeth

The annual California Health Interview Survey (CHIS) asks respondents about the condition of their teeth. Data from the 2022 CHIS – the latest year for which data is available – shows that more than one-third (37%) of adults ages 18 and over in San Bernardino County reported that the overall condition of their teeth was Excellent or Very Good (Figure 13). When compared to statewide trends, San Bernardino County adults were less likely than adults statewide to report that their teeth were in Excellent or Very Good condition (37% versus 41%) and slightly more likely to report that their teeth condition was poor (11% versus 8%).

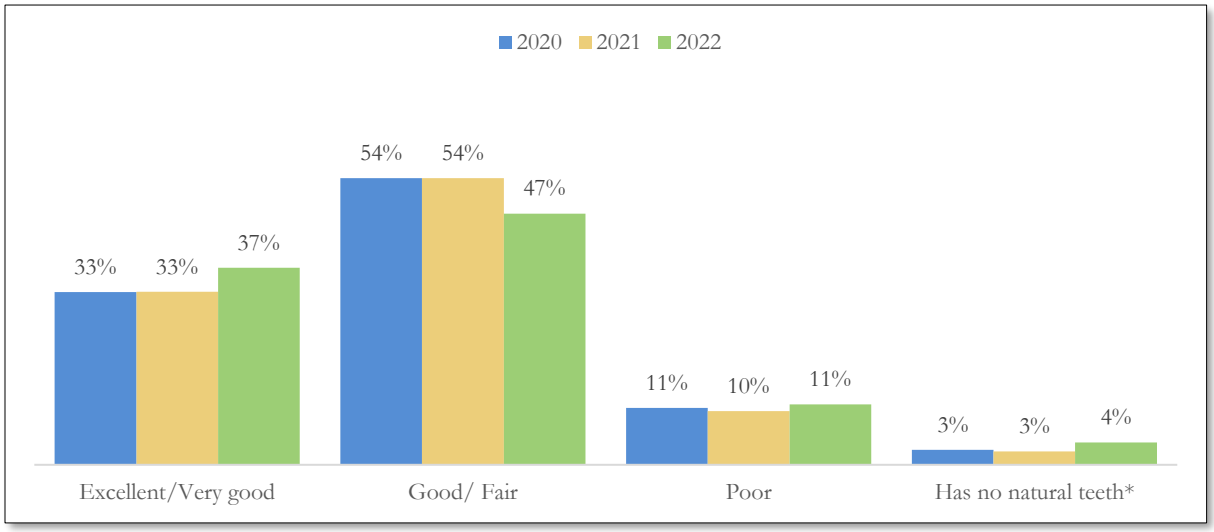
Figure 13: Overall Condition of Teeth for Adults in San Bernardino County and California, 2022



Source: California Health Interview Survey (self-reported data)

Overall, the rates of surveyed adults in San Bernardino County who reported having "no natural teeth" or in "poor" teeth condition have remained relatively unchanged from 2020 through 2022. However, between 2021 and 2022, the share of adults reporting their teeth as "excellent" or "very good" increased from 33% to 37%. During the same period, there was a decrease in the rate of adults stating their teeth were in "good" or "fair" condition (54% to 47%, respectively).

Figure 14: Change in Overall Condition of Teeth for Adults in San Bernardino County, 2020-2022



Source: California Health Interview Survey (self-reported data)

Rate of Complete Tooth Loss Among Older Adults

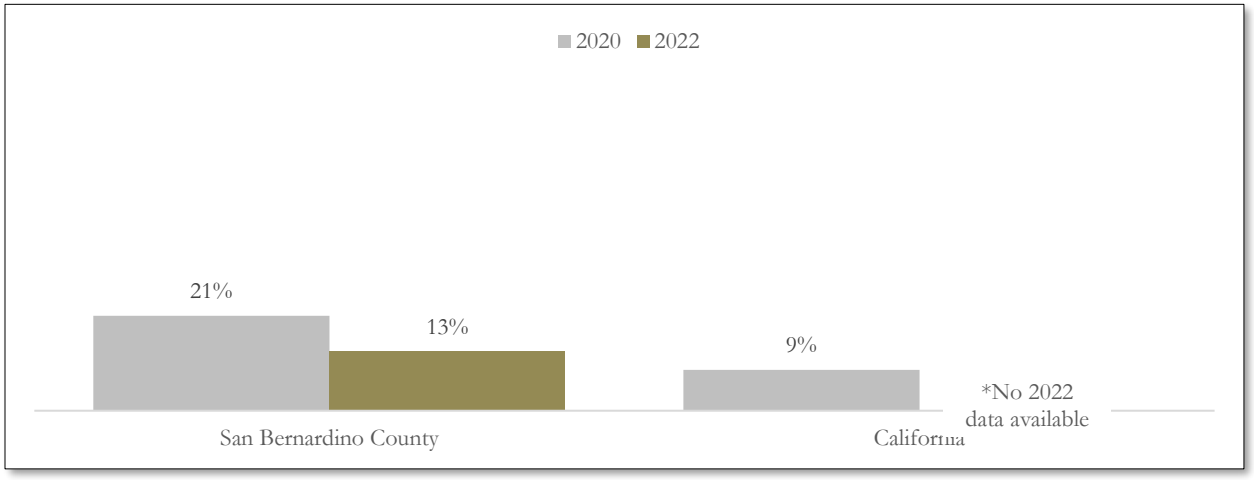
Total tooth loss can lead to a decline in overall health due to poor nutritional intake, low self-esteem, and other factors. According to the CDC, the total tooth loss has decreased among adults aged 65 and over in the United States. Between 1999 and 2004, more than a quarter (27%) of adults aged 65 or older had lost all their teeth. Between 2011 and 2016, 17% of older adults (65+) had lost all their teeth. This is a decrease of more than 30% between the two time periods.[8] [9]

Analysis of the CDC's Behavioral Risk Factor Surveillance System (BRFSS) data shows that the age-adjusted prevalence of adults aged 65 and older who had lost all their teeth in San Bernardino County was 12.4% in 2022, nearly equal to the national average of 12.6% for the same year. At the time this report was written, the BRFSS had not published the 2022 data for this measure in California. The prevalence in San Bernardino County has notably decreased compared to the 2020 rate of 20.9%, which was remarkably higher than the California average of 9.4% that year.

[8] Centers for Disease Control and Prevention. (2024, May 15). *Total tooth loss decreased in adults aged 65 or older* [Infographic]. National Center for Chronic Disease Prevention and Health Promotion, Division of Oral Health. https://www.cdc.gov/oral-health/php/infographics/total-tooth-loss-decreased-adults-65-older.html

[9] Fleming, E., Afful, J., & Griffin, S. O. (2020, June). *Prevalence of tooth loss among older adults: United States, 2015–2018* (NCHS Data Brief No. 368). National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db368.htm

Figure 15: Older Adults (Aged 65+) with Total Tooth Loss in San Bernardino County, 2020 and 2022



Source: Centers for Disease Prevention and Control, Behavioral Risk Factor Surveillance System

Dental Service Utilization

This section examines four core measures of dental service utilization in San Bernardino County: annual dental visits, preventive services for children ages 0–5, sealant application in children ages 6–9 among Medi-Cal recipients, and dental visits during pregnancy. Tracking preventive and routine care indicators in priority populations helps evaluate the effectiveness of early disease detection and prevention, thereby reducing the need for more complex and costly treatments in the future.

Annual Dental Visits Among Medi-Cal Recipients

This subsection presents an overview of the prevalence of annual dental visits and preventive dental visits among Medi-Cal dental recipients. An annual dental visit is counted each calendar year when an individual receives any qualifying dental care service, including most diagnostic services such as x-rays, as well as preventive, treatment, and surgical services. Receiving dental services at a safety net clinic, which typically serves underserved or vulnerable populations, is also included in this category.

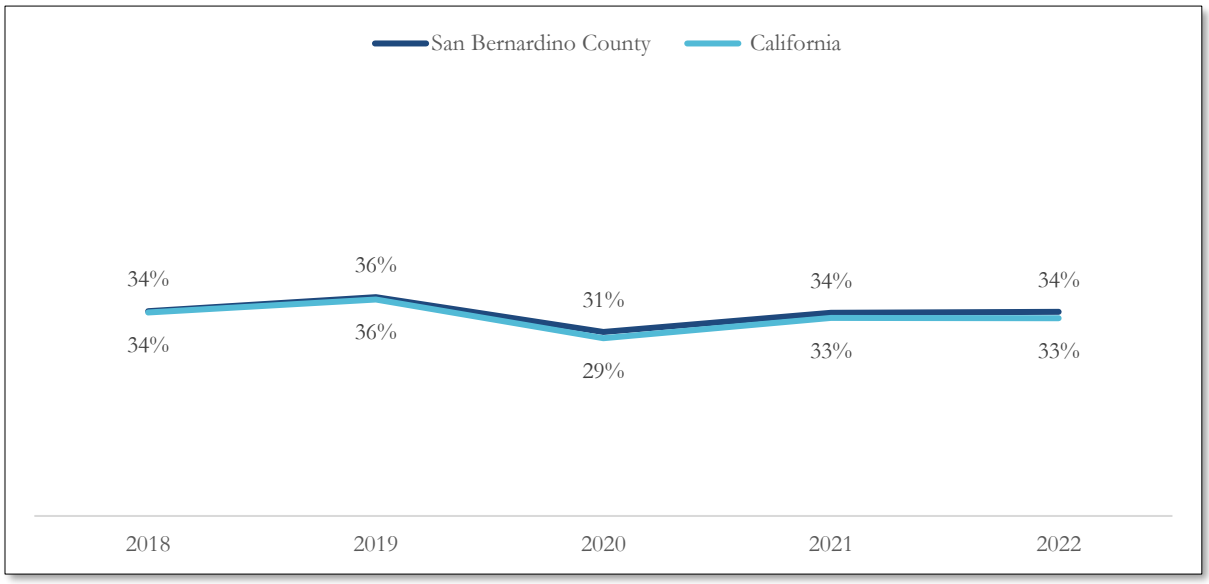
A preventive dental visit is counted each calendar year when an individual receives a service focused on preventing oral health problems, such as cleanings, sealants, and fluoride treatments, or qualifying preventive encounters at safety net clinics.

It is important to note that beginning in 2019, CPT code 99188 was added to both the annual dental visit and preventive dental visit categories. This billing code captures fluoride varnish applications provided by medical professionals. Its inclusion provides a more comprehensive measure of access to and utilization of preventive dental care services within the Medi-Cal population.

Annual Dental Visits

The utilization rates of annual dental visits among Medi-Cal recipients in San Bernardino County and California follow similar trends (Figure 16). Between 2018 and 2022, rates have fluctuated slightly but mostly remained the same. While there was a slight increase from 2018 to 2019, the rate declined the subsequent year, which was more pronounced in California as a whole. This decline can be explained by the onset of the COVID-19 pandemic in early 2020, which forced dental offices to make considerable changes to program operations, such as suspending routine services at least initially, and individuals being less willing to visit public spaces, particularly clinic settings, at that time. In 2021, the rates increased in the County and California, reverting to the pre-COVID level of 2018.

Figure 16: Utilization of Annual Dental Visit by Medi-Cal Recipients in San Bernardino County and California, 2018-2022

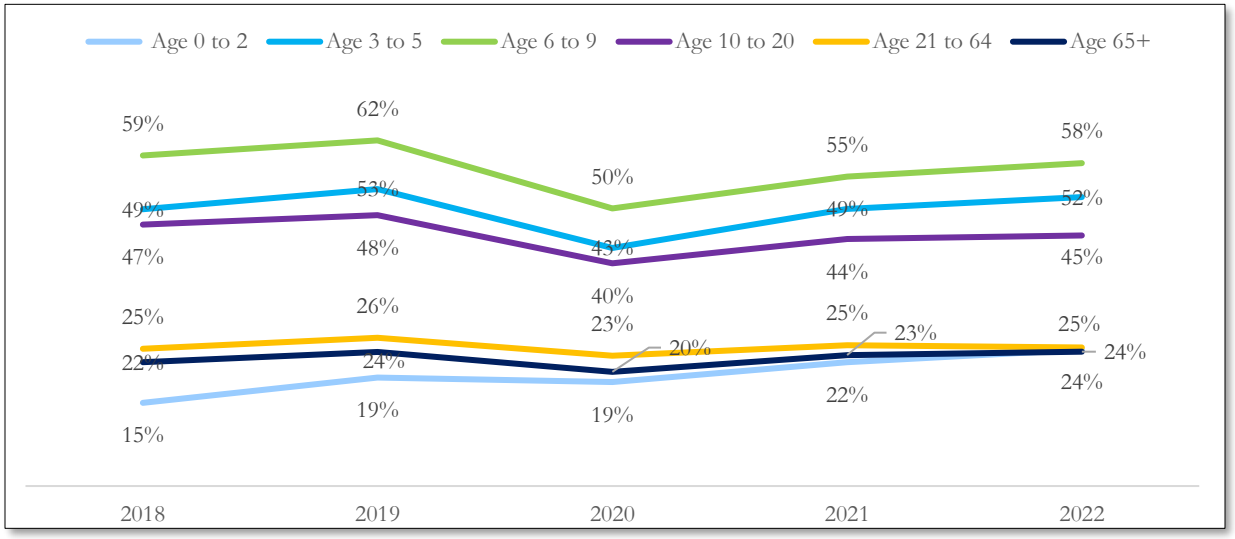


Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal

Taking a closer look at the data by age group and year reveals that between 2018 and 2019, the utilization rates of annual dental visits among San Bernardino County Medi-Cal recipients increased across all age groups, with the largest increases among children ages 0 to 2 and 3 to 5 (Figure 17). Between 2019 and 2020, nearly all groups saw a decrease in their rates, with the steepest decrease for children ages 6 to 9. This decrease coincides with the COVID-19 pandemic. In the same period, children ages 0 to 2 were the only age group whose rates remained the same.

Since 2020, the utilization rates of annual dental visits among Medi-Cal enrollees have increased for all age groups to pre-pandemic levels. From 2020 through 2022, the rates for adults 21 to 64 and older adults 65 have increased more modestly than other age groups. The youngest Medi-Cal recipients (ages 0 to 2) are the only group whose utilization of annual dental visits has surpassed their pre-pandemic levels.

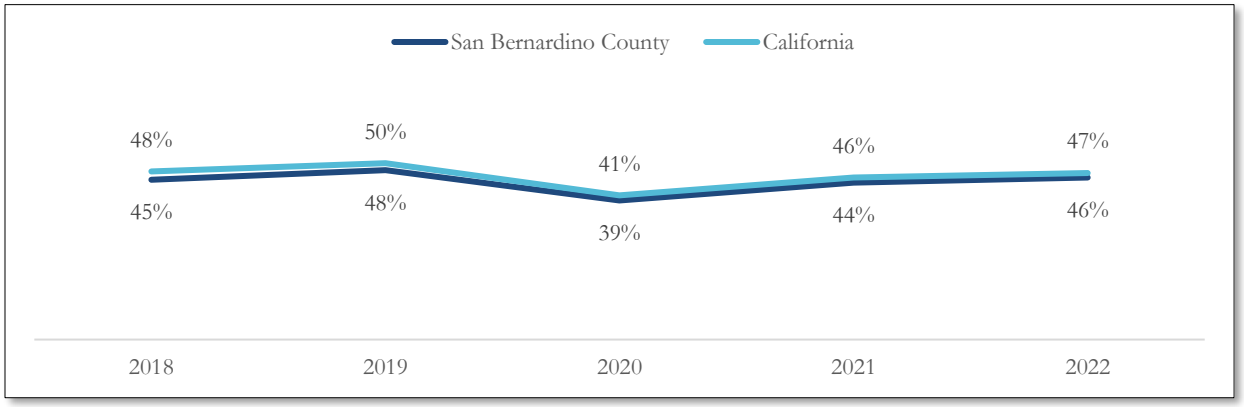
Figure 17: Utilization of Annual Dental Visit by Medi-Cal Recipients in San Bernardino County, by Age Group, 2018-2022



Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal

Combining the above data for children ages 0 to 20 show s that the utilization rates of annual dental visits for children 0 to 20 in San Bernardino County have consistently hovered below statewide utilization rates (Figure 18). However, the difference between San Bernardino and California rates has narrowed since 2018.

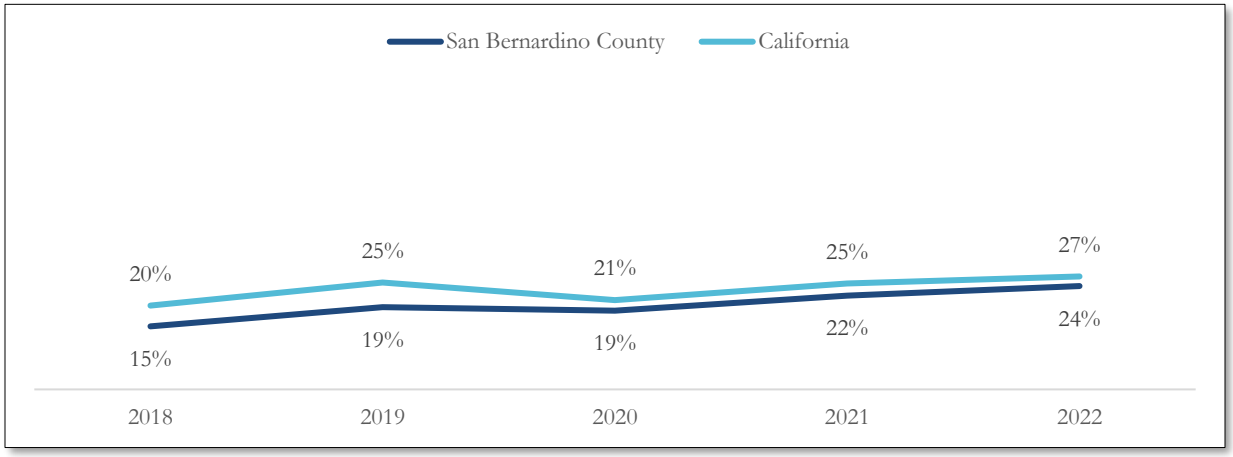
Figure 18: Utilization of Annual Dental Visit by Medi-Cal Children Ages 0-20 in San Bernardino County and California, 2018-2022



Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal

Comparing utilization rates for children ages 0 to 2 in the county with those in the state reveals that the county rates have consistently been lower than the statewide rates (Figure 19). The overall utilization rates for this age group have increased steadily between 2018 and 2022, except between 2019 and 2020, when the statewide rates decreased due to the pandemic – but remained unchanged in San Bernardino. By 2022, both San Bernardino County and California utilization rates had surpassed pre-pandemic levels.

Figure 19: Utilization of Annual Dental Visit by Children Ages 0-2 on Medi-Cal in San Bernardino County and California, 2018-2022



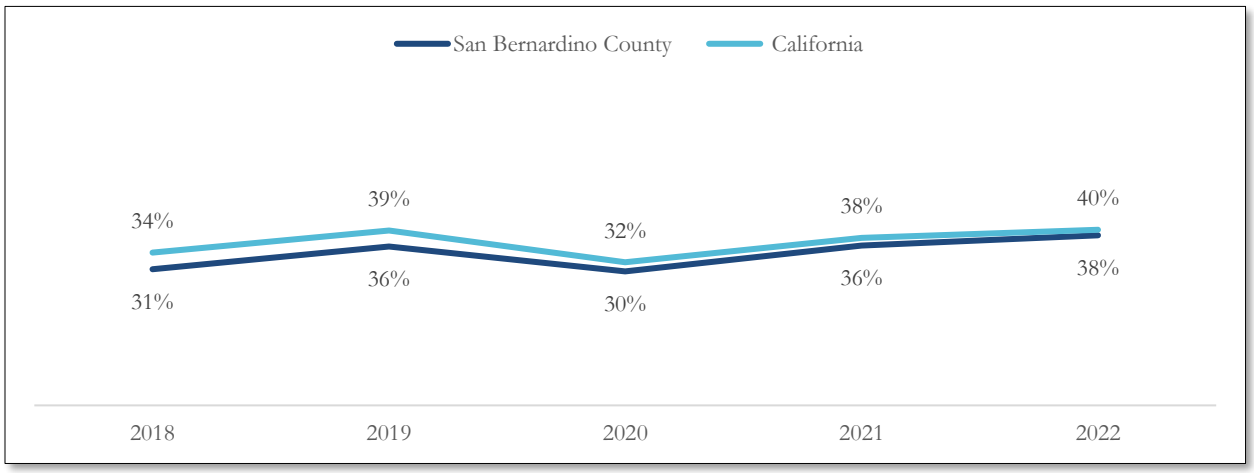
Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal

Preventive Dental Services – Children Ages 0 to 5

As mentioned above, a preventive dental visit is counted each calendar year when an individual receives a service focused on preventing oral health problems, such as cleanings, sealants, and fluoride treatments, or qualifying preventive encounters at safety net clinics.

Utilization rates of preventive services among children ages 0 to 5 in San Bernardino County are similar to statewide rates. Not only have rates increased steadily between 2018 and 2022 in the County and California – except from 2019 to 2020, but they have surpassed rates from 2018.

Figure 20: Utilization of Preventive Services by Medi-Cal Recipients Ages 0 to 5 in San Bernardino County and California, 2018-2022

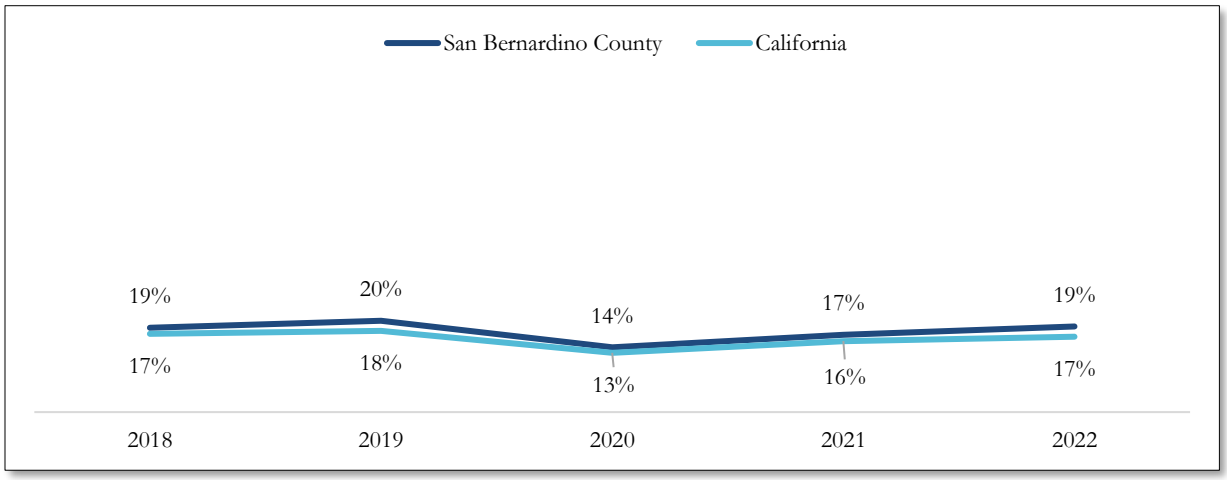


Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal

Dental Sealants – Children Ages 6 to 9

Dental sealant utilization rates among children ages 6-9 enrolled in Medi-Cal have remained essentially unchanged in San Bernardino County and California. While rates decreased between 2019 and 2020 due to the onset of the pandemic, they have increased modestly but remain persistently low. Based on 2022 rates, roughly one out of five children ages 6 to 9 had received dental sealants in San Bernardino County, slightly higher than the statewide rate (19% versus 17%).

