Public Health Department
Alameda County Health

THE OFFICE OF DENTAL HEALTH

ALAMEDA COUNTY ORAL HEALTH NEEDS ASSESSMENT

DECEMBER 2025

CONTENTS

Executive Summary 5

Introduction 8

Methodology 9

Accomplishments from 2019–2024 12

County Demographic Profile 14

Oral Health Outcomes of Alameda County Residents 17

- Young Children (0–5 Years Old) 17
- School-Aged Children (6–20 Years Old) 17
- Self-reported Condition of Teeth Among Teens 18
- Adults Oral Health Status 19
- Self-reported Condition of Teeth Among Adults 19
- Older Adults (65 Years and Older) 20
- Oral and Pharynx Cancer 20

Dental Services Utilization Among Medi-Cal Dental Beneficiaries 22

- Annual Dental Visits by Age Groups 22
- Preventive Dental Services 24
- Use of the Emergency Department for Non-Traumatic Dental Conditions 30

Common Risk Factors 32

- Sugary Drink Consumption 32
- Tobacco Use 32
- Diabetes 33

Protective Factors 34

- Dental Insurance 34
- Oral Health Workforce 35
- Community Water Fluoridation 39
- Available Resources and Programs 40

Qualitative Data Findings 43
Focus Groups 43
Key Informant Interviews 43
Kindergarten Oral Health Assessment (KOHA) Partners 44
Perinatal Dental Environmental Scan 45
Strategic Planning Community Meeting 46
Community Input 47

Identified Data Gaps 49

Recommendations 50

Conclusion and Next Steps 53

Appendices 54
Appendix A: Key Informant Interviews 54
Appendix B: School Health Centers with Dental Services 55
Appendix C: KOHA Partners Interview Guide 56

Endnotes 57

LIST OF FIGURES

Figure 1: Alameda County Residents by Age Category, 2025 and Projected 2030 Distribution. 14
Figure 2: Alameda County Population by Race, 2025 14
Figure 3: Poverty Rate Among Children and Youth Under 18 15
Figure 4: Population 25+ by Educational Attainment in Alameda County and CA, 2025 16
Figure 5: Self-reported Condition of Teeth Among Teens in Bay Area Region and California, 2019 and 2022 18
Figure 6: Percentage of Children 5+ who Missed School Due to Dental Problem in Alameda County and CA, 2023–2024. 19
Figure 7: Self-Reported Condition of Teeth Among Adults in Alameda County and CA, 2019 and 2022. 19
Figure 8: Age-adjusted Prevalence of Adults 65+ with Total Tooth Loss, Alameda County and CA, 2018-2022 20
Figure 9: Age-adjusted Incidence Rate Cases of Oral Cavity and Pharynx Cancer by 100,000, by Race/Ethnicity, All Stages and Late Stage, 2017–2021 21
Figure 10: Utilization of Annual Dental Visit by Medi-Cal Dental Beneficiaries by Age Group in Alameda County and CA, 2023. 22
Figure 11: Utilization of Annual Dental Visit by Medi-Cal Dental Beneficiaries Aged 0–20 by Race/Ethnicity in Alameda County, 2019–2023 23
Figure 12: Utilization of Annual Dental Visit by Medi-Cal Dental Adult Beneficiaries Aged 21–64 in Alameda County and CA, 2017–2023. 23
Figure 13: Utilization of Annual Dental Visit by Medi-Cal Dental Adult Beneficiaries Aged 65+ in Alameda County and CA, 2017–2023. 24
Figure 14: Utilization of Preventive Dental Services by Medi-Cal Dental Eligible Children Aged 0–5, in Alameda County and CA, 2017–2023. 24
Figure 15: Utilization of Preventive Dental Services Among Children with Medi-Cal Dental Aged <1, 1–2, and 3–5, Alameda County, 2017–2023. 25
Figure 16: Utilization of Preventive Dental Services by Medi-Cal Dental Eligible Children Aged 0–20, in Alameda County and CA, 2017–2023. 25
Figure 17: Use of Sealants Among Children with Medi-Cal Dental Aged 6–9 and 10–14 in Alameda County and CA, 2018–2023 26
Figure 18: Receipt of Dental Visit During Pregnancy Among Alameda County and CA Residents with a Recent Live Birth, 2016–2023 27
Figure 19: Receipt of Dental Visit During Pregnancy in Alameda County and CA Among Medi-Cal Beneficiaries with a Recent Live Birth, 2016–2023. 28
Figure 20: Average Rate of ED Visits for NTDC per 100,000 Population, Alameda County and CA, 2020–2021 and 2022–2023. 30
Figure 21: Rate of ED Visits for NTDC per 100,000 Population in Alameda County by Age Group, 2020-2021 and 2022–2023. 31
Figure 22: Age-adjusted Rate of ED Visits NTDC per 100,000 Population in Alameda County by Race/Ethnicity, 2020–2021 and 2022–2023 31
Figure 24: Percentage of Children with Dental Insurance in Bay Area Region and CA, 2019–2023 35
Figure 25: Geographic Distribution of Dentists by Region, Alameda County, 2024 36
Figure 26: Geographic Distribution of Medi-Cal Dental Providers by Region, Alameda County 37
Figure 27: Percentage Distribution of Dentists and General Population by Race/Ethnicity in Alameda County, 2024. 38

LIST OF TABLES

Table 1: Dental Visits During Pregnancy by Sociodemographic Factors, 2022–2023. 29
Table 2: Certified Eligible for Medi-Cal Population in July 2020 and 2025 34
Table 3: Spoken Languages by Dentists, 2024 38
Table 4: Dental Specialties, 2024 39

EXECUTIVE SUMMARY

Introduction

Oral health is a vital component of overall well-being, yet significant disparities persist across Alameda County, particularly among low-income, racially and ethnically diverse groups, and underserved populations. The 2025 Alameda County Oral Health Needs Assessment provides a comprehensive overview of the county's oral health landscape, highlighting progress made since 2018 and identifying ongoing challenges and opportunities for improvement. The findings aim to guide and inform future policy advocacy, improve data collection, and enhance cross-sector collaboration to address systemic inequities.

Methodology

The assessment used a mixed-methods approach, combining quantitative and qualitative data. Using a methodology consistent with the 2018 assessment, primary data were gathered through key informant interviews and focus groups, and were supplemented by surveys of community members, stakeholders, and dental providers collaborating with the Office of Dental Health (ODH) across multiple programs. Secondary data were drawn from the same core databases used in the prior assessment to support continuity and allow for comparison over time.

Accomplishments (2019–2024)

Throughout the past five years, the ODH continued to strengthen its comprehensive approach to improving oral health outcomes through equitable program expansion, systems integration, and strategic collaboration.

ODH advanced equitable access to oral health care across Alameda County by coordinating services for underserved populations, expanding school-based and perinatal programs, and strengthening provider training and referral systems. Through targeted communication and education efforts, ODH increased community awareness and early prevention practices. Workforce development was supported through mentorship, academic partnerships, and leadership cultivation. Integration of oral health into medical care was promoted via provider training and implementing a closed-loop referral process. Sustainability was ensured by embedding a core program component, the dental care coordination, into county operations and supporting policy advocacy. Program development was guided by continuous monitoring and evaluation, ensuring alignment with community needs and public health best practices. Stakeholder engagement remained central, with inclusive workgroups and committees shaping strategic priorities and fostering collaboration.

Key Findings

- Nearly one in four children ages 0–5 and half of school-aged children have caries experience, and only 43% of children with Medi-Cal 0–20 received preventive dental services in 2023.
- Kindergarten Oral Health Assessment (KOHA) participation remains consistently low across Alameda County. In 2018–2019, only 53% of schools reported KOHA data; by 2024–2025, this dropped to 36%.
- Despite importance of dental sealants to prevent cavities, only 11% of Medi-Cal beneficiaries aged 6–9 and 6% of those aged 10–14 received dental sealants in 2023.
- Despite increase in the overall percentage of receiving dental care during pregnancy, disparities exist in receiving dental care among subgroups of pregnant people.
- By 2030, Alameda County's population is projected to age significantly, with residents 65 and older increasing by more than 23%.
- Among older adults, oral cavity and pharynx cancer risk and burden are highest in men and particularly in White men, while older adults who are Black are more likely to be diagnosed at late stage.
- The high rate of seeking dental care at emergency

department (ED) for non-traumatic dental conditions (NTDC), especially among African American residents, indicates inadequate access to ongoing preventive and restorative care.

» There is shortage of specialty dental providers and a lack of workforce diversity compared with the communities they serve, limiting equitable access to care.

» County-level representative population-based data on oral health status and service utilization are limited for many population groups, making it difficult to monitor inequities and plan and evaluate interventions across the life course and groups.

Recommendations

Young Children

➜ **Integration:** Include dental care in routine pediatric visits and create referral systems to dental homes.

➜ **Awareness:** Educate families about the importance of early dental care through early childhood programs.

➜ **On-Site Services:** Provide preventive dental services in community settings.

➜ **Address Barriers:** Work with community health workers to overcome access issues like transportation and language.

School-Aged Children

➜ **Education:** Inform families about dental sealants and Medi-Cal benefits.

➜ **Access**: Expand school-based dental programs via partnerships.

➜ **Data & Billing:** Improve oral health data collection and advocate for billing systems that capture preventive services.

Kindergarten Oral Health Assessment (KOHA)

➜ **Capacity Building:** Train school staff to better implement KOHA and report data.

➜ **On-Site Services:** Organize dental screening events at schools.

➜ **Access & Engagement:** Help families complete assessments and connect children to dental care.

Pregnant and Postpartum People

➜ **Equity Focus:** Target outreach to underserved Medi-Cal populations.

➜ **Integration:** Add oral health assessments to prenatal/postpartum visits.

➜ **Referral Systems:** Link prenatal care with dental providers to establish dental homes.

➜ **Awareness:** Promote oral health through early childhood and maternal programs.

Older Adults

➜ **Advocacy:** Support expanded dental coverage for seniors.

➜ **Training:** Educate aging services staff on oral health.

➜ **Service Expansion**: Deliver dental care in senior living facilities.

➜ **Continuing Education:** Provide CE courses in geriatric dentistry.

➜ **Cancer Screening:** Promote oral cancer screening and tobacco cessation for high-risk groups.

Emergency Department Visits for Non-Traumatic Dental Conditions

- **Referral Systems**: Support creating referral pathways within hospitals that connect patients to dental care.
- **Advocacy:** Inform advocacy efforts about the importance of sustaining an adequate Medi-Cal Dental coverage.

Workforce Development

- **Cultural Competency:** Train providers in inclusive care practices.
- **Specialty Network:** Build a referral network for specialized dental care.
- **Diversity Pipeline**: Support training programs for diverse dental professionals.

Identified Data Gaps

- **Surveillance System:** Develop a coordinated oral health surveillance system across partners.
- **Data Sharing:** Establish shared data agreements to support standardized, de-identified data collection.
- **Reporting Tools:** Strengthen screening and reporting systems through training and standardized tools.

Conclusion

The 2025 Needs Assessment underscores both the progress made and the persistent challenges in achieving oral health equity in Alameda County. The findings directly inform the **2025–2030 Oral Health Strategic Plan**, which aims to close gaps in access, improve data-driven decision-making, and ensure that all residents—regardless of income, race, or background—can achieve optimal oral health.

INTRODUCTION

Oral health is an essential component of overall well-being for both children and adults. It impacts physical, mental, social, and economic health, influencing self-esteem, daily activities, and quality of life. Tooth decay is one of the most common chronic illnesses in children. National data show that about 11% of children aged 2–5 and nearly 18% of those aged 6–8 have untreated cavities in their primary teeth. Among teens aged 12–19, roughly 10% have at least one untreated cavity in their permanent teeth. These proportions are even more significant for children of color and those from lower-income backgrounds, who experience higher rates of decay.[1]

Access to preventive dental care and timely treatment is key to reducing the risk of tooth decay and supporting lifelong oral health. However, substantial barriers still exist, especially for vulnerable and underserved populations. Expanding access to dental services helps prevent disease, reduce disparities, and improve overall community health.[2]

The Alameda County Oral Health Needs Assessment was funded mainly by the California Department of Public Health, Office of Oral Health, Moving California Oral Health Forward. This assessment was developed to provide a comprehensive understanding of the county's oral health landscape, with a focus on identifying disparities in oral disease burden and access to dental care, available resources, service gaps, and opportunities for improvement.

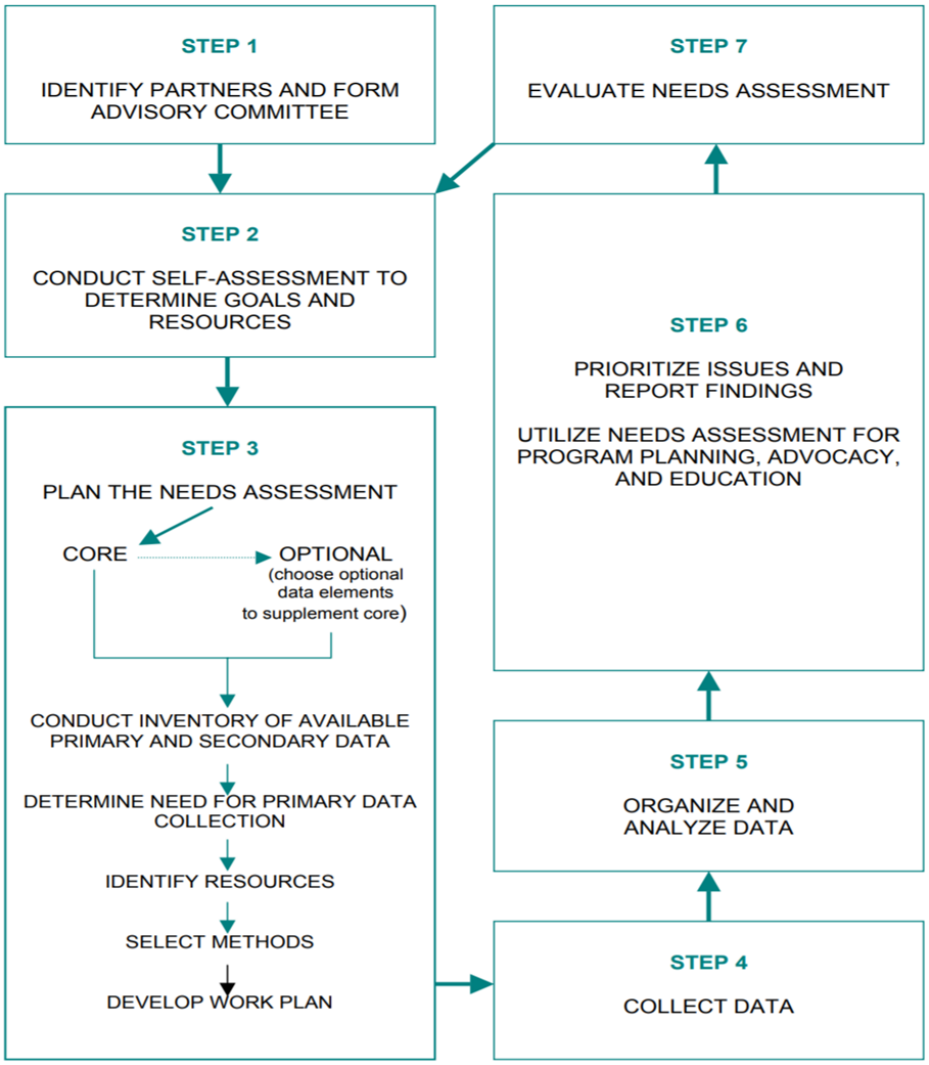
The assessment focused on priority populations, including children, adults, pregnant people, and older adults. It identified key issues such as the wide prevalence of untreated tooth decay in children, limited access to preventive care, and underutilization of dental services among Medi-Cal enrollees. The assessment also highlighted the progress that has been made since the previous needs assessment conducted in 2018. The findings aim to guide and inform future policy advocacy, improve data collection, and enhance cross-sector collaboration to address systemic inequities.

This comprehensive approach is designed to ensure that all Alameda County residents, regardless of background or income, can enjoy optimal oral health.

METHODOLOGY

The needs assessment was led by staff from the Alameda County Local Oral Health Program (LOHP). Using a methodology consistent with the 2018 assessment, primary data were gathered through key informant interviews and focus groups, and were supplemented by surveys of community members, stakeholders, and dental providers collaborating with the Office of Dental Health (ODH) across multiple programs. Secondary data were drawn from the same core databases used in the prior assessment to support continuity and allow for comparison over time.

The seven-step model for conducting needs assessments, developed by the Association of State and Territorial Dental Directors (ASTDD),[3] was used as a guide to conduct the Alameda County's oral health needs assessment. The steps are outlined in the diagram on the right.



The key areas of the assessment included:

- Main accomplishments since 2019
- Residents Demographic Characteristics
- Oral Health Outcomes
- Dental Services Utilization
- Common Risk Factors
- Protective Factors
- Available Resources
- Findings of Qualitative Data Analysis

Secondary Data Sources

- **U.S. Census Bureau** is the federal government's largest statistical agency. Detailed population-level data on demographics (age, race/ethnicity, sex), socioeconomic status (income, education, employment), housing, and geographic distribution were collected from their portal.
- **Centers for Disease Control and Prevention (CDC-PLACES data)** provides model-based estimates based on data from the Behavioral Risk Factor Surveillance System (BRFSS).
- **Healthy Alameda County:** Some data related to population demographics and common oral health risk factors are derived from Healthy Alameda County. This website is intended to help community members and policymakers learn about the health of the community.

- **The California Health Interview Survey (CHIS)** is a leading source of credible and comprehensive data on the health and health care needs of California's large and diverse population. Each year, CHIS interviews more than 20,000 households on a wide range of health matters.
- **Department of Healthcare Services (DHCS):** Data on Medi-Cal eligibility, enrollment, and utilization, including detailed information on dental service access, claims, provider participation, and preventive care use are available on the portal.
- **California Health and Human Services Agency Open Data Portal:** This platform offers wide range of public health and social service datasets, including indicators related to healthcare access, provider networks, public assistance programs, education, and community health outcomes.
- **California Department of Health Care Access and Information (HCAI):** The Emergency Department Encounters and Dental Provider profiles were obtained from the HCAI data.
- **The National Cancer Institute** is the U.S. government's quality improvement agency for cancer research. The State Cancer Profiles are produced in collaboration between the National Cancer Institute and the Centers for Disease Control and Prevention.
- **Community Programs Dental Screening**
  - Head Start
  - Federally Qualified Health Centers: Tiburcio Vasquez Health Center
  - Big Smile for Mobile Dental Services
- **System for California Oral Health Reporting (SCOHR):** SCOHR is the centralized reporting system adopted by the Office of Oral Health for managing kindergarten oral health assessment (KOHA) data.

Primary Data

ODH staff, ODH consultants (Miriam Abrams, Dr. Jared Fine, and Dr. Bahar Amanzadeh), and the Alameda County Public Health Department (ACPHD)—Quality Improvement & Accreditation (QIA) Division team were involved in both the primary data collection and analysis processes for this assessment. These data captured the real-life experiences of Alameda County residents and included insights and perspectives from a broad range of populations and agencies, including those who serve children, pregnant and postpartum individuals, older adults, and people with special health-care needs, among others.

FOCUS GROUPS

Twenty-eight community focus groups were conducted by ACPHD-QIA team in seven languages across 20 community organizations throughout the County as part of the Alameda County Health Needs Assessment. Participant-reported dental concerns from the focus groups were systematically synthesized to identify common themes and insights.

KEY INFORMANT INTERVIEWS

Key Community Partners:

As part of updating the oral health strategic plan, in June and July of 2024, consultant Miriam Abrams conducted eight key informant semi-structured interviews, reflecting a variety of current and potential partner organizations. Participants represented organizations serving priority populations, including pregnant people, older adults, children aged 0–5, school-aged children, individuals with special health care needs, as well as representatives of the County Oral Health Commission and one of the local dental societies. For the interview guide and the list of organizations and programs the interviewees represented, please see Appendix A.

Kindergarten Oral Health Assessment (KOHA) Partners:

In collaboration with the UCSF Dental Public Health Residency Program, ODH hosted a resident in 2024–2025. The main resident's project was to conduct a series of interviews with school districts representatives in Alameda County to better understand the KOHA implementation. Eight school district representatives were interviewed to identify

challenges in implementing KOHA and collecting and reporting KOHA data into SCOHR. Participants were selected based on their prior experience or knowledge of KOHA reporting systems and procedures. The series of interviews was conducted between March and April 2025, using a semi-structured interview format.

PERINATAL DENTAL ENVIRONMENTAL SCAN

An environmental scan was conducted between June 2023 and December 2023 to systematically assess resources and identify gaps in dental care access for the perinatal population, with the goal of informing future strategies and interventions to improve oral health access and outcomes for pregnant and postpartum individuals.

A comprehensive, multimethod approach was designed to identify resources and gaps in dental care for the perinatal population. The methods included several primary data collection strategies:

» **Population Survey (N=59):** In English, Spanish, and Cantonese to capture participants' perceptions of access barriers, dental care use, awareness of available resources, and recommendations for improvement.

