Attachment A

Humboldt County Department of Health & Human Services Public Health Branch

Dental Transformation Initiative

Local Dental Pilot Program Application

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Section 1 LDPP Lead Entity and Participating Entity Information (1.1, 1.2):

	Humboldt County Department of Health & Human Services-Public Health Branch
Type of Entity	✘ **County** County Entity City and County Tribe Indian Health Program UC or CSU campus Consortium of counties serving a region consisting of more than one county
Contact Person	**Leigh Pierre-Oetker**
Title	**Oral Health Coordinator**
Telephone	**707-268-2172**
Email Address	**lpierre-oetker@co.humboldt.ca.us**
Mailing Address	**529 I Street Eureka, CA 95501**

Organization Name and Address	Description of Organization	Contact Name, Title, Telephone and Email	Role in LDPP
Open Door Community Health Centers/Burre Dental Center *959 Myrtle Avenue* *Eureka, CA 95501*	FQHC providing oral health services to majority of our Denti-Cal 0-20 population	**Cheyenne Spetzler, Chief Operations Officer, Open Door** (707) 826-8633 x5131 cspetzler@opendoorhealth.com **Dr. Carter Wright, DDS, Dental Director, Open Door-Burre Dental Center** (707) 442-7078	Training Coordinator and Community Dental Health Worker assigned to medical side of clinic for OHA's, prevention/education and referrals. Use of standardized CRA Eligible to bill Medi-Cal *Data Sharing Partner*
Redwoods Rural Health Center (RRHC) *101 West Coast Rd.* *Redway, CA 95560*	FQHC providing oral health services our Denti-Cal 0-20 population to the remote southern Humboldt region.	**Tina Tvedt, Executive Director** (707) 923-2783 ttvedt@rrhc.org	Community Dental Health Worker position Eligible to bill Medi-Cal Use of standardized CRA
K'ima:w Medical Center *P.O Box 1288* *Hoopa, CA 95546*	Tribal FQHC providing oral health services to the tribal population in Eastern Humboldt County primarily Hupa	**Dr. Doyle Bradshaw, DDS** (530) 625-4261 x311 doyle.bradshaw@kimaw.org	FQHC providing oral health services to the tribal community Pilot Community Dental Health Worker position for tribal families. Use of standardized CRA Eligible to bill Medi-Cal *Data Sharing Partner*
Redwood Community Action Agency (RCAA) *904 G Street* *Eureka CA 95501*	Local nonprofit organization that provides services to low and moderate income residents. TOOTH Education & Outreach Program HRSA Education & Outreach grant School-based oral health education programs serve Pre-K, K, 1st, 3rd & 5th graders county-wide	**Lorey Keele, Program Director** (707) 269-2052 lkeele@rcaa.org	Employ 2 Oral Health Educators to provide education and oral health literacy to identified high risk populations. Use of standardized CRA *Data Sharing Partner*

Humboldt State University-California Center for Rural Policy (CCRP) *1 Harpst Street-House 71* *Arcata, CA 95521*	CCRP conducts research to inform policy, build community, and promote the health and well-being of rural people and environments.	**Dawn Arledge, Director of Health** (707) 826-3420 dawn.arledge@humboldt.edu	Responsible for Data Collection & Monitoring, Evaluation and Quality Improvement Plan
Public Health Women, Infants, & Children (WIC) Program *317 2nd Street* *Eureka, CA 95501*	The WIC Supplemental Nutrition Program is for income-eligible pregnant, breastfeeding, and non-breastfeeding women and children under the age of 5 who have a nutritional need. Currently WIC services are offered at 4 sites throughout Humboldt County. WIC also provides dental themed children's books and toothbrushes. Our WIC program serves approximately 2600 clients annually.	**Irene Gill, Public Health Nutritionist Supervisor-WIC** (707) 269-2289 igill@co.humboldt.ca.us	Revamp WIC Well Child Dental Visits to provide CRA's, varnishing and appropriate referrals if needed. Incentivize WIC staff to assist in greater appointment scheduling and reduced no shows as well as basic oral health literacy Eligible to bill Medi-Cal Use of standardized CRA *Data Sharing Partner*
Humboldt Network of Family Resource Centers *P.O. Box 6863* *Eureka, CA 95502*	The Humboldt Network of Family Resource Centers (formerly known as the Healthy Start, Schools and Communities Partnership) is a consortium of coordinators from Healthy Start programs, Community Resource Centers and Family Resource Centers located throughout Humboldt County, California.	**Taffy Stockton, Network Coordinator** (707) 834-6460 hsscpcoordinator@gmail.com	Pilot place-based services at school-based specific FRC/CRC sites around prevention related activities including CRA's, varnishing and proper referrals if appropriate combined with oral health literacy in partnership with RCAA's TOOTH program-oral health educators.
Oral Health Solutions, Inc. *101 Broadway, Suite 248* *Oakland, CA 94607*	Oral Health Solutions (OHS) provides sophisticated data management tools and support services to public oral health programs to help manage and document the delivery of dental services and care coordination.	**Bruce E. Boyer, CEO** (510) 629-4929 bboyer@oralhs.com	Develop and deploy the **LDPP Data Tracking System**