Figure 21: Utilization of Dental Sealants by Children Ages 6 to 9 on Medi-Cal in San Bernardino County and California, 2018-2022



Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal

Dental Visits during Pregnancy

During pregnancy, numerous physical and nutritional changes occur that can adversely impact oral health and well-being. Gum inflammation due to hormonal changes (also known as pregnancy gingivitis) is one of the most common effects of pregnancy on oral health. Another common effect is tooth decay due to food cravings and frequent snacking. Furthermore, untreated oral diseases can negatively impact a pregnancy. Research studies have shown that pregnant people with periodontal disease (severe gum inflammation) have a higher risk than those without it of developing gestational diabetes, preeclampsia, and delivering preterm.[10]

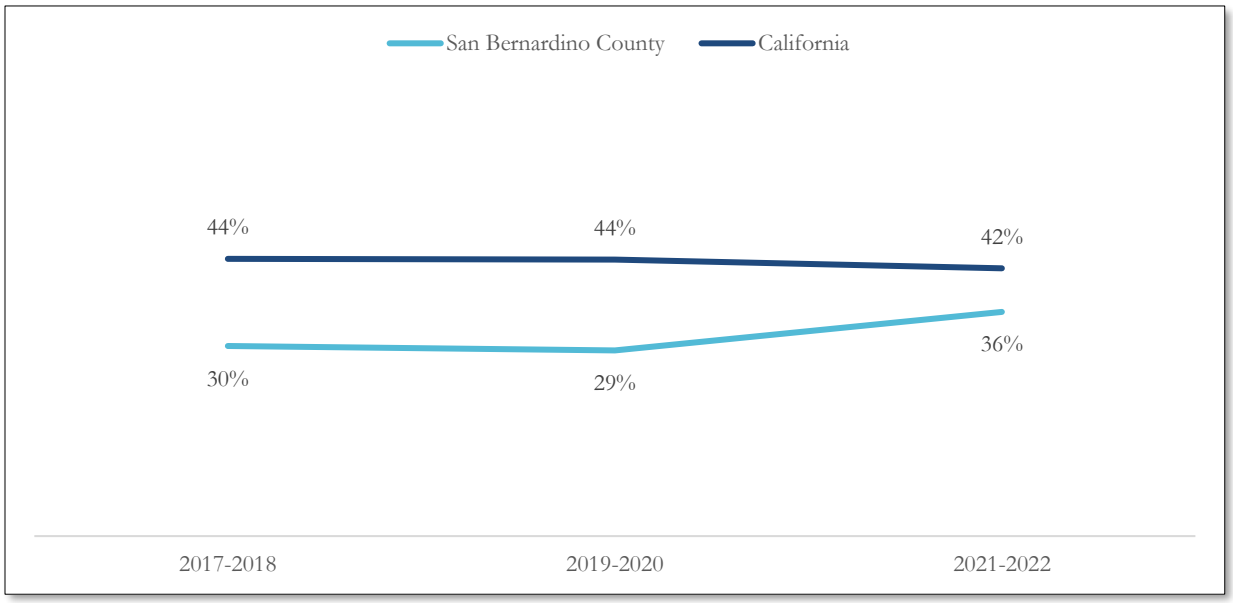
Therefore, it is essential that pregnant people maintain good oral hygiene and receive regular dental cleanings throughout pregnancy. However, most pregnant individuals do not see the dentist for various reasons – some of which include access barriers (e.g., difficulties finding dentists who accept Medi-Cal) and misconceptions about the safety of receiving oral care while pregnant. While it is completely safe and recommended to receive dental care during pregnancy, the misconception on safety can have detrimental impacts on the oral health of the mother and the child, and overall health and birth

[10] FDI World Dental Federation. (2024, August). *Oral health and pregnancy fact sheet* [Fact sheet]. Retrieved June 26, 2025.

outcomes. This section analyzes self-reported data on oral health status of pregnant people from the 2017-2018, 2019-2020, and 2021-2022 California Maternal & Infant Health Assessment (MIHA).[11]

Overall, less than half of pregnant people in San Bernardino County and California reported seeing a dentist during their pregnancy (Figure 22). Pregnant women in San Bernardino County visited the dentist at lower rates than women statewide, but the difference is narrowing. While rates increased for pregnant women in San Bernardino by 7% between 2019-2020 and 2021-2022, they decreased slightly statewide from 44% to 42% in the same time period.

Figure 22: Percentage of Women with a Recent Live Birth Who Visited the Dentist During Pregnancy, by Year, 2017-2022

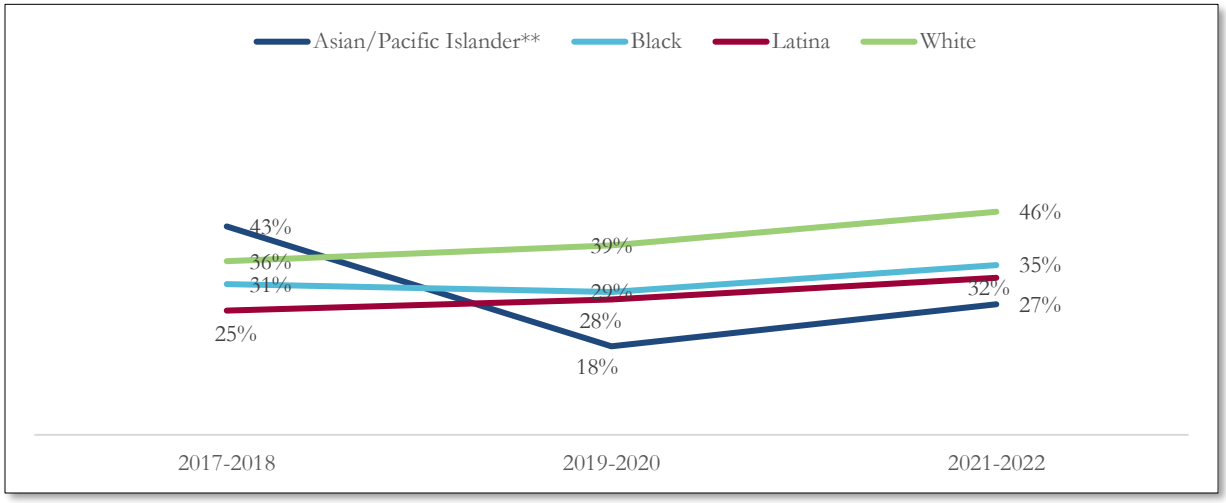


Source: Maternal and Infant Health Assessment (MIHA) Survey (self-reported data)

Disaggregating the data by race and ethnicity illustrates persistent disparities. Pregnant individuals who self-identify as white had the highest rates of visiting the dentist during pregnancy of all race/ ethnic groups, at 46%. The rates were the lowest for Latino and Black people compared to their white counterparts. In the 2021-2022 data, one-third of Latino/a (32%) and over one-third (35%) of Black individuals with a recent live birth saw the dentist during their pregnancy. While the Asian/Pacific Islander group experienced a steep decline between 2017 and 2020 and had the lowest rate in 2021-2022 among all groups, their estimates had low statistical reliability and should be interpreted with caution.

[11] The MIHA is a statewide survey administered annually to California residents with a recent live birth that asks about their maternal experience, attitudes and behaviors, before, during, and after pregnancy. In 2012, the MIHA added items concerning dental care during pregnancy.

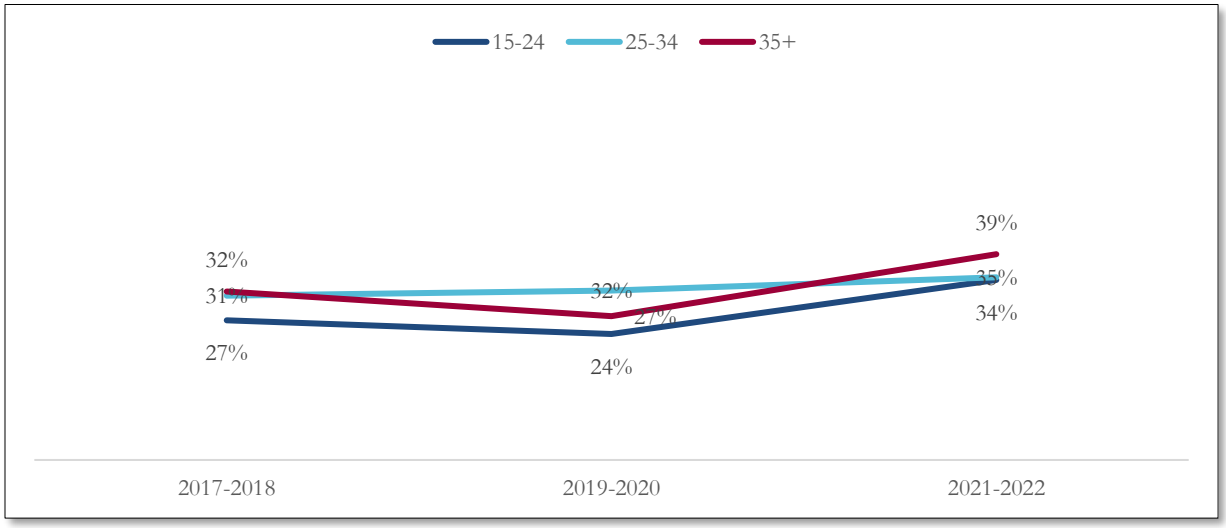
Figure 23: Percentage of Women with a Recent Live Birth who Visited the Dentist During Pregnancy in San Bernardino County, by Race/ Ethnicity, 2017-2022**



Source: Maternal and Infant Health Assessment (MIHA) Survey (self-reported data)
**The estimates for Asian/Pacific Islanders should be interpreted with caution due to low statistical reliability.

In 2021-2022, the oldest pregnant individuals (aged 35 and above) had the highest rates of visiting the dentist during pregnancy compared to the younger age groups. While the rates of 25 to 34-year-olds increased slightly between 2019-2020 and 2021-2022, rates for the youngest and oldest age groups saw steep increases during the same period.

Figure 24: Percentage of Women with a Recent Live Birth who Visited the Dentist During Pregnancy in San Bernardino County, by Age Group, 2017-2022

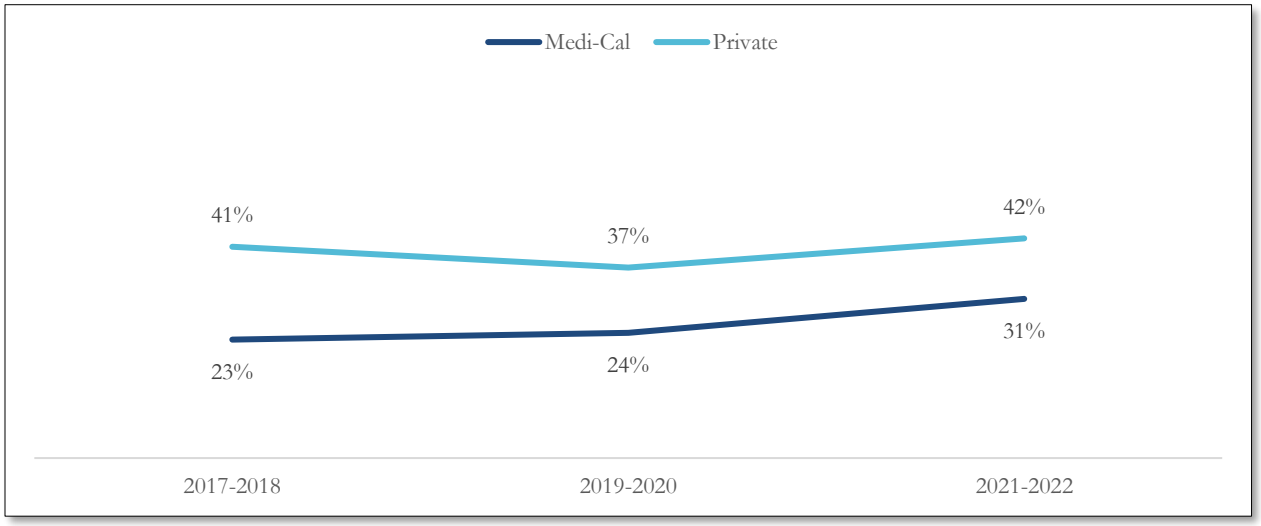


Source: Maternal and Infant Health Assessment (MIHA) Survey (self-reported data)

When looking at the data by insurance type, pregnant people enrolled in Medi-Cal are consistently much less likely to have visited the dentist while pregnant compared to individuals with private insurance (Figure 25). However, time trends suggest that the gap between the two groups is narrowing. While the 2021-2022 rates for privately insured

pregnant people are the same as the 2017-2018 rates, the rates for pregnant people enrolled in Medi-Cal increased by 8% over the same period.

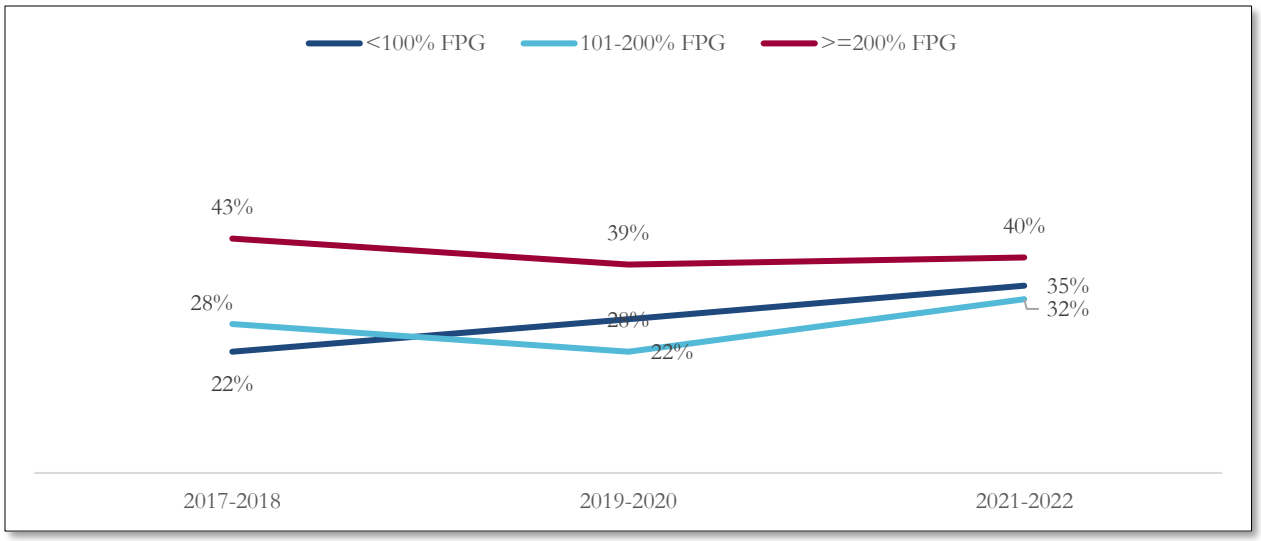
Figure 25: Percentage of Women with a Recent Live Birth who Visited the Dentist During Pregnancy in San Bernardino County, by Insurance Type, 2017-2022



Source: Maternal and Infant Health Assessment (MIHA) Survey (self-reported data)

In San Bernardino County, pregnant people with the highest income (>=200% FPG) were more likely to have seen the dentist during pregnancy compared to people with lower incomes (Figure 26). However, the difference in rates across income groups was not as stark in 2021-2022 as it was in 2017-2018. The rates for individuals in the lowest income group (<100% FPG) have increased steadily from 2017 through 2022.

Figure 26: Percentage of Women with a Recent Live Birth who Visited the Dentist During Pregnancy in San Bernardino County, by Federal Poverty Guideline Level, 2017-2022



Source: Maternal and Infant Health Assessment (MIHA) Survey (self-reported data)

Access to Dental Services

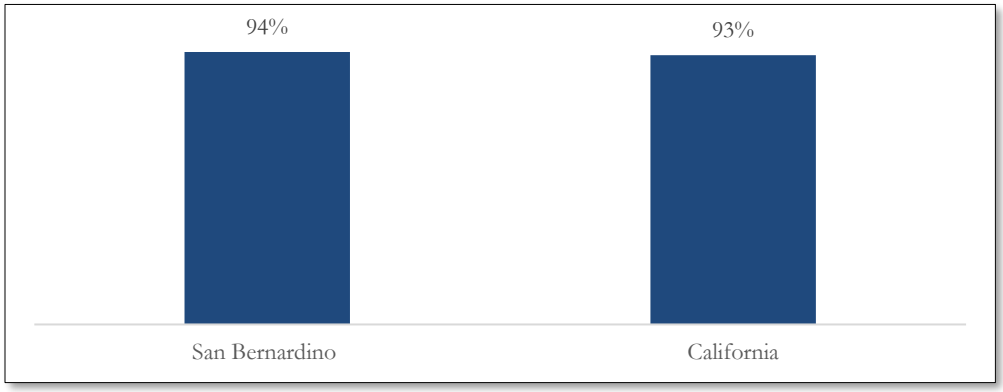
Access to dental care is an essential foundation for maintaining healthy communities. Although dental insurance coverage and the geographic distribution of providers—including those accepting Medi-Cal – capture only part of the access picture, they offer essential insights into key barriers to care. Where data allow, these measures are further disaggregated by region and socio-demographic group to reveal deeper patterns of inequity. That said, having dental insurance does not guarantee that someone will use it, due to various factors (e.g., access issues, cost).

Dental Insurance Coverage

Dental insurance plays an important role in promoting oral health by improving access to dental care. Having dental insurance does not equate to access to care or utilization of services. Nevertheless, by reducing financial barriers, insurance coverage can encourage individuals to receive regular check-ups, early interventions, and necessary treatments, all of which help prevent the development of serious oral health concerns.

The CHIS survey asks parents/ caregivers whether they have any insurance that pays for all or part of their children's dental care. Combined CHIS data for years 2021 through 2023 show that most (94%) children aged 3 to 11 in San Bernardino County had dental insurance coverage. This rate is similar to the statewide share of children with dental insurance coverage, at 93%, for the same time period.

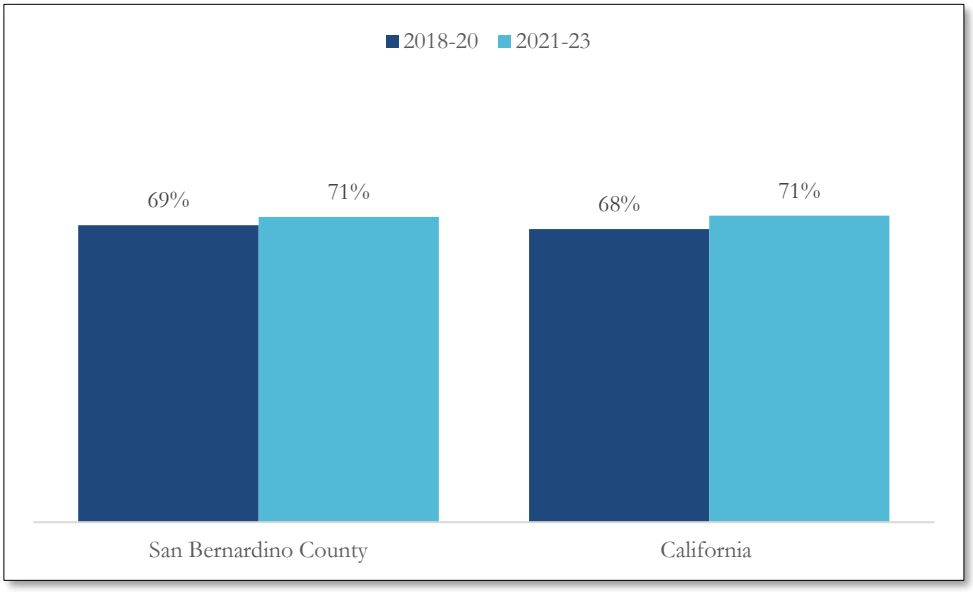
Figure 27: Dental Insurance Coverage for Children in San Bernardino County and California, 2021-2023



Source: California Health Interview Survey (self-reported data)

Analysis of dental insurance coverage among adults shows comparable rates for San Bernardino County and California. Between 2018-20 and 2021-23, there was a slight increase in the share of adults who reported having dental insurance coverage for the county (from 69% to 71%) and the state (from 68% to 71%). Although the share of adults with dental insurance has increased, they are less likely than children aged 3 to 11 to report having some dental insurance coverage.

Figure 28: Dental Insurance Coverage for Adults in San Bernardino County and California, 2021-2023



Source: California Health Interview Survey (self-reported data)

Dental Providers Distribution and Dentist to Population Ratios

This section examines the distribution of all dentists in San Bernardino County using license renewal data, including those who accept Medi-Cal and those who do not. The following section focuses specifically on Medi-Cal dental providers. As this is the first dataset received from HCAi, points of comparison are limited; however, it establishes a baseline for future evaluation of the county's dental workforce.

In San Bernardino County, the population-to-dentist ratio for 2024 is 2,214,281:1,480, meaning there is one dentist for almost 1,500 people in San Bernardino County. In contrast, for the Medi-Cal population, this ratio for Medi-Call enrollees to Medi-Cal dental providers is 856,910:475. The ratio of Medi-Cal dentists to all dentists in the County is 475:1,480, meaning only 3 out of 10 providers accept Medi-Cal. Although this rate is still low, it is an improvement over findings in the previous needs assessment, when only 1 in 10 providers accepted Medi-Cal (ADA 2016). When this ratio is broken down by specialty, only 10% (1 out of 10 specialists) accept Medi-Cal. It is also essential to note that many of these dentists do not see Medi-Cal patients full-time. Geographically, there are significant disparities in the availability of dentists in areas of the county with known access barriers. Dentist-to-population ratios are highest in the southwestern valley, while High Desert areas, including those across the eastern Morongo Basin, fall below 16 per 100,000, resulting in long travel times and disrupted care. Medi-Cal safety-net clinics are scarce in remote regions like Lucerne Valley and Needles, despite high poverty rates. Countywide, pediatric dentists, endodontists, and oral surgeons remain in very short supply.