» **Stakeholders' Surveys (community partners (N=21) and dental providers (N=45)):** Gathered input from community partners and dental providers on current practices, provider training and comfort in serving pregnant patients, service delivery challenges, and strategies to improve access and integration.

» **Focus Groups (N=13):** Total of three focus groups, held in English and Spanish to collect qualitative insights into participants' dental care experiences, beliefs, and barriers to care.

» **Key Informant Interviews (N=11):** Conducted with healthcare providers, dental professionals, and community leaders to explore systemic barriers, workforce gaps, and potential solutions.

» **Referral Form Analysis (N=146):** Reviewed data from care coordination referrals (Sept 2023–Jan 2024) to describe demographics and dental needs of referred pregnant and postpartum patients.

» **Patient Satisfaction Surveys (N=44):** Administered by phone to assess satisfaction with care coordination services and gather suggestions for improvement.

STRATEGIC PLANNING COMMUNITY MEETINGS

The ODH convened two large in-person community meeting in November 2024 and May 2025 to gather a dedicated group of community leaders, health professionals, and advocates to discuss the Oral Health Strategic Planning 2025–2030. Participants outlined key goals and strategies, and they framed the implementation priorities and offered suggestions on data sharing and coordination—essential components for evaluating the progress and outcomes of implemented activities.

COMMUNITY INPUT

The ODH collected a series of success stories and conducted patient satisfaction surveys, which contributed to improving, strengthening, and sustaining our efforts. This data captured what is working, where gaps exist, and how ODH initiatives impact real people. The success stories were captured from ongoing communication with key partners and community members.

ODH SCREENING DATA

ODH School-Based Dental Program conducts dental screening at Berkeley and Livermore school districts. Additionally, the clinical team visits five WIC sites across Alameda County to offer dental screening for beneficiaries. Findings of those dental screenings are included in this report.

ACCOMPLISHMENTS FROM 2019–2024

The Office of Dental Health (ODH) made significant strides across all six focus areas: Access, Communication and Education, Oral Health Workforce Development, Integration of Oral Health and Medical Care, Policy and Sustainability, and Surveillance and Evaluation. The accomplishments outlined below reflect the commitment to advancing oral health equity for all Alameda County residents.

Access to Oral Health Care

ODH plays a central role in increasing access to oral health services across the county. As a part of the Healthy Teeth Healthy Communities (HTHC) initiative, a robust countywide care coordination system was implemented. This model of care coordination demonstrated success in bringing people into care, impacting state policy for the Community Health Worker benefit. Despite funding cutbacks in 2020, from 2022–2025, the ODH care coordination team assisted 2,220 children to establish a dental home.

ODH expanded the dental sealant program in Berkeley Unified School District to Livermore Valley Joint Unified School District. From January 2019 to June 2024, 1,955 students were screened, 604 received dental sealants, and 900 received fluoride varnish and teeth cleaning.

In early 2023, the California Department of Public Health awarded the ODH a three-year grant to develop a model for improving access to dental care for pregnant and postpartum individuals in the county, called the Perinatal Dental Demonstration Project (PDDP).

Since its launch, the PDDP has successfully increased awareness about the importance and safety of dental care during pregnancy by providing oral health training to staff and other professionals involved with pregnant and postpartum individuals, including WIC, Early Childhood programs, public health nurses, home visitors, and prenatal care sites, such as the Comprehensive Prenatal Services Program (CPSP) coordinators. Over 150 key staff from various programs attended at least one training session.

In partnership with the Alameda County Dental Society through the Community of Practice program, a free continuing education (CE) course focusing on the importance and safety of dental care during pregnancy was offered to local dental providers to improve their capacity to serve this population.

A key achievement of this project was establishing a closed-loop referral process, which ensures that referral sources are informed about the status of their referrals on a regular basis. In this process, patients referred to ODH from CPSP coordinators, WIC, and community partners were connected to appropriate dental care via ODH's care coordination team. Through this interdisciplinary collaboration, the care coordination team has successfully facilitated over 300 dental appointments for the perinatal population since the project launch.

Communication and Education

ODH continued to elevate oral health as a public health priority by regularly participating in community outreach events, offering direct engagement with residents across diverse communities. These efforts helped build trust, increase awareness about oral health services, and connect families to dental homes. From 2021–2025, ODH staff engaged with 20,557 residents through these outreach events. ODH provided specialized oral health trainings to prenatal medical providers, primary care medical providers and clinical staff, as well as early childcare center staff, to strengthen early prevention, screenings and referral practices. We conducted 59 sessions from 2020–2025, training 1,391 staff members at partner organizations as well as medical professionals. In addition, ODH developed and distributed oral health education resources tailored for all life stages, from early childhood through older adulthood.

Oral Health Workforce Development

ODH developed a Community of Practice (COP) for dental professionals, a continuing education and mentorship program for general dentists focused on treating priority populations, in collaboration with the UCSF School of Dentistry. ODH expanded COP through a new partnership with Alameda County Dental Society, ensuring ongoing professional development and a shared commitment to oral health.

ODH has actively contributed to strengthening the capacity of the oral health workforce by hosting residents from the UCSF dental public health residency program and interns from the Health Career Connection program. This opportunity provides them with valuable hands-on experience in the public health field. Through this partnership, residents and interns gain real-world exposure to aspects of county-level oral health programming, including program evaluation and performance management, development and dissemination of large-scale health communication messages, and oral health integration within prenatal care and early childhood centers. These experiences not only enhance their understanding of population-based oral health approaches but also help build a pipeline of skilled future professionals.

Integration of Oral Health and Medical Care

ODH strengthened the integration of oral health into broader health systems, including training 430 primary care providers and clinic staff on the application of fluoride varnish during well-child visits.

The establishment of a closed-loop referral process between ODH and CPSP coordinators as prenatal care providers, and WIC as an early childhood care program, represents meaningful integration of oral health into these care settings. This initiative marks an important step forward in collaborative and coordinated patient care.

Policy and Sustainability

Following the conclusion of the HTHC grant in 2020, ODH embedded key components—particularly care coordination and the Community of Practice—into ongoing county efforts, ensuring their continuation beyond the life of the grant. ODH also supported sustainability across the county by partnering with and advocating for community-based organizations as they sought funding and policy changes to integrate care coordination into their workflows and to continue implementation of other strategic plan priorities.

Surveillance and Evaluation

ODH maintained a strong commitment to data-driven planning and decision-making. The infrastructure built throughout previous strategic plans supported continued monitoring of service gaps, workforce capacity, and oral health disparities. Evaluation activities helped shape program design and policy recommendations, ensuring alignment with community needs and public health best practices.

Stakeholders Engagement

Throughout the last five years, ODH maintained a strong commitment to keeping stakeholders and community partners actively engaged. Engagement continues through three dedicated workgroups focused on Early Childhood, Children with Special Health Care Needs, and Individuals Experiencing Homelessness. In addition, a KOHA Committee, established in early 2024, strengthens participation in KOHA at the district, school, and student levels. The Oral Health Committee of the Alameda County Public Health Commission meets quarterly and plays a vital role in aligning countywide oral health efforts with broader public health priorities. As part of updating the 2019–2024 Oral Health Strategic Plan, ODH hosted two large in-person stakeholder meetings to foster partner buy-in and ensure continued participation in implementing the 2025–2030 plan.

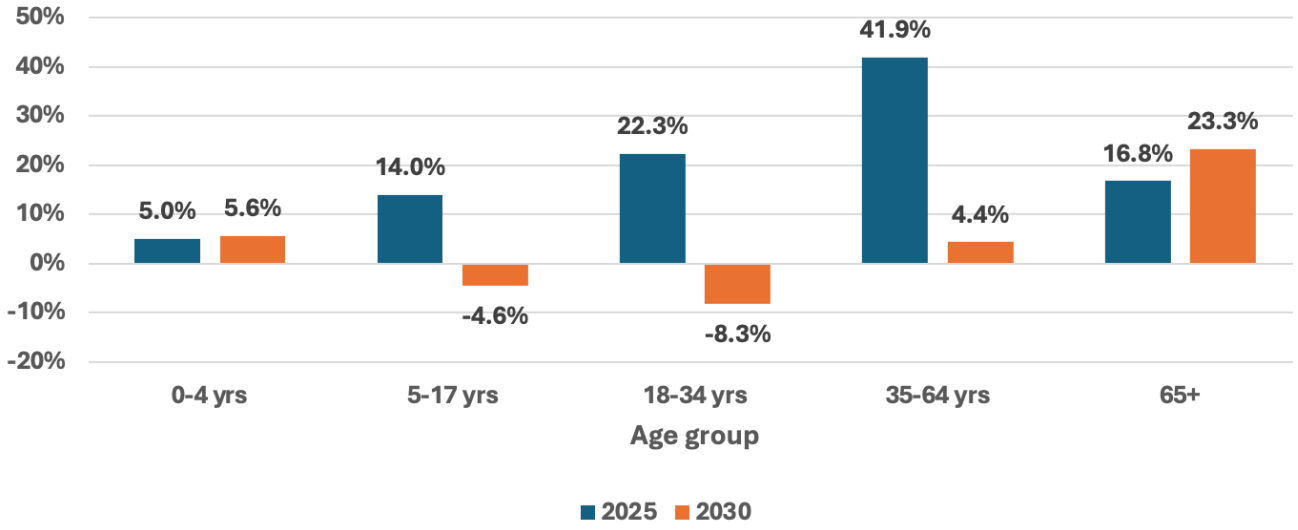
COUNTY DEMOGRAPHIC PROFILE

According to the Healthy Alameda County[4] and as of this report, the total population of Alameda County is 1.62 million people. Over the last five years, the population decreased by 3.32%, which is higher than the state average of 1.69%. By age, the largest age group in Alameda County is 35–64 years, comprising 41.94% of the population. Young Adults (18–34 years) account for 22.25%, while School-Age Children (5–17 years) make up 14.00%. Seniors (65+ years) represent 16.81%, and Young Children (0–4 years) constitute only 5.01%.

Alameda County's population is projected to undergo notable demographic shifts by 2030. The most significant trend is the rapid growth of the older adult population, with residents aged 65 and older increasing by more than 23% (from approximately 273,000 to 337,000).

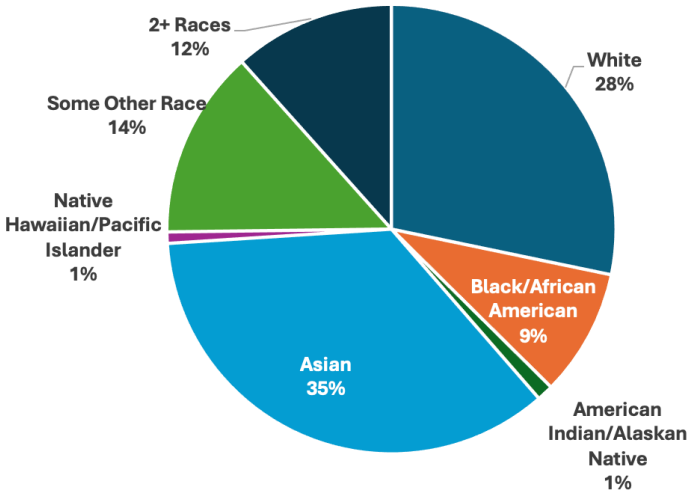
On the other hand, younger age groups are expected to decline. The school-age population (5–17 years) will decrease by about 4.6%, and the young adult group (18–34 years) will drop by 8.3%. The working-age group (35–64 years) will grow modestly by 4.4%. The 0–4 years group will see a slight increase of 5.6%.[5] Overall, these trends point toward an aging county with fewer young residents, as shown in Figure 1.

FIGURE 1: ALAMEDA COUNTY RESIDENTS BY AGE CATEGORY, 2025 AND PROJECTED 2030 DISTRIBUTION



By race, Alameda County is quite diverse, with a particularly high percentage of Asian residents compared to other racial groups. The county also has a notable percentage of Black/African American residents and a lower percentage of White residents compared to the state average (39%), as shown in Figure 2. By ethnicity, 24% of the population is Hispanic/Latino, compared to 42% statewide.

FIGURE 2: ALAMEDA COUNTY POPULATION BY RACE, 2025

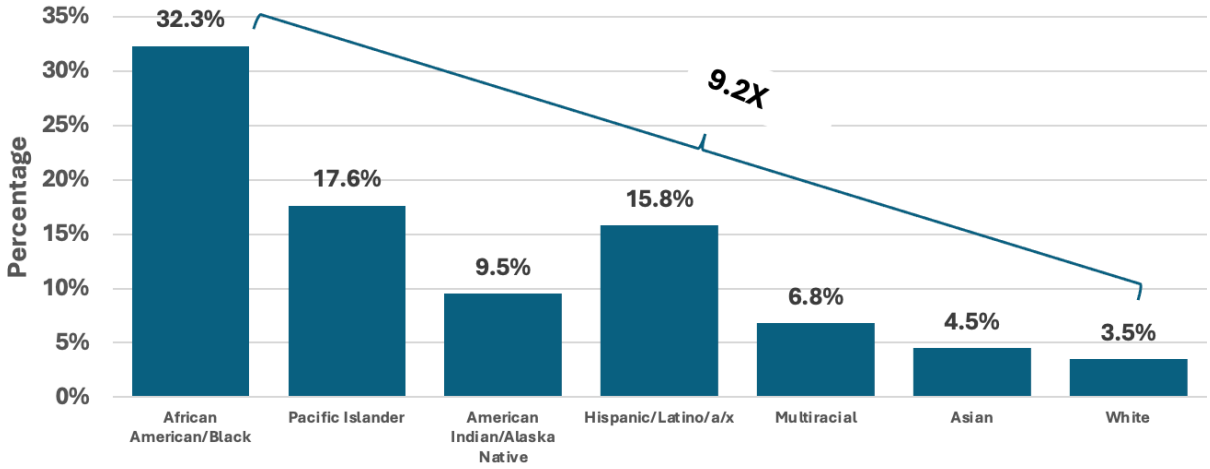


By spoken languages, Alameda County exhibits notable linguistic diversity, particularly due to a significant number of Asian/Pacific Islander and Indo-European language speakers. The proportion of Spanish speakers in Alameda County is significantly lower than the state average of 28%. The following languages are also spoken in the county: Chinese (9%), Hindi or related languages (5%), and Filipino/ Tagalog (4%).

The overall economic status of Alameda County is relatively favorable and stronger than that of California as a whole. However, disparities among some groups are evident. Almost 6% of the Alameda County families live below the federal poverty level, which is lower than the California average (9%). The percentage of families with children below the poverty line in Alameda County is 3.68%, well below the California average of 5.83%.

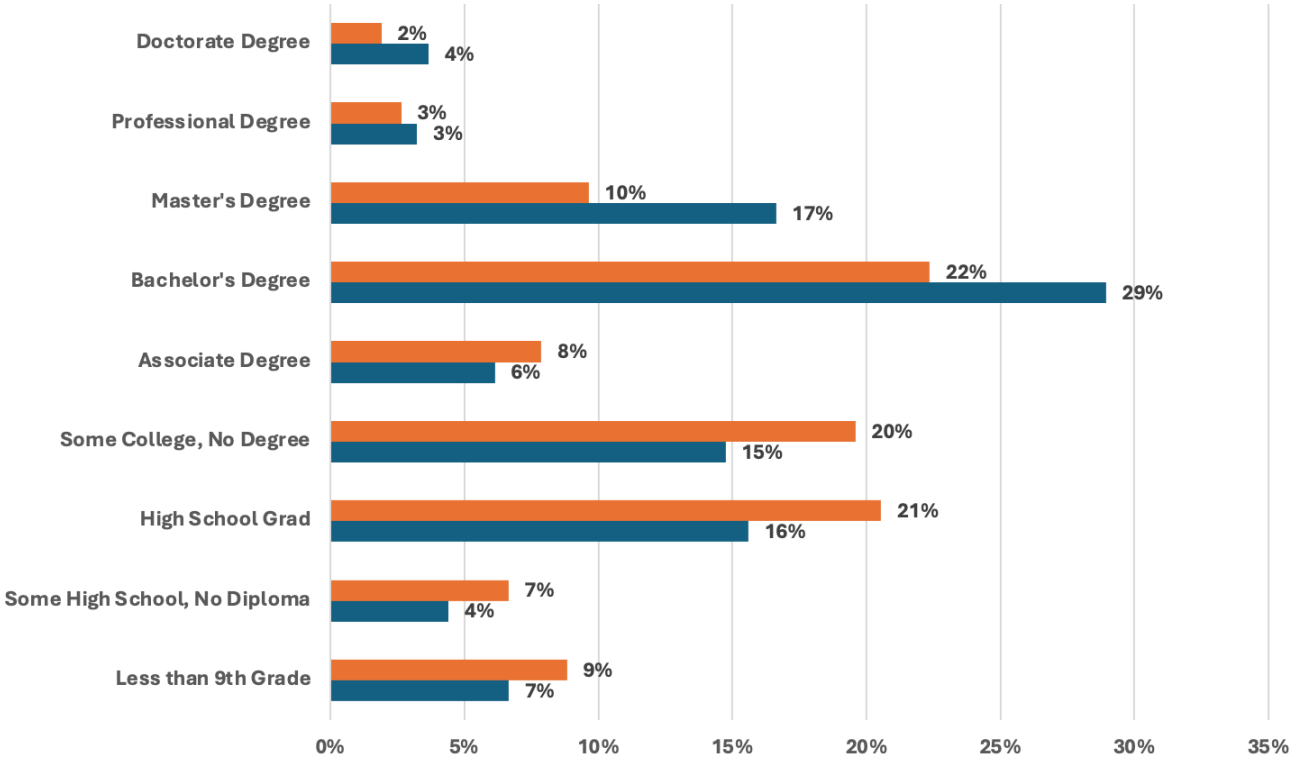
Data from the American Community Survey, 2022, shows that disparities in poverty rate by race/ethnicity are evident, with African American/Black and Pacific Islander populations experiencing the highest poverty levels, followed by American Indian/Alaska Native and Hispanic/Latino/a/x groups, all exceeding the overall poverty rate and more than double the rate among White residents. These inequities are even more pronounced when focusing on children under 18, with African American/Black children experiencing the highest poverty rate at 32.3%, nine times and seven times more likely than White children (3.3%) and Asian children (4.5%), respectively, as shown in Figure 3.

FIGURE 3: POVERTY RATE AMONG CHILDREN AND YOUTH UNDER 18



Alameda County demonstrates a notably higher level of educational attainment compared to the California state average. A significantly larger proportion of its residents hold Bachelor's, Master's, and Doctorate degrees, compared to state average. Conversely, the county has a smaller share of individuals with less than an associate's degree compared to California, as shown in Figure 4.

FIGURE 4: POPULATION 25+ BY EDUCATIONAL ATTAINMENT IN ALAMEDA COUNTY AND CALIFORNIA, 2025



ORAL HEALTH OUTCOMES OF ALAMEDA COUNTY RESIDENTS

In this section, we will examine available data that can shed light on the status of oral health of Alameda County residents through the life course. Data sources included local screening dental programs, including ODH's school-based dental program and other dental providers, SCOHR data for the Kindergarten Oral Health Assessment,[6] CHIS data for self-reported condition of teeth and missed school days for dental problems,[7] CDC-PLACES data for the total tooth loss among adults 65+,[8] and the State Cancer Profile for the prevalence of Oral and Pharynx cancer.

Young Children (0–5 Years Old)

Data showing the current oral health status of children aged 0–5 years comes from the Office of Dental Health program, Head Start, Early Head Start, Tiburcio Vasquez Health Center, and the Alameda County Dental Society. During FY 24–25, these organizations assessed the oral health of 831 children. The findings showed that 153 children (18%) had untreated decay. At least 82 children, or 9%, needed urgent dental care. Caries experience was noted in 203 children, representing 24% of those assessed.

School-Aged Children (6–20 Years Old)

ODH School-Based Dental Program

The dental screening of 576 students at Berkeley School Unified and two schools in Livermore School District showed that during the last two school years, 2023–2024 and 2024–2025, 29% had untreated tooth decay, and 8% required urgent dental care. Additionally, 50% of the screened students had experienced caries, which includes both treated and untreated tooth decay.

Big Smiles

Big Smiles Dental offers on-site dental services across various districts in Alameda County. During the 2024–2025 period, they provided care to multiple schools throughout the county, examining a total of 1,886 students. Among these students, 19% had untreated tooth decay, and 6% needed urgent dental care.

Kindergarten Oral Health Assessment (KOHA)

The Kindergarten Oral Health Assessment (KOHA) is a California state mandate that requires children enrolled in public school for their first year in Transitional Kindergarten (TK), Kindergarten, or first grade to receive a dental screening from a licensed dental professional. Schools are responsible for collecting the completed assessment forms and entering the data into the SCOHR, which supports statewide oral health surveillance.