1.3 Letters of Participation/Support:

Letters of Participation (See Attachment 1) These letters are from all of the partners that we propose to fund as part of the Humboldt County LDPP.
Open Door Community Health Centers
Redwoods Rural Health Center
K'ima:w Medical Center
Redwood Community Action Agency
California Center for Rural Policy-Humboldt State University
Public Health WIC
Humboldt Network of Family Resource Centers
Oral Health Solutions, Inc.

Letters of Support from Stakeholders (See Attachment 2) These letters are from DAG, POHILT and other partners that will support the work of the LDPP.
North Coast Clinics Network
First 5 Humboldt
Humboldt Area Foundation
Northcoast Children's Services
Humboldt County Office of Education
Smullin Foundation
St. Joseph Health- Humboldt County
Changing Tides Family Services
State Assemblymember Jim Wood
Partnership HealthPlan
Union Labor Health Foundation

1.4 Collaboration Plan:

Since early 2000, we have worked as a County to integrate and collaborate around children's oral health issues. Beginning with the inception of the **Dental Advisory Group (DAG)** and the *Circle of Smiles*, a significant dental initiative from The California Endowment, Humboldt County has been a leader in addressing children's oral health needs. The work of the DAG, comprised of front line providers in our community representing government, schools, nonprofit agencies, funders and clinics, has continued over the years to assess and transform how we go about meeting the oral health needs of children in our community.

In 2012, fearing that earlier efforts were beginning to wane, local Foundations including First 5 Humboldt, funded the California Center for Rural Policy at Humboldt State University to complete a *Children's Dental Strategic Plan (CDSP)* for Humboldt County, which surfaced the need for a comprehensive look at county-level children's oral health data in order to inform future efforts to reduce dental decay. The *CDSP* was a result of a Children's Oral Health Summit for stakeholders representing government, clinics and nonprofits alike who cared about the issue. Their input helped to reinvigorate the work and provide strategic direction for our joint efforts as a community.

As a result of recommendations in the strategic plan, the Humboldt County Department of Health & Human Services-Public Health formed the **Pediatric Oral Health Initiative Leadership Team (POHILT)** in 2014. POHILT is a working group of agency leaders with a goal to improve children's oral health and respond collaboratively to recommendations outlined in the *Children's Dental Strategic Plan (CDSP)*.

The quality of the relationships and communication that we have built over time amongst all our partners including the creation of entities like our POHILT and the work of the existing DAG strategically positions us for the opportunity that the DTI/LDPP presents. The goals of the LDPP are in line with our own strategic direction to **significantly** address and minimize silos while improving access to and continuity of care. The development of this application included a high degree of input from DAG and POHILT members and Public Health worked with key stakeholders to design the pilot program. Groundwork for this collaborative design was made possible by the long term commitment and high quality contributions from our collaborative partners.

As we have stated above, the strength of this earlier work informed the creation of the LDPP structure we are proposing. This structure will include, in part, a formal **MOU** *(see Attachment 4 to application)* with all LDPP stakeholders hereto known as the **Local Dental Pilot Program (LDPP) Advisory Team** (those who have signed letters of participation) and the Humboldt County Department of Health & Human Services-Public Health, as the Lead Entity, that will include:

1. A commitment to actively participate on the **LDPP Advisory Team** which will meet on a quarterly basis. Attendance at these meetings will be considered mandatory.
2. Agreement to participate in all data sharing to not only support performance objectives but measure the quality of the work.

3. The **LDPP Advisory Team** will also act as the quality assurance mechanism for the whole of the LDPP.
4. Acknowledgement that Public Health, as the lead entity, makes all final decisions and is ultimately responsible to uphold the obligations of the DTI's STC's.
5. **LDPP Coordinator**, as an employee of the Lead Entity, will serve as the point of contact for all programmatic-related issues.