San Bernardino County's dental workforce in 2024 exhibits significant geographic and demographic variation, with 1,480 dentists distributed unevenly across the county's

regions and ZIP codes. The highest concentrations of dentists are found in a few key urban zip codes within the Valley region, while more rural areas such as the High Desert and East Desert experience much lower dentist-to-population ratios. These disparities, along with notable differences in provider specialties and linguistic diversity, have important implications for access to dental care throughout the county.

The four zip codes that contain nearly a third of all dentists practicing in the county are 92354 (Loma Linda), 92373 (Redlands), 91709 (Chino Hills), and 91730 (Rancho Cucamonga). In contrast, many other zip codes have much lower counts, with several areas reporting fewer than 40 dentists. Some major cities with low counts are Apple Valley, Barstow, Twentynine Palms, Big Bear and Needles. Additionally, 17 zip codes in the county have only one dentist each.

Table 1 illustrates the distribution of the dental providers in the county across the 15 zip codes with the highest concentration of dentists.

Table 1: Top 15 zip codes and their representing cities with the highest number of dentists in San Bernardino County, 2024

Dentist Count	Zip Code	City
188	92354	Loma Linda
151	92373	Redlands
100	91709	Chino Hills
89	91730	Rancho Cucamonga
78	91786	Upland
67	92374	Redlands
60	91710	Chino
51	91739	Rancho Cucamonga
44	91784	Upland
39	92399	Yucaipa
38	91762	Ontario
37	92335	Fontana
35	92395	Victorville
33	91761	Ontario
33	92336	Fontana
Total: 1,043		

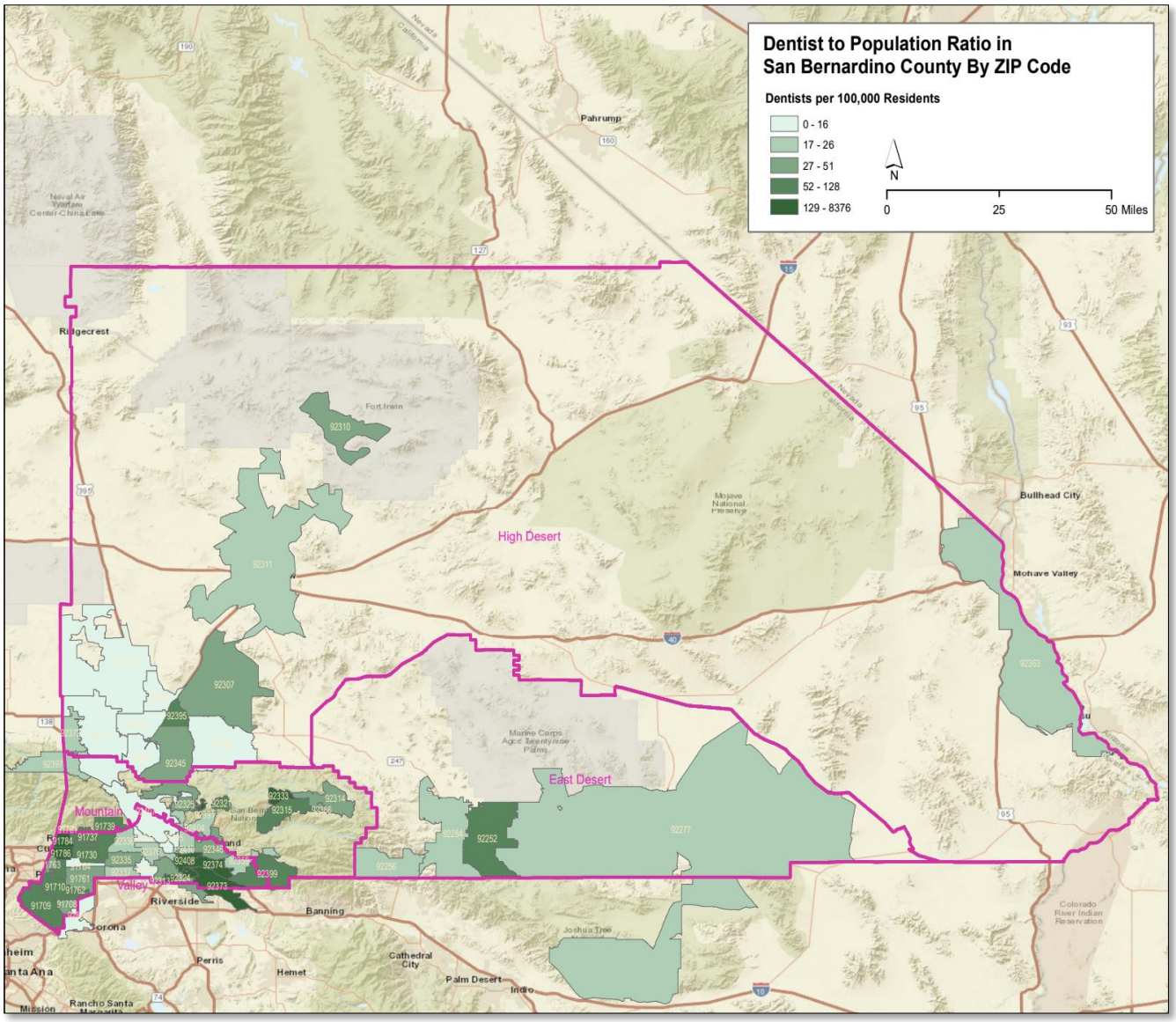
Source: California Department of Health Care Access and Information

The dentist-to-population ratio across San Bernardino County varies significantly by region and zip codes, as shown on the map on the next page**.** The highest ratios of dentists per 100,000 residents are concentrated in the southwestern part of the county, particularly in the Valley area, where they have 52+ dentists per 100,000 residents. Mountain areas also show a higher dentist-to-population ratio around specific zip codes. While this suggests there may be more dentists practicing/living in this area, upon examining the providers accepting Medi-Cal, only one dentist accepts it, creating an even greater disparity in the Mountain area for those enrolled in Medi-Cal. The Big Bear Lake area (encompassing the three zip codes, including 92333) has only about 5,000 residents. Arrowhead (92391) also has a population of 12,400, and none of the dentists

in the area accept Medi-Cal. A similar situation is true for zip code 92321, being Cedar Glen, with 1,300 population and no Medi-Cal dentists.

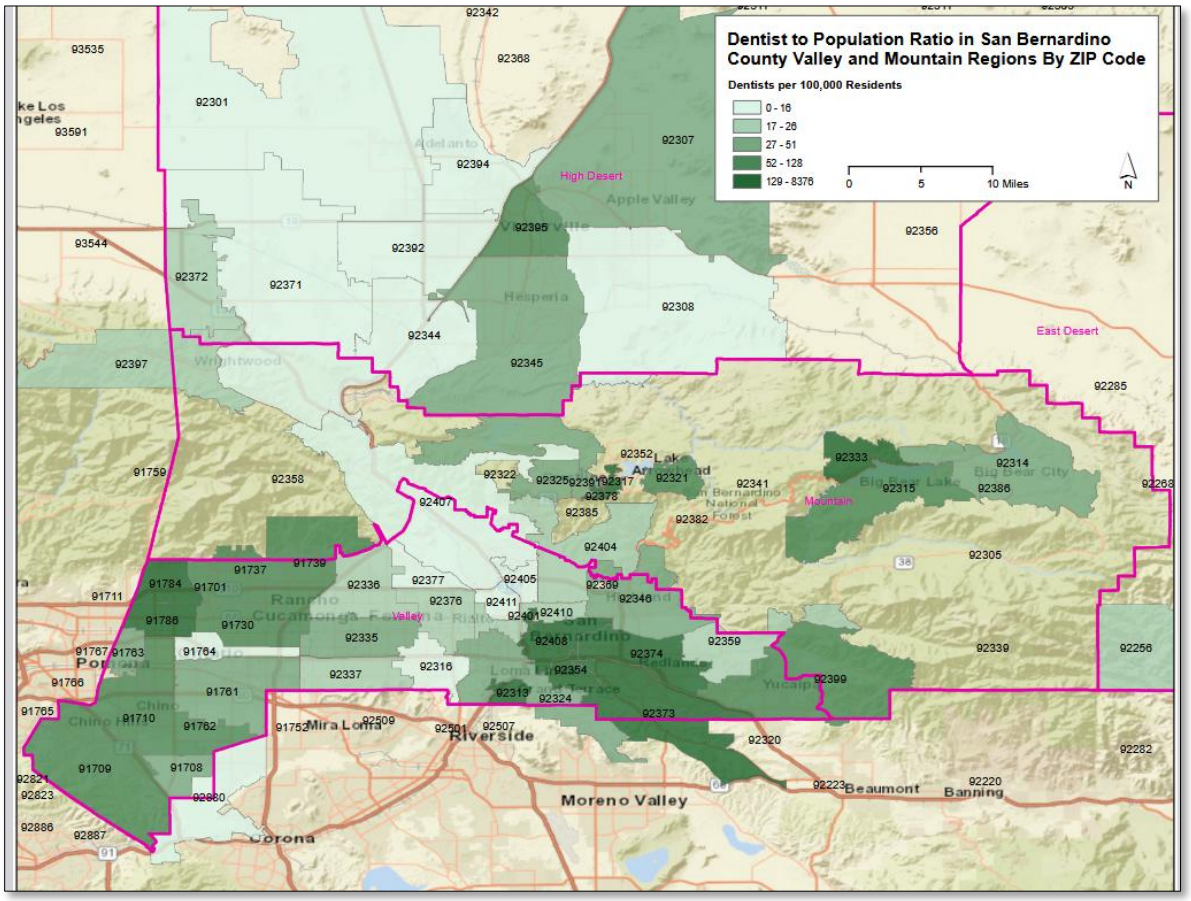
In contrast, the High Desert and East Desert regions have significantly lower dentist-to-population ratios, regardless of Medi-Cal certification, with many zip codes reporting fewer than 16 dentists per 100,000 residents. These areas may face significant access challenges, as residents must travel long distances to reach dental care providers.

Figure 29: Map of Dentist to Population Ratio in San Bernardino County, 2024



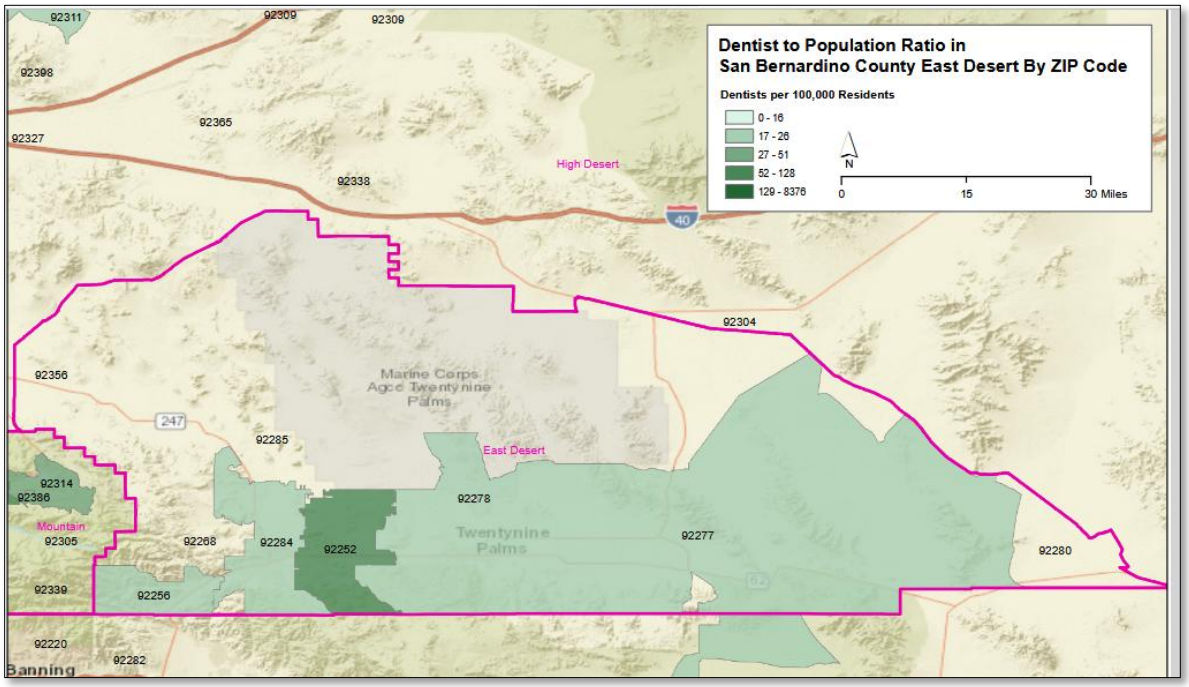
Source: California Department of Health Care Access and Information

Figure 30: Map of Dentist to Population Ratio in San Bernardino County's Valley and Mountain Regions, 2024



Source: California Department of Health Care Access and Information

Figure 31: Map of Dentist to Population Ratio in San Bernardino County's East Desert, 2024



Source: California Department of Health Care Access and Information

Racial and Ethnic Profile

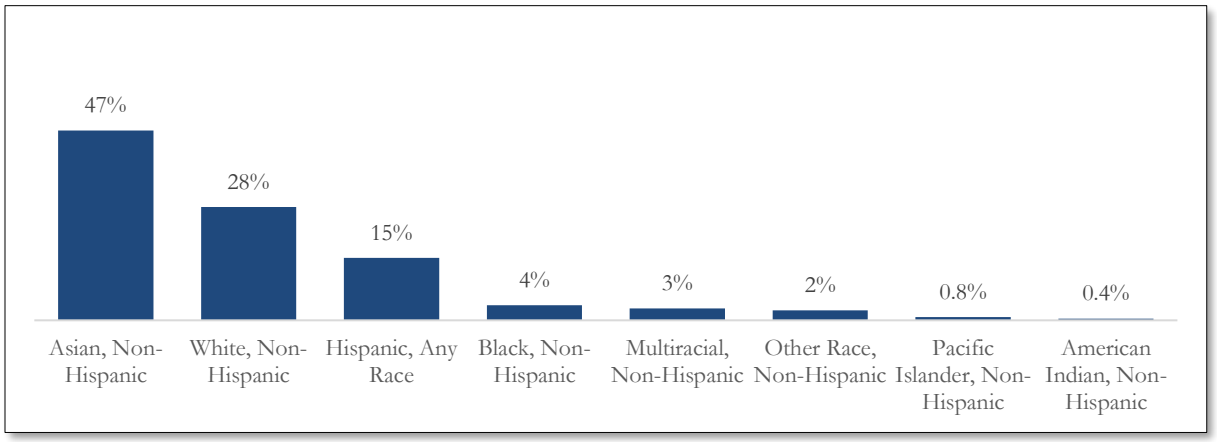
The racial and ethnic profile of dentists in San Bernardino County in 2024 reflects notable diversity, with Asian, non-Hispanic dentists making up the largest share at 47%. This is followed by White, Non-Hispanic dentists at 28% and Hispanic dentists of any race at 15%. While the majority of the county's population is Hispanic or Latino (roughly 52%), there is an observed underrepresentation of this group in the dentists' workforce. Smaller proportions of dentists are Black, Non-Hispanic (4%), Multiracial, Non-Hispanic (3%), and Other Race, Non-Hispanic (3%). Pacific Islander and American Indian dentists, both non-Hispanic, represent less than 1% each (0.8% and 0.4%, respectively), as shown in Figure 32.

In California, in 2016, the largest share of California dentists (49.7%) was White, and half were non-White. Nearly 40% of the state's dentists were Asian, 8.2% were Hispanic, 1.9% were black, and 1.8% were of other races. The percentages of blacks and Hispanics among California's dentists were lower than the percentages of Blacks (6.5%) and Hispanics (39.3%) in the state's population.[12]

While these data are from different time points, San Bernardino County appears to have a higher proportion of Asian dentists than the CA average and a lower proportion of Latino dentists.

[12] https://www.ucop.edu/uc-health/reports-resources/profession-specific-reports/dentistry1.pdf

Figure 32: Dentist Workforce by Race/Ethnicity in San Bernardino County, 2024

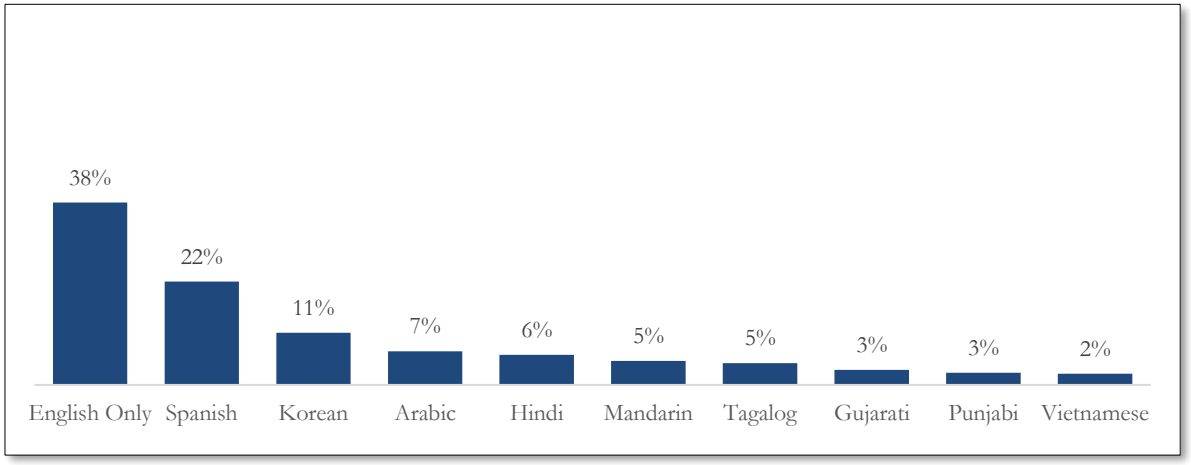


Source: California Department of Health Care Access and Information

Languages

The five most spoken languages by dentists in San Bernardino County in 2024 were English only (38%), Spanish (22%), Korean (11%), Arabic (7%), and Hindi (6%). Other languages spoken, though less common, include Mandarin and Tagalog (each at 5%), as well as Gujarati, Punjabi (both at 3%), and Vietnamese (2%), reflecting the county's linguistic diversity, as shown in Figure 33.

Figure 33: Ten Most Spoken Languages by Dentists in San Bernardino County, 2024



Source: California Department of Health Care Access and Information

Dental Specialties

In 2024, the vast majority of dentists in San Bernardino County were general practitioners, accounting for approximately 78% of the total. Whereas 5% of dentists chose Orthodontics (e.g., braces) as their primary area of practice, 4% chose Pediatric Dentistry (dentists working with children), and only 3% chose Endodontics (e.g., root canals). This distribution highlights that general dentistry continues to be the backbone of oral health care in the county, with a smaller but significant presence of specialized dental services. These rates are not that far from California averages.

In California, as of March 2019, the majority of dentists practice general dentistry (81.2%). The rest practiced endodontics (2.2%), oral surgery (2.3%), orthodontics (3.8%), pedodontics (2.4%), periodontics (2.1%), and other specialties (6.1%). [13]

Table 2: Distribution of dentists by specialty in San Bernardino County, 2024

Primary Area of Practice	2024 Weighted Percent	2024 Estimated Count
Dental Anesthesiology	1.15%	17
Endodontics	2.57%	38
General Anesthesia	0.00%	0
General Practice	78.63%	1164
Oral and Maxillofacial Pathology	0.15%	2
Oral and Maxillofacial Surgery	2.67%	40
Orofacial Pain	0.24%	4
Orthodontics	4.82%	71
Pediatric Dentistry	4.04%	60
Periodontics	1.51%	22
Prosthodontics	2.28%	34
Public Health	0.22%	3
Other	1.72%	26

Source: California Department of Health Care Access and Information

Retirement

In 2024, when dentists were asked about their anticipated retirement timeline, the majority (63%) reported plans to retire in 11 years or more, suggesting relative workforce stability. However, 17% expect to retire within 6-10 years, and 13% within 3-5 years, while 7% plan to retire in less than 2 years.

Gender

In 2024, the majority of dentists identified as male (61.2%), while 38.8% identified as female, and 0.16% did not identify as male, female, or transgender. According to the most recent census data, nearly 50% of the population is female, indicating that men are significantly overrepresented in the dental workforce compared to the general population.

Medi-Cal Dental Providers and Safety Net Clinics

The availability of dentists who accept Medi-Cal has long stood as a significant barrier to timely care for the most vulnerable residents in the community. This section maps providers and safety-net clinics against local population characteristics—by region and poverty—to highlight geographic and equity gaps in access to dental services.

[13] https://www.ucop.edu/uc-health/reports-resources/profession-specific-reports/dentistry1.pdf

By Dental Specialty:
General Practitioners (Dentists Only) are by far the most common, with 438 providers, while Certified Orthodontists (13) and Pediatric Dentists (15) represent the following most frequent specialties. Other specialties are present in much smaller numbers: Endodontists (4), Periodontists (2), Oral Surgeons (7), and Anesthesiologists (1). This distribution highlights the predominance of general dentistry, with limited availability of specialized dental services. There are 5 Registered Dental Hygienists in Alternative Practice (RDHAP) in the county who are enrolled with Medi-Cal Dental.