According to SCOHR data, in school year 2018–2019, 53% of Alameda County schools reported KOHA data to the system. Among the 19,900 enrolled kindergarten students, 23% completed and returned their KOHA forms, 2% submitted waivers, and 75% did not return their forms to school. Of the submitted waivers, 72% cited non-consent or the belief that the child would not benefit from the assessment. In school year 2024–25, only 36% of schools submitted KOHA reports to SCOHR. Among the students in those reporting schools, 35% completed and returned the KOHA form, 26% submitted a waiver, and 39% did not return any form. Of the students who submitted a waiver, 89% cited either a lack of dental insurance or difficulty finding a provider who accepts their insurance.

Although the KOHA data entered into SCOHR reflects the oral health status of students who completed and returned the KOHA form, such as experiencing tooth decay or having untreated tooth decay, it appeared unreliable and was challenging to use in this report. Therefore, we limited our reporting in this document to the measures described above. This challenge underscores the need for improved technical assistance and resources to support school districts in accurately entering KOHA data.

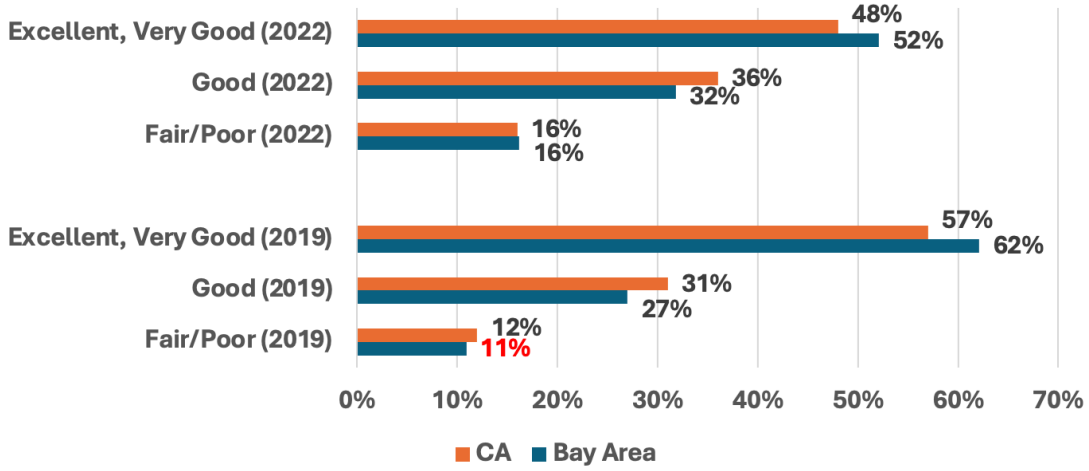
The Office of Dental Health (ODH) will work collaboratively with school districts to strengthen KOHA mandate implementation. Planned efforts include providing training to school staff, improving data entry processes, coordinating on-site dental screening events at schools, and helping schools address additional access barriers that prevent families from completing the assessment.

Self-reported Condition of Teeth Among Teens

Figure 5 illustrates trends in teens' self-reported condition of teeth in the Bay Area Region and California for 2019 and 2022 when asked: "How would you describe the condition of your teeth?" Bay Area regional data was used instead of Alameda County's data due to the statistical instability for this measure at the county level.

In 2019, 62% of Bay Area teens rated their teeth as excellent/very good, compared to 57% in California. By 2022, these percentages have declined to 52% in the Bay Area and 48% statewide. Throughout both years, a consistently higher percentage of teens in the Bay Area perceived their dental condition as excellent/very good compared to the statewide average. The proportion of teens reporting their teeth as good rose from 27% in the Bay Area teens and 31% statewide in 2019 to 32% and 36%, respectively, in 2022. Eleven percent of teens in the Bay Area (which was statistically unstable) and 12% statewide reported the condition of their teeth as fair/poor, which increased to 16% in both the Bay Area and California in 2022.

FIGURE 5: SELF-REPORTED CONDITION OF TEETH AMONG TEENS IN BAY AREA REGION AND CALIFORNIA, 2019 AND 2022



Missed School Days Due to Dental Problems

Dental diseases and the pain they cause are significant contributors to missed school days among children, impacting both educational achievement and overall well-being. As part of the CHIS, respondents were asked: "During the past 12 months, did (he/she) miss any time from school because of a dental problem? Do not count time missed for cleaning or a check-up." This variable is not asked of everyone: Asked of children aged 5 and older who attend school.

FIGURE 6: PERCENTAGE OF CHILDREN 5+ WHO MISSED SCHOOL DUE TO DENTAL PROBLEM IN ALAMEDA COUNTY AND CALIFORNIA, 2023-2024

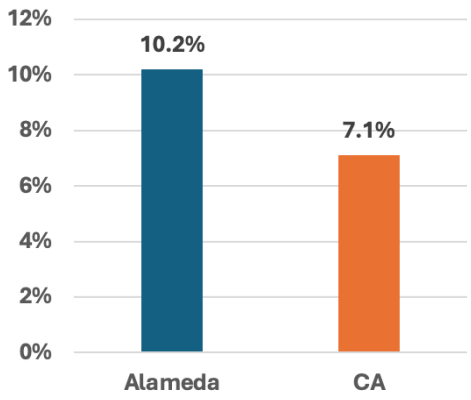


Figure 6 displays the percentage of children aged 5 and older who missed school due to dental problems in Alameda County and California, based on data from pooled (combined) years, 2023 and 2024, to address data instability observed in individual annual estimates. Alameda County showed a higher rate (10.2%) than Statewide average (7.1%).

Data for the years 2018–2019 were determined to be statistically unstable for both Alameda County and Bay Area Region. Subsequently, they were not used for comparison.

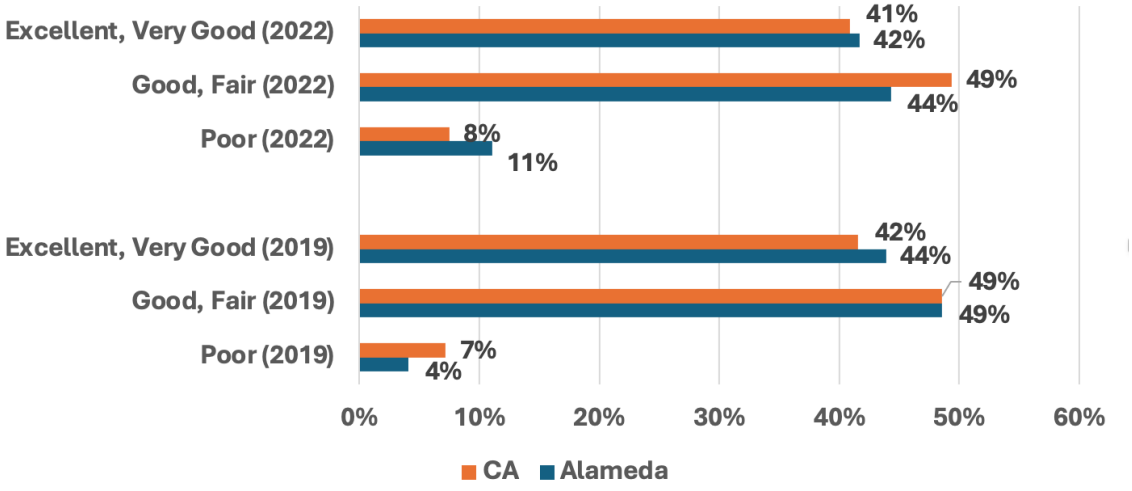
Adults Oral Health Status

Self-reported Condition of Teeth Among Adults

Figure 7 illustrates the self-reported condition of teeth among adults in Alameda County and California in 2019 and 2022 when asked: "How would you describe the condition of your teeth?" In 2019, nearly 50% of adult respondents in both Alameda County and Statewide classified the condition of their teeth as "good/fair", which was slightly higher than the proportion rating their teeth condition as "excellent/very good" (44% in Alameda and 42% Statewide). By 2022, this pattern remained consistent: 44% of adults in the County reported their teeth condition as "good/fair," compared to 42% reporting "excellent/very good." Statewide, 49% of adults considered the condition of their teeth as "good/fair" compared to 41% "excellent/very good," during the same year.

A notable increase occurred in the percentage of adults considering the condition of their teeth as "poor" between 2019 and 2022, rising from 4% to 11% in Alameda County, compared to only a one percent increase Statewide.

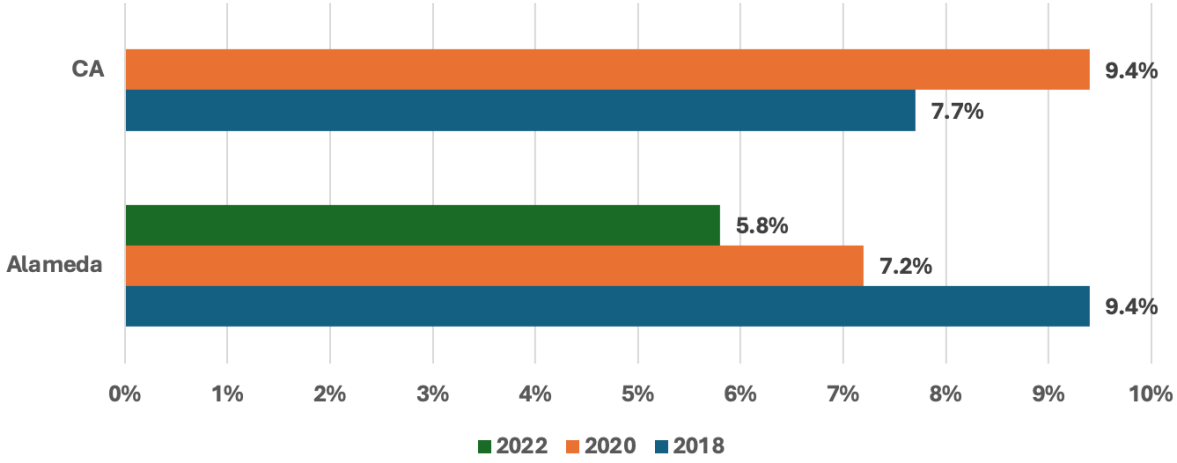
FIGURE 7: SELF-REPORTED CONDITION OF TEETH AMONG ADULTS IN ALAMEDA COUNTY AND CALIFORNIA, 2019 AND 2022



Older Adults (65 Years and Older)

Figure 8 depicts the age-adjusted prevalence of adults aged 65 and older in Alameda County and California who have lost all their teeth from 2018 to 2022. The graph demonstrates a steady decrease in the prevalence from 9.4% in 2018 to 5.8% in 2022 in Alameda County. In contrast, California showed an increase in this prevalence from 7.7% in 2018 to 9.4% 2020. Statewide data for 2022 is not yet available.

FIGURE 8: AGE-ADJUSTED PREVALENCE OF ADULTS 65+ WITH TOTAL TOOTH LOSS, ALAMEDA COUNTY AND CALIFORNIA, 2018-2022



Oral and Pharynx Cancer

Oral cancer forms in tissues of the mouth or the oropharynx (the part of the throat at the back of the mouth). The known risk factors for developing oral cancer are tobacco use and heavy alcohol consumption. According to the American Cancer Society, individuals who both smoke and drink excessively are 30 times more likely to develop oral cancer than those who do not smoke or drink.[9]

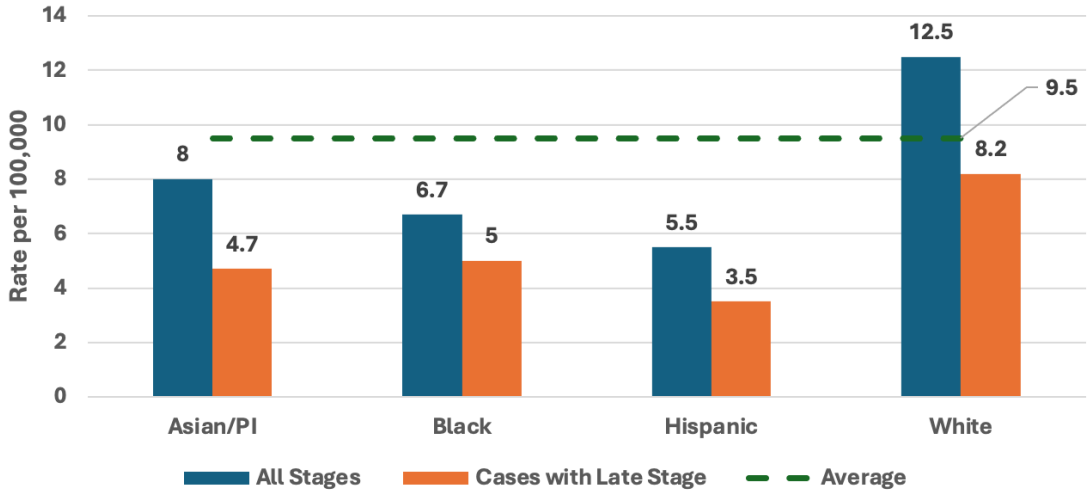
The data on incidence rate for oral cavity and pharynx cancer is derived from the National Cancer Institute and State Cancer Profile for incidence across different population subgroups.[10] The analysis of age-adjusted incidence rates for oral cavity and pharynx cancer from 2017 to 2021 reveals notable disparities by race/ethnicity, age, and sex. The average incidence rate is 9.5 per 100,000, showing a slight decrease from the previous period, 2016-2020, at 9.4 per 100,000.

Figure 9 shows the age-adjusted incidence rate of oral cavity and pharynx cancer by 100,000, by race/ethnicity, all stages, and late stage, 2017–2021.* White individuals bear the highest overall burden, with incidence rates of 12.5 per 100,000 for all stages and 8.2 per 100,000 for late-stage disease. Black individuals, while having a lower overall incidence (6.7 per 100,000), face the highest proportion of late-stage diagnoses, with approximately 75% (5 out of 6.7 per 100,000) of cases identified at an advanced stage. Asian and Pacific Islander individuals have a relatively high incidence rate of 8 per 100,000, with 4.7 per 100,000 (59%) presenting with late-stage disease. Hispanic populations have the lowest incidence, at 5.5 per 100,000 for all stages and 3.5 per 100,000 for late-stage cases.

* Data for American Indian/Alaska Native has been suppressed to ensure confidentiality and stability of rate estimates as counts were fewer than 16.

The age-related burden is dramatic: incidence rises from 5.2 per 100,000 among those under 65 to 39 per 100,000 among those 65 and older. There is also a pronounced sex disparity, with males experiencing more than twice the incidence seen in females (13.4 vs. 6.1 per 100,000). These findings underscore the importance of focusing prevention, screening, and early detection efforts on White and Black communities, older adults, and males to reduce both overall incidence and late-stage diagnosis.

FIGURE 9: AGE-ADJUSTED INCIDENCE RATE CASES OF ORAL CAVITY AND PHARYNX CANCER BY 100,000, BY RACE/ETHNICITY, ALL STAGES AND LATE STAGE, 2017-2021



DENTAL SERVICES UTILIZATION AMONG MEDI-CAL DENTAL BENEFICIARIES

This section summarizes the prevalence of key dental utilization measures, including annual and preventive dental visits and sealant use, among Medi-Cal dental beneficiaries. The Medi-Cal Dental program is California's version of the federal Medicaid program. Data is derived from the California Health and Human Services Open Data Portal.[11]

An annual dental visit is recorded when a beneficiary receives qualifying dental care at least once per calendar year. This includes a range of services such as diagnostics (e.g., X-rays), preventive care, treatments, and surgeries, as well as visits to safety net clinics dedicated to serving underserved or vulnerable communities.

A preventive dental visit is documented each calendar year when a beneficiary obtains services specifically aimed at preventing oral health issues, like professional cleanings, sealant applications, fluoride treatments, or other preventive encounters at safety net clinics.

Use of sealant: A dental sealant is a protective coating that is painted onto the chewing surfaces of the back teeth. It acts as a barrier to preventing cavities in children.

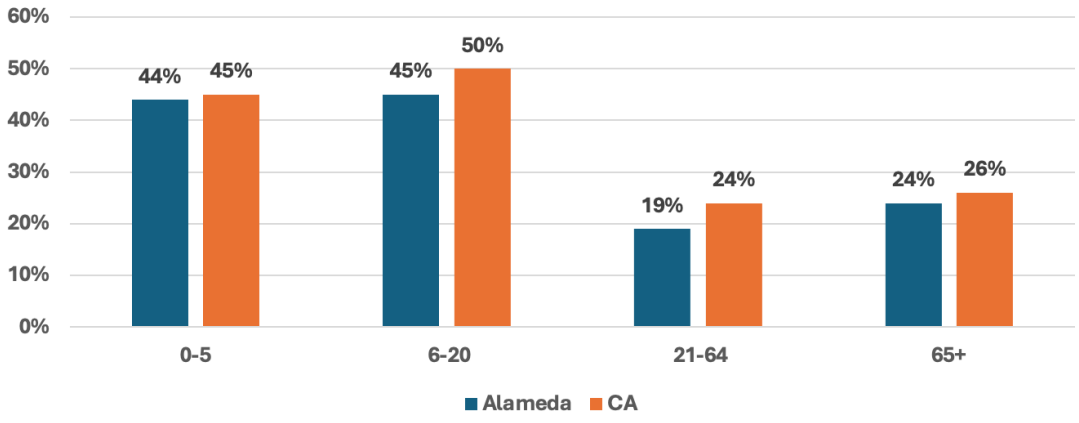
It should be noted that beginning in 2019, CPT code 99188 was incorporated into both annual and preventive dental visit codes. This code captures fluoride varnish applications provided by medical professionals, offering a more comprehensive view of preventive dental service access and utilization among the Medi-Cal population. Additionally, in 2018, the Dental Transformation Initiative (DTI) was launched to enhance the delivery and coordination of dental care for Medi-Cal beneficiaries. Together, these efforts can be partly attributed to the observed increase in Medi-Cal dental service utilization in 2019.

Annual Dental Visits by Age Groups

Figure 10 displays the percentage of annual dental visit utilization among Medi-Cal Dental beneficiaries by age group in Alameda County and California in 2023. For children aged 0–5, utilization rates were slightly similar, at 44% in Alameda County and 45% statewide. For those aged 6–20, Alameda showed a 45% utilization rate, lower than California's 50%. Among adults aged 21–64, Alameda had the lowest rate at 19%, compared to 24% in California. For adults aged 65+, utilization was 24% in Alameda and 26% statewide.

Overall, the highest utilization was observed among the 6–20 age group, while the lowest was among adults aged 21–64 in both regions. Across all age groups, California consistently had higher utilization rates than Alameda County.

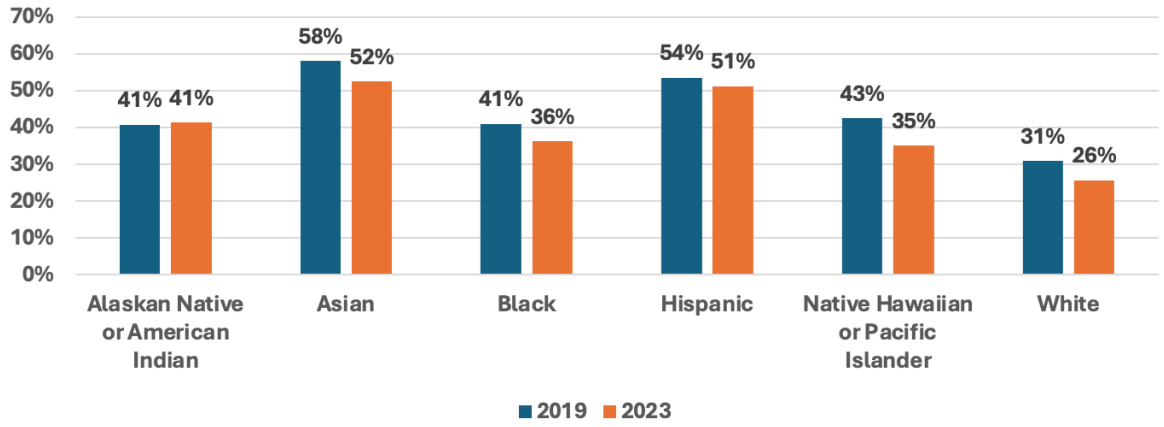
FIGURE 10: UTILIZATION OF ANNUAL DENTAL VISIT BY MEDI-CAL DENTAL BENEFICIARIES BY AGE GROUP IN ALAMEDA COUNTY AND CALIFORNIA, 2023



Children Aged 0–20

Figure 11 illustrates trends in annual dental visit utilization among Medi-Cal Dental beneficiaries aged 0–20 in Alameda County across different racial and ethnic groups from 2019 to 2023. Asian children consistently had the highest utilization rates, with a slight decrease from 58% in 2019 to 52% in 2023, followed by Hispanic children, whose rates also declined slightly from 54% to 51% over the same period. Steeper decreases were observed among Black, Native Hawaiian or Pacific Islander, and White children, who had the lowest utilization rates in both years (31% in 2019, 26% in 2023). Alaskan Native or American Indian children showed no change, remaining at 41% in both years. Despite the relatively higher rates among Asian and Hispanic children, the overall trend reflects persistent disparities in access to dental care for children and youth in Alameda County.