The **LDPP Advisory Team** will also present to the **Pediatric Oral Health Initiative Leadership Team (POHILT)** twice a year on all activities related to the DTI/LDPP and particularly how it relates to the integration of the LDPP into the existing *Children's Dental Strategic Plan (CDSP*). DAG and POHILT members represent the totality of the providers in our community who provide education, prevention and intervention services to our Medi-Cal population of children. The LDPP will provide an opportunity for increased emphasis on **intentional and strategic** integration to improve the continuity of care between and across agencies. Our collaboration history and our strategic approach to the LDPP will minimize traditional silos and create spaces for our agencies to work together on the oral health delivery system for children on Medi-Cal.

Our **Humboldt County LDPP Advisory Team** will consist of the following *(see Figure 1)*:

- Open Door Community Health Centers/Burre Dental Center (FQHC)
- Redwood Community Action Agency
- Humboldt County Public Health
- Humboldt County WIC Program
- Humboldt Network of Family Resource Centers
- California Center for Rural Policy at Humboldt State University
- Redwoods Rural Health Center (FQHC)
- K'ima:w Medical Center (FQHC)

The Oral Health Coordinator for Public Health will be the **LDPP Coordinator** and main point of contact for all participating partners while coordinating all communication and information as well as trouble shooting issues involved in implementation of the LDPP strategies and providing supervision to the Oral Health Care Coordinators employed by Public Health and working as the LDPP's "Care Coordination Hub." The **LDPP Coordinator** will also be responsible for documenting all the work of not only the **LDPP Care Coordination Team** but also the overall challenges and successes and lessons learned through this DTI process to ensure that valuable strategies or unsuccessful efforts are recorded for future reference.

The **Pediatric Oral Health Initiative Leadership Team (POHILT)**, a working group of agency leaders with a goal to improve children's oral health county-wide, will continue to provide input and support in grounding the work in the existing Humboldt County *Children's Dental Strategic Plan*. The county-wide **Dental Advisory Group (DAG)** will continue in its role, meeting every other month, as a convening body for all local interests in oral health that participate specifically with clients essentially "on the ground."

The importance of both the DAG and POHILT cannot be understated in that their continual leadership in this work will assist us in how we frame our future sustainability efforts. Their input will be invaluable as we work to integrate and embed this new model into an on-going Medicaid/Denti-Cal billing structure.

Figure 1, see below, illustrates the current members of both DAG and POHILT, as well as the future partners and potential referring entities for Humboldt County's LDPP.

Figure 1: Humboldt County Children's Oral Health Initiative Collaboration Structure and Local Dental Pilot Program LDPP Integration Strategy				
Agency	**County Dental Advisory Group**	**County Pediatric Oral Health Initiative Leadership Team**	**LDPP Advisory Team**	**LDPP Referring Agency/Serves Children 0-12**
DHHS Public Health *(LDPP Lead Entity)*	X	X	X	X
North Coast Clinics Network		X		
Open Door Community Health Centers-Burre Dental Center	X	X	X	X
First 5 Humboldt		X		X
Humboldt Area Foundation	X	X		
Redwood Community Action Agency	X	X	X	X
Northcoast Children's Services	X	X		X
Humboldt County Office of Education	X	X		X
Redwoods Rural Health Center		X	X	X
K'ima:w Medical Center	X		X	X
California Center for Rural Policy	X	X	X	X
Public Health WIC	X	X	X	X
Humboldt Network of Family Resource Centers	X	X	X	X
Smullin Foundation	X	X		
United Indian Health Services		X		X
St. Joseph Health- Humboldt		X		X
Changing Tides Family Services	X	X		X

Communication and collaboration will be accomplished through the following mechanisms:

- Quarterly LDPP Advisory Team Meetings (mandatory for all funded partners)
- Monthly LDPP Care Coordination Team Meetings (mandatory for all LDPP staff)
- Quarterly Pediatric Oral Health Initiative Leadership Team Meetings
- Quarterly Dental Advisory Group Meetings
- Monthly E-Newsletter to all partners sent by LDPP Coordinator

- Sharing of quarterly and annual data reports produced by CCRP
- Facilitated discussions in meetings around LDPP goals, progress, challenges, and successes
- LDPP Coordinator will visit each funded site and meet with LDPP staff at least four times a year

Section 2 General Information and Target Population:

2.1 Target Population:

The LDPP will serve children currently enrolled in Medi-Cal, with a prioritized focus on the following populations:
1) Children ages 0-12
2) Children residing within tribal communities
3) Children residing in remote geographic regions of the county

There will also be a prioritized focus on children who are classified as high or extreme risk based on the Caries Risk Assessment (CRA). Based on the CRA risk category, participants will be tracked into a pre-determined set of preventive services and/or case management. Each year the CRA will be administered to track changes over time. **The goals will be 1) to increase the number of and regularity by which children receive CRA, and 2) to deliver the preventive and case management services outlined based on the risk level.**

Referrals to the LDPP will initially come from the key partner agencies and organizations that currently work with families on Medi-Cal. In addition to referrals from the lead agency's WIC program, the following key partners will be able to refer families: Humboldt County Network of Family Resource Centers, Redwood Community Action Agency's TOOTH program, and the Federally Qualified Health Care Clinics including Open Door Community Health Centers, Redwoods Rural Health Center and K'ima:w Health Center *(see Figure 1 in Section 1.4*).