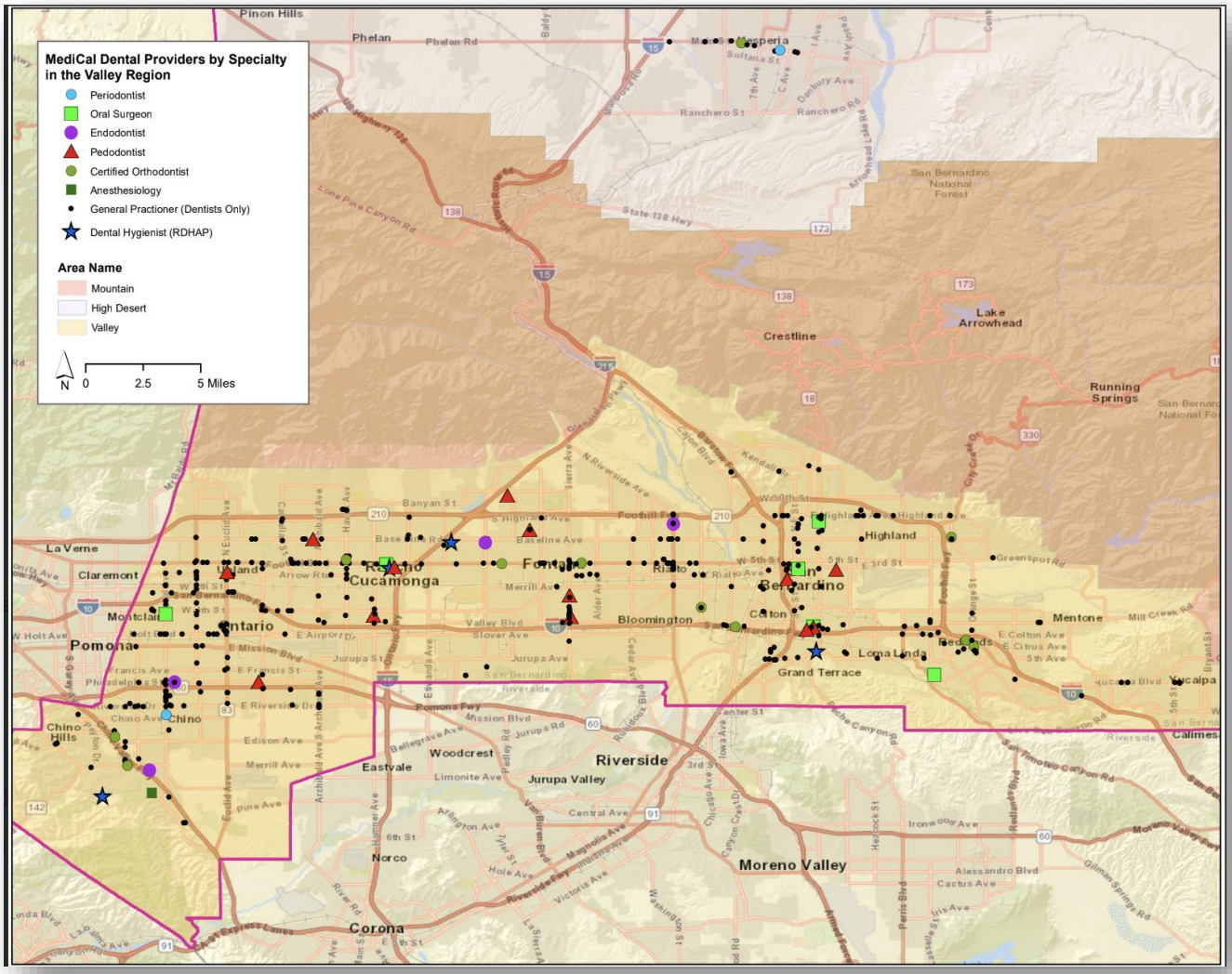
Table 3: Distribution of Medi-Cal Dentists by Specialty in San Bernardino County, 2024

Specialty	Count
General Practitioners (Dentists only)	438
Certified Orthodontists	13
Pediatric Dentists	15
Endodontists	4
Periodontists	2
Oral Surgeons	7
Anesthesiologists	1
Registered Dental Hygienists in Alternative Practice (RDHAP)	5

Source: Department of Health Care Services

The geographic distribution of Medi-Cal Dental providers by their specialties varies significantly across the four main regions in the county. The highest density of Medi-Cal dental providers and specialists is found in the Valley region, as shown in Figure 34. In contrast, the High Desert has fewer Medi-Cal Dental providers, primarily concentrated in Apple Valley, Victorville, Hesperia, and Barstow, with a majority of general dentists and a limited number of specialists.

Figure 34: Medi-Cal Dental Providers by Specialty in the Valley Region



Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal

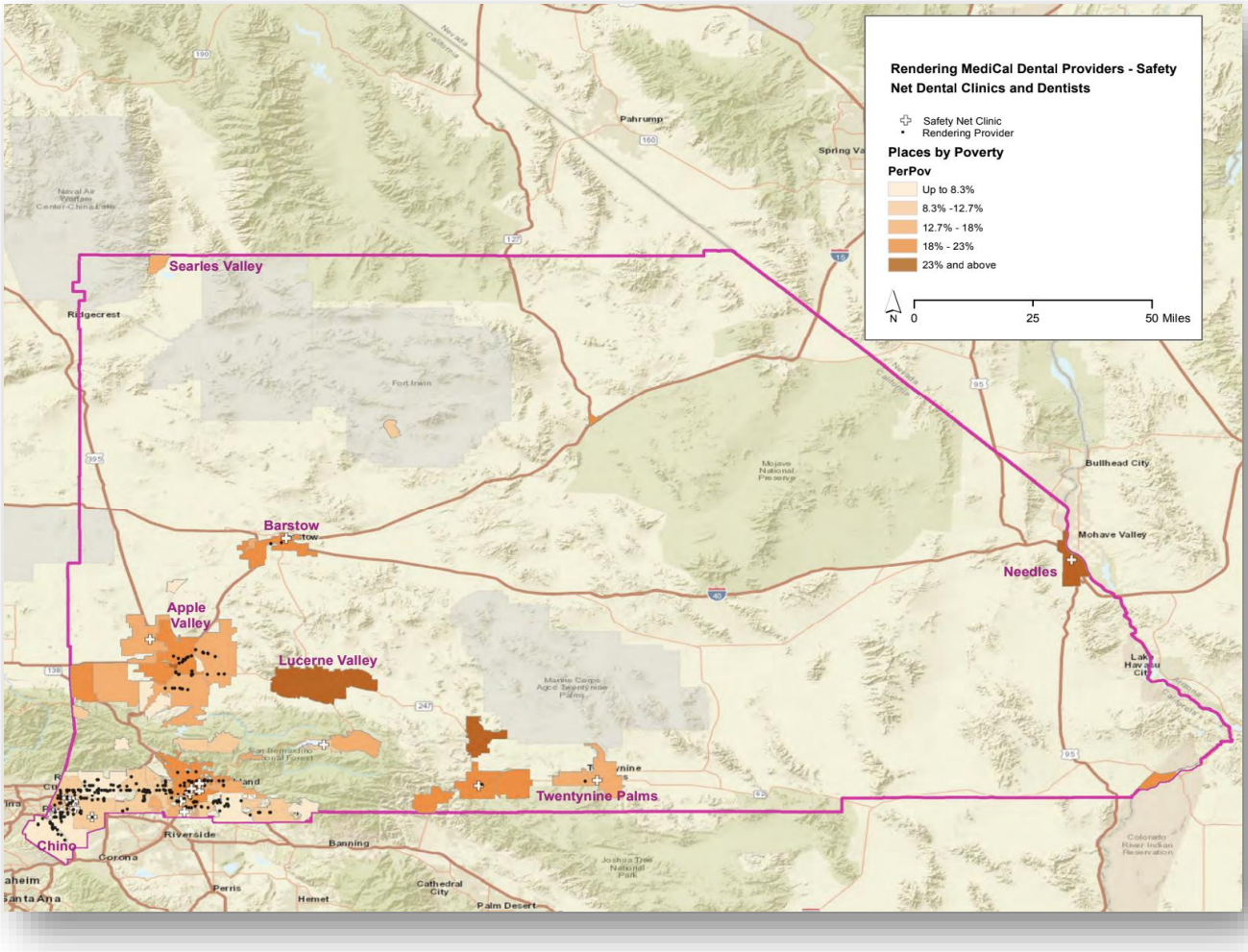
Geographic Distribution by Poverty Level:

The map on the next page illustrates a clear disparity in the distribution of dentists and dental clinics in San Bernardino County when viewed in conjunction with poverty levels. Most safety net clinics and Medi-Cal-receiving dental providers are heavily clustered in the southwestern areas, where there are both higher and lower poverty zones. In contrast, large rural and remote areas, especially in the High Desert and eastern parts of the county, such as Lucerne Valley, Morongo Basin, and Needles, have very few or no dental providers, despite many of these regions exhibiting higher rates of poverty (indicated by the darker orange shading on the map).

This pattern reveals that communities with the highest poverty rates often have the least access to Medi-Cal Dental providers and safety net clinics. Those resources are intended primarily to serve these communities.

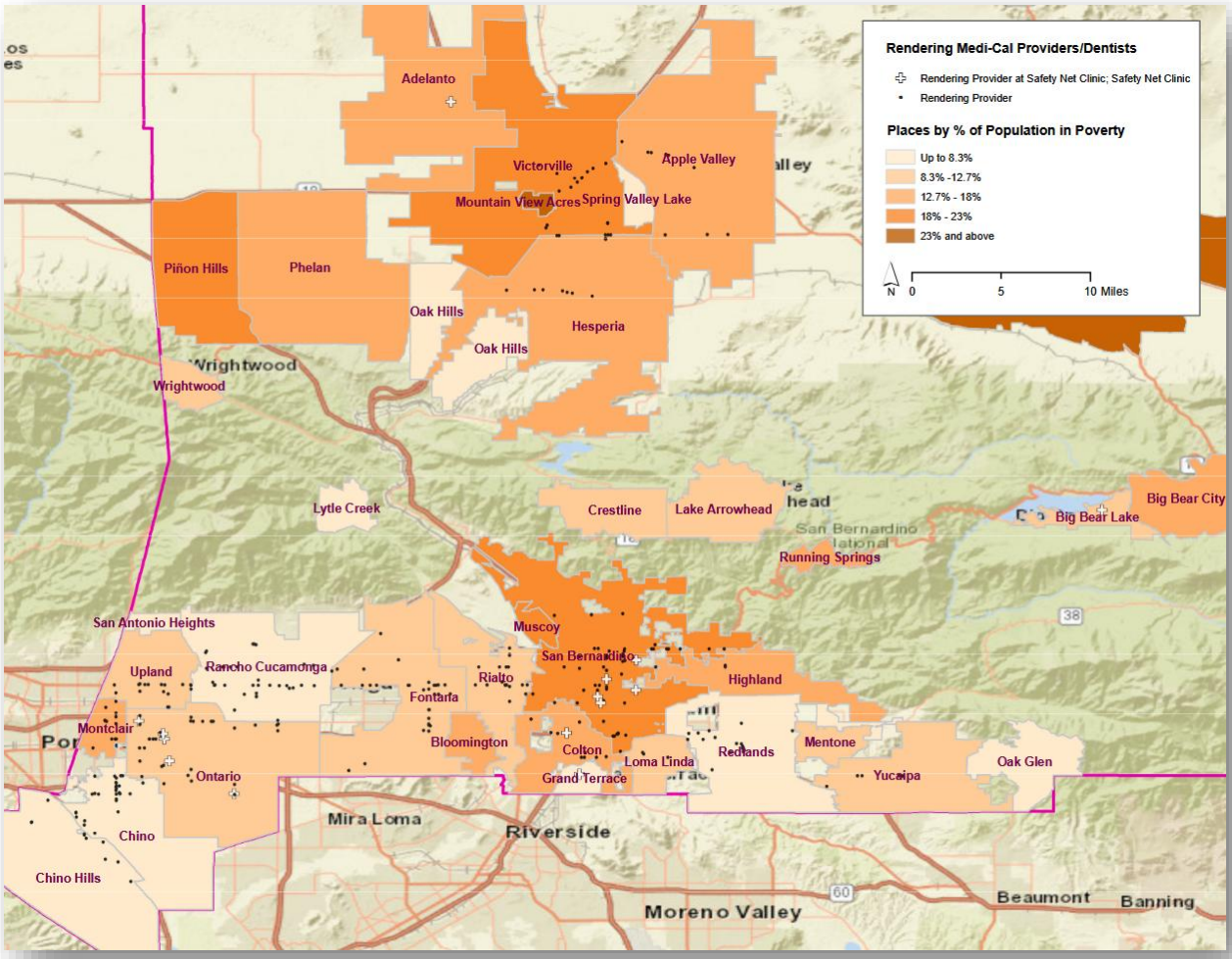
The rendering dental provider is the individual, licensed dental professional who provides the service for the Medi-Cal beneficiary. This is different from the “Billing Provider,” which is the individual, practice, clinic, or organization that submits claims and receives payment from Medi-Cal.

Figure 35: Rendering Medi-Cal Dental Providers Safety Net Dental Clinics and Dentists in San Bernardino County



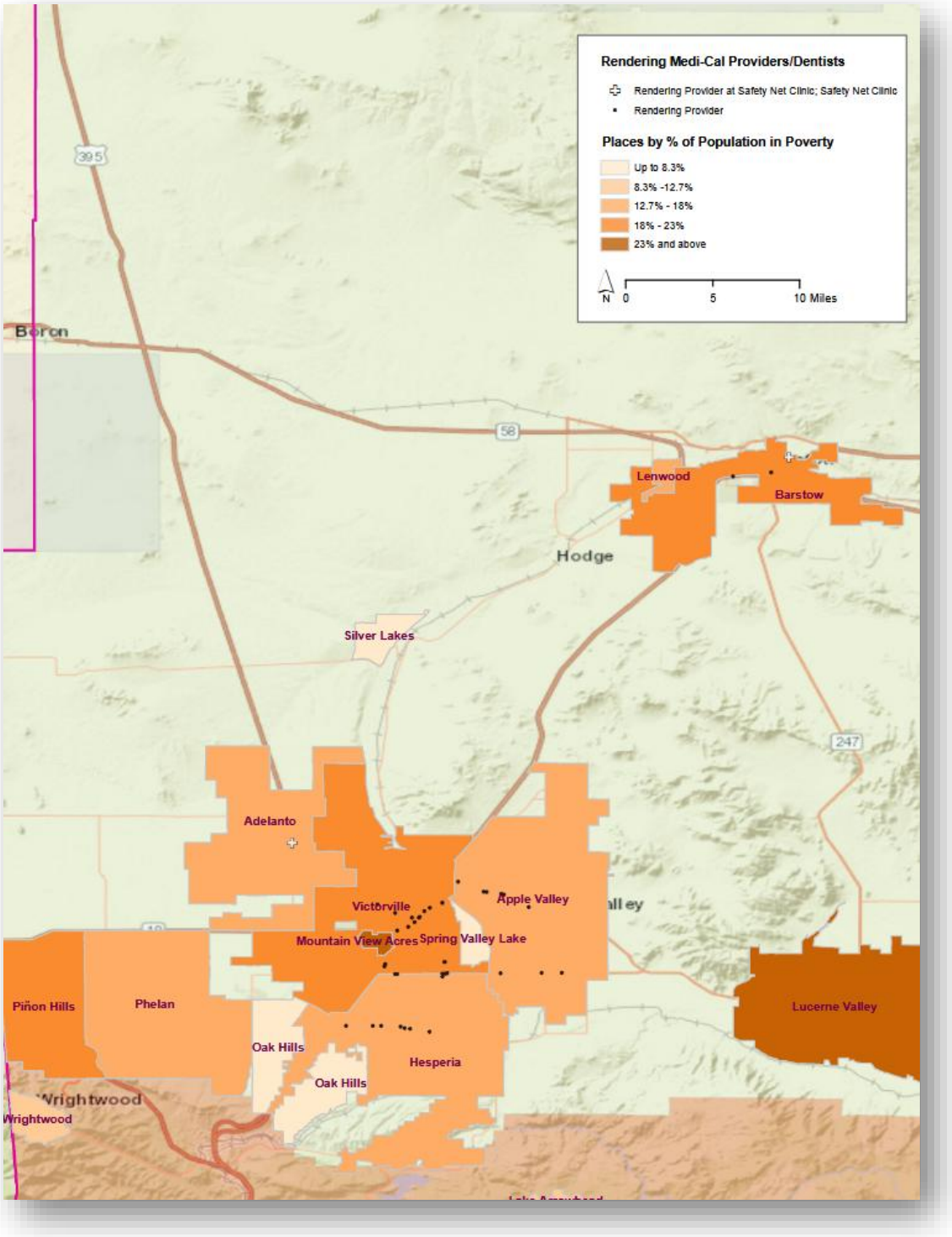
Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal; U.S. Census American Community Survey Poverty Data 2025

Figure 36: Medi-Cal Rendering Map Safety Net Clinics and Rendering Providers in Valley and Mountain Areas



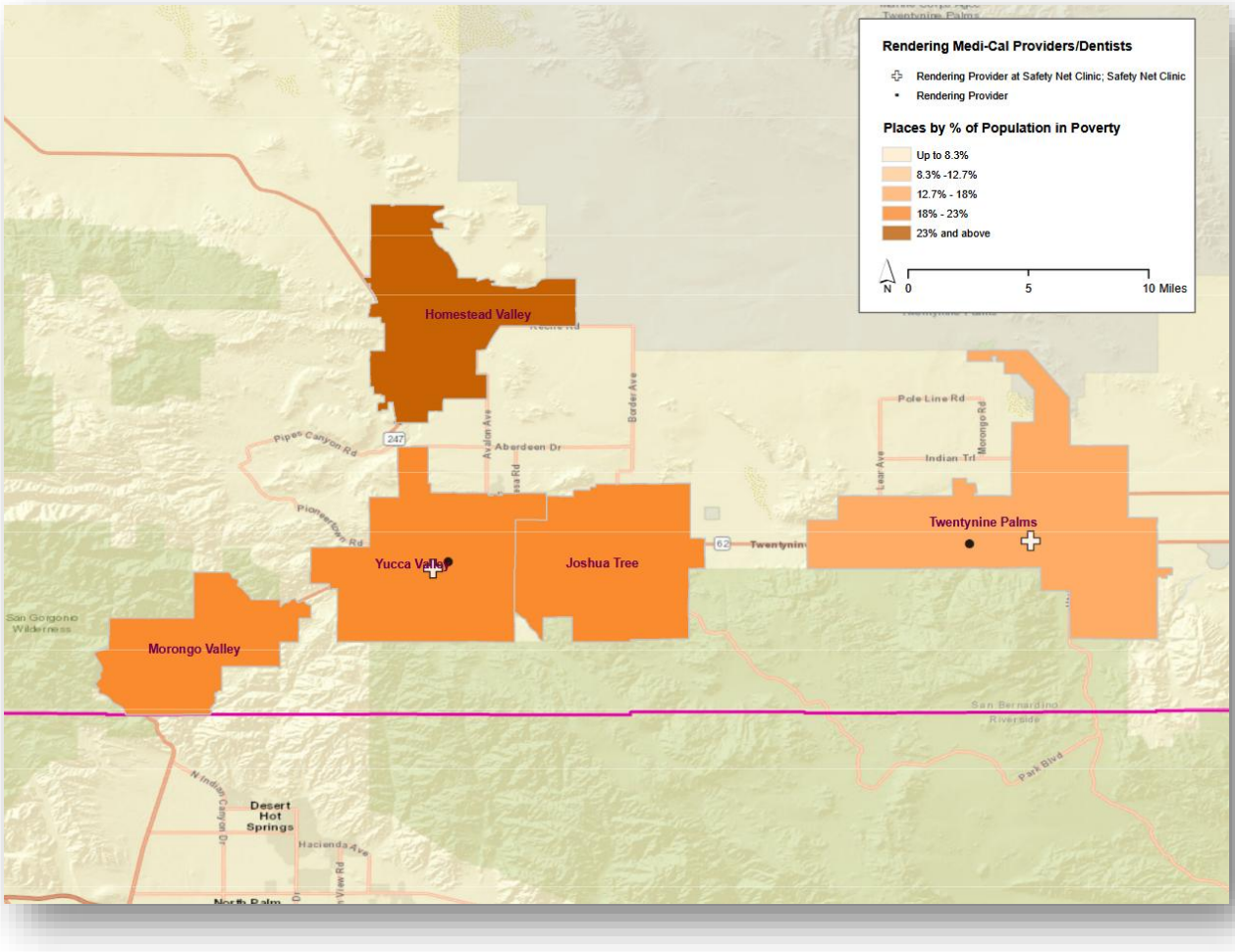
Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal; U.S. Census American Community Survey Poverty Data 2025

Figure 37: Medi-Cal Rendering Map of Safety Net Clinics and Rendering Providers in High Desert



Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal; U.S. Census American Community Survey Poverty Data 2025

Figure 38: Medi-Cal Rendering Map of Safety Net Clinics and Rendering Providers in East Desert



Source: Department of Health Care Services, accessed through California Health and Human Services Open Data Portal; U.S. Census American Community Survey Poverty Data 2025

Health Professional Shortage Areas

The Health Resources and Services Administration (HRSA) uses a rating system to identify population groups (e.g., unhoused individuals, farmworkers, low-income groups, etc.), geographic areas, or medical facilities that lack sufficient primary medical care, mental health, and dental providers to meet community needs. When HRSA identifies an area or group in high need, it designates it as a Health Professional Shortage Area (HPSA). Receiving an HPSA designation enables these high-need areas/groups to meet eligibility for certain federal and state resources. A Dental HPSA scores range from 1 to 26, with higher scores indicating a greater level of need.

Table 4 below lists the designated Dental HPSA in San Bernardino County. While the county does not have any HPSA with the highest score of 26, there are nine HPSAs with a score of 25. All of these are FQHCs.

Table 4: Dental Health Professional Shortage Areas in San Bernardino County

HPSA Name	Designation Type	HPSA Score	Rural Status
ME/MSSA 143-Big River/Needles	Medicaid Eligible Population HPSA	20	Rural
ME MSSA-144.3 Twentynine Palms	Medicaid Eligible Population HPSA	20	Rural
Central Neighborhood Health Foundation	Federally Qualified Health Center	25	Non-Rural
Pomona Community Health Center	Federally Qualified Health Center	21	Non-Rural
Inland Behavioral and Health Services, Inc.	Federally Qualified Health Center	25	Non-Rural
Health Service Alliance	Federally Qualified Health Center Look-alike	19	Non-Rural
St. Jude Neighborhood Health Centers	Federally Qualified Health Center	21	Non-Rural
Chemehuevi	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	10	Rural
Tri-State Community Healthcare Center	Federally Qualified Health Center	25	Rural
Friends Of Family Health Center	Federally Qualified Health Center	21	Non-Rural
Central City Community Health Center, Inc.	Federally Qualified Health Center	23	Non-Rural
Hi-Desert Memorial Health Care District	Federally Qualified Health Center	25	Rural
Center for Family Health & Education	Federally Qualified Health Center	23	Non-Rural
San Manuel Health Clinic	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	20	Non-Rural
Community Health Systems, Inc.	Federally Qualified Health Center	25	Non-Rural
Sac Health System	Federally Qualified Health Center	25	Rural
St. John's Well Child And Family Center, Inc.	Federally Qualified Health Center	25	Non-Rural
San Bernardino, County of	Federally Qualified Health Center	25	Non-Rural
High Desert Family Medical Clinic	Rural Health Clinic	19	Rural
Unicare Community Health Center, Inc.	Federally Qualified Health Center	23	Non-Rural
University Muslim Medical Association, Inc.	Federally Qualified Health Center	25	Non-Rural
Barstow Outreach Office	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	20	Rural
Family Health Center of Joshua Tree	Rural Health Clinic	19	Rural
FCC - Victorville	Correctional Facility	12	Non-Rural
LI-MSSA 149/Barstow	Low Income Population HPSA	16	Partially Rural
ME - MSSA 151i/Colton Southeast/Grand Terrace/Loma Linda/Redlands	Medicaid Eligible Population HPSA	8	Non-Rural
LI - MSSA 146/Big Bear Lake	Low Income Population HPSA	18	Partially Rural
ME MSSA 151j - Mentone/Redlands South/Yucaipa	Medicaid Eligible Population HPSA	16	Unknown
Mission City Community Network, INC	Federally Qualified Health Center	23	Non-Rural
Blessing Community Health Center	Federally Qualified Health Center Look-alike	13	Non-Rural

Source: Health Resources and Services Administration. Note: Although, some of the listed organizations may have headquarters outside San Bernardino County, all listed have at least one satellite clinic in San Bernardino County.