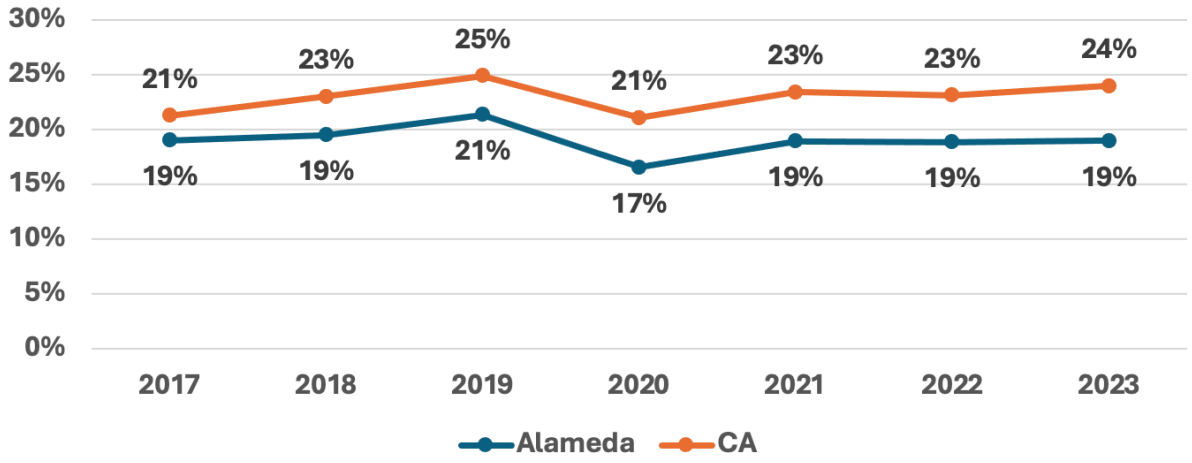
FIGURE 11: UTILIZATION OF ANNUAL DENTAL VISIT BY MEDI-CAL DENTAL BENEFICIARIES AGED 0-20 BY RACE/ETHNICITY IN ALAMEDA COUNTY, 2019-2023



Adults Aged 21–64

Figure 12 illustrates the utilization of annual dental visits among Medi-Cal Dental adult beneficiaries aged 21–64 in Alameda County and California from 2017 to 2023. Throughout this period, California consistently showed higher utilization rates compared to Alameda County. From 2017 to 2019, both regions experienced a steady increase in utilization: Alameda County rose from 19% to 21%, while California increased from 21% to 25%. However, in 2020, both saw a sharp decline, largely attributed to the COVID-19 pandemic and its impact on access to dental services.

FIGURE 12: UTILIZATION OF ANNUAL DENTAL VISIT BY MEDI-CAL DENTAL ADULT BENEFICIARIES AGED 21-64 IN ALAMEDA COUNTY AND CALIFORNIA, 2017-2023

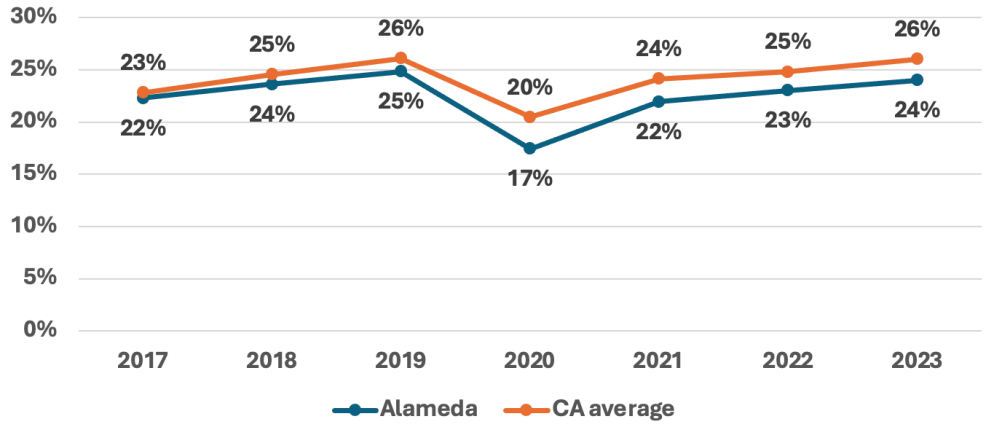


By 2021, utilization rate of annual dental visit among adults aged 21–64 began to rebound. Alameda County returned to 19% and remained stable through 2023. California showed a stronger recovery, reaching 23% in 2021 and slightly increasing to 24% by 2023.

Older Adults

Figure 13 illustrates the utilization of annual dental visits among Medi-Cal adult beneficiaries aged 65 and older in Alameda County and California from 2017 to 2023. Both regions experienced a gradual increase in utilization rates from 2017 to 2019. In Alameda County, the rate rose from 22% to 25%, while California saw an increase from 23% to 26%. A sharp decline occurred in 2020, likely due to the COVID-19 pandemic, with utilization dropping to 17% in Alameda and 20% statewide. By 2021, rates began to rebound—22% in Alameda and 24% in California—and continued to rise steadily through 2023, reaching 24% in Alameda County and 26% in California.

FIGURE 13: UTILIZATION OF ANNUAL DENTAL VISIT BY MEDI-CAL DENTAL ADULT BENEFICIARIES AGED 65+ IN ALAMEDA COUNTY AND CALIFORNIA, 2017-2023

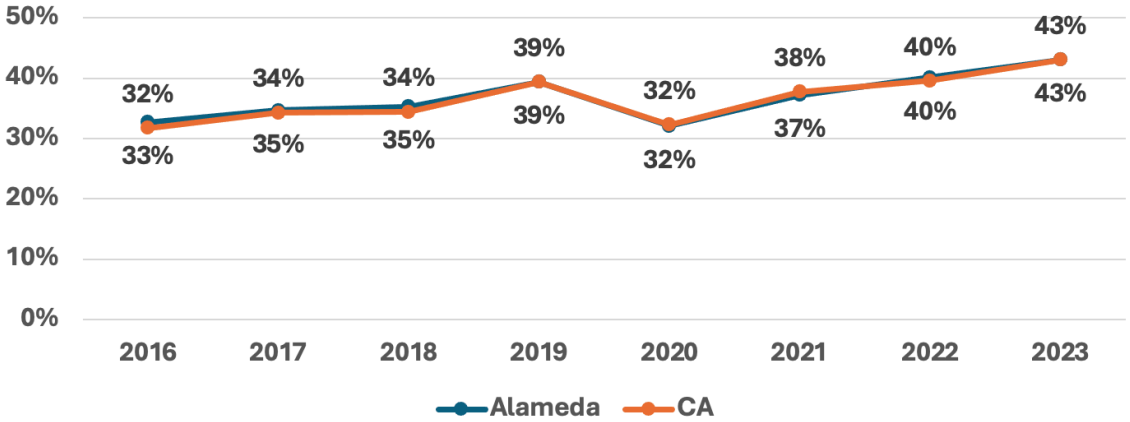


Preventive Dental Services

Children Ages 0–5

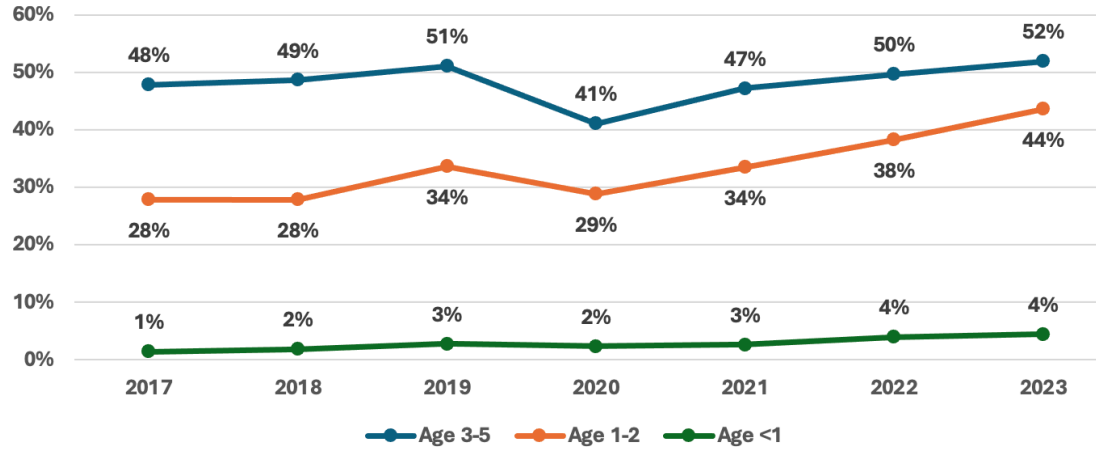
Figure 14 shows the percentage of children aged 0-5 eligible for Medi-Cal Dental who utilized preventive dental services in Alameda County and California from 2017 to 2023. Utilization rates in Alameda County were generally nearly similar to the state average, ranging from 32% to 43%. Alameda County and California were at their lowest at 32% in 2020, most likely due to the COVID-19 pandemic, followed by a steady increase, reaching 43% in 2023. Notably, there was an observed increase from 2018 to 2019, coinciding with the addition of CPT code 99188 and the initiation of the Dental Transformation Initiative (DTI).

FIGURE 14: UTILIZATION OF PREVENTIVE DENTAL SERVICES BY MEDI-CAL DENTAL ELIGIBLE CHILDREN AGED 0-5, IN ALAMEDA COUNTY AND CALIFORNIA, 2017-2023



Breaking down the age group 0-5 into 3 age groups: <1, 1–2, and 3–5 years old showed some disparities among groups, as shown in Figure 15. Overall, there is a consistent trend of higher utilization among children 3–5 years old, increasing from 48% in 2017 to 52% in 2023. In contrast, children aged <1 had the lowest utilization, remaining below 5% across all years, despite the recommendation by both the American Academy of Pediatrics and the American Academy of Pediatric Dentistry that children should receive their first dental visit by their first birthday or first tooth. There was an observed drop in utilization across groups in 2020, mostly due to COVID-19 pandemic. The slight increase observed in 2019 can be partly attributed to the introduction of the CPT code 99188, and the implementation of the DTI in the county.

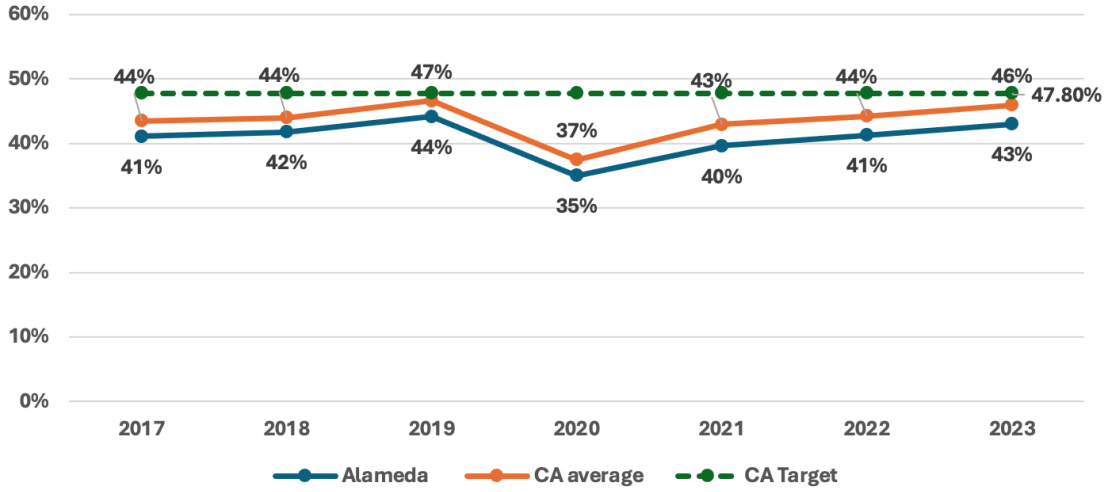
FIGURE 15: UTILIZATION OF PREVENTIVE DENTAL SERVICES AMONG CHILDREN WITH MEDI-CAL DENTAL AGED <1, 1-2, AND 3-5, ALAMEDA COUNTY, 2017-2023



Children Ages 0–20

Figure 16 presents the utilization of preventive dental services among Medi-Cal Dental eligible children aged 0–20 in Alameda County and California from 2017–2023, compared to the state target. Over this period, Alameda consistently lagged the California average, with rates ranging from 35% to 44%. Both regions showed a gradual increase in utilization rates over the years, with a noticeable dip in 2020, likely due to the COVID-19 pandemic. In 2019, Alameda County reached its highest utilization rate at 44%, while California peaked at 47%. Despite these gains, both remained below the statewide target of 47.8%. From 2021 to 2023, a gradual recovery was observed in both regions; however, neither met the state benchmark during this period.

FIGURE 16: UTILIZATION OF PREVENTIVE DENTAL SERVICES BY MEDI-CAL DENTAL ELIGIBLE CHILDREN AGED 0-20, IN ALAMEDA COUNTY AND CALIFORNIA, 2017-2023



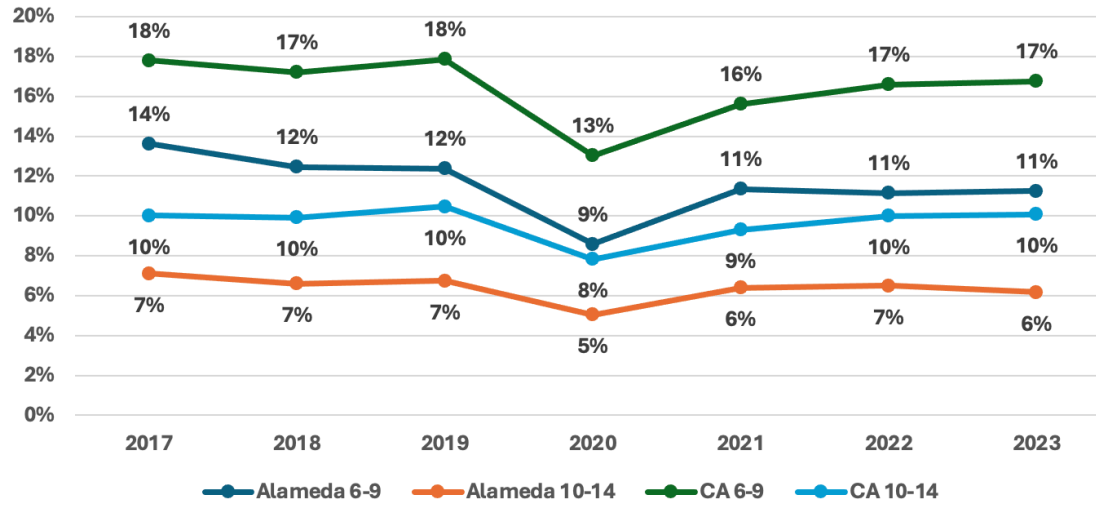
Use of Sealants

Dental sealants are a simple, effective, and affordable way to prevent cavities, especially in children. They work by coating the chewing surfaces of back teeth, blocking out food and bacteria that cause decay. Public health programs, particularly school-based sealant initiatives, have been shown to significantly reduce oral health disparities and save on treatment costs. These programs are especially impactful for children in low-income communities who may not have regular access to dental care.[12]

Figure 17 illustrates the use of dental sealants among children ages 6–9 and 10–14 with Medi-Cal Dental in Alameda County and California from 2018 to 2023. Sealant rates among children 6–9 years old continue to be higher than those 10–14 years old in both Alameda County and California, despite the importance of sealants in dental cavity prevention in both age groups. Throughout the years, children ages 6–9 in California had the highest sealant usage, ranging from 13% in 2020 to 18% in 2019, with a steady rate of 17% in both 2022 and 2023. Alameda County's 6–9 age group consistently followed, maintaining rates around 12% for most years but dropping to a low of 9% in 2020 before gradually recovering to 11% by 2023. For children aged 10–14, California also showed higher usage (10% annually except for a slight dip to 8% in 2020), while Alameda County rates were lower, starting at 7%, dipping to 5% in 2020, and returning to 6% by 2023.

The graph reveals a significant dip for all groups in 2020, likely due to pandemic-related disruptions, followed by a partial recovery in subsequent years. Overall, sealant use in Alameda County remains lower than the California average, especially among older children.

FIGURE 17: USE OF SEALANTS AMONG CHILDREN WITH MEDI-CAL DENTAL AGED 6-9 AND 10-14 IN ALAMEDA COUNTY AND CALIFORNIA, 2018-2023



Pregnant People

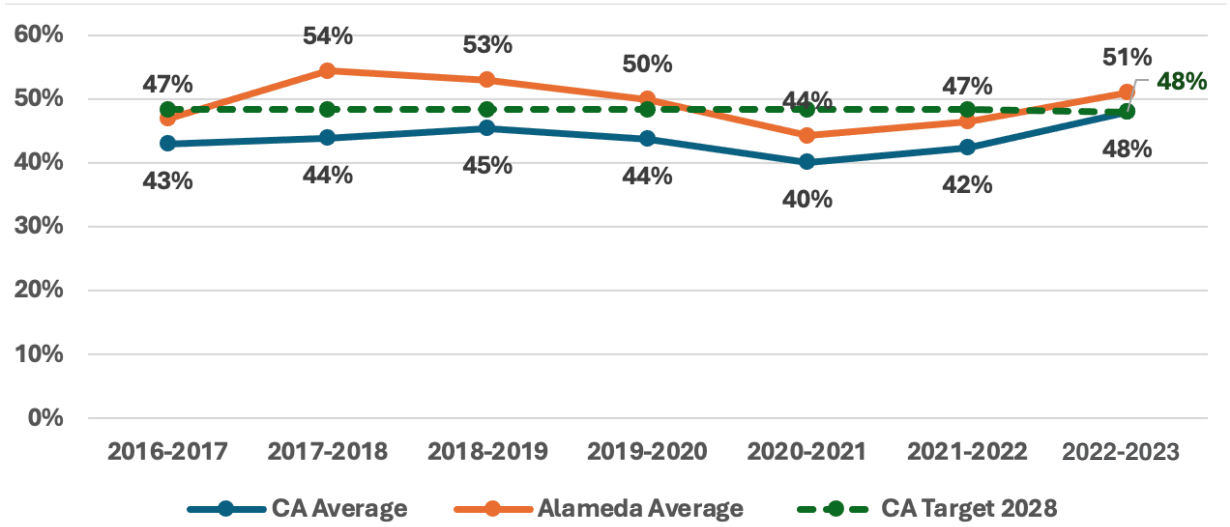
During pregnancy, various physical and nutritional changes can negatively affect oral health and well-being. Hormonal changes may lead to gum inflammation, known as pregnancy gingivitis, which affects up to 75% of pregnant individuals. Tooth decay is also common, driven by factors such as food cravings and more frequent snacking. Untreated oral diseases in pregnancy may result in poor pregnancy outcomes, including premature delivery and low birth weight. The landmark 2012 publication, Oral Health Care During Pregnancy: A National Consensus Statement, highlighted that dental care during pregnancy is important, safe, and recommended, yet many pregnant individuals still face substantial barriers to accessing care. Recognizing these ongoing challenges, the American Public Health Association (APHA) released a policy brief in 2020 calling for expanded education, integration of health services, and improved insurance coverage to enhance dental access for pregnant individuals.

Therefore, maintaining optimal oral hygiene and obtaining routine dental cleanings during pregnancy are critical components of maternal health care. Despite this, many pregnant individuals do not receive dental services due to a range of factors, including limited access to providers who accept Medi-Cal and persistent misconceptions regarding the safety of dental treatment during pregnancy.

This section presents an analysis of self-reported oral health data among pregnant people from the 2016–2017 through 2022–2023 California Maternal and Infant Health Assessment (MIHA).

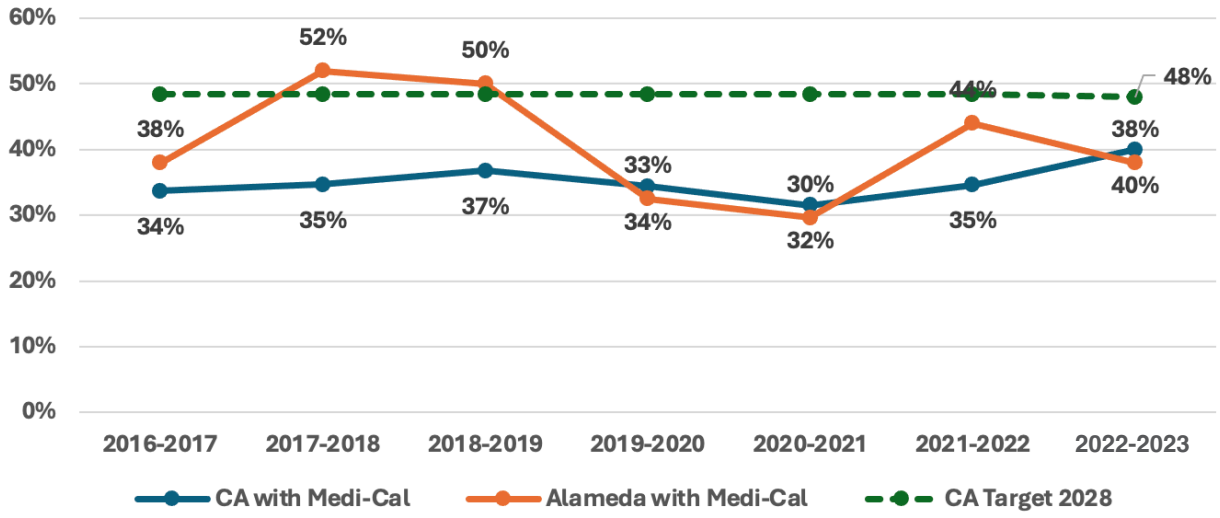
Figure 18 presents the percentage of individuals receiving dental care during pregnancy in Alameda County and California. Alameda County has consistently exceeded the statewide average over the past several years, as shown in the data from 2016 to 2023. The rate peaked at 54% in Alameda County during 2017–2018 and, despite a notable decline through 2020–2021, the rate rebounded to 51% in 2022–2023. In contrast, the California state average remained lower, dipping to 40% in 2020–2021 before increasing to 48% most recently. Both Alameda County and statewide rates now align closely with California's 2028 benchmark goal of 48%, reflecting measurable progress towards improving access to prenatal dental services at county and state levels.

FIGURE 18: RECEIPT OF DENTAL VISIT DURING PREGNANCY AMONG ALAMEDA COUNTY AND CALIFORNIA RESIDENTS WITH A RECENT LIVE BIRTH, 2016-2023



Among Medi-Cal beneficiaries with a recent live birth, Alameda County demonstrated higher rates of dental visits during pregnancy compared to the California average for the same population in most years from 2016 to 2023, as shown in Figure 19. Rates in Alameda peaked at 52% in 2017–2018, then declined to a low of 30% in 2020–2021 before recovering to 38% in the latest reporting period. The statewide average remained lower throughout the timeline, reaching only 32% in 2020–2021 and increasing to 40% in 2021–2023. Despite improvements in the most recent years, both Alameda County and California access for this population declined in 2023, indicating ongoing barriers to care and missed opportunities for intervention specifically for this population.

FIGURE 19: RECEIPT OF DENTAL VISIT DURING PREGNANCY IN ALAMEDA COUNTY AND CALIFORNIA AMONG MEDI-CAL BENEFICIARIES WITH A RECENT LIVE BIRTH, 2016–2023



In 2022–2023, the percentage of women with a recent live birth who received a dental visit during pregnancy was higher in Alameda County (51%) compared to the statewide average of California (48%), as shown in Table 1. Examination by family income reveals greater disparities: women from households above 200% of the federal poverty guideline (FPG)** had substantially higher rates of dental visits (59%) in both Alameda County and California, compared to only 41% in Alameda and 39% statewide among those at or below 100% FPG. Rates of dental visits were also higher among those with private prenatal health insurance (58% Alameda, 56% California) compared to those with Medi-Cal (38% Alameda, 40% California). Age and educational attainment were both associated with higher dental visit rates, with the highest utilization among older women (62% for age 35+ in Alameda, 54% statewide) and college graduates (61% Alameda, 60% California), while the lowest rates were observed among younger age groups and those with a high school education or less (33–38%) in both Alameda County and California. These findings indicate persistent socioeconomic disparities in access to dental care during pregnancy at both the county and state levels.

** For 2022, the Federal Poverty Guideline for a single-person household in the contiguous states was $13,590, and for a four-person household, it was $27,750. These guidelines are set by the Department of Health and Human Services and vary by household size, with separate, higher guidelines for Alaska and Hawaii.

TABLE 1: DENTAL VISITS DURING PREGNANCY BY SOCIODEMOGRAPHIC FACTORS, 2022–2023

	Total		
Alameda County	51%		
California	48%		
Family Income	**<=100% FPG**	**101–200% FPG**	**>200% FPG**
Alameda County	41%	41%	59%
California	39%	38%	59%
Prenatal Health Insurance	**Medi-Cal**	**Private**	
Alameda County	38%	58%	
California	40%	56%	
Age	**15–24**	**25–34**	**35+**
Alameda County	33%	47%	62%
California	38%	48%	54%
Educational Attainment	**High school or less**	**Some college**	**College graduate**
Alameda County	38%	36%	61%
California	39%	41%	60%

Use of the Emergency Department for Non-Traumatic Dental Conditions

Limited access to preventive and routine dental care often leads to untreated dental problems, causing individuals to seek help for non-traumatic dental conditions (NTDCs) in emergency departments (EDs). EDs can only provide temporary relief, primarily through prescribing pain medications, including opioids, or antibiotics, rather than treating the root cause. A recent CDC data brief shows that opioid prescriptions for dental pain at ED visits have declined recently, but opioids alone or combined with other analgesics remain a common approach when dental care is inaccessible. It is noteworthy to mention that public insurance is the payor for the majority of all these visits, representing not only a substantial and avoidable public expense but also highlighting deeper systemic challenges in connecting the population to timely and regular dental care.[13]

Figure 20 displays the average rate of ED visits for NTDC per 100,000 population in Alameda County and California for two time periods: 2020–2021 and 2022–2023.

In 2020-2021, Alameda County had an ED visit rate of 325.2 per 100,000 population, which was notably higher than California's statewide rate of 278.5 per 100,000. By 2022–2023, rates increased in both regions, with Alameda rising to 382.1 and California to 349.3 per 100,000 population. Overall, the graph highlights that ED visits for NTDC rose in both Alameda County and California over the analyzed periods, and Alameda County consistently experienced higher visit rates compared to the statewide average.

FIGURE 20: AVERAGE RATE OF ED VISITS FOR NTDC PER 100,000 POPULATION, ALAMEDA COUNTY AND CALIFORNIA, 2020-2021 AND 2022-2023

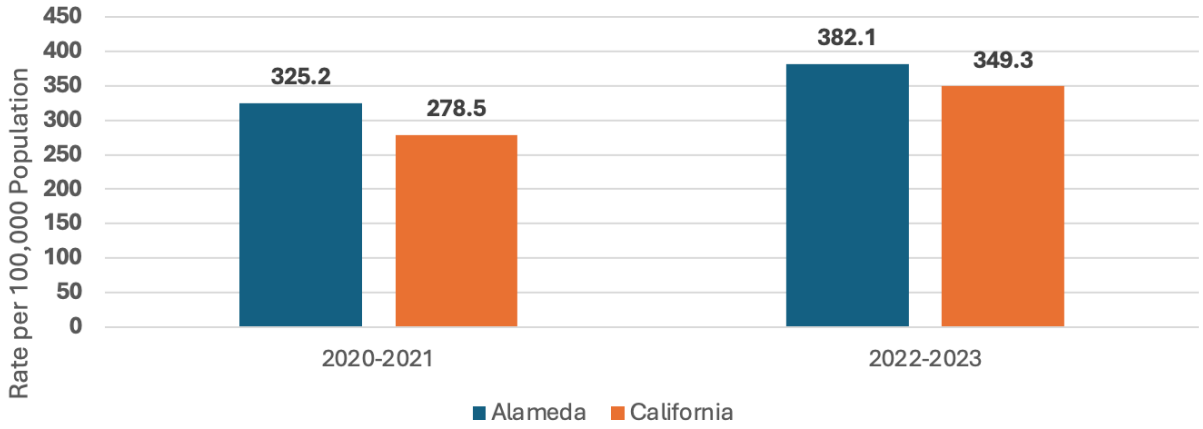
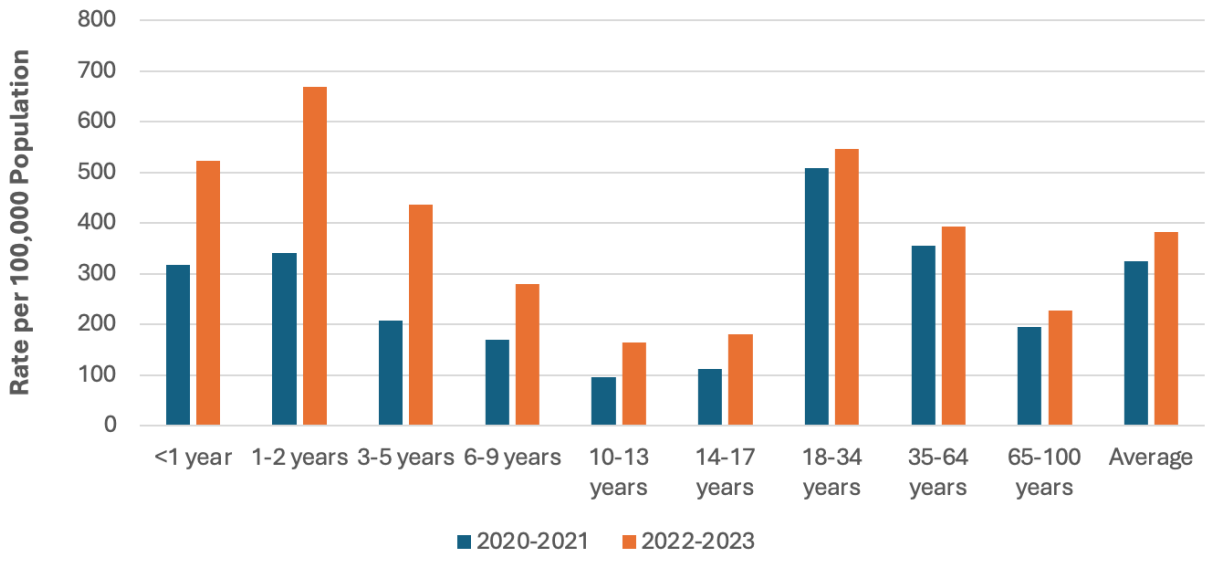


Figure 21 displays the rate of ED visits for NTDC per 100,000 population by age group, comparing 2020–2021 rates to those in 2022–2023. There was an overall increase in ED visit rates across all age groups in 2022–2023 compared to the earlier period. The largest increases were observed in children ages 0–5 years, with the 1–2-year-old group showing the most dramatic rise. Individuals aged 18–34 have the highest rate among adult age groups and higher than the average for all ages. These trends suggest a growing burden of emergency dental visits, particularly among very young children and young adults.

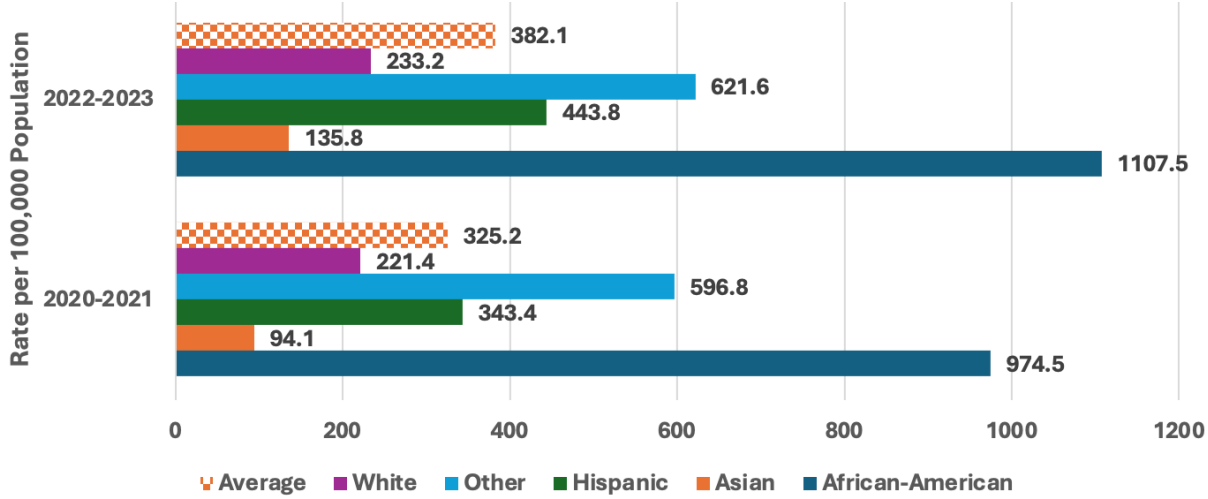
FIGURE 21: RATE OF ED VISITS FOR NTDC PER 100,000 POPULATION IN ALAMEDA COUNTY BY AGE GROUP, 2020-2021 AND 2022-2023



When age-adjusted rates of ED visits for NTDC were broken by race and ethnicity for 2020–2021 and 2022–2023, striking disparities were observed, as shown in Figure 22.

African American residents are dramatically more likely to visit an ED for dental issues than other groups, with a rate of 1,107.5 per 100,000 population in 2022–2023—nearly three times the county average (382.1) and far surpassing rates among Hispanic (443.8), White (233.2), and Asian (135.8) populations. Disparities persisted across both years, with African American residents also reporting the highest NTDC ED visit rate in 2020–2021 (974.5).

FIGURE 22: AGE-ADJUSTED RATE OF ED VISITS NTDC PER 100,000 POPULATION IN ALAMEDA COUNTY BY RACE/ETHNICITY, 2020-2021 AND 2022-2023



COMMON RISK FACTORS

In the next section, we will examine the extent of common risk factors that contribute to dental diseases in the population. Sugary drink consumption, tobacco use, and diabetes are frequently associated with increased rates of tooth decay and gum disease. These behaviors and conditions can damage oral tissues, lower resistance to infection, and complicate effective prevention and treatment.

Sugary Drink Consumption

The consumption of sugary drinks is associated with weight gain, obesity, and an increased risk of dental cavities. The most recent guideline from the Department of Health and Human Services and the U.S. Department of Agriculture recommend limiting daily consumption of the added sugars to less than 10 percent of calories per day.[14]

In the next section, we will examine the extent of consuming Sugar-Sweetened Beverages (SSB) in Alameda County, based on data derived from Healthy Alameda County and CHIS. This indicator reflects the percentage of persons who reported drinking soda or other SSB at least once per day.

In 2021–2022, 9.6% of adults in Alameda County reported daily consumption, compared to 14.6% statewide. This represents a slight decrease from 9.9% in 2019–2020, while the state average increased from 13.7%.[15]

Consumption patterns vary across communities. The highest rates were observed in Ashland (15.7%), Cherryland (15.6%), and Hayward (13.4%), with elevated rates also noted in San Leandro and San Lorenzo. In contrast, the lowest rates were found in Piedmont (5.1%), Berkeley (5.4%), and Pleasanton (6.8%).[6]

It is worth noting that among children and teens, when respondents were asked, "[Yesterday,] how many glasses or cans of sweetened fruit drinks, sports drinks, or energy drinks did you (your child) drink?", 15% reported drinking two or more glasses in Alameda County, compared with 19% statewide.[16]

Tobacco Use

Tobacco use, whether smoked or smokeless, has serious consequences for oral health. It increases the risk of oral cancer, gum disease, tooth loss, and cavities. Tobacco also slows healing after dental procedures, raises the chance of dental implant failure, and contributes to bad breath, dry mouth, and tooth staining. Smokeless tobacco also increases the risk of oral cancer and mucosal lesions and can cause gum thickening, tooth discoloration, bad breath, enamel erosion, gum recession, bone loss, periodontal disease, cavities from added sugars, and ultimately tooth loss.[17]

Recent studies suggest that vaping is linked to higher risks of periodontitis and dental caries. People who vape appear to experience more oral health problems than non-smokers, although these effects are generally less severe than those seen with conventional cigarette use. The growing popularity of vaping, particularly among youth, underscores the need for increased awareness of its potential oral health harms.[18]

In the next section, we will examine the extent of smoking and e-cigarette use among adults and teens in Alameda County, compared to California, based on data derived from Healthy Alameda County and CHIS.[19]

Adult Smoking in Alameda County

According to data from 2022–2023, 6.9% of adults in the county reported currently smoking, slightly higher than the California state average of 5.5%. This marks an increase from 5.7% in 2019–2020, while the state rate declined from 6.7% during the same period.

Smoking prevalence varies notably by age, gender, and race/ethnicity. Adults aged 25–44 had the highest smoking rate at 9.5%, followed by those aged 45–64 (6.4%), 18–24 (5.2%), and 65+ (3.1%). Men were nearly twice as likely to smoke as women (9.2% vs. 4.7%).

By race/ethnicity, Black/African American had the highest smoking rate at 14.4%, followed by Hispanic/Latino (10.7%), Asian (5.4%), and White (3.7%).

Geographically, smoking rates also varied across cities. The highest rates were observed in Ashland (8.4%), Cherryland (7.1%), and Oakland (6.9%), while the lowest were in Piedmont (2.4%), Albany (3.4%), and Berkeley (3.7%).

Adult E-Cigarette Use in Alameda County

This indicator reflects the percentage of adults who reported using electronic cigarettes (e-cigarettes or vapes) in the past 30 days. In Alameda County, adult e-cigarette use increased from 2.5% in 2019–2020 to 4.5% in 2021–2022, aligning closely with the California state average of 4.6% during the same period. This upward trend suggests a growing need for public health efforts focused on vaping prevention and cessation among adults.

Use of e-cigarettes varies across communities. The highest rates were observed in Ashland (5.9%), Cherryland (5.5%), and Berkeley (5.3%), while the lowest rates were found in Piedmont (2.5%), Pleasanton (3.7%), and Castro Valley (3.8%).

Teen E-Cigarette Use in Bay Area Counties

According to CHIS data, teen respondents were classified as current e-cigarette smokers if they reported using an e-cigarette or other electronic vaping product at least once in their lifetime and on at least one day in the past 30 days. For this indicator, data from the Bay Area Counties region were used, and survey years 2022–2024 were pooled to deal with data instability for Alameda County.

Current e-cigarette use was higher among teens in the Bay Area region than in California overall during the years 2022–2024. An estimated 5.6% of Bay Area teens were current e-cigarette smokers, compared with 3.4% of teens statewide.

Teen Cigarette Use in Oakland

This indicator reflects the percentage of high school students who reported smoking cigarettes on at least one day in the past 30 days. In Oakland, cigarette use among high school students increased from 2.4% in 2019 to 3.8% in 2021.

By race/ethnicity, White teens in Oakland reported the highest rate of smoking cigarettes on at least one day in the past 30 days (14.5%), compared with Hispanic/Latino teens (3.2%) and Black/African American teens (1.6%).

Diabetes

Diabetes poses a serious threat to oral health. Individuals with diabetes are at increased risk for periodontal disease, dry mouth, oral infections such as thrush, delayed healing after dental procedures, and tooth decay. These oral health issues are not only more common but also more severe in people with diabetes. Importantly, the relationship between diabetes and oral health is bidirectional. Poor glycemic control can exacerbate oral health problems, while untreated oral infections and inflammation can make it more difficult to manage blood sugar levels. This underscores the need for integrated care approaches that address both medical and dental health, particularly in high-risk communities.[20]

According to data from CHIS, when respondents were asked if they had ever been diagnosed with diabetes,*** 9.2% of adults in Alameda County were diagnosed with diabetes, compared to 11.2% statewide in 2022–2023. The previous year, the county's rate was even higher at 11.5%, surpassing the state average of 10.7%. Certain cities within the county experience disproportionately high rates of diabetes, including San Lorenzo (15.9%), San Leandro (15.7%), and Union City (15.6%). In contrast, cities like Berkeley (6.7%), Piedmont (8.3%), and Albany (8.6%) report lower prevalence.

Older adults are particularly affected, with 18.6% of Alameda County residents aged 65 and older living with diabetes. Racial and ethnic disparities are also evident: prevalence is highest among individuals identifying as two or more races, non-Hispanic (11.4%), followed by Asian (10.6%), Hispanic (10.4%), Black/African American (10.1%), and White (6.5%) populations.[21]

*** Women who were diagnosed with diabetes only during their pregnancy were not included in this count.

PROTECTIVE FACTORS

Dental Insurance

Health and dental insurance play a critical role in improving access to care by reducing financial barriers that often prevent people from seeking needed health services. Having adequate coverage increases the likelihood of routine dental visits and preventive care, leading to earlier detection of oral health problems and better overall health outcomes.

Table 2 demonstrates the numbers and percentages of Alameda County residents who were certified eligible for Medi-Cal in July 2020 and 2025, compared to California, according to the Department of Health Care Services data.[22] From July 2020 to July 2025, the percentage of certified eligible Medi-Cal enrollees increased from 25% to 30% in Alameda County, and from 33% to 38% statewide, as shown in the table below.

TABLE 2: CERTIFIED ELIGIBLE FOR MEDI-CAL POPULATION IN JULY 2020 AND 2025

	JULY 2020			JULY 2025		
	Count Medi-Cal Eligible	Population	Percentage Medi-Cal Eligible	Count Medi-Cal Eligible	Population	Percentage Medi-Cal Eligible
Alameda County	412,583	1,679,664	25%	502,817	1,649,199	30%
California	13,001,042	39,535,726	33%	14,764,909	39,299,708	38%

According to data from the California Health Interview Survey, the percentage of adults with dental insurance increased in both Alameda County and California between 2019–2023, while the rate declined among children in the Bay Area region and California over the same period. Overall, Children continue to have dental insurance at a higher rate than adults at both at county and state levels, as shown in Figures 23 and 24. Bay Area regional data was used instead of Alameda County's data due to the statistical instability for this measure at the county level.