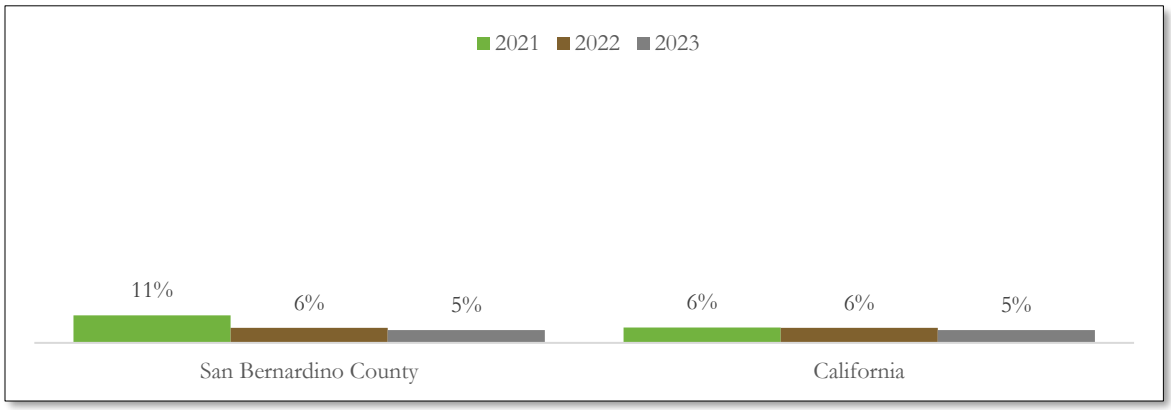
Risk factors

Tobacco Use

Tobacco use causes serious health problems among users, including heart disease, type 2 diabetes, lung diseases, and cancer. Smoking tobacco is a major risk factor for oral cavity and oropharyngeal cancers. According to the CDC, smoking cigarettes and exposure to secondhand smoke cause over 480,000 preventable deaths in the U.S. yearly.[14]

Analysis of CHIS data indicates that the self-reported rates of current adult smokers in San Bernardino County have decreased. Between 2021 and 2022, there was a notable decrease in the share of adult smokers – from 11% to 6% (Figure 39). Since 2022, the smoking rates among adults in San Bernardino County and California have been the same. There were some variations in smoking trends in the county by sex. Male residents in the county are nearly twice as likely as women to be current smokers. Based on 2023 CHIS data, 7% of males reported being current smokers, whereas only 4% of women were current smokers.

Figure 39: Percentage of Current Adult Smokers in San Bernardino and California, by Year, 2021-2023

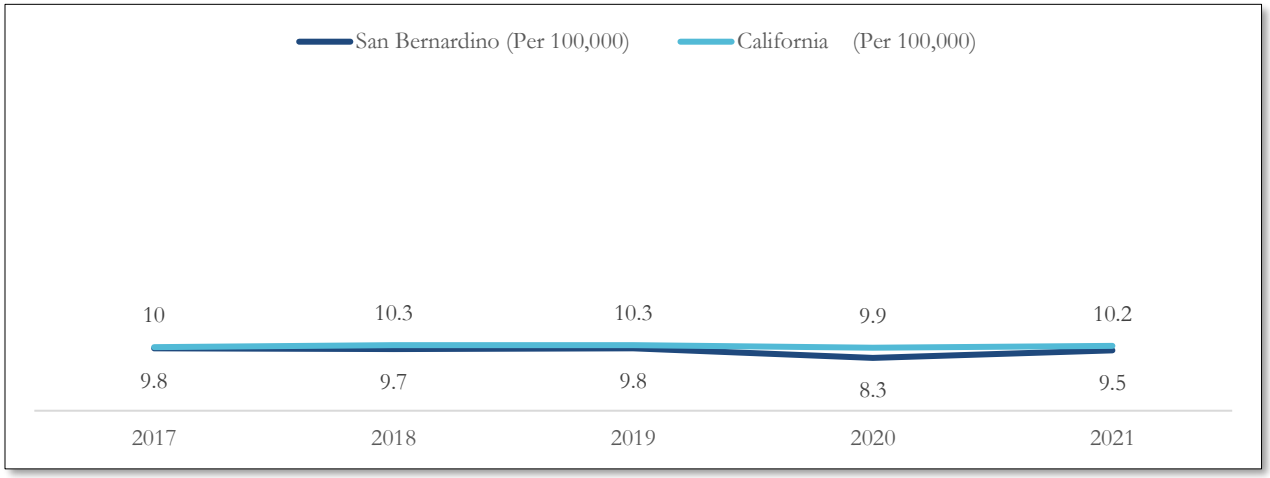


Source: California Health Interview Survey (self-reported data)

Incidence rates of oral cavity and pharynx cancer per 100,000 population have remained essentially unchanged. Between 2017 and 2021, the incidence rates in San Bernardino County and California followed similar trends, with county rates consistently hovering just below statewide rates.

[14] Centers for Disease Control and Prevention. (2024, June 11). *Smoking and Tobacco Use*. Retrieved June 23, 2025, from https://www.cdc.gov/tobacco/about/index.html

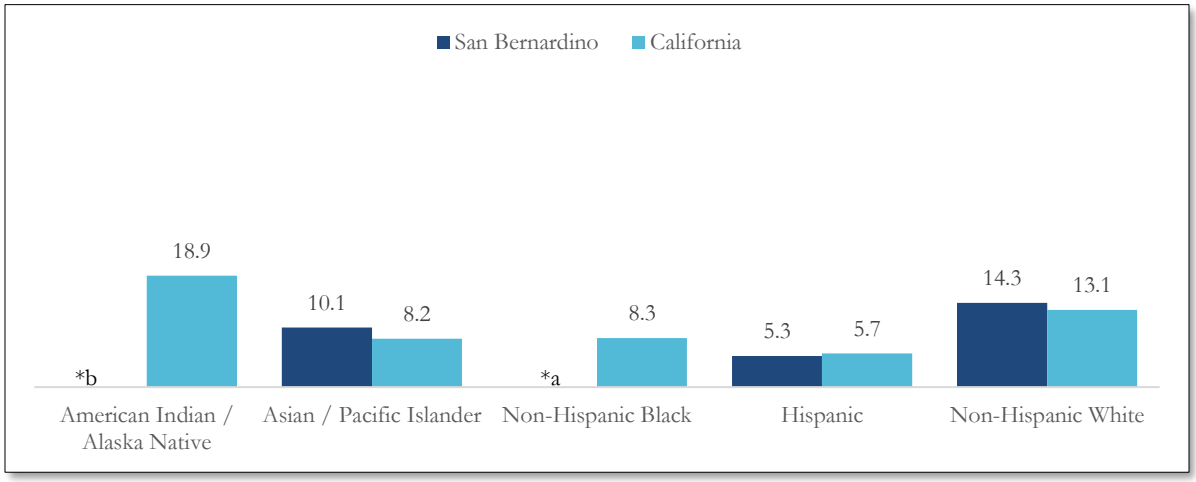
Figure 40: Oral Cavity and Pharynx Cancer Trends in Incidence Rates, California and San Bernardino County (per 100,000 population), 2017-2021



Source: California Cancer Registry

Oral cavity and pharynx cancer trends by race/ethnicity revealed some disparities (Figure 41). In 2021, the latest year for which data is available, non-Hispanic white residents in the county had the highest incidence rates of oral cavity and pharynx cancer, at 14.3 per 100,000 residents. Asian/ Pacific Islander residents in the county had the second-highest incidence rates at 10.1 per 100,000 population. These rates were slightly higher than the statewide rates.

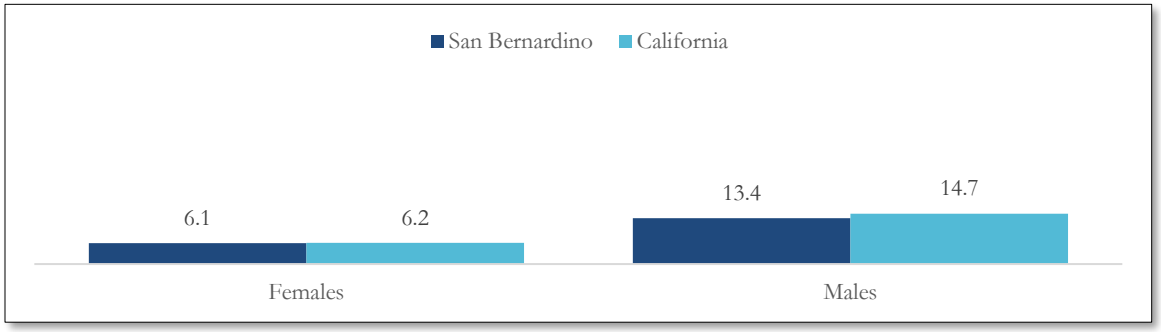
Figure 41: Oral Cavity and Pharynx Cancer Trends in Incidence Rates, California and San Bernardino County (per 100,000 population), by Race/ Ethnicity, 2021



Source: California Cancer Registry; [a]Age-adjusted rates are not shown if based on less than 15 cases [b]Age-adjusted rates are not shown if based on less than 15 cases and a population less than 20,000

Analysis of oral cavity and pharynx cancer incidence rates by sex shows a higher rate for males than females in the County (13.4 cancer cases per 100,000 for males compared to 6.1 per 100,000 for females). While county and statewide rates were similar for females, males statewide had a slightly higher incidence of oral cavity and pharynx than males in San Bernardino County (14.7 compared to 13.4).

Figure 42: Oral Cavity and Pharynx Trends in Incidence Rates, California and San Bernardino County (per 100,000 population), by Sex, 2021



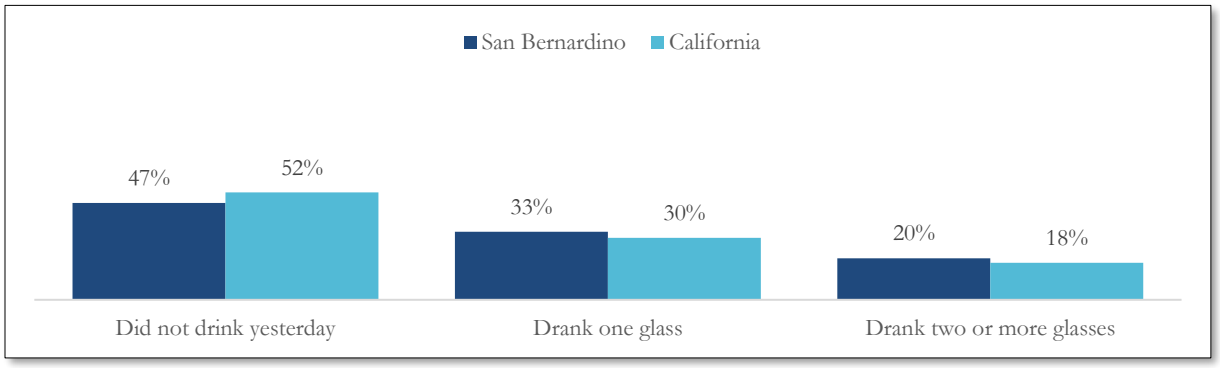
Source: California Cancer Registry

Sugary Drink Consumption

Consumption of sugar-sweetened beverages is a known risk factor for poor oral health outcomes. These drinks are a leading cause of tooth decay due to their high sugar content. They are also linked to obesity and other major chronic diseases, such as type 2 diabetes.[15]

The CHIS asks parents of children aged 2 years or older and all adolescents about their child's consumption of sugar-sweetened beverages (e.g., fruit drinks/ sports drinks) on the day before. In 2022, the latest year for which data are available, fewer than half (47%) of children aged 2 or older and adolescents in the county reported not consuming sugary drinks (other than soda) the day before. In comparison to rates across California, children and adolescents in the county were less likely than those statewide to report not having consumed any sugary drinks (other than soda) the day before (47% compared to 52%). On the other hand, children and adolescents in the county were more likely than those statewide to have drunk one or two glasses of sugary drinks or more the day before (53% versus 48%).

Figure 43: Sugary drinks consumed yesterday (other than soda) among children 2 years or older and adolescents in San Bernardino County and California, 2022

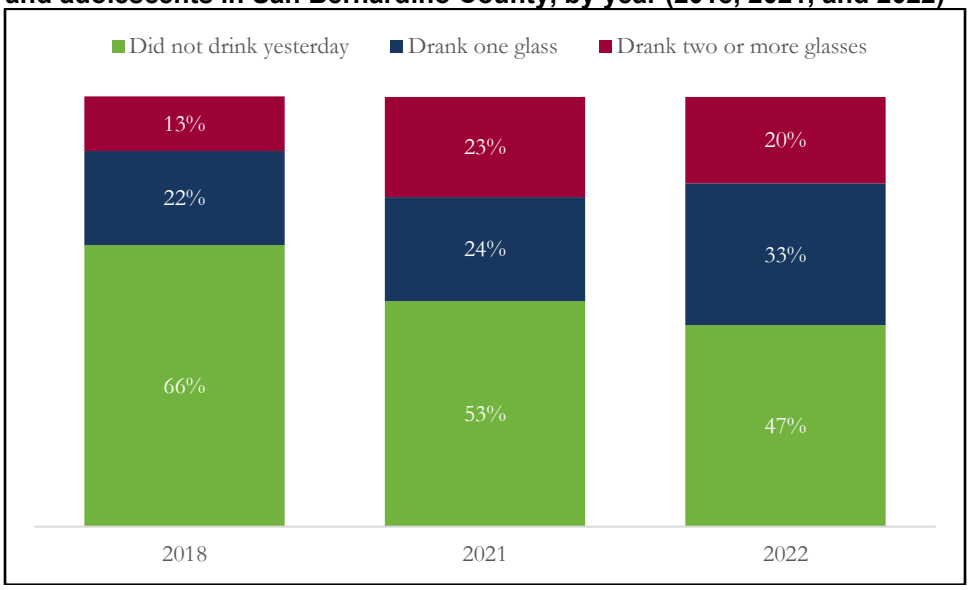


Source: California Health Interview Survey (self-reported data)

[15] Kim, S., Park, S., & Lin, M. (2017). *Permanent tooth loss and sugar-sweetened beverage intake in U.S. young adults. Journal of Public Health Dentistry, 77*(2), 148–154. https://doi.org/10.1111/jphd.12192

CHIS data help track time trends related to sugar-sweetened beverage consumption. Analysis of CHIS data from 2018, 2021, and 2022 indicates that children and adolescents in San Bernardino County are consuming sugary drinks at higher rates than previously reported. While in 2018, a little more than one-third (35%) of surveyed parents reported that their child/ren drank one or two glasses of sugary drinks or more the day before, this rate had increased to 53% by 2022.

Figure 44: Sugary drinks consumed yesterday (other than soda) among children 2 years or older and adolescents in San Bernardino County, by year (2018, 2021, and 2022) **



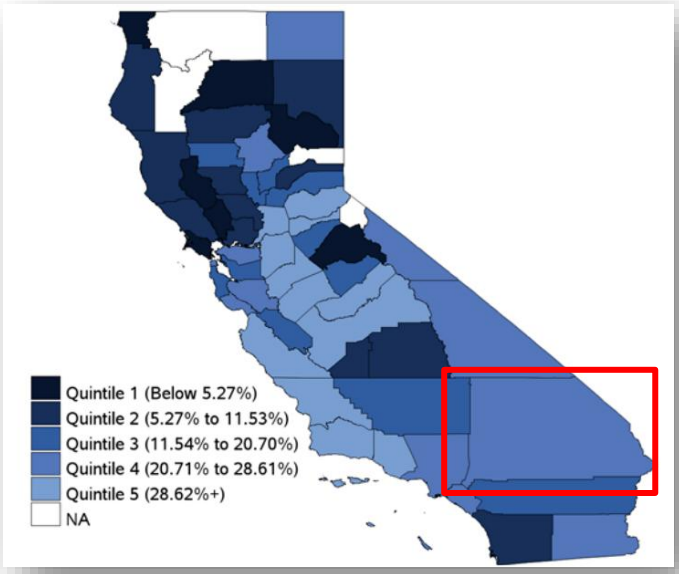
Source: California Health Interview Survey (self-reported data); **** Note:** No CHIS data available for 2019 or 2020

Protective Factors

Fluoride Varnish Application by Managed Care Plans

Fluoride varnish (FV) is highly effective in preventing tooth decay. According to the CDC, FV prevents roughly one-third of caries in primary "baby" teeth. Not only is FV cost-effective, but healthcare professionals in non-dental settings can easily apply it (e.g., nurse practitioners, nurses, and medical assistant staff). The 2022 Preventive Services Report from the California Department of Health Care Services revealed that the delivery of FV applications by pediatric medical providers fell within the fourth quintile, compared to the rest of the state. This quintile has an application rate of 21% to 29%, which is higher than that of some other counties in the State. At the same time, given the effectiveness of early evaluation and prevention, San Bernardino County has much room for improvement in that area. This level of FV provision has remained the same, as it was also in the same quintile in the 2020 report. As Smile SBC expands its efforts to encourage greater medical-dental integration and deepens its already strong collaboration with the Managed Care Organizations, it is hoped that this rate will increase in future years.

Figure 45: Fluoride Varnish Application by County, 2021



Source: 2022 Preventive Services Reports by Managed Care Quality and Monitoring Division, California Department of Health Care Services

Community Water Fluoridation

Community Water Fluoridation (CWF) is recognized as one of the most effective public health measures for preventing tooth decay across all age groups. None of the public water systems in San Bernardino County (SBC) add fluoride to their water systems. According to the 2024 report on water systems in SBC, the county has a total of 154 public water systems—26 of which have some level of naturally occurring fluoride in the water. This means the fluoride levels in these systems occur naturally and have not been removed, added, or treated. To learn more about your specific water system, you can visit the CDC's My Water's Fluoride tool (https://nccd.cdc.gov/doh_mwf/default/default.aspx).

Qualitative Findings

This qualitative analysis draws on insights from five focus groups and 11 key informant interviews, including those with nonprofit home visitors, foster care providers, therapists, dental school leaders, school district liaisons, and managed care strategists, to map San Bernardino County's current oral health landscape and identify avenues for improvement. Across the county, there is a rich tapestry of programs – state-mandated KOHA, in-school varnish-and-sealant clinics, home-visit toolkits from Community Health Workers (CHWs), mobile dental units, and managed-care fluoride incentives – that together form a solid foundation for prevention and early intervention. Community health centers, school-linked programs, and trusted local champions (for example, El Sol CHWs who report "moms texting me photos of their toddlers brushing") amplify these efforts.

Yet, families continue to face significant hurdles. Rural and mountain residents often contend with two-hour bus trips; urban families report being assigned to distant HMO networks; only about 15–20% of KOHA-flagged children complete follow-up care; and sedation-based and special-needs dental appointments frequently have multi-year waitlists. Language differences, provider shortages, and persistent misconceptions about fluoride further temper uptake. These underscore the need for more coordinated, culturally attuned approaches.

This report explores the following core areas:

1. Access to Care Barriers & Disparities
2. Population-Specific Needs & Barriers
3. Prevention & Early Intervention
4. School-Based/School-Linked Programs & KOHA
5. Access & Navigation to Care
6. Oral Health Education, Promotion & Trust
7. Integration & Collaboration
8. Equity for Vulnerable Groups
9. Strengths in Oral Health
10. Challenges and Opportunities for Improvements in Oral Health Integration
11. Opportunities: Summary

This report aims to highlight both existing assets and thoughtful opportunities – inviting county-wide partners, MCOs (including IEHP, Molina and Kaiser), clinicians, and community organizations to build on what works and explore new, collaborative strategies.

Each section profiles current assets, identifies obstacles with illustrative voices, and the "Opportunities: Summary" outlines collaborative enhancements for the County's next strategic phase.

1. **Access to Care Barriers & Disparities:** Access to oral health in San Bernardino County hinges on provider capacity, community logistics, and system architecture.

    - **Provider-Level Context:** Dental workforce constraints and practice policies affect appointment availability. *"We wish more dentists would join Medi-Cal—we struggle to find local care,"* shared a foster-youth liaison.
    - **Community-Level Context:** Geographic isolation, scheduling inflexibility, and health-literacy gaps deter many families. *"I missed three appointments – bus schedules don't match my work hours,"* recalled a high-desert farmworker.
    - *"It was a two-hour round trip on the bus just for a check-up,"* recalled a desert-area mother, pointing out access to care barriers. *"My [insurance] card points me to Colton, not the clinic two miles away,"* highlighting network assignment issues.
    - **System-Level Context:** Insurance assignments and data delays disrupt coordinated outreach. *"We can't track dental visits in our EHR (Electronic Health*

Record) until three months later," noted a Primary Care Physician (PCP), underscoring the need for real-time integration.

Challenges in Oral Health for Communities

- **Misconceptions about baby teeth.** *"Most times, parents think they're baby teeth. Don't worry about it. It's going to fall out, and new teeth are going to come in. If they started early, taking care of the teeth, controlling the bacteria load, it would prevent having cavities on their permanent teeth." – Dental Provider*
- **Growing concerns over fluoride.** *"…There's some resistance to some things, and unfortunately fluoride is one of them, and so…trying to come up with messaging that is promoting fluoride as safe…it's really hard because then I feel you're towing a very delicate line, but...some people, as soon as they see it, they just...say no, but just being able to provide that information in a digestible way for the population to understand it, and at least maybe reconsider…if maybe previously they were adamant that they didn't want that, that maybe they'll reconsider in the future." – IEHP representative*
- **Oral Health Priority and Social Barriers.** See barriers to accessing oral care as well. *"I just think it is the lack of education, though, in understanding how important (oral health is). But again, they're worried about their living situation and their food situation, their food source, or… fighting going on at home, who knows, but still knowing the importance of oral care education." – The Friendly Flosser, Mobile RDHAP*

2. **Population-Specific Needs & Barriers:** Below are regional-level barriers along with specific barriers affecting marginalized and priority populations:

Regional-level barriers: Given the dispersed, vast geography of San Bernardino County, certain regions experience higher levels of oral health disparities and barriers to access to care. Below are two regions that were brought up:

- **Rural/ High Desert Region:** Residents in rural and high-desert regions experience specific barriers to care.
    a. **Coordinating medical/dental care is hard for the population, especially since many of them are a mobile population.** Key informant from Morongo Unified relayed that people living in the high desert tend to come from "…down in the cities [in San Bernardino]" because it's more affordable. However, residents who frequently move may struggle to establish and maintain medical and dental care. While the families they help are assigned a medical provider by their plan, they shared that sometimes it is someone in Los Angeles or another location that is far from the families. Illustrative quote:
    "*So it takes a little bit of time to get that changed over. We can do it pretty quickly once we find out about it, but most of the time we'll have families that will say… our primary care doctor is in Colton, or our managed care is out of Colton, so we're not eligible to access services in the local area."*

    b. **Transportation:** Families in the rural/high desert region face challenges with transportation, which is perceived by the Morongo Unified representative as the most significant barrier to accessing dental care.
- **Mountain Region:** Given the geographic barriers and lack of dental providers, those living in the Mountain areas have their specific challenges in finding access to dental care as follows:
    a. **Too few pediatric dentists.** A dental provider emphasized*"…it's also the access of dental care and treatment because in talking to a lot of parents, for example, we get a lot of patients from Big Bear. They're telling me that there aren't many pediatric dentists out there. Most of the time, you're seeing a general dentist. Even out here, a majority of kids are mostly seeing …general dentists and a lot of the time (even those appointments) are getting pushed up [delayed]."*
    b. **Workforce shortage in the area.** The key informant from the Family Resource Center in the Big Bear area shared that their pediatric Nurse Practitioner was retiring at the time of the interview. Although they partner with agencies from locations outside Big Bear, these agencies sometimes cancel and fail to appear due to inclement weather conditions (e.g., snow). She said: *"We're in Big Bear, it snows here, so when we contract to outside agencies, we have found historically that people/organizations will say they will come, and they mean well, (but) when you're trying to come up here at six in the morning, and it snowed two feet the night before, and you're not comfortable on a mountain road, (as a result) we see a lot of cancellations."*

Specific Populations: Oral health challenges also disproportionately impact specific groups who face layered social, medical, and logistical hurdles. For these populations, universal strategies fail, and tailored interventions are essential. The following subsections delve deeply into the needs, barriers, and context for each high-risk group.