FIGURE 23: PERCENTAGE OF ADULTS WITH DENTAL INSURANCE IN ALAMEDA COUNTY AND CALIFORNIA, 2019–2023

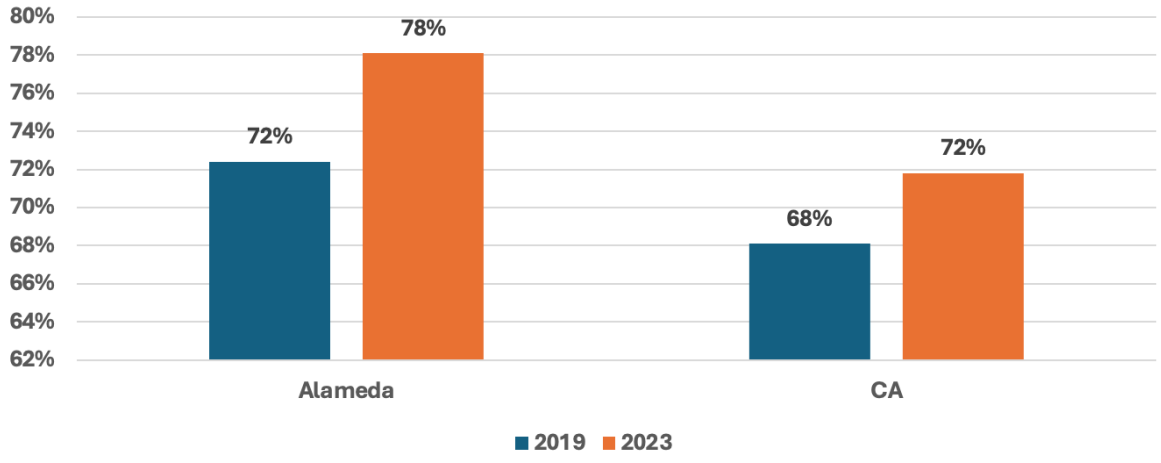
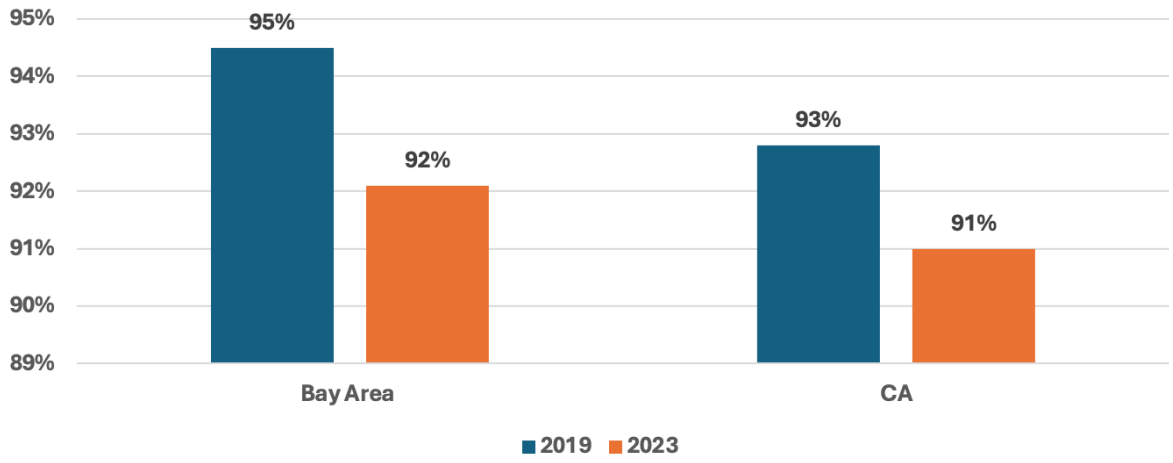


FIGURE 24: PERCENTAGE OF CHILDREN WITH DENTAL INSURANCE IN BAY AREA REGION AND CALIFORNIA, 2019-2023



Oral Health Workforce

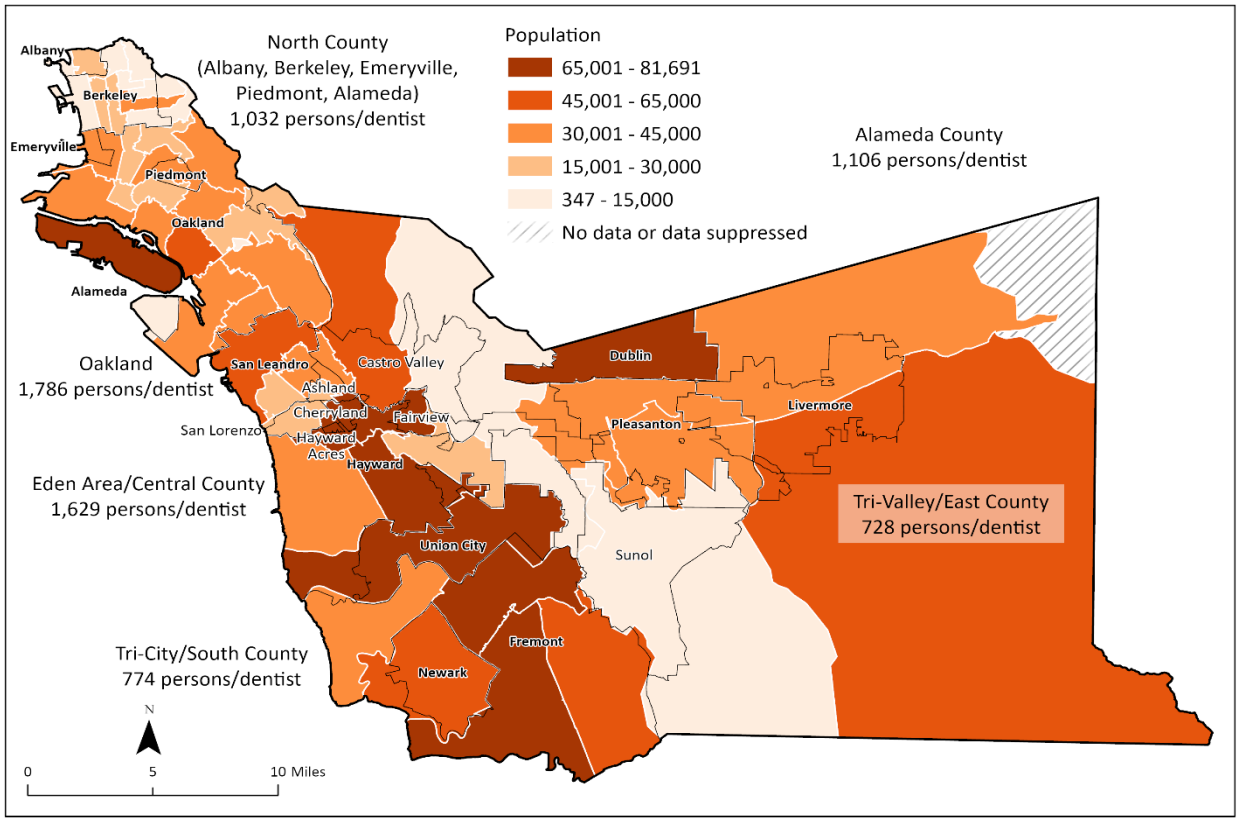
This section presents an overview of the dental workforce availability in Alameda County, using HCAI[23] licensure renewal data to describe the characteristics of the local dental workforce and DHCS[24] data to illustrate the geographic distribution of Medi-Cal–enrolled dental providers. As this is the first time, we have received data HCAI, comparative analysis is limited; however, these findings establish a valuable baseline for future evaluation of the county's dental workforce.

Alameda County's dental workforce in 2024 shows notable geographic and demographic variation, with a total of 1,529 dentists.

Geographic Distribution

The map below illustrates substantial variation in the ratio of residents to dentists across Alameda County. The overall county average is 1,106 persons per dentist, but this ratio varies across regions, from more favorable availability of dentists in Tri-Valley/East County (728 persons per dentist) and Tri-City/South County (774) to higher ratios in North County (1,032), Eden Area/Central County (1,629), and Oakland, where the ratio reaches 1,786 persons per dentist, indicating the least availability.

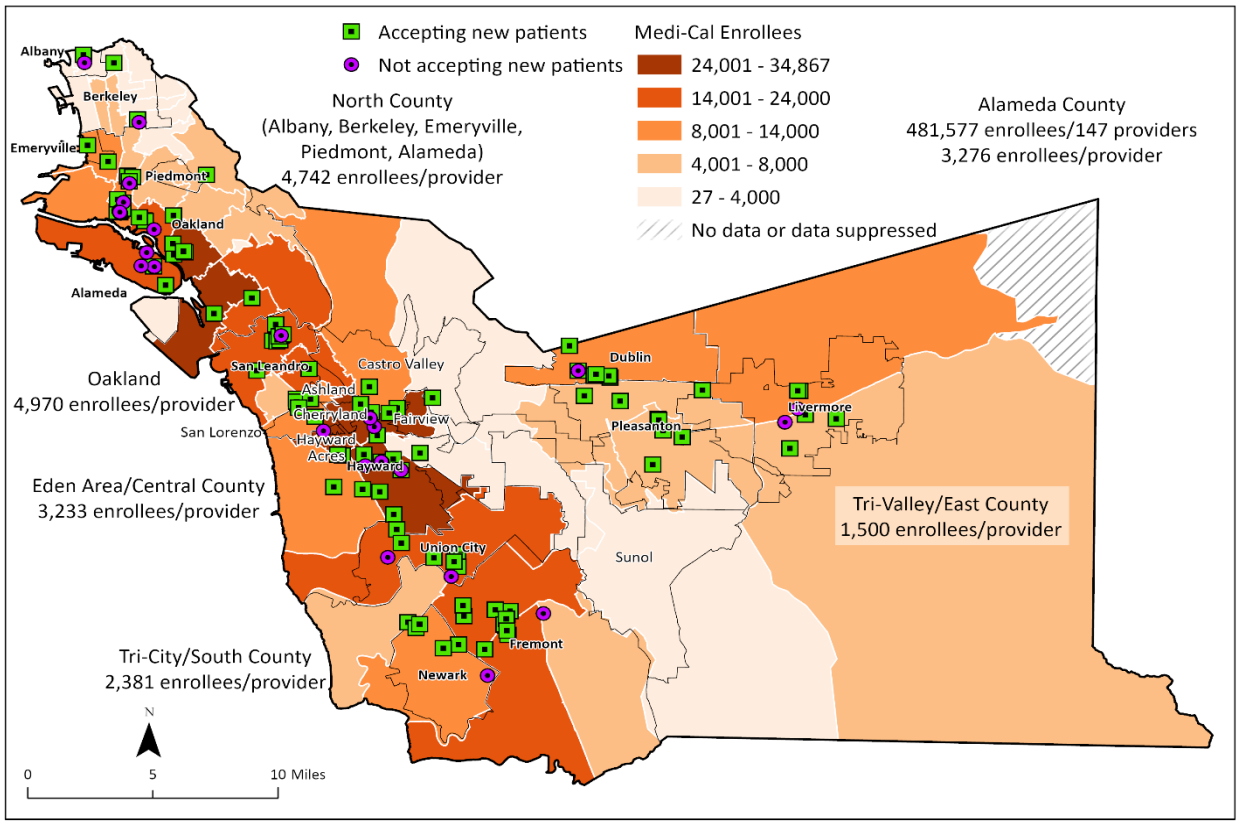
FIGURE 25: GEOGRAPHIC DISTRIBUTION OF DENTISTS BY REGION, ALAMEDA COUNTY, 2024



Source: ACPHD CAPE, with data from HCAI 2025.

The ratios of Medi-Cal enrollees to Medi-Cal dental providers vary markedly across Alameda County, indicating uneven access to care for Medi-Cal members. Countywide, there are 3,276 Medi-Cal enrollees per provider, but this ratio ranges from 1,500 enrollees per provider in Tri-Valley/East County to 2,381 in Tri-City/South County, 3,233 in Eden Area/Central County, 4,742 in North County, and 4,970 in Oakland, where Medi-Cal enrollees face the most limited provider availability, as shown in the map below. While many providers are accepting new patients, some are not, further constraining access in areas that already have high enrollee-to-provider ratios.

FIGURE 26: GEOGRAPHIC DISTRIBUTION OF MEDI-CAL DENTAL PROVIDERS BY REGION, ALAMEDA COUNTY



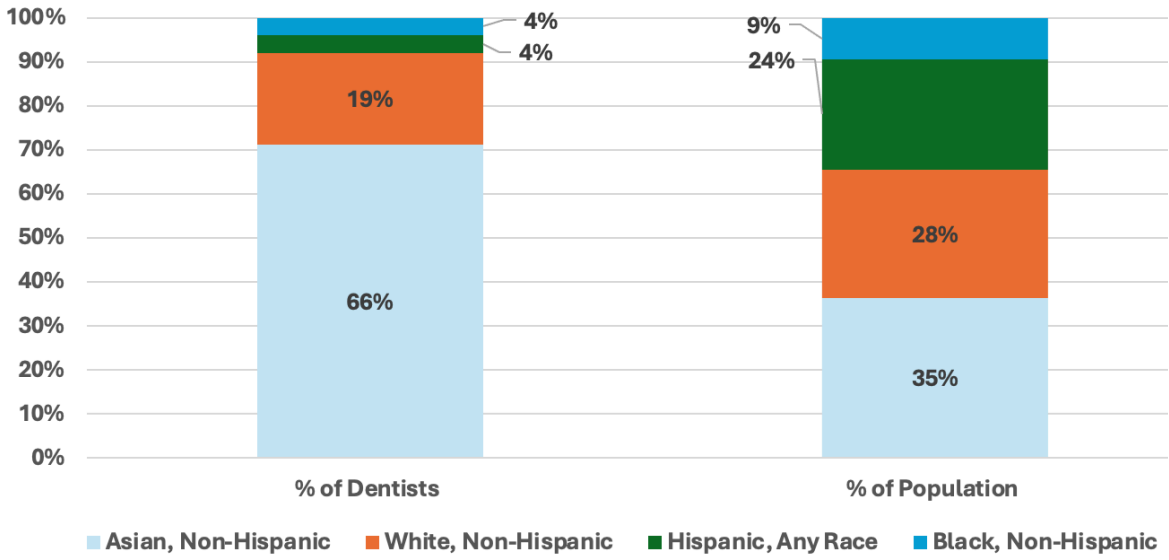
Source: ACPHD CAPE, with data from ACBHD MEDS file, July 2025.

Racial and Ethnic Profile

The HCAI data revealed significant racial/ethnic distribution of dentists when compared to the county's general population, as shown in Figure 26. Asian, non-Hispanic dentists represent 66%, while comprising only 35% of the general population. This indicates their substantial overrepresentation in the dental workforce. White, non-Hispanic individuals make up 19% of dentists, compared to 28% of the population, showing a moderate underrepresentation. Hispanic individuals of any race account for only 4% of dentists, despite representing 24% of the population—a notable underrepresentation. Black, non-Hispanic individuals also constitute 4% of dentists, while making up 9% of the population, reflecting another significant gap.

In addition to the larger racial groups, Pacific Islander, non-Hispanic, make up 0.96% (15 dentists), and American Indian, non-Hispanic, comprises just 0.88% (13 dentists). These proportions highlight the limited representation of these groups within the county's dental workforce.

FIGURE 27: PERCENTAGE DISTRIBUTION OF DENTISTS AND GENERAL POPULATION BY RACE/ETHNICITY IN ALAMEDA COUNTY, 2024



Spoken Languages

The linguistic profile of dentists in Alameda County demonstrates significant diversity, which has important implications for language access in dental care. Table 3 shows the seven most spoken languages by dentists in Alameda County. English only remains the predominant language, spoken by 41.24% of dentists (631 providers). While this is a large share, it means that nearly 59% of dentists speak at least one additional language, highlighting strong multilingual capacity in the county. Hindi emerges as the second most common language at 14.82% (227 dentists), then Spanish and Mandarin follow closely, accounting for 11.28% (172 dentists) and 10.63% (162 dentists) respectively. These languages are critical for serving large South Asian, Latino, and Chinese-speaking populations in Alameda County. Tagalog (8.24%, 126 dentists) and Cantonese (6.45%, 99 dentists) further underscore the county's linguistic diversity, particularly among Filipino and Cantonese-speaking communities. Punjabi, spoken by 6.11% (93 dentists), adds another layer of cultural and linguistic representation.

TABLE 3: SPOKEN LANGUAGES BY DENTISTS, 2024

Language	Weighted Percent	Estimated Count
English only	41.24%	631
Hindi	14.82%	227
Spanish	11.28%	172
Mandarin	10.63%	162
Tagalog	8.24%	126
Cantonese	6.45%	99
Punjabi	6.11%	93

Dental Specialties

Table 4 indicates the percentage and count of dentists with their specialty in Alameda County in 2024. Most dentists in the County continue to practice general dentistry, with a smaller but essential representation across various specialties. This distribution reflects the limited availability of specialized care in the county.

- General Practice dominates the dental workforce, accounting for nearly 80% of all practitioners.
- Pediatric Dentistry and Orthodontics are the most common specialties, each comprising around 5% of the workforce.
- Surgical and advanced specialties such as Oral Surgery, Periodontics, and Endodontics are present but limited in number.
- Public Health Dentistry and Dental Anesthesiology remain critically underrepresented, with fewer than 10 practitioners combined.
- Oral Medicine has no reported specialists in the county, indicating a potential gap in care for patients with complex oral-systemic conditions.

TABLE 4: DENTAL SPECIALTIES, 2024

Primary Area of Practice	Weighted Percent	Estimated Count
General Practice	79.80%	1,220
Pediatric Dentistry	5.33%	81
Orthodontics	5.00%	76
Oral and Maxillofacial Surgery	3.58%	55
Periodontics	2.31%	35
Endodontics	2.08%	32
Prosthodontics	1.07%	16
Public Health	0.35%	5
Dental Anesthesiology	0.22%	3
Other	0.21%	3
Oral and Maxillofacial Pathology	0.07%	1
Oral Medicine	0.00%	0

Retirement

In 2024, when asked about their anticipated retirement timelines, most dentists (57%) indicated plans to retire in 11 years or later, suggesting relative stability in the workforce. Meanwhile, 21% expect to retire within 6 to 10 years, 17% within 3 to 5 years, and 5% plan to retire in less than 2 years.

Other Dental Workforce

According to 2024 HCAI data, Alameda County's dental workforce extends beyond dentists to include a substantial number of allied dental professionals who play a critical role in oral health care delivery.

- **Registered Dental Assistants (RDAs):** The largest segment of the allied workforce, with 1,129 professionals, RDAs are essential for supporting clinical operations, assisting with procedures, and ensuring efficient patient care.
- **Registered Dental Hygienists (RDHs):** Numbering 674, RDHs provide preventive services such as cleanings, oral health education, and periodontal care, contributing significantly to disease prevention and early intervention.
- **Registered Dental Hygienists in Alternative Practice (RDHAPs):** Although a smaller group (30 professionals), RDHAPs are uniquely positioned to serve patients in nontraditional settings, including community-based and home care environments, improving access for vulnerable populations.

Community Water Fluoridation

Community Water Fluoridation is the controlled adjustment of fluoride in public water supplies to the optimal level for preventing tooth decay. Recognized by the CDC as one of the ten greatest public health achievements of the 20th century, water fluoridation is a safe and cost-effective strategy to reduce dental caries across the lifespan.[25] The optimal fluoride level recommended by the U.S. Public Health Service is 0.7 mg/L (parts per million [ppm]) to maintain caries prevention benefits and reduce the risk of dental fluorosis.[26]

In Alameda County, community water fluoridation

coverage is inconsistent and varies by city and water district. Key highlights include:

» **Cities with fluoridated water:** Oakland, Alameda, Berkeley, Hayward, Pleasanton, and Fremont, among others, receive fluoridated water from the San Francisco Public Utilities Commission (SFPUC) and other sources that fluoridate.

» **Cities without fluoridated water:** Livermore, several smaller communities and private water systems, especially in the eastern and unincorporated areas of the county, do not receive optimally fluoridated water. [27]

Available Resources and Programs

ODH Programs:

The Office of Dental Health (ODH) works on strengthening the county's oral health system by connecting residents to needed dental care, delivering preventive services in community settings like schools and WIC sites, and building the capacity of both dental and medical providers. By expanding the oral health workforce and collaborating with community partners, the program helps increase access and reduce barriers to care. ODH administers the following programs:

DENTAL CARE COORDINATION

ODH accepts referrals from partner organizations to support families in finding a dentist, scheduling dental appointments, providing oral health counseling, and linking them to appropriate care and community resources. Eligible populations include children ages 0–20 and perinatal individuals who reside in Alameda County and are eligible for Medi-Cal Dental.

HEALTHY SMILES

Initiated in 2002, this program provides gap coverage for urgent dental needs for children aged 0–19 who are uninsured or underinsured. Families receive assistance with scheduling an appointment or referral to a dentist within Alameda County for preventive care or dental treatment needs at no cost.

SCHOOL-BASED DENTAL SEALANT PROGRAM

Provides essential dental screenings and sealants directly to students at schools and connects them to urgent dental services when needed.

ODH-WIC COLLABORATION

The ODH clinical team provides on-site preventive services for the WIC beneficiaries, assists them in establishing dental homes, and participates in their community event.

COMMUNITY PRACTICE (COP) PROGRAM

It provides free continuing education to dental professionals, enhancing their skills and capacity to serve priority populations and promote equitable oral health care.

OUTREACH AND EDUCATION THROUGH PARTNERSHIPS

Capitalizing on our strong and well-established partnerships with community-based organizations and programs, ODH staff participate in community events to improve oral health awareness among community members and share available resources. The program also offers oral health training for organizational staff and provides community workshops.

PERINATAL DENTAL DEMONSTRATION PROJECT

A three-year, state-funded project (2023–2025) is piloting a model to improve access to dental care for pregnant and postpartum individuals in the county. In collaboration with prenatal care providers and early childhood programs, the initiative promotes the importance and safety of dental care for both pregnant individuals and their infants. Efforts focus on integrating dental assessment and referral into prenatal and early childhood care and providing dental care coordination for pregnant and postpartum patients who need assistance finding a dental provider.

THE ORAL HEALTH COMMITTEE AND WORKGROUPS

ODH works closely with and is guided by organizations serving priority populations in Alameda County. The Oral Health Committee of the Public

Health Commission meets once every quarter. ODH has also formed workgroups that include local organizations and community members who understand the unique oral health needs of the priority population. These groups work continuously to improve coordination and accountability throughout the implementation of the five-year Oral Health Strategic Plan, ensuring that we effectively meet the needs of our community.

School Health Centers with Dental Services:

There are 13 School Health Center (SHC) locations that offer preventive and treatment dental services in Alameda County. Of these, 11 sites have dental operatories located onsite, providing convenient access for students. Two SHCs are situated adjacent to schools, Edendale Middle School (Fuente) and San Leandro High School (Barbara Lee Center), while one site, Elmhurst, delivers services through a mobile dental van. The full list and location of those centers is in Appendix B.

Other ACPHD Programs:

NUTRITION SERVICES

Nutrition Services promote healthy eating and active living across Alameda County by engaging with communities to improve access to fresh foods, encourage physical activity, and reduce chronic disease. Nutrition services lead a variety of disease- and population-specific health education initiatives throughout the County.

One of the nutrition services programs is the Diabetes Program, which provides self-management classes for adults diagnosed with pre-diabetes and Type 2 diabetes and develops a treatment plan to assist participants in controlling their condition. ODH supports this program by offering staff oral health training to promote the importance of oral health for patients with diabetes.

Nutrition Services supports several health campaigns throughout the year to help Alameda County residents maintain and improve their healthy habits. ODH participates in one of their campaigns, Rethink Your Drink, encouraging the community to choose healthier beverages and raise awareness about the harmful effects of sugary drinks on dental health through their presentations and distributing resource materials at community outreach events and on social media.

TOBACCO CONTROL PROGRAM

The Tobacco Control Program provides tobacco education, prevention services, and technical assistance to government agencies, community-based organizations, law enforcement, hospitals, clinics, businesses, and residents.

ODH supports these efforts by providing a tobacco cessation continuing education course unit for dental providers as part of the COP program and in collaboration with Alameda County Dental Society Training. ODH also shares the Tobacco Cessation Toolkit for Dental Providers with participants.

CARE PARTNERS

Care Partners is a care coordination program that provides engagement, information, education, resources, and advocacy to older adults and people with disabilities in Alameda County so that they can stay safely at home with an improved quality of life. ODH provides oral health training for the program's staff to equip them with essential oral health information and available resources tailored to the needs of older adults.

MATERNAL, PATERNAL, CHILD, AND ADOLESCENT HEALTH (MPCAH) PROGRAM

Maternal, Paternal, Child, and Adolescent Health (MPCAH) coordinates services for Alameda County families—including teens, pregnant women, mothers, fathers, caregivers, and children. The program improves access to comprehensive, quality health care with a focus on early intervention and prevention.

ODH supports the MPCAH program and its Home Visiting Integration & System of Care program by providing oral health training for staff, inviting their team leaders to participate in the Oral Health Committee and Workgroups, and offering dental care coordination for their clients as needed.

COMMUNITY ASSESSMENT, PLANNING, AND EVALUATION (CAPE)

CAPE provides information, evaluation, planning, and technical support to programs, partners, decision makers, and residents to improve community health and address health inequities. ODH has been working collaboratively with CAPE, managing and analyzing program's data and analyzing secondary data to inform about oral health at the county level.

QUALITY IMPROVEMENT & ACCREDITATION DIVISION (QIA)

QIA supports all ACPHD programs by offering tailored technical assistance, training, resources, and innovative solutions to advance continuous quality improvement and enhance public health outcomes. ODH staff regularly participate in the workforce development trainings to strengthen their programmatic skills and get professional support as needed.

QUALITATIVE DATA FINDINGS

Focus Groups

Findings from community focus groups reveal that access to dental care continues to be a significant challenge for many residents, particularly those belonging to vulnerable groups such as older adults. Some participants reported that dental services are expensive and difficult to obtain in a timely manner, with older adults highlighting the increased difficulty in paying for costly procedures. In addition, some community members noted barriers in finding affordable dentists, while caregivers and parents expressed a need for more dental screenings in schools to support children's oral health. These collective voices underscore persistent gaps in access and affordability for essential dental services, especially among seniors and children in the community.

Key Informant Interviews

Key Community Partners

The key informant interviews were conducted to gather partner perspectives on the Office of Dental Health's current performance, future direction, and role within the broader oral health system in Alameda County. Interview questions explored ODH's strengths and areas for improvement, community oral health needs and gaps, emerging opportunities and threats, promising practices, and ODH's unique contributions relative to other organizations. The objective was to generate practical, stakeholder-informed recommendations to guide strategic planning, strengthen partnerships, and prioritize actions that will improve oral health outcomes for priority populations.

The findings below provide a detailed picture of ODH's contributions, emerging community needs, and opportunities for strengthened coordination, communication, and sustainability. The interviews analysis revealed five main themes as summarized in the following section: 1. Strengths, 2. Areas for Improvement, 3. Community Oral Health Needs and Challenges, 4. Promising Practices, and 5. Recommendations.

Summary of Themes Findings

Theme 1: Strengths

ODH is widely viewed as a trusted, responsive partner with strong relationships across community organizations and systems. Partners especially praised staff's approachability, follow-through, and active participation in collaborations that support pregnant people, young children, and children with special health care needs.

Theme 2: Areas for Improvement

Partners noted that limited staffing, turnover, and broader county administrative constraints can disrupt relationships and slow program momentum. They also reported a need for more proactive communication and clearer role definition to increase awareness of ODH's services and collaboration opportunities.

Theme 3: Community Needs and Challenges

Interviewees described persistent gaps in oral health knowledge, particularly around early prevention, dental visits by age one, and the safety of dental care during pregnancy. Ongoing access, workforce, insurance, and cost barriers, especially for Medi-Cal-enrolled families, continue to limit the ability to establish and maintain dental homes.

Theme 4: Promising Practices

Partners highlighted several existing efforts as strong foundations for future work, including Head Start toothbrushing and classroom education, care coordination and navigation models, the Rethink Your Drink campaign, and the KOHA program. These initiatives were seen as effective vehicles for prevention, behavior change, and linkage to care.

Theme 5: Recommendations

Key recommendations centered on strengthening coordination and resource-sharing infrastructure, including an online portal and searchable provider

database; expanding education and outreach with consistent, multilingual messaging; and deepening collaboration and integration across public health and education systems. Partners also emphasized the importance of advocacy to improve Medi-Cal provider participation, support elder-friendly dentistry, and advance long-term workforce and access solutions.

Kindergarten Oral Health Assessment (KOHA) Partners

The KOHA partners' interviews aimed to understand the KOHA implementation process, identify the related barriers and facilitators experienced by the school districts, and explore opportunities to improve the school districts' KOHA participation. The qualitative analysis revealed the five main themes summarized below. For the interview guide, please refer to Appendix C.

Summary of Themes Findings

Theme 1: Schools and students' participation in KOHA

Participants have shared that many schools struggle to obtain completed KOHA forms from families, resulting in low return rates and incomplete data. Because KOHA is not legally enforceable like immunization requirements, schools have no mechanism to require participation, and there is no formal accountability or incentive structure at the school, district, or county levels to support consistent follow-through. Limited staff capacity to remind and follow up with families, combined with a cumbersome multi-page form and the lack of translations into key languages, further depresses return rates and creates barriers for families, especially those with limited English proficiency. Some districts have improved participation by adjusting deadlines and leveraging school-based health centers to complete assessments on-site.

Theme 2: Access to dental professionals

Interviewees described ongoing systemic and resource constraints that make it difficult for schools and families to fully participate in KOHA. Access to dental care remains limited in many low-income communities, and some schools lack the staffing, funding, or partnerships needed to bring dental providers on campus or organize regular on-site screenings. At the same time, participants noted that when families have an established dental home and schools have school-based health centers, it becomes much easier for students to get assessment forms completed and for KOHA participation to fit naturally into existing care and school health routines.

Theme 3: Lack of awareness, communication, and key stakeholders' involvement

Interviewees described significant process and capacity barriers that undermine consistent KOHA and SCOHR reporting, even when staff are committed to the requirement. A general lack of awareness, training, and clear role definition, especially amid turnover and staffing cuts, has left many schools uncertain about what needs to be reported, how to use SCOHR, and who is responsible, leading to incomplete, inconsistent, or missing data. These gaps are compounded by competing priorities such as immunizations and attendance, the loss of centralized district data-entry support, reliance on outdated forms at some sites, and wide variation in local practices, although targeted leadership outreach, technical assistance from ODH and state or county partners, and principal- and nurse-led communication efforts have begun to improve awareness, form completion, and reporting in some districts.

Theme 4: Operational

Interviewees described operational barriers that make it difficult for schools and districts to implement KOHA reliably, even when they value the requirement. Misaligned timelines between dental and other health forms, heavy workloads, and small or overstretched teams mean that KOHA tasks such as collecting forms, tracking completion, and entering data are often delayed or deprioritized compared with higher-stakes requirements. At the same time, participants noted that when schools have dedicated on-site support staff, such as health assistants who are embedded in daily

school operations, these staff can consistently monitor needs, collect forms, follow up with families, and help keep KOHA activities on track.

Theme 5: Best Practices and Recommendations

Interviewees described a set of emerging best practices and recommendations to strengthen KOHA implementation by making the process easier for families, schools, and providers. They emphasized proactive communication and technical assistance, including having the LOHP participate in school nurse meetings to explain KOHA requirements, offer hands-on support, and ensure consistent messaging across districts. Collecting KOHA forms during registration, sending due-date reminders before major school breaks, and encouraging active involvement from registrars, enrollment staff, directors of student services, and principals were highlighted as effective strategies to boost family participation and improve completion rates.

Participants also recommended system-level improvements, such as having dental providers enter data directly into electronic systems, simplifying and shortening forms, aligning KOHA deadlines with other health requirements, exploring automated or technology-assisted data capture, and gathering feedback from school sites and dental professionals. Those approaches would reduce manual workload, minimize data errors, and move toward a more streamlined, sustainable KOHA process.

Perinatal Dental Environmental Scan

The next section presents findings of the environmental scan conducted between May 2023 and November 2023 to assess available resources and existing gaps related to oral health services for the pregnant and postpartum population in Alameda County. The findings served as a foundation to inform the subsequent phases of the Perinatal Dental Demonstration Project.

Population Survey

A survey targeting pregnant and postpartum individuals revealed important insights into dental care perceptions, barriers, and needs. Key findings include a high recognition of the importance of dental care (99%), but significant barriers such as cost, lack of information, and inconvenient appointment times hinder access for 57% of respondents. While 53% had a dental visit in the past year, 40% had not seen a dentist for over a year. Only 55% were aware of Medi-Cal Dental coverage.

Half of the respondents did not receive dental care advice during pregnancy, with physicians being the most common source for those who did (29%). Only 10% received advice from a dental provider. Of those who received advice, 64% were more likely to visit the dentist, especially when advised by physicians or doulas.

The survey highlighted the need to integrate dental care into prenatal care settings, increase awareness, and target interventions to address barriers and improve access to dental services for pregnant individuals.

Key Partners Survey

A survey of stakeholders working with pregnant and postpartum individuals revealed general agreement on the importance of oral health during pregnancy. However, only 37% felt confident discussing dental care with their clients, and 38% believed cultural norms discouraged dental visits. Suggestions to improve access included enhanced training with cultural sensitivity, integrating oral health into workflows, and providing relevant educational materials.

Dental Providers Survey

A survey of 45 dental providers revealed that 64% felt comfortable treating pregnant patients, though 36% were somewhat to very uncomfortable. Despite guidelines affirming the safety of dental care during pregnancy, 40% preferred providing preventive services in the second trimester, with 63% favoring this trimester for restorative services. Concerns included safety, anesthesia, medication, x-rays, and legal issues. Additionally, 27% of respondents do not treat pregnant women with Medi-Cal due to

enrollment and reimbursement issues. However, 77% believed that adding Medi-Cal incentives could motivate more dentists to treat this population. Some suggested training needs for dental providers include pharmacology, managing co-morbidities, and handling emergencies.

Focus Group Findings

Three focus groups with 13 diverse pregnant and postpartum participants revealed key barriers to dental care during pregnancy, including concerns about the safety of dental procedures, x-rays, and medications. Some participants were advised by their dentists to postpone dental care until after pregnancy, leading to misconceptions about its safety and importance. Additionally, many participants expressed the need for assistance in finding a dentist.

Key Informant Interviews

Eleven interviews with key informants working with this priority population revealed a significant need to equip organizational staff with oral health information to educate families effectively. Oral health was identified as a primary unmet need. Suggestions included sharing community-based research on the safety and importance of dental care during pregnancy, establishing a network of dental and medical providers to reinforce oral health messages, inviting experts to share best practices, and creating an efficient referral process between medical and dental providers. The ongoing shortage of dental providers and support staff, exacerbated by the COVID-19 pandemic, was also highlighted.

Referral Forms

The ODH care coordination program started accepting referrals for pregnant and postpartum individuals in July 2023. An analysis of 146 referral forms from September 2023 to January 2024 revealed that most referred individuals were aged 25–34 (60%), followed by those aged 35 and above (23%) and 15–24 years (18%). Hispanics constituted the largest ethnic group (58%), with a notable preference for Spanish (49%) over English (32%). Dental concerns were absent in 62% of cases, but issues like dental pain (16%), gum disease, and tooth decay/broken teeth (11% each) were reported. Urgency of care was mixed, with 40% requiring urgent care and 60% considering their needs routine.

Patients' Satisfactory Survey Findings:

The responses of the care coordination patient satisfaction survey from pregnant and post-partum patients highlighted the strong impact of the care coordination program in assisting those patients with dental appointment scheduling and addressing additional needs. The team's flexibility, communication, and attentiveness to patients' schedules and challenges were frequently mentioned. Many respondents appreciated the team's efforts to provide timely appointments, assist with transportation issues, and offer ongoing follow-up support. A few standout comments that effectively convey the program's success were:

"Got me an appointment ASAP, something that I couldn't do for myself; Advocated for me effectively and in a timely manner."

"Everything: great with scheduling; had a problem with my ride, but the team was able to help me call another ride."

"Very careful with the appointment; Speaking with me made everything go smoothly afterward, especially given that I had experienced many setbacks with making an appointment."

These quotes underscore the program's efficiency, advocacy, and positive outcomes for patients in accessing dental care.

Strategic Planning Community Meeting

In November 2024, about 60 community stakeholders and partners came together to reaffirm that advancing oral health equity in Alameda County requires prioritizing underserved populations, young children, people with disabilities, those experiencing homelessness, Medi-Cal beneficiaries, and uninsured families. Participants emphasized the need to expand and diversify the oral health

workforce, address structural and financial barriers to care (such as low reimbursement, transportation, childcare, and long wait times), and leverage schools, childcare settings, and community organizations as key access points. The group refined a set of strategic focuses and articulated a 2035 vision of universal coverage, coordinated care, diverse providers, robust data sharing, and timely inclusive services with no disparities in oral health outcomes.

Community Input

Alameda County Office of Dental Health (ODH) regularly collects oral health success stories as a qualitative primary data source to demonstrate real-world program outcomes. These stories provide direct evidence from participants, partners, and community members about how ODH programs are helping to improve oral health across Alameda County. A brief description of services provided and representative testimonial quotes from various ODH programs are provided below.

School-Based Sealant Program:

In partnership with selected elementary schools in Berkeley and Livermore, ODH provides free preventive dental services to third-grade students enrolled in 14 elementary schools across these districts. These services include oral screenings, sealants, polishing, fluoride varnish, and classroom-based oral health education to ensure that students not only receive necessary care but also develop lifelong oral health habits. Selected testimonials from key personnel at the elementary schools are shared below.

"This has been a wonderful collaboration to detect early decay for our third-grade students at Marylin Avenue and Junction School. The partnership has allowed those students identified at the screenings to receive dental care with outside partnerships, our students, who otherwise would not have gotten care, received free sealants to prevent future decay and problems. All of this has allowed students to remain in school and thrive."
—School Nurse

"This is such a great public-school service! Thank you for your service to our students."
—Principal, Emerson Elementary School, Berkley Unified School District

WIC Dental Days Program:

Another program the clinical team at ODH is implementing is the WIC dental days program, where the team provides on-site dental screenings, fluoride varnish treatments, anticipatory guidance, and offers dental care coordination for WIC beneficiaries at five County WIC sites. The director of WIC shared a testimonial with ODH stating:

"ODH and WIC have had a strong partnership since the late 2000s. The Dental Day program was piloted in Hayward and since then has been implemented at 5 of the PHD WIC's locations all over Alameda County. It continues to be a successful collaboration, providing dental screenings and fluoride varnish to young children as young as 1 year old... It has expanded to also serve pregnant mothers in the last two years. Families are appreciative and thankful that this service is available at their local WIC office. I recall the ADA Executive Director, in the late 2000s, saying that this partnership is the 'Cadillac of dental care!' And after 15+ years, it's still going strong!"
—WIC Director

Dental Care Coordination Program:

Since the early 2000s, ODH's dental care coordination model has significantly improved access to dental services for Medi-Cal–eligible clients aged 0–20 and the perinatal population through collaboration with WIC and other community-based organizations and clinics. The ODH-FSCCs connect families with dental providers by educating families on the importance of dental care, assisting with appointment scheduling, and helping establish a consistent dental home. Staff update referral statuses with partnering agencies as a closed-loop referral approach. A few testimonials from served clients are presented below.

"Having someone help make sure what I was looking for was available for my child."

"I am very grateful for your help. My child was able to have his dental emergency taken care of very soon.

Your reminder texts and calls helped me remember to take my son to his appointments. Thank you very much!"

Perinatal Dental Demonstration Project:

This project has strengthened the collaboration between ODH and community partners to improve access to dental care for pregnant and postpartum individuals in Alameda County. By providing oral health training and establishing a closed-loop referral process connecting patients to care, the project has helped facilitate dental care for the perinatal population. The following testimonial from a CPSP coordinator highlights how this collaboration has enhanced access to dental care and supported healthier outcomes for expectant individuals and families.

"I want to express my sincere gratitude for the invaluable partnership we've established with the Alameda County Office of Dental Health. Before our collaboration, many of our patients faced significant challenges accessing essential dental care. The streamlined referral process, expertly managed by you and your team, has been transformative.... This collaborative approach eliminates a major hurdle for our patients, significantly improving their access to critical oral health services. The positive impact on our patients' well-being and their overall experience has been truly rewarding. We here at Eastmont Wellness Center Women's Services are incredibly appreciative of this successful partnership and look forward to its continued success."
—A CPSP Coordinator.

Input from Key Partners:

ODH collaborates with a broad network of partners to ensure coordinated efforts in addressing shared oral health priorities. These partners include internal county programs, early childhood education programs, primary care clinics, Federally Qualified Health Centers (FQHCs), and local dental providers. Key partners frequently express their appreciation of the collaboration and its outcomes. Below is a testimonial from a local dental provider.

"Since 2019, my team and I have had the privilege of partnering with the ODH. Over the years, this relationship has consistently provided a streamlined referral channel and improved access to care for vulnerable and underserved pediatric patients, including those with special health care needs. One of the most valuable aspects of this partnership has been the ease of communication through the dedicated staff members. Through the ODH's ongoing efforts, including CE opportunities and focused workgroups, we've also built relationships with other like-minded providers and organizations who share our commitment to serving children in need. I'm truly grateful for the impact this partnership has had on our practice and the patients we serve."
—A local dental anesthesiologist

Community of Practice:

In partnership with the Alameda County Dental Society through the Community of Practice (COP) program, ODH offers free continuing education (CE) courses for dental professionals to enhance their capacity to serve priority populations and to strengthen a shared commitment to oral health.