Individuals with Special Health Care Needs. Systems of care frequently overlook how sensory overload, motor impairments, or communication barriers render brushing and dental visits traumatic. Occupational therapists often need to provide hands-on training in adaptive brushing techniques. Early and frequent fluoride application can prevent decay, but in many cases, these individuals require sedation for dental treatments. As an Occupational Therapist (OT) mentioned: *"Our OT taught mom how to brush her own teeth—and then how to brush the kid's,"* one therapist recalled, highlighting the need for specialized training. Children and adults with developmental disabilities, neurological conditions, and complex medical needs experience both a higher risk of dental disease and greater difficulty accessing routine care. Their daily lives may revolve around extensive therapy, specialized equipment, and multiple medical appointments, *"leaving little bandwidth for oral hygiene."*

Barriers:

- **Sensory & Behavior:** Ordinary dental chairs and bright lights can trigger panic and refusal, leading to skipped appointments.

- **Therapy Overload:** Families already juggle dozens of specialist visits; adding dental feels insurmountable.
- **Sedation Wait-Lists:** Hospital dentistry programs have multi-year backlogs for safe sedation in patients with cognitive impairments.

Suggested improvements:

- Sensory-Informed Clinics: Equip designated rooms with dimmable lights, weighted blankets, and unlined chairs to reduce anxiety.
- OT-Dental Partnerships: Foster on-site collaboration between therapists and hygienists—two professionals guiding brushing in a single session.
- Rapid-Access Sedation Slots: Reserve operating-room blocks exclusively for pediatric and special-needs dental care to reduce wait times.

Foster & Unhoused Youth. Youth in foster care and those experiencing housing insecurity carry trauma and instability that do not necessarily prioritize dental health. Frequent placement changes break dental record continuity, and foster caregivers often lack training or resources to manage follow-through. These young people can languish for months without access to a toothbrush or a dental exam. Caregivers, overwhelmed by placement logistics, may struggle to schedule appointments or navigate Medi-Cal dental benefits.

Barriers:

- **Record Portability:** The absence of a standardized "Dental Passport" means dental history and treatment plans are lost with each relocation.
- **Placement Stress:** Youth in crisis placements receive minimal orientation on health services.
- **Resource Gaps:** Foster families may lack reliable transportation or flexible work schedules.

Suggested Improvements:

- Dental Passport Implementation: Issue a durable, wallet-sized record ("Passport") or utilize online systems to capture treatment history, allergies, and follow-up exam dates.
- Foster-Care CHWs: Deploy specialized community health workers to bridge placements, ensuring every child has a consistent dental navigator.
- Trauma-Informed Dental Training: Provide continuing education for dentists on trauma-sensitive communication and procedural accommodations.

Pregnant Women & Perinatal Populations. Hormonal changes during pregnancy increase susceptibility to gingivitis and dental caries, yet oral health is often under-addressed in prenatal care, and persistent myths about the safety of dental treatment during pregnancy continue to limit utilization (ACOG[16]; ADA[17]). Untreated oral disease during pregnancy has been associated with systemic inflammation, infection, and adverse

[16] American College of Obstetricians and Gynecologists (ACOG). *Oral Health Care During Pregnancy and Through the Lifespan.* Committee Opinion No. 569 (reaffirmed)
[17] American Dental Association (ADA). *Pregnancy and Oral Health.* ADA Oral Health Topics

birth outcomes, including preterm birth and low birth weight (Offenbacher et al[18].; Boggess & Edelstein[19]). Integrating routine dental screenings, referrals, and preventive care into prenatal services can improve maternal oral health and support healthier pregnancy outcomes (CDC[20]; ACOG[21]).

Barriers:

- **Safety Concerns:** Many women fear that dental treatments or X-rays will harm the fetus.
- **Fragmented Referrals:** Obstetrics clinics rarely maintain active referral lists for local dentists who accept pregnant patients.
- **Language & Cultural Beliefs:** Non-English-speaking mothers may rely on ancestral health norms, which can lead to the dismissal of dental care.

Suggested Improvements:

- Prenatal Dental Co-Sessions: Schedule dental visits on the same day as Obstetrician/Gynecologist (OB/GYN) check-ups, ideally within the prenatal clinic setting.
- Provider Cross-Training: Educate OB/GYN staff on prenatal oral exam protocols and safe radiography.
- Community Promotor(a)s: Enlist bilingual health promoters to lead small-group sessions in clinic waiting rooms, dispelling myths and scheduling on-site.

Spanish-Speaking & Immigrant Families. One Key Informant Interview (KII) illustrated, "*Our population is heavily Spanish-speaking—if you don't speak the language, it's hard to provide care,"* noted a faculty member from Loma Linda School of Dentistry, underscoring the critical need for bilingual services. Limited English proficiency and immigration fears create unique anxieties that suppress dental utilization, even among individuals who are fully eligible for Medi-Cal dental benefits.

A significant portion of the county's population often places greater trust in their family and community networks than in formal institutions. They seek straightforward, culturally relevant information and welcoming settings that do not require extensive paperwork.

Barriers:

- **Language Discordance:** Many clinics lack Spanish-speaking staff or on-demand translation services.
- **Documentation Fears:** Worries over "too many papers" can deter families from signing consent forms.
- **Perceived Cost:** Even when covered by Medi-Cal, many believe dental care must be out-of-pocket.

Suggested Improvements:

[18] Offenbacher S, et al. *Periodontal infection as a possible risk factor for preterm low birth weight*. Journal of Periodontology, 1996
[19] Boggess KA, Edelstein BL. *Oral health in women during preconception and pregnancy: implications for birth outcomes and infant oral health*. American Journal of Obstetrics and Gynecology, 2006
[20] Centers for Disease Control and Prevention (CDC). *Oral Health Care During Pregnancy*
[21] American College of Obstetricians and Gynecologists (ACOG). *Oral Health Care During Pregnancy and Through the Lifespan*. Committee Opinion No. 569 (reaffirmed)

- Promotor(a)-Led Pop-Ups: Host neighborhood dental fairs in churches and strip-malls with no-ID, no-paperwork entry.
- Simplified Materials: Produce one-page, infographic-style guides in Spanish, explaining "Your Medi-Cal Dental Card = Free Check-Up."
- Community Radio & WhatsApp Campaigns: Utilize robust radio spots and WhatsApp voice notes to explain benefits and schedule appointments in local dialects.

3. **Prevention & Early Intervention:** Prevention remains the foundation of San Bernardino County's oral health strategy. Fluoride varnish programs, home-visit toolkits, and KOHA screenings provide multiple touchpoints for early detection of decay. However, uptake varies across practices and events, which limits the overall impact.

"We've varnished 200 kids this quarter—I can see the cavities drop," celebrated one family practitioner.
"If you station at the supermarket, people come right over," advised a ParkTree FQHC clinic manager, highlighting the power of accessible locations.

4. School-Based/School-Linked Dental Programs & Kindergarten Oral Health Assessment (KOHA): Schools serve as critical hubs for preventive oral health services and education, from state-mandated KOHA screenings to in-class varnish and sealant clinics. These platforms ensure broad early detection and access to preventive services, yet the journey from screening to treatment remains uneven.

"KOHA saved my daughter's smile – she was the only one in her class with cavities," shared a grateful parent.

"We planned for 50 students, but only five signed up," recalled a Friendly Flosser mobile dental coordinator, illustrating consent challenges.

Challenges:

- **Coordinating Urgent Dental Needs:** One dental provider described a child flagged six months earlier for urgent treatment, yet on return visits, the child's condition remained unaddressed. *"The complication is that it doesn't always reach the parent,"* they noted, and added, *"a lot of the people doing screenings are far away from access to care."* Loma Linda University School of Dentistry (LLUSD) corroborated this: "*We believe children's care is still the greatest need—many schools get screened, but not enough receive actual treatment unless they secure a dental home."*
- **Consent-Form Completion:** Providers often struggle to obtain signed parental consents. *"Parents will agree verbally, but forms never return,"* explained one coordinator. Lengthy, three-page packets can overwhelm busy families, and fewer than five consents mean no clinic day can be scheduled, even after hosting health fairs to drive sign-ups.

- **KOHA Data Entry & Follow-Up Gaps:** Friendly Flosser mobile dental teams report that most districts enter KOHA data into local systems but neglect the state portal, limiting countywide tracking. *"I've offered to submit SCOHR (System for California Oral Health Reporting) data for the district, but they still haven't entered it,"* one outreach lead shared. They also face barriers to fetching accurate Medi-Cal IDs— *"Families give us Inland Empire Health Plan (IEHP) numbers, but not full Medi-Cal information,"* frustrating hygienists who cannot verify coverage.
- **First-Year Uptake:** Even well-funded initiatives, such as "Give Kids a Smile," can experience low turnout. *"We targeted 500 students, but only six signed up despite free care,"* recounted LLUSD. Friendly Flosser notes this is typical in year one—teachers often become the strongest advocates after witnessing positive student experiences.
- **School Buy-In:** Securing administrative support remains essential. *"Principals need to see how screenings align with academic success,"* said one KII, urging outreach to leadership and embedding screenings as an annual priority. Another noted, *"Schools not contracted with a provider can be reluctant until they see the positive impact on attendance and behavior."*

Additional Rural School Insights

School nurses in rural districts report high satisfaction with integrated programs but identify areas for refinement:

- **Mobile Dental Program:** Nurses from a High Desert school district praised biannual campus visits for both preventive and restorative care. *"[Our mobile dental provider comes] twice a year per campus and provides screenings and some restorative work—they've been a great resource, and we were surprised by how many families signed up."* The same nurse noted challenges in capturing patient data and ensuring follow-through: *"Sometimes a dentist goes 'rogue' and just treats a child; their insurance be damned,"* highlighting accountability gaps.
- **School-Nurse Follow-Up Protocols:** In a school district in the high desert, nurses personally call every family whose child scores a 2 or 3 on screening, informing them of the following steps: *"We have the staff to make those calls—other districts may not, which could limit their follow-up."*
- **Slow Start of School Programs:** A representative from a high desert school district mentioned that a new partnership initially yielded only six enrolled students. *"There was no marketing and no translated materials,"* explained the district nurse, stressing the importance of outreach and accountability. She also looks forward to their new school-based health center, which will feature a dedicated dental suite launching this fall.
- **Reviving Pre-COVID Enrollment Models:** Several key informants emphasized re-establishing centralized enrollment uses: *"Pre-COVID, we had a big registration event where kids submitted docs and got screened on the spot. We'd love to see that return – it completed KOHA in one visit."*

5. **Access and Navigation to Care:** San Bernardino County's dental-care ecosystem spans school programs, community clinics, private practices, and managed-care supports, yet families frequently navigate a maze of referrals, transportation gaps, and

administrative hurdles. Integrating these elements into a coherent system requires intentional collaboration, real-time data, and dedicated navigators.

System Strengths & Innovations: Below are some strengths and innovations in the systems of dental care that were mentioned through Focus Groups and Key Informant Interviews:

- **School Dental Networks:** An expanding web of school-linked screening, varnish, and sealant clinics offers routine preventive care.
- **Community Health Workers (CHWs):** Embedded in health education departments, CHWs are beginning to weave oral-health modules into their existing curriculum –*"they teach our full wellness classes; now they're sprinkling in dental content,"* an IEHP strategist noted.
- **Mobile Vans & Shuttle Routes:** Mobile units periodically visit remote regions, and pilot shuttle services translate into higher screening uptake.

Workforce & Capacity Challenges: When it comes to the system of care, there are specific challenges in terms of workforce and capacity of the providers providing care, as they are illustrated below:

- **Dentist & Allied-Staff Scarcity:** Community and private clinics cite gaps in the availability and capacity of the dental workforce, straining every available chair.
- **Complex Chronic-Care Coordination:** Long-term patients with multiple medical issues often cancel or drop out of dental treatment plans. *"They start a root canal and never return,"* one dentist admitted. *"I would say complex treatment plans… sometimes patients cancel and get lost from care,"* reported a local endodontist.
- **Untapped Registered Dental Hygienist in Alternative Practice (RDHAP) Potential:** Recent increases in Registered Dental Hygienists in Alternative Practice promise outreach capacity, though many lack field experience.

Role of Managed-Care Organizations: Managed Care Organizations (MCOs) in San Bernardino County—particularly Inland Empire Health Plan (IEHP) and Kaiser Permanente—are uniquely positioned to convene partners, align incentives, and pilot system-level innovations in oral health. Interviews with IEHP strategists and Kaiser leaders surfaced several opportunity areas, summarized below.

- **Embedding Oral Health into Community Education & Outreach.** Both IEHP and Kaiser see Community Health Workers (CHWs) as a natural bridge between clinical services and the neighborhoods they serve. IEHP has recently chartered its CHWs within the Health Education Department, sending them beyond wellness centers into member homes, churches, and community fairs. Today, oral health appears only piecemeal in its broader curriculum. As one IEHP lead reflected, *"The CHWs … will do our classes that used to be just held at the community wellness centers. Now they're expanding to alternate sites to try and reach more of our members. … I'm sure there's little pieces of oral health in there, scattered a little bit."* By developing a dedicated oralhealth module—complete with mythbusting handouts, interactive "brushthedoll" kits, and mobile "dental-popup" events—MCOs can turn CHWs into true oralhealth ambassadors. Piloting CHWled dental

fairs at highneed sites would both raise awareness and immediately capture consents and apply varnish on the spot.

- **Aligning Clinical Incentives & Integrating into Workflows.** Interviewees from both plans emphasized that modest changes in primary-care workflows—like adding fluoride varnish to well-child or prenatal visits—can produce outsized benefits when backed by the right incentives. An IEHP staff representative noted, *"At a minimum, you should be doing this and you should be ensuring that they have a dental home. But doing the additional step of a fluoride varnish application … some providers just opt not to pursue that or incorporate it into their practice."* Similarly, Kaiser's fluoride-varnish working group has convened monthly to share best practices and troubleshoot clinic barriers. Formalizing per-application incentives, embedding varnish prompts into EHR order sets, and recognizing high-performing providers through "Oral Health Champion" awards would reinforce these small but impactful workflow shifts.
- **Building Data & System Integration.** Delayed dental claims and disconnected systems emerged as a shared frustration. An IEHP pediatric partner lamented, *"We don't see dental records in our EHR until three months later … by then, kids have often missed two appointments."* Kaiser leaders likewise called for tighter cross-county data links to spot gaps early. Creating a secure EHR–Denti-Cal API pilot—feeding varnish and screening data into medical records within 24 hours – would power automated outreach by CHWs, school nurses, and care managers. Convening a quarterly MCO–County–Dental steering committee to monitor a shared oral-health dashboard (tracking KOHA follow-up rates, varnish uptake, and high-risk patients) would cement joint accountability and continuous improvement.
- **Expanding Workforce Pipelines & Specialty Capacity.** Both MCOs recognize the County's need for more pediatric sedation specialists, special-needs dentistry training, and mobile providers in rural areas. Kaiser described plans to partner with neighboring counties' anesthesia programs as an *"educational resource,"* while IEHP highlighted a burgeoning cadre of RDHAPs ready to staff school-based clinics. As an IEHP school-services coordinator observed, *"We've gotten a lot of new RDHAPs…willing to do this work… I can even reach out when we have a school site that has a good turnout."* Co-funding a regional sedation fellowship at Loma Linda School of Dentistry, along with contracting RDHAPs for quarterly rural mini-clinics, will both build capacity and foster continuity of care in underserved pockets of the County.
- **Leveraging Cal-AIM.** While conversations around Cal-AIM remain nascent, both plans see Enhanced Care Management (ECM) and Community Supports as vehicles to fund oralhealth navigation and wrap-around services. Under Cal-AIM's flexible CommunityDefined Supports, "Dental Kits + CHW Home Visits" could be reimbursable for high-need families. Similarly, tying payments to timely KOHA follow-up and varnish coverage would align financial incentives with the County's equity goals.
- **Hygienist Access to Member Data**. Granting dental hygienists direct lookup of Medi-Cal member ID numbers and formally recognizing them as authorized providers within managed-care plans would streamline billing workflows, ensure accurate reporting of preventive services (like fluoride varnish), and strengthen the

continuity of care in school-linked and community programs. As one Friendly Flosser hygienist noted, *'If we can't look up the Medi-Cal number, we can't report varnish applications,' underscoring how the inability to verify member IDs undermines accurate service tracking and follow-up. Granting dental hygienists direct access to Medi-Cal member ID lookup and formally recognizing them as authorized providers within managed-care systems would streamline billing, improve data integrity, and strengthen continuity of care for school-linked and community oral-health programs."*

Next Steps

By embedding oral health into education, workflows, data systems, workforce pipelines, and emerging value-based payments, IEHP and Kaiser can transform San Bernardino's robust prevention ecosystem into a seamlessly integrated oral health system—where every child has timely access to high-quality, culturally attuned care.

Core Coordination Barriers: Although San Bernardino County boasts a rich array of dental programs – from school screenings to prenatal varnish clinics – persistent gaps in coordination blunt their impact. Urgent referrals too often stall in hand-off limbo, leaving *"visible decay in a KOHA screening"* unaddressed at home. Meanwhile, delayed claims and siloed data force staff into manual tracking, draining time that could be spent on patient outreach. Layered atop this, insurance-network quirks and ID-verification hurdles break continuity of care, and rural families face multi-hour bus commutes and after-hours shortages that magnify every missed appointment.

- **Fragmented Referrals:** Without a standardized warm handoff, many urgent needs "never reach the parent."
- **Data Silos:** Delayed claims reporting forces time-consuming manual tracking.
- **Network Complexities:** Insurance plan assignments and ID verification hurdles break continuity.
- **Capacity Constraints:** Rural transit schedules and limited after-hours clinics disproportionately burden working families.

Next Steps for a Seamless System

Turning these fragmentation points into launchpads for innovation requires a concerted push toward integration. By rolling out e-consent portals and bidirectional referral platforms, schools, clinics, and CHWs can close warm-handoff loops in real time. Expanding navigator roles—embedding CHWs/Promotoras, and school nurses as oral-health guides—will ensure families never fall through the cracks. Flexible staffing models (RDHAPs, teledentistry), and co-located clinic hubs that blend dental, medical, and social services, these steps promise a truly seamless, family-centered dental care ecosystem. Below is a summary of these solutions:

- **Streamline Electronic Referrals:** Implement e-consent and referral portals linking schools, clinics, and CHWs.
- **Expand Navigator Roles:** Embed CHWs, Promotor(a)s, and school nurses as dedicated oral-health guides.
- **Flexible Workforce Models:** Incentivize RDHAPs and tele-dentistry for mobile or remote care.

- **Integrated Clinic Hubs:** Co-locate dental, medical, and social services in community wellness centers to simplify access.

By realigning these disparate elements into an orchestrated system, San Bernardino County can ensure that every family, regardless of ZIP code or insurance, navigates to the proper care at the right time, minimizing dropouts and boosting overall oral health outcomes.

6. Oral Health Education, Promotion & Trust: Misinformation around fluoride and baby teeth undermines trust. Community-led, bilingual education initiatives and hands-on toolkits can restore confidence. "I thought fluoride would poison my baby's teeth," admitted one mother, highlighting safety fears.

Countywide, a range of culturally and contextually tailored education efforts are already in place. Home visitors, therapists, school-based programs, and clinics each bring unique strengths to oral-health promotion, building trust and engagement among families.

- **Home Visitation Curricula**. El Sol's CHWs integrate oral-health lessons into every prenatal and parenting visit. They present core concepts both verbally and through take-home handouts, always "mindful of cultural and personal beliefs," as one CHW reflected: *"I once met a mom whose toddler had severe front-teeth decay. Sharing gentle, judgment-free guidance helped her see the importance of early care."*
- **Allied Health Integration.** Occupational therapists working with special-needs families naturally incorporate oral-motor coaching into therapy sessions. One OT recounted: *"A mother admitted she'd never brushed her child's teeth because no one taught her. I showed her adaptive techniques – and now she's confident at home."*
- **School & Classroom Partnerships**. Friendly Flosser teams collaborate with teachers and Parent Teacher Associations (PTAs) to integrate brief oral health modules into classroom lessons and parent-teacher conferences. "*When teachers invite us to present, families pay attention,"* noted a program coordinator.

Emerging Education Themes

Interviewees highlighted a few key topics that need broader emphasis in the community's oral health approaches and education:

- **Dental Hygiene Materials Guidance:** "Many parents don't know which toothpaste or brush to use – especially for infants," observed a pediatric dentist.
- **Early Visit Awareness:** "We see rampant decay by 18 months," a clinician noted, underscoring the misperception that first visits can wait until age three.
- **Interactive Learning:** "Imagine a clinic day where kids 'brush off' cavities on a model tooth – fun, memorable, effective," suggested another provider.
- **Oral-Systemic Link:** "Cavities are more than cosmetic—they can signal broader health issues," explained an IEHP strategist.
- **Digital Micro-Lessons:** "Short, 3–5-minute videos on a website can empower busy parents," proposed a health-promotion coordinator.

- **Training and Materials on Working with Kids on the Autism Spectrum for Providers:** Dental teams often report feeling unprepared for the sensory and communication needs of autistic children – *"A lot of our kiddos…don't tolerate having anything in their mouth,"* one provider shared, leading to skipped appointments and distress. Short, focused trainings – on using visual schedules, social stories, and calming tools like weighted blankets – alongside easy-to-use brushing guides can build clinician confidence and caregiver skills. As an OT put it, *"Our OT taught mom how to brush her teeth – and then how to brush the kid's*," illustrating how hands-on, autism-tailored resources create more successful, less stressful visits.