Post-session surveys and two-month follow-up surveys are conducted with participating dental professionals. Selected quotes are presented below.

"Essential and super helpful educational materials and real-life cases. Big thanks to Dr. Saghezchi!"
—Dentist, Private provider, CE participant, course titled Oral Surgery

"Good reminder to open our practices to those who have intellectual disabilities and see what we can do."
—Dentist, FQHC, CE participant, course titled Special Care Dentistry

"Great presentation. Useful tips and strategies to help us talk to patients about tobacco cessation."
—Dentist, CE participant course titled Tobacco Cessation in Dental Settings

IDENTIFIED DATA GAPS

Gaps in Local Data

County-level representative population-based data on oral health status and service utilization is limited for many population groups, making it difficult to monitor inequities and plan and evaluate interventions across the life course and groups.

Children

Data from school-based dental screenings are fragmented, as providers do not have a standardized mechanism for aggregating and sharing these data countywide.

KOHA data are underutilized because not all schools submit data to the state system, and concerns remain about completeness and data entry accuracy.

The Basic Screening Survey (BSS) of third graders only provides regional estimates, and local data stratified by key sociodemographic factors are sparse or unavailable.

Adults

Quantitative data on the oral health status of pregnant and postpartum people is not currently available, despite strong evidence that parents' oral health directly influences their young children's oral health outcomes.

Surveillance data on the oral health status of high-risk adults, including people with diabetes, are limited, even though diabetes is associated with increased risk and severity of periodontal disease.

Data on older adults' oral health are also scarce, with a lack of data for community-dwelling seniors and those in long-term care settings.

Special Populations

There is no routine local data collection on oral health status and dental care access for people experiencing homelessness, people with special health care needs, foster youth, or immigrant and refugee communities, even though these groups face significant barriers to care.

Prevention Policies and Protocols

The county lacks a centralized inventory of school oral health policies and protocols (e.g., KOHA implementation practices, fluoride varnish protocols, sealant programs, oral health education), limiting the ability to monitor policy adoption and impact.

Local data is not systematically collected on the proportion of residents in each city who regularly consume optimally fluoridated tap water.

There is no countywide information on the number and geographic distribution of dental practices that routinely screen for tobacco use and provide cessation counseling, despite the importance of tobacco exposure for oral health outcomes.

RECOMMENDATIONS

Recommendations to Address Data Gaps

Build a coordinated surveillance system

Develop an Alameda County oral health surveillance framework that defines core indicators, data sources and population groups, aligned with state and national guidance.

Establish data-sharing agreements with major systems (Managed-Care Plans, FQHCs, hospitals, school districts, WIC, early childhood programs, home visiting, long-term care) to routinely receive de-identified, standardized oral health data.

Ensure all new and improved data systems can disaggregate by race/ethnicity, language, income, disability, geography, and housing status to identify inequities and track progress over time.

Strengthen existing data sources

Improve KOHA and school screening data quality through providing technical assistance and staff training, clear workflows, and regular data validation, and advocate for enhancements to SCOHR reporting and feedback tools.

Explore the use of automated technology to scan KOHA forms to streamline reporting. This will also help reduce manual data entry to avoid human errors.

Dental providers participating in community screening events to use the same basic screening tool, allowing standardized data capture and documentation across providers and events.

Recommendations to Address Gaps in Services and Disparities

KEY FINDING: Nearly one in four children ages 0–5 and half of school-aged children have caries experience, and only 43% of children with Medi-Cal 0–20 received preventive dental services in 2023.

Recommendations:

- Integrate dental assessment, anticipatory guidance, and Fluoride Varnish within the primary care setting and at well-visit child.
- Implement a closed-loop referral process between primary care sites, pediatric providers, early childhood programs, and prenatal acre sites so families are actively connected to dental providers and children establish a dental home.
- Promote awareness among families and caregivers about the importance of establishing a dental home by age one through CPSPs, WIC, home visiting, and early childhood education programs.
- Coordinate with dental providers to offer on-site preventive services (e.g., screening, fluoride varnish, sealants) in public health and community settings frequented by young children and school-aged youth.
- Assist families in addressing structural barriers (transportation, insurance literacy, language, and limited clinic hours) by collaborating with community health workers and care coordinators to support families in attending visits.

KEY FINDING: KOHA participation remains consistently low across Alameda County. In 2018–2019, only 53% of schools reported KOHA data; by 2024–2025, this dropped to 36%.

Recommendations:

- Provide technical assistance and training to school staff.
- Coordinate on-site dental screening events at schools.
- Support schools in addressing barriers that prevent families from completing the assessment.
- Ensure that students identified as needing dental care to be connected to appropriate dental providers and help establish a dental home.

KEY FINDING: Despite the importance of dental sealants to prevent cavities, only 11% of Medi-Cal beneficiaries aged 6–9 and 6% of those aged 10–14 received dental sealants in 2023.

Recommendations:

- Increase parent and caregiver awareness about the benefits of sealants and the fact that these services are covered for children with Medi-Cal.
- Expand school-based and school-linked sealant programs so more FQHCs, mobile dental providers, and RDHAPs would deliver on-site services in high-need schools and community settings.
- Advocate for a billing system that allows FQHCs to document specific preventive services delivered at each encounter, including fluoride varnish and sealants, to better track performance.

KEY FINDING: Despite the increase in the overall percentage of receiving dental care during pregnancy, disparities exist in receiving dental care among subgroups of pregnant people.

Recommendations:

- Integrate oral health assessment and anticipatory guidance into prenatal and postpartum medical visits, including counseling on how new parents can protect their own and their infant's oral health.
- Establish a closed-loop referral process between sites serving perinatal populations, including prenatal care, social programs, and dental care coordination programs, so pregnant and postpartum people are actively connected to dental providers and supported in establishing a dental home for themselves and their infants.
- Promote awareness among pregnant and postpartum individuals through CPSP, WIC, home visiting, and early childhood education programs, about the importance of maintaining oral health during pregnancy and establishing a dental home for the child by age one.

KEY FINDING: By 2030, Alameda County's population is projected to age significantly, with residents 65 and older increasing by more than 23%.

Recommendations:

- Inform advocacy efforts to prioritize comprehensive and adequate dental coverage for older adults.
- Partner with programs and organizations serving this population to train staff on oral health and how to connect clients to appropriate dental care.
- Collaborate with RDHAPs to expand on-site preventive and basic dental services in senior

living facilities and other congregate settings.

- Provide regular continuing education opportunities on geriatric dentistry for dental and medical providers.

KEY FINDING: Among older adults, oral and pharynx cancer risk and burden are highest in men and particularly in White men, while older adults who are Black are more likely to be diagnosed at the late stage.

Recommendations:

- Advocate for implementing risk-based oral cancer screening protocols in dental and medical settings for highrisk groups, particularly when combined with a history of tobacco or alcohol use or Human Papillomavirus (HPV) infection.
- Disseminate tobacco cessation counseling toolkits to dental providers to support integration of cessation services into routine care.
- Coordinate training for dental providers in geriatric dentistry to better address the needs of older adults.
- Partner with programs and organizations serving these populations to increase awareness among highrisk subgroups about the importance of oral cancer screening.

KEY FINDING: The high rate of seeking dental care at the emergency department (ED) for nontraumatic dental conditions, especially among African American residents, indicates inadequate access to ongoing preventive and restorative care.

Recommendations:

- Work with hospitals to establish a dental referral process that connects ED patients to community health centers or dental homes for follow-up care.
- Inform advocacy efforts about the importance of sustaining Medi-Cal Dental benefits for adults to prevent costly and inefficient ED visits for NTDC.

KEY FINDING: There is shortage of specialty dental providers and a lack of workforce diversity compared with the communities they serve, limiting equitable access to care.

Recommendations:

- Provide dental workforce training on culturally and linguistically appropriate standards and responsive care.
- Collaborate with dental societies to establish a specialty dental provider network to address the need for this care.
- Collaborate with residency programs at FQHCs to train a diverse dental workforce, including residents from diverse racial/ethnic backgrounds, with a focus on Dental Public Health.

KEY FINDINGS: County-level representative population-based data on oral health status and service utilization are limited for many population groups, making it difficult to monitor inequities and plan and evaluate interventions across the life course and groups.

Recommendations:

- Develop a coordinated oral health surveillance system with shared data agreements across major community and health partners, enabling standardized, de-identified data collection and disaggregation to monitor inequities and progress.
- Strengthen existing data quality and reporting systems, such as dental screenings and SCOHR, through training, technical assistance, and the use of standardized screening tools across providers.

CONCLUSION AND NEXT STEPS

Over the last five years, ODH has built a strong network of partners working together to expand and improve oral health services for low-income and racially and ethnically diverse communities. Efforts to integrate oral health into schools, medical practices, young children's services, and programs such as WIC and Head Start have contributed to lasting changes in these systems. School-based initiatives that combine oral health education, screening, preventive services such as fluoride varnish and sealants, and linkage to dental homes are showing promise in supporting lifelong positive oral health behaviors.

Despite this progress, substantial challenges remain. Available data reveal marked disparities in oral health status and in access to prevention by race/ethnicity, with dental caries and untreated decay continuing to affect many children. These findings have substantially informed the local leaders and community partners in the development of the Alameda County Oral Health Strategic Plan for 2025–2030. The new plan is designed to address many of the identified gaps in data, access, and services, and to guide coordinated efforts toward improving oral health and reducing inequities across the county.

APPENDICES

Appendix A: Key Informant Interviews

List of Represented Organizations or Programs

- California Children's Service Program
- Care Partners Program
- Hayward Unified School District
- Oakland Unified School District, Health & Wellness Services
- Alameda County Dental Society, Community Outreach Committee
- Castro Valley School Board, Public Health Commissioner
- WIC Manager
- Comprehensive Prenatal Services Program Coordinator, Alameda Health System Women's Wellness Clinic, Eastmont

Interview Guide

INTRODUCTION:

Alameda County Office of Dental Health is starting a strategic planning process to determine how we can increase our impact. We are starting the process by gathering input from key people, including you, as well as others in the field. Your input will help us evaluate the ODH performance during the currently implemented strategic plan and inform how we can improve and strengthen our collaboration in the upcoming plan for 2025–2030. We will be analyzing and summarizing the results of all the people and organizations we are interviewing and discussing them at our strategic planning retreat this fall.

QUESTIONS:

1. **Strengths:** What do you think the Office of Dental Health does best? What are its strengths? Where are we having an impact?
2. **To improve:** How could we improve? How could we increase our impact?
3. **Community needs and wants:** What are the greatest needs, gaps, and/or challenges to improve oral health in Alameda County?
4. **Opportunities and threats:** What are the opportunities? (What is happening in the community—locally, statewide and/or nationally that could impact oral health, and/or the programs and populations the interviewee is involved with?) What is important to keep in mind as we plan for the future? What are the threats? (e.g. funding cuts, decreases in program participation, etc.)
5. **Promising practices:** What are practices that show promise in effectively reaching this population and/or in improving oral health? What has momentum? How might ODH effectively build on this? What might be some opportunities to collaborate about this?
6. **ODH's unique role:** Thinking about other organizations/entities (including your own) who are already addressing the issues identified in questions #3 and #4 fairly well, what role could ODH play in addressing the identified issues, needs, gaps and/or take advantage of the opportunities. What does ODH uniquely bring to these issues? Who are potential partners for this, including your organization?
7. **Prioritizing recommendations:** If you could wave a magic wand and change/improve one thing about ODH (and/or the specific program), what would it be?
8. **Closing question:** Anything else we haven't covered that you think is important to address in the strategic planning process?

Appendix B: School Health Centers with Dental Services

Agencies	School	District
East Bay Agency for Children		
Frick Health Center	Frick United Academy for Language	Oakland
East Bay Asian Youth Center		
Shop 55 Wellness Center	Oakland High	Oakland
Fred Finch Youth Center		
Rising Harte	Bret Harte Middle School	Oakland
La Clinica de La Raza		
Fuente Wellness Center	Edendale Middle School (offsite)	San Lorenzo
Havenscourt Health Center	Coliseum College Preparatory Academy	Oakland
Roosevelt Health Center	Roosevelt and Garfield	Oakland
Tiger Clinic	Fremont High	Oakland
LifeLong Medical Care		
Elmhurst Health Center	Elmhurst United Middle (van)	Oakland
West Oakland Health Center	West Oakland Middle	Oakland
Emeryville Health Center	Anna Yates & Emery High	Emery
Native American Health Center		
Madison Health Center	Madison Park Academy	Oakland
United for Success Health Center	United For Success Middle & Life Academy High	Oakland
Barbara Lee Center	San Leandro High (offsite)	San Leandro

Appendix C: KOHA Partners Interview Guide

1. Please tell me about your District's KOHA program and your role regarding KOHA.
2. Please tell me about the current process regarding KOHA.
3. How are KOHA data collected?
    a. *Prompt: do you bring in screeners to the school or send forms home?*
4. Who else helps you with the KOHA program?
5. Please tell me about the current system used for reporting KOHA data. Please walk me through the process first. *Keep track of each step and who does each step.*
6. What are the steps on reporting?
7. What is your role on KOHA reporting?
8. Who enters the data into SCOHR?
    a. *Can you describe their steps or strategy for data entry?*
9. How would you describe your experience with KOHA reporting?
10. What would make KOHA data reporting easier?
11. What are the challenges in reporting?
    a. *What have you and your team tried to overcome those challenges?*
12. How often is KOHA data reported?
13. What other priorities compete with KOHA for your and your team's time? How serious is KOHA?
14. Would on-site screenings facilitate KOHA at your school district?
15. Is there anything you would like to add?

Anonymous demographic questions

1. Gender
2. Position/Title
3. Years in school system
4. Years working with KOHA
5. Number of schools supporting

Thank you very much for your participation.

ENDNOTES

1 Centers for Disease Control and Prevention. “2024 Oral Health Surveillance Report: Selected Findings.” Retrieved from https://www.cdc.gov/oral-health/php/2024-oral-health-surveillance-report/selected-findings.html

2 American Dental Association. “Oral-Systemic Health.” Available at: https://www.ada.org/resources/research/science-and-research-institute/oral-systemic-health

3 Association of State and Territorial Dental Directors. State Oral Health Improvement Planning and Needs Assessment. Available at: https://www.astdd.org/state-oral-health-improvement-planning-and-needs-assessment/. Accessed December 1, 2025.

4 Healthy Alameda County. 2024 Demographics: Ethnicity Data for County–Alameda. Claritas data, updated March 2024. Available at: https://www.healthyalamedacounty.org/demographicdata?id=238&sectionId=941. Accessed December 3, 2025.

5 California Department of Finance, Demographic Research Unit. Population Projections, Baseline 2024 (Vintage 2025). Available at: https://dof.ca.gov/forecasting/demographics/projections/. Accessed December 3, 2025.

6 System for California Oral Health Reporting (SCOHR). AB 1433 Kindergarten Oral Health Assessment Overview [Internet]. Available at: https://www.ab1433.org/home/overview. Accessed December 5, 2025.

7 UCLA Center for Health Policy Research. (2023). Access CHIS Data. California Health Interview Survey. https://healthpolicy.ucla.edu/our-work/california-health-interview-survey-chis/access-chis-data.

8 Centers for Disease Control and Prevention. PLACES: Local Data for Better Health–2024 data [Internet]. Atlanta (GA): CDC. Available at: https://data.cdc.gov/browse?category=500+Cities+%26+Places&q=2024&sortBy=relevance&tags=places&pageSize=20. Accessed December 5, 2025.

9 American Cancer Society. (2018). Risk Factors for Oral Cavity and Oropharyngeal Cancers. Available at: https://www.cancer.org/cancer/types/oral-cavity-and-oropharyngeal-cancer/causes-risks-prevention/risk-factors.html.

10 National Cancer Institute; Centers for Disease Control and Prevention. State Cancer Profiles–Oral Cavity & Pharynx Cancer Incidence Rates, California by County (2017–2021). Bethesda (MD): NCI; Atlanta (GA): CDC. Available at: https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=06&areatype=county&cancer=003&race=00&sex=0&age=001&type=incd. Accessed December 5, 2025.

11 California Health and Human Services Agency. Healthcare–California Health and Human Services Open Data Portal [Internet]. Sacramento (CA): CHHS. Available at: https://data.chhs.ca.gov/group/healthcare. Accessed December 5, 2025.

12 Griffin SO, Naavaal S, Scherrer CR, Griffin PM, Harris K, Chattopadhyay S. School-based dental sealant programs prevent cavities and are cost-effective. Health Affairs (Millwood). 2016;35(12):2233-2240. doi:10.1377/hlthaff.2016.0839.

13 Schappert SM, Santo L. Emergency department visits for tooth disorders: United States, 2020–2022. NCHS Data Brief. 2025 Jun;(531):1–11. Available at: https://www.cdc.gov/nchs/products/databriefs/db531.htm. DOI: 10.15620/CDC/174597.

14 Dietary Guidelines for Americans, 2020–2025. 9th ed. U.S. Department of Agriculture and U.S. Department of Health and Human Services; December 2020. Available at: https://www.dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf. Accessed November 26, 2025.

15 Healthy Alameda County Indicator Dashboard. Oakland (CA): Alameda County Public Health Department; 2021–2022 data, updated 2024 Oct. Available at: https://www.healthyalamedacounty.org/indicators/index/view?indicatorId=5261&localeId=238. Accessed November 26, 2025.

16 UCLA Center for Health Policy Research, California Health Interview Survey; [cited 2025 Nov 26]. Available at: https://healthpolicy.ucla.edu/our-work/askchis/askchis-dashboard#!/results.

17 Tobacco use and cessation: American Dental Association; [updated 2024; cited 2025 Nov 26]. Available at: https://www.ada.org/resources/ada-library/oral-health-topics/tobacco-use-and-cessation.

18 Iacob AM, Escobedo Martínez MF, Barbeito Castro E, Junquera Olay S, Olay García S, Junquera Gutiérrez LM. Effects of vape use on oral health: A review of the literature. Medicina (Kaunas). 2024;60(3):365. doi:10.3390/medicina60030365. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC10972225/.

19 Healthy Alameda County Indicator Dashboard. Oakland (CA): Alameda County Public Health Department; 2021–2022 data, updated 2024. Available at: https://www.healthyalamedacounty.org/indicators/index/view?indicatorId=8&localeTypeId=39. Accessed November 26, 2025.

20 Diabetes and oral health: National Institute of Dental and Craniofacial Research, National Institutes of Health; [updated 2024]. Available at: https://www.nidcr.nih.gov/health-info/diabetes. Accessed November 26, 2025.

21 Adults with diabetes. Healthy Alameda County Indicator Dashboard. Oakland (CA): Alameda County Public Health Department; c2024. Available at: https://www.healthyalamedacounty.org/indicators/index/view?indicatorId=81&localeId=238. Accessed November 26, 2025.

22 California Department of Health Care Services. Medi-Cal Certified Eligibles Data by Month with Demographics–By Medicare Dual Status. Sacramento (CA): California Health and Human Services Open Data Portal; 2017–2025. Available at: https://data.chhs.ca.gov/dataset/medi-cal-certified-eligibles-with-demographics-by-month/resource/9ade93e4-0676-4117-adbe-a53378d7fe84. Accessed December 1, 2025.

23 Department of Health Care Access and Information (HCAI). "Health Workforce Data." California Health Workforce Research Data Center. Updated September 29, 2025. Available at: https://hcai.ca.gov/workforce/health-workforce/workforce-data/.

24 California Department of Health Care Services. "Medi-Cal Dental Provider Directory Search." Medi-Cal Dental Program. Available at: https://dental.dhcs.ca.gov/Members/Medi_Cal_Dental/Find_A_Dentist/DentalProviderDirectorySearch. Accessed December 17, 2025.

25 American Public Health Association. Water fluoridation. Available at: https://www.apha.org/topics-and-issues/fluoridation. Accessed December 1, 2025.

26 U.S. Department of Health and Human Services Federal Panel on Community Water Fluoridation. U.S. Public Health Service recommendation for fluoride concentration in drinking water for the prevention of dental caries. Public Health Reports. 2015;130(4):318–331. doi:10.1177/003335491513000408. Available at: https://pmc.ncbi.nlm.nih.gov/articles/PMC4547570/. Accessed December 1, 2025.

27 Fluoride Action Network. California 2020 Fluoridation Status Report [Internet]. 2021 Aug 16. Available at: https://fluoridealert.org/content/california-2020-fluoridation-status-report/. Accessed December 5, 2025.

Public Health Department
Alameda County Health

THE OFFICE OF DENTAL HEALTH

1100 San Leandro Blvd., 4th Floor, San Leandro, CA 94577
(510) 208-5900

acphd.org/about/our-organization/community-health-services-division