By streamlining and linking these diverse education channels—home visitation, therapy, schools, clinics, and digital media – San Bernardino County can foster a unified, trust-building narrative that resonates across cultures and communities.

7. Integration & Collaboration. Medical-dental integration and the coordination of medical and dental records were identified as areas where SBC can focus more. Some challenges in aligning incentives were shared. Initiatives through Managed Care Organizations, including EHR-claims dashboards, training for pediatric providers, creating accountability for pediatric providers, and regular MCO–County task forces, can enhance collaboration on medical-dental integration.

"*We don't see dental visits in our EHR until months later,"* reported a primary-care provider, illustrating data delays. *"If I could see those claim updates live, I'd know who still needs varnish,"* added another clinician.

Coordinating medical and dental records and aligning incentives remains a key challenge. Shared EHR-claims dashboards and regular MCO–County task forces can enhance collaboration. *"We don't see dental visits in our EHR until months later,"* reported a primary-care provider, illustrating data delays. *"If I could see those claim updates live, I'd know who still needs varnish,"* added another clinician.

Existing Successful Integration Examples:

- *El Sol Home Visitation Staff* embed dental questions into family assessments: "…*we just kind of use that opportunity to check in with them regarding that aspect of the dentist and things like that."*
- *Mountain Resource Center* leverages Healthy Steps for on-site kits and education. "..*you know, the need for early and often oral care, you know, so many people don't think they have to touch their baby's mouth…"* Geographical barriers – the mountain region did not have WIC prior to COVID, but residents/ leaders petitioned the public health to get WIC, and they were able to get it recently
- *IEHP Incentives* encourage PCPs to offer varnish in-office. IEHP stated that some providers are not receptive to incorporating oral health into their practice/ clinical workflow due to competing priorities. That said, IEHP relayed that providers who did incorporate FV into their practice indicated that it was not a huge undertaking.

- *Friendly Flosser* shepherds urgent cases from screening to clinic appointments. Friendly Flosser's model weaves screening and follow-up into a single, coordinated pathway: hygienists flag urgent needs during on-campus assessments and immediately "warm hand off" families to Medi-Cal providers. Staff then proactively contact caregivers explaining results, scheduling appointments, and troubleshooting barriers like transportation and check back after each visit. By maintaining an up-to-date clinic roster and staying in touch, they turn one-time screenings into a seamless continuum of care.

8. Equity for Vulnerable Groups
Targeted equity initiatives will close enduring gaps: portable "Dental Passports" for foster youth, sensory-friendly dental suites for special-needs patients, and co-located prenatal-dental clinics for expectant mothers. Expanding sedation fellowships and local dental-assisting pipelines will strengthen the workforce where it's needed most.

9. Strengths in Oral Health: San Bernardino County's oral health efforts benefit from strong partnerships, multi-system collaboration, and dedicated leadership that together sustain and amplify prevention. County stakeholders consistently highlighted four overarching strengths:

- **Cross-Sector Partnerships:** Smile SBC has united public health, school districts, FQHCs, and managed-care organizations into a shared vision.
- **Collaborative Frameworks:** Programs like KOHA, mobile dental professionals including RDHAPs, and managed care plan health navigators in schools demonstrate how medical, dental, and educational systems can coordinate seamlessly.
- **Smile SBC Leadership:** The County's oral-health program has maintained focus and momentum, shepherding MOUs and countywide coalitions through policy and funding challenges.
- **School Dental Programs:** Both school-based and school-linked initiatives deliver regular preventive care right on campus, meeting children where they already are.

The following programs surfaced as exemplars of these strengths:

- **Family Resource Center (Mountain Region):** The Healthy Steps Specialist accompanies every well-child visit with a dental kit and tailored guidance. Strong bilingual staffing and deep community roots—two staff members live locally—have fostered exceptional trust and engagement.
- **School Program Referrals:** Some mobile dental professionals with school programs utilize school screening models that include a warm handoff to local Medi-Cal dentists, reconciling outdated provider lists with real-time referrals.
- **Mobile Dental Clinics:** Home-visitation teams cited mobile vans as vital for remote families—bringing exams and education directly to doorsteps.
- **Loma Linda Postdoctoral Programs:** Co-location of pediatric, sedation, endodontics, and hospital dentistry under one roof enables rapid referrals and evidence-based safety for all patients.

- **Flexible Provider Practices:** Several dental leaders emphasized adaptability—honoring late arrivals, treating regardless of insurance, and prioritizing patient wellbeing above scheduling rules.

10. Challenges – Opportunities for Improvements in Oral Health Integration: While partnerships are robust, several systemic and operational challenges present opportunities for enhancement when it comes to integrating oral health within other services and medical-dental integration.

- **Geographic Scope & Provider Shortages:** The County's sheer size and uneven provider distribution leave rural and mountain areas under-resourced.
- **Medical–Dental Coordination:** Pediatricians seldom integrate oral screening or varnish into well-child visits. One dentist noted rampant decay by age one: "Many parents only bring their child at 18 months—too late for prevention."
- **Data Sharing and Accountability:** MCOs, such as IEHP, report lags in Denti-Cal claim data, hindering timely follow-up. Stakeholders expressed a desire for parity between the quality tracking of medical and dental services.
- **Post-COVID Relaunch Needs:** Many promising school-health partnerships and virtual-care pilots were paused during the pandemic, leaving gaps in both preventive outreach and care coordination. One notable example—the Ontario–Montclair virtual-care pilot—had established secure telehealth links between school nurses, dental hygienists, and off-site dentists to triage urgent cases and streamline referrals. When COVID struck, school closures and shifting funding priorities put these MOUs on hold. Reviving and updating these agreements now can extend reach, rebuild trust, and leverage lessons learned from remote service delivery:

11. Opportunities Summary: Building on the County's existing strengths and insights from the interviews conducted, a range of collaborative opportunities across the eight focus areas has been identified. Each opportunity for consideration is offered as a springboard for partnership, cocreation, and shared stewardship—inviting all stakeholders to explore and refine these ideas together.

- **Leveraging Community Health Workers (CHWs) and Health Navigators Across Sectors.** Several managed-care and community organizations are expanding CHW roles into oral health education and coordination. As one IEHP representative explained: *"CHWs have just recently solidified their role in health education—they teach our full curriculum, now at alternate sites, and are starting to weave in oral-health content."* In addition, including RDHAPs and managed care plan health navigators in schools can optimize coordination of care after screenings.
- **Maintaining an Updated Special-Needs Provider Directory**. Ensuring families know where to turn for complex care is critical. A CSF supervisor noted: *"Any resource we can give parents is appreciated—we often only tell them about Loma Linda, but there are other sedation-capable clinics that should be on the list."*
- **Expanding Mobile Dental Units in Remote Areas**. Rotating vans through high-desert and mountain zones can overcome transport gaps, bringing varnish, exams, and sealants to off-grid communities.

- **Fostering Medical-Dental Integration**. Embedding Fluoride varnish application into medical visits offers a seamless preventive touchpoint. As one KII observed: *"At a minimum, practices should ensure every child has a dental home—adding varnish [application during well-child visits] is a [relatively] small step but can make a big difference."*
- **Exploring CalAIM Opportunities**. Several stakeholders saw potential to fund oral health activities through CalAIM flexibility, although details remain under discussion (see NVivo coding for full context).
- **Strengthening Academic Alliances**. Partnerships with institutions like Loma Linda University can boost training and service capacity. Kaiser stakeholders are "exploring cross-county anesthesia resources" to expand safe, hospital-based dentistry.
- **Deepening Local Collaborations**. Expanding and deepening collaborations will result in even more enhanced programs. In one example, dental school leaders expressed eagerness to continue work with Smile SBC: *"We hope our connection with Smile SBC will spark regular in-service sessions on integrated care—there is so much we can share."* Beyond student rotations and clinical placements, dental school leaders are keen to embed ongoing, two-way learning with Smile SBC. By hosting quarterly in-service workshops for faculty, residents, and community partners, they envision sharing best practices in integrated medical-and dental care, coordinating referral pathways, and co-developing culturally responsive patient-education materials. These sessions could cover topics such as embedding fluoride varnish into pediatric visits, trauma-informed approaches for special-needs populations, and data-driven quality improvement. In turn, Smile SBC and county public-health staff would gain firsthand exposure to the latest evidence-based protocols and clinical tools. This structured collaboration promises to accelerate workforce training, strengthen care continuity, and translate academic innovations into real-world impact across San Bernardino County.
- **Scaling School-Based Programs in Rural Schools**. Trust-based approaches—wherein schools host clinic days twice per year—resonate in rural districts. As a Big Bear educator reflected: *"When services come to school, attendance rates rise—kids show up, and families appreciate the convenience."*
- **Data and System Integration:** Develop near-live EHR dashboards and convene a quarterly MCO–County–Dental Steering Committee.
- **Culturally Aligned Education:** Produce bilingual, myth-busting media and community-co-created toolkits.
- **Workforce Pipelines:** Expand pediatric sedation fellowships, special-needs training, and local RDA/hygienist programs.

By transforming these opportunities into concrete pilots and policies, San Bernardino County can continue its journey toward truly equitable and accessible oral health for all.

Environmental Scan

The Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis summarized below reflects responses collected from the Smile SBC Advisory Committee using

Mentimeter. Committee members were asked to identify key strengths, weaknesses, opportunities, and threats related to oral health in SBC.

Strengths: Advisory Committee members were asked, "What do we do exceptionally well? What do community members say we do really well? Key achievements?" The responses were categorized into the main themes presented below:

- **Community Engagement and Support**. Efforts to connect with and support the community through direct services and outreach events are exerted. Community members are provided with resources and information that help them better understand and access oral health care, including coverage under Medi-Cal.
- **Collaboration and Partnerships**. Collaboration is demonstrated by effective partnerships with educational institutions, local school districts, stakeholders, First 5 San Bernardino, Smile SBC and other public health programs, FQHCs, and other neighboring counties such as Riverside County. These collaborative efforts enhance the reach and leverage collective resources and expertise to benefit the broader community.
- **Communication and Information Sharing**. Consistent communication is maintained through educational videos and open channels between the oral health program and its partners. Training and information are provided to schools and other partners, ensuring that important messages about oral health are widely disseminated and understood.
- **Organizational Strength**. The LOHP (Smile SBC) benefits from robust leadership and a supportive organizational structure. Strong leadership fosters a positive environment, encourages collaboration, and ensures that oral health initiatives are well-coordinated and effectively managed.
- **Availability of Services and Resources**. A wide range of services and resources are available to the community, including mobile dentists and mobile dental units and a substantial network of committed providers. These resources ensure that oral health care is accessible and responsive to the needs of diverse populations.

Weaknesses: AC members were asked: "What could we improve? Skills/ knowledge we are lacking? What disadvantages do we have?" The responses were categorized into the main themes below:

- **Limited Funding and Resources.** Uncertainty of funds, lack of resources in rural areas, and insufficient support for dental providers, especially those who are enrolled with Medi-Cal.
- **Access and Services Availability.** Shortage of dental specialty care options, dental resources in High Desert and rural areas, and in Medi-Cal providers.
- **Collaboration and Integration Challenges:** Need for more partnerships, especially with CBOs, and better integration with the broader health, hospital setting for patients with special care needs, and education communities.
- **System Navigation and Communication Barriers:** Difficulty navigating Medi-Cal, lack of awareness about RDHAP and their roles, lack of parental awareness, and ineffective communication with teachers and parents.

Opportunities: AC members were asked: “What can we do today that is not being done? Are there emerging trends that can positively impact our work?” The responses were categorized into the main themes below:

- **Collaboration and Partnerships**. Expand on collaboration with organizations that share similar goals, such as mobile dental professionals, non-profit dental programs, and managed care organizations. Build a referral network and foster partnerships with both medical and dental professionals to enhance service integration, streamline care, and ensure more comprehensive support for community members.
- **Education and Awareness.** Enhancing education and awareness efforts with strategies such as presentations for healthcare staff, school districts, educational campaigns, and the creation of informational videos for parents. These initiatives aim to improve understanding of the importance of oral health and highlight the links between oral health and overall well-being, including mental health.
- **Service Expansion and Access.** There is a substantial opportunity to expand services and improve access by increasing the number of dental providers, offering more preventive hygiene services at no cost, and partnering with providers who offer specialty services. Additional events at schools using tele-dentistry and offering case management for children needing additional dental care.
- **System Integration and Navigation.** Integrating oral health into broader health and education systems and creating networks for warm hand-offs between facilities will ensure continuity of care and better navigation for families seeking services.
- **Addressing Barriers and Sustainability.** Proactively responding to funding cuts and other obstacles by seeking innovative solutions will help sustain and expand oral health programs.

Threats: AC members were asked: “What obstacles do we face? Are there changes to our political or economic context that could threaten our success?” The responses were categorized into the main themes below:

- **Funding and Financial Stability.** Concerns about funding cuts dominate the identified threats, with repeated references to reductions in federal and state funding, grant availability, and Medi-Cal reimbursements. The uncertainty and instability of financial resources pose a significant risk to sustaining oral health programs and expanding services, making this the most frequently cited and urgent challenge in the responses.
- **Political and Policy Environment.** The current political climate is a recurring theme, with multiple responses highlighting how shifts in public health policy, debates over community water fluoridation (CWF), and broader political changes are directly impacting funding streams and program support. The unpredictability of political decisions creates ongoing threats to the continuity and effectiveness of oral health initiatives.
- **Access and Service Delivery.** Barriers to accessing services include a lack of staff to provide oral health care, scheduling conflicts within schools, and restrictions on allowing dental providers onto school campuses. These operational

challenges limit the reach and impact of oral health programs, particularly for children.

- **Education and Awareness.** A lack of education about oral health, poor dental literacy, especially regarding fluoridation, and the spread of misinformation on social media are significant threats.
- **Immigration and Safety Concerns.** Fear and uncertainty related to immigration status, including concerns about applying for Medi-Cal or other state assistance, present additional barriers. These issues can prevent eligible individuals from seeking care, further exacerbating disparities in oral health access.

As part of the environmental scan process, the advisory committee members were asked the following questions:

What are the existing educational programs, referrals to Oral Health services, and prevention and advocacy programs in the County? The responses revealed a diverse landscape of educational, referral, prevention, and advocacy programs supporting oral health in the county. Key findings highlight strong partnerships with local organizations, schools, and health initiatives, such as Geri Smiles and The Friendly Flosser, Kaiser-Thriving Schools, and Healthier Generation, as well as nutrition-focused campaigns like Rethink Your Drink and First 5 San Bernardino. The county benefits from established local dental and dental hygiene programs, the IEHP Health Navigator Program, and ongoing collaboration with regional coalitions, such as the Inland Empire School Health Coalition. Additional resources include specialized groups such as Revive Smile Foundation and Healing California, along with FQHCs providing nutrition counseling and tobacco prevention initiatives like Tobacco-Free SBC. Community Health Workers and programs like Head Start are further strengthening outreach and service delivery.

What resources can we leverage to support our work? Among the resources identified to support oral health initiatives, community health workers stood out as the most frequently mentioned asset, highlighted by many respondents in the advisory committee. Other key resources included dental schools, dental health partners, organizations such as CDA Cares, Thriving Schools, and Kaiser Permanente[22], Healthier Generation, the Tri-County Dental Society (TCDS), and the Tri-County Dental Hygienists' Society (TCDHS), as well as opportunities for school events, oral health education, and expanded partnerships. Additionally, grant funding from Delta Dental and Care Quest, as well as support from Healing California, would further strengthen the capacity to deliver and expand oral health services.

What programs can we tap into to expand our reach? The responses highlighted a variety of initiatives that can significantly broaden the impact of oral health efforts. Many respondents highlighted social media education as a powerful tool for raising awareness and disseminating information widely throughout the community. Leveraging established

[22] "Thriving Schools KP" refers to Kaiser Permanente's "Thriving Schools" initiative—an effort led by Kaiser Permanente (KP) to foster health and wellness in school communities through programs, partnerships, and resources that support students, staff, and families.

resources such as the Community Health Center Association Inland Southern Region (CHAISR) was also emphasized. Other key opportunities include participation in Back to School Nights and distributing information at enrollment events to reach parents and caregivers, ensuring they are informed about available services and resources.

What are some policies and practices that we can build upon to expand our work? The responses highlighted several promising avenues for strengthening and expanding oral health initiatives. Key suggestions include leveraging the Child Youth Behavioral Health Initiative (CYBHI) to integrate behavioral and oral health and engaging with the Local Education Agency (LEA) Collaborative Reinvestment Committee. Respondents also emphasized the importance of reinstating incentives for schools to participate in the Kindergarten Oral Health Assessment (KOHA), which can facilitate the early detection of dental caries in children and enhance prevention efforts. Additional opportunities include partnering with the California School-Based Health Alliance and utilizing the Dental Transformation Initiative (DTI) preventive reimbursements to encourage and sustain preventive care.

Conclusion

By synthesizing the findings of this needs assessment and engaging stakeholders in the co-creation of an equity-driven oral health action plan, San Bernardino County can build on its robust preventive infrastructure. This includes kindergarten KOHA screenings, school based varnish and sealant programs, community health worker home visits, mobile dental units, and managed care fluoride incentives. These efforts can be further strengthened by integrating key public health strategies such as near real-time surveillance dashboards, interoperable referral systems, expanded care navigator roles, and culturally tailored health promotion. This coordinated, population-centered approach will strengthen continuity across the care continuum, linking upstream prevention to timely treatment and advance oral health equity so that all residents, irrespective of geography, socioeconomic status, or insurance coverage, can attain optimal oral health and overall well-being.

Appendix A: Best Practice References

Key Resources for Best Practices

- Association of State and Territorial Dental Directors (ASTDD), Best Practices Approach Reports
    - Community Water Fluoridation, Sealant Delivery, and Care Coordination
- Community Preventive Services Task Force: Recommendations on School-Based Sealant Programs and Fluoride Varnish Applications
- American Academy of Pediatric Dentistry (AAPD): Guidelines on Age-One Dental Visit and Oral Health Care for Pregnant Women
- Centers for Disease Control and Prevention (CDC): Division of Oral Health resources on community interventions and surveillance
- California Department of Public Health, Oral Health Program: California Oral Health Plan 2018–2028, including local policy toolkits
- World Health Organization (WHO), Oral Health Program: Global strategies for integrating oral health into chronic disease prevention
- Health Resources and Services Administration (HRSA): Oral Health Workforce Maps and Community Dental Health Coordinator Training

Appendix B: List of Key Informants and Focus Groups

Organization(s)	Key Informants	Number of Participants
San Bernardino County Superintendent of Schools	Cecilia Holguin, Parent and Family/Community Engagement Content Manager	1
The Friendly Flosser	Jennifer Nowotney, Terri Pina	2
El Sol Home Visitation Program	Yolanda Reyes; Rocio Quintanar-Del Moral; Sandra Perez	3
School Nurses/ Administrators in Rural Areas	Tammy Lash, Silver Valley Unified; Kami Murphy, Silver Valley Unified; Wendy Johnson, Apple Valley Unified	3
Family Resource Center in the Mountain Area	Meagan Meadors	1
Loma Linda University School of Dentistry	Dr. Eunice Cho; Dr. Gary Kerstetter	2
Kaiser Permanente	Sarah Legg; Tamara Bondar; Emily Sindon	3
Inland Empire Health Plan	Marcella De Santis; Beth Donovan; Carmen Vega	3
Parktree Community Health Center	Dr. Melgoza	1
Dental Providers	Dr. Yaghoubi; Dr. “J” Jhawar; Dr. Navin Moheieldin	3
California Children's Services	Victoria Merenda	1
Total		**23**

Focus Group Populations	Number of Participants
Parents of children in childcare	3
Caregivers of those with special healthcare needs	7
Spanish-speaking parents in the high desert	6
Pregnant individuals with black infant health group	4
Foster youth caregivers	3
Total	**23**

Appendix C: Cities/ Communities by San Bernardino County Region

West Valley	East Valley	High Desert
Alta Loma	Big Bear	Adelanto
Chino	Bloomington	Apple Valley
Chino Hills	Colton	Baker
Etiwanda	Crestline	Barstow
Fontana	Devore	Fort Irwin
Montclair	Forest Falls	Helendale
Mt. Baldy	Grand Terrace	Hesperia
Ontario	Highland	Joshua Tree
Rancho Cucamonga	Lake Arrowhead	Landers
Upland	Loma Linda	Lucerne Valley
	Lytle Creek	Morongo Valley
	Mentone	Needles
	Muscoy	Oro Grande
	Redlands	Phelan
	Rialto	Trona
	Running Springs	Twentynine Palms
	San Bernardino	Victorville
	Yucaipa	Wrightwood
		Yermo
		Yucca Valley

References to "Mountain Region" include cities such as:

Big Bear
Crestline
Forest Falls
Lake Arrowhead
Lytle Creek
Mt. Baldy
Running Springs
Wrightwood

Appendix D: Focus Group Summaries

Focus groups were conducted with priority populations, including caregivers of individuals with special health care needs, foster parents, parents of children in childcare, pregnant individuals, and Spanish-speaking parents of school-aged children in the high desert. The focus groups were held either in person or virtually over Zoom. Everyone who participated in a focus group received a $40 honorarium to thank them for their time. Below are summaries of the conversations from each focus group.

Caregivers of Individuals with Special Health Care Needs

On March 27, 2025, the external consultant conducted two focus groups with parents/ caregivers of individuals with special health care needs. The Inland Regional Center (IRC) helped recruit the focus group participants and provided a conference room to host the focus group on-site. In total, seven parents/ caregivers of individuals with special health care needs shared their experiences accessing oral care. Four people joined the focus group in person, and one joined virtually. Two parents/ caregivers joined the second focus group, which was held on Zoom. However, one of the two had technical difficulties and only joined for the first 15 minutes of the conversation. All participants had lived in San Bernardino County for periods ranging from 12 years to five decades.

Key takeaways:

- Lack of dental providers who are well-equipped to tailor oral care for individuals with special health care needs.
- Severely long wait times for specialty care are a challenge.
- Desensitization training could potentially improve the experience for individuals with special health care needs and their families.
- Parents/ caregivers find it difficult to keep up with oral health hygiene at home, often getting creative with tools and gadgets to maintain good oral health practices.

Barriers to Accessing Dental Care

Overall, participants rated their dental health more favorably than that of their child. Participants were asked to rate their oral health and that of their children on a scale of one to five, with one being "poor" and five being "excellent." Most gave themselves a rating of four or five, but gave their children a rating of one or two.

Without any prompting, participants then began describing the challenges they have faced in accessing dental care for their children. One common theme of feedback from participants was the challenge of finding a general dentist who was willing and had the necessary skill set to provide oral care for individuals with special health care needs. One participant, who is a parent of four children with special health care needs, shared that despite taking her children to a dentist every six months, they always ended up with a dental issue that required specialized care.

“I can go anywhere I want to go to the dentist, but no one will take my son.”

Long wait times for specialty care were another common theme that surfaced from the focus groups. Participants noted that their children have had to wait anywhere from a year to 18 months to receive specialty care. These substantial delays in accessing care can cause urgent dental needs to escalate into emergencies. One participant described how her adult son was in severe pain due to an infection and went to the emergency department (ED) to receive care. Because they went to the ED at a hospital that had an on-call dentist, they were seen the next day.

“Similar situation for me of being put on a waitlist. My adult son was in a lot of pain due to an infection. We wound up in the emergency room…because they have an on-call dentist and he was seen the next day in their student clinic. They were able to address the cellulitis in his jaw and gave him a painful injection…he got sick enough that they saw him.”

Participants also expressed their frustration with having to put their children under general anesthesia for dental procedures. One participant shared that dentists who are not equipped to provide care for children with special health care needs tend to propose general anesthesia instead of attempting to provide care without it. At the time of the focus group, one parent shared that her adult son (36 years old) was dealing with multiple health conditions, including congestive heart failure, and could not be put under general anesthesia to address his urgent dental needs – nor did she want him to be sedated. A participant added that to hold an appointment for a dental procedure, dental clinics require a $300 cash deposit from the parent/ caregiver. While the clinics refund this money, she explained that this deposit can be cost-prohibitive for families.

Co-occurring medical conditions present additional challenges for individuals with special health care needs seeking dental care. Three participants noted that their children’s health conditions have prevented them from receiving dental care. One parent/ caregiver shared that their adult child had recently been diagnosed with stage 2 chronic kidney disease, and their dentist could not put him under general anesthesia because of it. Additionally, she shared that her adult child had been taking Tegretol to manage seizures, but a side effect of the medication has led to poor oral health and accelerated tooth decay.

“But since he's had the kidney problem, they said his kidney numbers are too high for them to put him under anesthesia. So, it's just been getting worse and worse, and [his teeth are] coming out, they're starting to come out.”

Enhancing Oral Care Delivery for Individuals with Special Health Care Needs
During the focus groups, participants shared suggestions to help improve the oral care experience in dental clinics. These included the following:

- Dental intake questionnaire should include an item about the patient’s sensory needs. One participant felt that intake forms should ask about a child’s sensory

needs (e.g., whether music is soothing for the child, any light sensitivity, etc.) and allow the family/ child to bring any tools that help calm their child.
- Parents/ caregivers could assess a clinic's environment before taking their child. One participant shared that many dental offices can be overstimulating for children with special health care needs. She considered various factors when choosing a dentist for her children, selecting one that is calming and features colors reminiscent of the outdoors, such as woods and trees.
- Offering desensitization training for individuals with sensory sensitivities by gradually introducing patients to the dental environment. However, participants acknowledged that it takes more coordination and time for providers to offer desensitization. One participant noted that Medi-Cal providers should get reimbursed for desensitization.
- Dental providers, if not already doing so, could use effective communication strategies to create a warm and welcoming environment for individuals with special health care needs. One participant shared the following: "If you got my kids in the chair, show them what the room is going to be like. Letting them know this is what to expect on their appointment."

Additionally, one participant suggested that organizations, such as IRC, could advocate for individuals with special healthcare needs by collaborating with dental providers.

Experience Accessing Oral Care

While parents were generally satisfied with their children's dentists, the common sentiment among participants was that finding a dentist who they felt was equipped to treat their children involved trial and error. One participant shared that they went to a few dental clinics before finding the current dentist who provides dental care for her four children with special health care needs. She relayed that the previous dentist had a poor bedside manner and would talk over her children instead of to them, and that her current dentist treats her children well. Another participant relayed that she had been taking her son to a particular dentist for years, and they recently put his oral care on hold due to his kidney disease.

Oral Health Care Practices

When asked about oral health practices, participants described various creative strategies they have used for maintaining proper oral hygiene at home. One participant stated that the water flosser was a game-changer to help her child floss his teeth, given that he disliked the regular dental floss. Another participant shared that her child's occupational therapist helped make oral health practices more engaging by providing step-by-step photos of tooth brushing, which she laminated and placed in her bathroom at home. This participant added that they purchased Paw Patrol or Spiderman toothbrushes and didn't use toothpaste. They also found floss that had no flavor.

"It's hard as a parent. We're doing all the things we're told to do right out the gate, and it still doesn't work. And then you go [seek dental care] and [are] not supported. There are constant roadblocks. One son, I've tried every brand of toothbrush that vibrates. We've

done it all and it seems like, no matter what, it's still an issue [and] we still wound up with extensive oral health needs."

In addition, some mentioned limiting their child's consumption of sugar-sweetened beverages and processed foods to help maintain good oral health.

Oral Health Education
Participants were also asked what resources or materials are needed to help promote good oral care. One participant shared that simple information and picture books could be distributed to parents/ caregivers of children with special health care needs. Beyond resources and materials, one participant shared that partnering with pediatricians is one way to capture parents/ caregivers' attention on oral health.

Foster Parent Focus Group

The external consultant facilitated a virtual focus group on the evening of April 2, 2025, to gather feedback from foster care parents regarding their experiences accessing dental care for foster youth in their care. Children and Family Services staff graciously assisted with outreach and recruitment efforts. The focus group was roughly an hour and was held over Zoom. Three individuals participated in this focus group. All three had called San Bernardino County home for at least a decade or longer, with one resident having lived in the county for 40 years. At the time of the focus group, one participant had recently become a foster parent, another had been fostering for three years, and the third was a seasoned foster parent with over 15 years of caregiving for children in the foster care system.

Key Takeaways

- Foster parents face significant barriers accessing specialized dental care, especially for children with special health care needs or complex dental issues.
- Routine preventive care is generally accessible, but foster parents experience difficulties obtaining referrals for specialty care.
- Communication between social workers, dental providers, and foster parents is crucial for accessing oral health services for foster youth.
- Insurance coverage limitations often prevent dental treatments (e.g., braces and anesthesia).

Experiences Accessing Dental Care for Foster Children
In general, focus group participants shared that it had been easy to establish and access preventive dental care for their foster youth. One participant described initial challenges in finding a good pediatric dentist. She shared that she was not happy with one of the dentists because they were often backlogged and would schedule appointments far out. At the time of the focus group, she had found a dentist she was happy with, and she was consistently taking her children for preventive care there.

When it came to accessing specialty care for complex dental issues, participants had a less-than-positive experience. Two of the three participants who had tried accessing specialty care for their foster youth reported that they had to be persistent in advocating for the child's dental needs. At the time of the focus group, one participant whose foster child had cerebral palsy and sensory issues reported major difficulties accessing specialty care for them. She received a referral for one organization and had an unpleasant experience with their dental clinic, as well as being given the runaround by their dentistry department regarding a referral to another clinic. She was looking to take her foster child to the Children's Hospital of Orange County for specialty care. She shared the following:

"I took my granddaughter to the [local] dentist…and they said, they actually scheduled her with the adult dentist, but the pediatric dentist came in and saw her... He was very rough with her. This little girl is nonverbal. She has cerebral palsy. So, we do what we can. But we were asking him questions and stuff, and he was basically just pushing us off. He gives us his paper and tells us that we need to call the outpatient and schedule her so that she can have X-rays done. And so, they would do the X-rays, see what needed to be done, because it wasn't like she had bad teeth. It was the fact that she grinds her teeth, and just grinds them down, and they crack. So, I called to schedule it, and they told me that because she has asthma and sleep apnea, I need a different referral to a different visit, a different dentist, or whatever to take her to so that all this can be done. OK, I'll let the dentist know and we'll get back to you. Every week, every week I call about this and get nothing from them."

Foster Youth Oral Health Status

Many children enter foster care with urgent dental needs. Participants were asked to describe the oral health status of the foster children when they first arrived in their homes. Given that some had fostered several children, they were asked to describe the trends they had observed over the years regarding the dental conditions of foster children. The participant, who had fostered roughly 42 youth over fifteen years, shared that most children arrived at her home with poor oral health. She added that some had a lot of cavities, others needed braces that were not covered by their Medi-Cal insurance, and unfinished dental procedures. The 13-year-old foster youth she was currently caregiving for had an unfinished root canal that was started when she was at a group home, and the staff never took her back to complete it.

Foster youth with special health care needs face additional challenges. The foster parent of the child with special health care needs shared that she has a challenging time keeping up oral hygiene at home due to the child's sensory issues. At the time of the focus group, she was looking to take her foster child to the children's hospital in Orange County.

Insurance and Coverage Challenges
Regarding insurance coverage, participants raised challenges about dental coverage through Medi-Cal. One participant shared that Medi-Cal frequently denies coverage for braces, describing strict qualification criteria.

"They needed braces that they couldn't qualify for because you have to have a certain scale or number, I assume. And only a few of them met that number. So they were, you know, forced to keep their teeth crooked, and they couldn't really chew their food well, which I thought was really unfortunate. But the child I have now is the same thing. They started a root canal at the group home and never took her back. And the dentist did say that they needed to finish her root canal, which was started. He said that her teeth were spaced and we're trying to get the county to pay for her to have braces because even though she can chew, she still has these big spaces and it's embarrassing, especially for a teenager."

One of the participants also shared that Medi-Cal does not typically cover the costs of anesthesia and must be paid out-of-pocket by families, which can be especially challenging for low-income families.

Strategies for Maintaining Good Oral Health
Participants identified various ways they ensure their children are practicing good oral hygiene at home. One parent shared that her two foster children, both under 5, avoid brushing their teeth, but her husband steps in to help them get it done.

"Yep. I mean, with my experience with my little ones, it's a little bit different because they don't like it. They don't like it, you know. The only way that I have them to brush their teeth is if my husband helps them. They're very, like, daddy's girl, you know. Looks like they don't listen to me, but my husband. So, we are both a team, and he helps me a lot with the girls."

One participant bought an electric toothbrush for their foster child, who was receptive to it due to their sensory needs. They also mentioned that they purchase a child-friendly toothpaste with a mild mint flavor. Another participant shared that her current foster youth is diligent about her oral hygiene, brushing her teeth both in the morning and at night.

Disseminating Oral Health Information
Toward the end of the focus group, participants identified potential locations for disseminating oral health information to foster parents. One participant suggested that educational materials about oral health could be placed at the Department of Children and Family Services (DCFS) office and distributed to foster family agencies that frequently interact with foster parents. Another participant noted that oral health information could also be shared during the monthly foster care meetings.

Parents of Children in Child Care

On the evening of April 3, 2025, one of the external consultants facilitated a virtual focus group with parents/ caregivers of children between 0 and 5 years old. Staff from the Child Care Resource Center (James Moses, Christina Aranda, and Cynthia Franco) contacted childcare centers affiliated with the Child Care Resource Center (CCRC) and asked center staff to promote the focus group with their parents/ caregivers. The focus group was facilitated in English over Zoom. In total, three parents participated in the conversation. All participants were female; one had two children under the age of five, and the other participants each had one child under five. Two of the three participants had lived in the county for more than three years. The third participant had recently moved to San Bernardino County from Riverside County.

Key Takeaways

- Participants are aware of the importance of oral hygiene and shared challenges in maintaining children's oral health at home (e.g., brushing teeth due to a lack of cooperation from the child).
- Two of the three participants had taken their child to the general dentist.
- Two of the three participants had not seen the dentist in more than three years. One cited cost as a barrier to accessing oral care.

Child and Parent/ Caregiver Oral Health Status

Focus group participants were asked to rate their child's oral health status using a scale from one to five, with one indicating poor oral health and five indicating excellent oral health. All participants rated their children's oral health as three. One common theme of feedback from participants is that it is challenging to brush their children's teeth due to a lack of cooperation from their children. One participant shared the following:

"I think it's a three because of the fact that, like, it's a hit or miss with trying to get her teeth brushed every day. It's not from lack of trying, but that's mostly why I say a three and not like a five."

Another participant shared that her child is autistic and that it is difficult to keep up with oral health practices at home as well. She relayed the following:

"He doesn't let me [brush his teeth], and even chew on the brush, but sometimes he refuses, so it's very hard to maintain [a routine] with him, because, you know, the sensory thing and he doesn't want it."

When asked how they would rate their oral health on the same scale, participants gave themselves a higher rating. Two participants rated their oral health at a four, and the third gave themselves a five. The latter reported that she is intentional about her oral hygiene at home and brushes and flosses her teeth twice daily.

Experiences Accessing Dental Care for their Children and Themselves

At the time of the focus group, two of the three participants had taken their child to the general dentist. One of the two participants had a four-year-old and a six-month-old and had only taken her four-year-old to the dentist, even though her infant's teeth were starting to erupt. Both participants take their child to a local dentist every six months.

The third participant had not taken her child to the dentist yet because she believed her child was too young to visit the dentist and needed to be at least two years old. When asked whether oral care had been discussed during the pediatric well-child visits, she didn't recall with certainty but thought her provider had recommended taking her child to the dentist at the age of two.

When asked how they found this local dentist, one participant shared that it was the only option she was given that accepted Medi-Cal. The other participant shared that she signed her daughter up through their website. According to her, she received a call back and an appointment for her daughter quickly.

In terms of satisfaction with the pediatric dental clinic, participants were generally satisfied. One participant felt that the staff was welcoming and friendly. The other participant noted that she appreciates the weekend availability, since she doesn't have to take time off work. She also appreciates that the clinic is flexible if she needs to reschedule appointments.

While most participants reported taking their children to the dentist every six months, it was a different story when it came to seeking dental care for themselves. One participant was seeing the dentist regularly for periodontal maintenance, the other two had not seen a dentist in years. One participant shared that dental care is very expensive in the United States; she used to live in North Carolina. She added that she last saw the dentist roughly three years ago in Mexico because dental care is more affordable there than in the US. At the time of the focus group, she felt she did not need dental care but was going to look for a dentist after her current pregnancy. She said:

"No. For myself, no, I'm being honest, no [I haven't sought dental care in San Bernardino]. I feel like I don't need it. But yeah, probably after this pregnancy, I would like to try to find something. I hear that's important after having a baby, because your body changes."

The other participant shared that she had not seen the dentist in over four years. While she believed she had dental insurance through work, she had not yet made it a priority to see the dentist. Prior to having dental coverage, she was receiving care from Loma Linda School of Dentistry. She said:

"So, it's been about four years for me. I think I have dental insurance that I signed up for. My job, I just haven't made the time to find a dentist, and then previously, when I was seeing a dentist, I was actually going to the Loma Linda, they have this school of dentistry, so I was going there for my dental care, which I thought was actually a nicer experience to do an entire practice from my own path experience, but it did take a lot of days [to complete the procedure]."

Additionally, the participant stated that Loma Linda dental students provided oral health education, such as demonstrating how to floss.

Oral health practices

Participants shared different ways they ensure their children practice good oral hygiene at home. In addition to brushing and flossing, one participant shared she limits sugary drinks at home, and that she waters down any juice she gives her child. Another participant shared that she purchases different types of kid-friendly toothbrushes and has her children pick their favorite one, and she does not give them any sweets before bed. She added that she uses washcloths to clean her infant's gums.

Information Sources on Oral Health

Regarding where oral health information could be shared to reach parents of children ages 0 to 5, participants highlighted the physical and digital locations below:

- Social media (e.g., TikTok, Instagram)
- Daycares
- Health fairs
- Pediatrician visit

Pregnant Individuals

On March 31, 2025, one of the external consultants facilitated an in-person focus group with pregnant or recently pregnant moms from the Black Infant Health (BIH) program, a state-funded program aimed at improving the health outcomes of Black mothers and their babies. BIH Program Coordinator (Kanisha Neal) supported recruitment efforts of pregnant and postpartum moms and kindly offered their office space to hold the focus group. Four moms participated in the focus group. At the time of the focus group, three of the four moms were pregnant, and the fourth had recently given birth. Most of the moms had been living in San Bernardino County their entire lives. One had moved to the County about a year ago.

Key Takeaways

- Most participants had access to oral care during pregnancy. However, only a few visited the dentist while pregnant.
- Two participants had not seen a dentist while pregnant: one had safety concerns, and the other struggled to find an appointment that fit her schedule.
- Pregnant individuals trust programs like BIH and WIC, making them key avenues for delivering oral health education.
- None of the participants recalled any discussion about oral health from their OB/GYN during prenatal check-ups.

Pregnant Moms' Experiences with Dental Care Access

After introducing themselves, focus group participants were asked to rate their own dental health on a scale of one to five, with one being poor and five excellent. All rated their dental health in good or excellent condition. One participant shared that the BIH program informed her about the importance of oral health during pregnancy.

Participants were asked about their experiences accessing dental care during pregnancy. While most had a dental provider, the frequency of seeking dental care during their pregnancies varied among the group. One focus group participant reported

that she was diligent about visiting the dentist for teeth cleanings throughout her pregnancy, as she had done the same for her previous pregnancies. Another participant shared that, although she had not visited a dentist during her pregnancy, she maintained good oral hygiene at home by brushing her teeth in the morning and at night. The third participant, who had recently given birth, shared that while she had access to dental care, she did not prioritize going to the dentist during her pregnancy for safety concerns. The fourth participant was having difficulties finding a dental provider to get a dental cleaning. One clinic did not work out due to limited appointment availability that conflicted with her schedule.

"I just needed to go for a cleaning. A deep teeth cleaning, but I haven't found one yet. The one that I was trying to go didn't work with my scheduled due to bad timing. I requested an afternoon appointment but didn't have any during those days."

"I just didn't go to the dentist during my pregnancy. It wasn't a priority for me. I just focused on taking my calcium pills. For me it was just I was just like oh I don't want to go and get x-rays."

Oral Health Practices

To assess knowledge of good oral health practices, focus group participants were asked what they thought was important to do during pregnancy to have good oral health. Participants' responses focused on oral health practices at home. Although some participants had noted at the beginning of the focus group that they had seen the dentist during their pregnancy, no one mentioned seeking dental care when this question was asked. Participants shared the following:

- Brushing teeth twice a day – at night and in the morning
- Taking prenatal vitamins
- Flossing
- Eating healthy/ nutritious foods (e.g., eating fruit instead of sweets, not buying junk food)
- Limiting sugary drinks

When asked if they had noticed any changes to their oral health during pregnancy, one participant reported having sensitive teeth, while another noted bleeding gums. Additionally, one participant noted that she constantly craved ice while pregnant with twins.

Oral Health Education in the Community

Toward the end of the focus group, participants were asked where they had received information about maintaining good oral care during their pregnancy. Given that they were all in the BIH program, all participants noted that someone from the county gave a presentation on the importance of oral health during pregnancy and gave them gift bags with oral health supplies. One participant stated that the presenter emphasized that pregnant individuals should continue going to the dentist, which made her realize that it was important to seek dental care. When asked about their prenatal visits, they all reported that none of their OB/GYN providers had discussed oral care during medical visits.

Participants were also asked about the best ways to deliver oral health education to pregnant individuals in the community. Aside from BIH, some mentioned setting up booths at health and dental fairs. Others mentioned that WIC would be a great way to disseminate this information to pregnant individuals, as it is well-known and trusted in the community.

Spanish-speaking Parents of School-aged Children from the High Desert

To incorporate diverse viewpoints from priority populations on the county's oral health system, the external consultant facilitated a focus group with Spanish-speaking parents from the Apple Valley Unified School District (AVUSD). We want to thank AVUSD staff (i.e., Wendy Johnson, Mariana Torres, and Aurora Martinez) for recruiting Spanish-speaking parents and allowing us to host the focus group at their family center. The focus group was facilitated in Spanish and took place on the morning of March 27, 2025.

A total of six parents/ caregivers participated in the in-person discussion that day. All the parents/caregivers were female, spoke Spanish, and identified as Latina. Most had lived in San Bernardino County for at least three years or longer, except for two. One participant was a recent migrant who had lived in the county for one and a half years, and the other for approximately 7 months, having recently moved from Fresno.

Key Takeaways

- Adult dental care is perceived as harder to access than pediatric care. Nearly all participants reported taking their children to the general dentist every six months, but described challenges accessing dental care for themselves.
- Participants have a positive perception of Inland Empire Health Plan (IEHP). They described IEHP as having various offices and, therefore, easily accessible.
- Participants prefer taking their child/ren to the dentist over school-based dental screenings. They appreciate school-based programs but choose to take their child to their general dentist.

Experiences Accessing Dental Care for their Children and Themselves

Nearly all participants had taken their child/ren to the general dentist, except for one. Those who had taken their child/ren to the dentist did so before the child was five, ranging between one and four years old. One parent/ caregiver took their child to the dentist when the child's first tooth erupted. When asked about the frequency of dental check-ups, all participants reported taking their children to the dentist every six months for routine dental care, including teeth cleanings.

While all parents/caregivers who had taken their child/ren to the general dentist had done so without notable issues, they identified challenges in accessing dental care for themselves. Based on their personal experience, one parent felt that finding and accessing dental care for adults was more complicated than for children. Another participant shared that her Medi-Cal coverage in San Bernardino County no longer covered dental services that were covered when she lived in Fresno County. As a result,

she was traveling back to Fresno for dental care. One participant in the group shared that she did not have a dentist or dental insurance but wanted to find out more about insurance coverage. Lastly, one participant mentioned that in her home country of Mexico, she had not seen a dentist there but had established dental care in the county and was diligent about going to her teeth cleanings.

During the focus group, participants, without being prompted, started sharing their level of satisfaction with their Medi-Cal managed care plans. Roughly half of the participants were covered by IEHP, some of whom had previously been covered by another MCO before switching to IEHP.

Oral Health Practices
When asked about oral health practices to ensure their child/ren have good oral health, the participants mentioned the following:

- Looking after baby teeth
- Limiting infant bottle use
- Using dental floss
- Making oral health practices fun and engaging (i.e., singing)
- Limiting sweets to prevent tooth decay

Participants shared that they brush their teeth and floss regularly. One participant shared that teeth cleanings helped her address her inflamed gums.

School Dental Programs
None of the participants had children in kindergarten (or children who had recently completed kindergarten), and thus, the facilitator skipped the Kindergarten Oral Health Assessment-related questions. That said, participants did share their thoughts on dental screenings. Two parents noted that while they appreciate school dental programs, they preferred taking their children to the general dentist themselves instead of participating in the school-oral health programs. One of the parents noted that when their child participated in the school dental program, they were unable to get a dental cleaning from their dentist because their Medi-Cal insurance had already been billed for this service.

Oral Health Education & Overall Feedback
Participants were also asked where they had received oral health information. They highlighted the following programs, organizations, and activities:

- Head Start. One parent mentioned that her child's Head Start program offered parent classes on oral health.
- IEHP managed care organization
- Health fairs
- School districts
- Mail

- Social media (Facebook, TikTok, etc.)

The focus group concluded by asking parents/ caregivers what they might change if they had a magic wand to maintain optimal oral health. One participant said they would remove the barrier of looking for general dentists and having increased access to dental clinics. Two participants would make braces more affordable. One of the two mentioned that their eldest son needed braces, which were expensive, as their Medi-Cal insurance did not cover the cost. That said, another participant stated that her daughter's Medi-Cal covered the cost for braces, but she was traveling to Los Angeles (El Monte) for the dental care.