Outreach efforts to enroll eligible children in the LDPP will also include the following:

- Development of outreach materials (such as a brochure, poster, news release, information on website) to promote enrollment in LDPP. Some materials will be tailored to parents of children enrolled in Medi-Cal and some will be tailored to providers to explain and describe how the referral process works and what LDPP participants can expect from the program. LDPP outreach materials will include the existing Smile Humboldt logo and will be enhanced by other educational materials already developed through the HRSA partnership. This will be done by the LDPP Coordinator. All LDPP outreach materials will include any branding that DHCS recommends or requires.
- Existing community partners listed in Figure 1 will lead efforts at their agency to disburse outreach materials and make referrals to LDPP. The LDPP Coordinator will make one-on-one contact with community partners to address referral barriers and ensure that community partners understand LDPP and how to refer potential participants.

- Targeted outreach to identified programs and partners that work with potentially eligible children through one-on-one meetings, sharing of outreach materials, and regular communication and follow-up to ensure that referrals are being made. This will be done by the LDPP Coordinator.
- Targeted outreach to medical providers that are serving Medi-Cal enrolled children through one-on-one meetings, sharing of outreach materials, and regular communication and follow-up to ensure referrals are being made. This will be done by LDPP Care Coordinators.
- Outreach will also be conducted on an ongoing basis through the place-based work conducted by our Oral Health Educators through RCAA. Schools will be targeted as those seen to have "high risk" populations for oral health decay as demonstrated by local data obtained through the Kindergarten Oral Health Assessments. Family Resource Centers will have outreach materials on hand and LDPP Care Coordinators will work with the schools, RCAA educators and FRC staff to ensure that Medi-Cal enrolled children are invited to participate in LDPP and that children who may be eligible but are not currently enrolled in Medi-Cal are connected to enrollment assistors through the Department of Health & Human Services.
- Outreach materials and referral instructions will be shared with Department of Health & Human Services Call Center staff and eligibility workers to ensure that new Medi-Cal enrollees are connected and aware of their eligibility to participate in LDPP.

In terms of the numbers we expect to serve or the enrollment caps we might set, we will have a quality improvement and assurance plan in place that will allow the **LDPP Advisory Team** to make timely decisions with data to inform their decisions. According to Partnership HealthPlan of California (Humboldt County's Medi-Cal Managed Care Plan), we have **16,878** children 0-17 enrolled in Medi-Cal. The entire population of our county is 134,493, which means approximately **12.5%** of our total population is comprised of children 0-17 on Medi-Cal.

We also know that close to **40% of our county's population is enrolled in Medi-Cal**, according to DHCS' Research and Analytic Studies Division. This number translates to 51,185 individuals enrolled in Medi-Cal. Based on our needs assessment data we have selected three focus populations (children 0-12, children residing in tribal communities, and children residing in remote regions) to prioritize enrollment in the pilot program.

Figure 2 includes numbers enrolled in Medi-Cal by age.

Data was provided by the Partnership HealthPlan of California. Additionally, we have data indicating the city of residence for our Medi-Cal enrolled population, which will allow us to check that we are reaching children in areas where we have high percentages of residents enrolled in Medi-Cal.

Figure 2: Humboldt County Medi-Cal Eligibility as of 5/3/2016		
Age	**Member Count**	**Percentage**
0-1	2,047	4.0%
2-4	3,045	5.95%
5-10	5,963	11.65%
11-14	3,351	6.55%
15-19	3,757	7.34%
20-24	4,121	8.05%
25-44	16,283	31.81%
45-64	10,152	19.83%
65+	2,466	4.82%
Sum	**51,185**	

We have set a target of reaching 1,687 children during the pilot program which would translate to 10% of our total population of children on Medi-Cal. This would translate to approximately 421 children per year. Because we can't anticipate the exact percentage of children in the pilot program who will be classified as high or extreme risk, it is difficult to estimate the exact number that staff will have the capacity to serve.

The care coordination and preventive service delivery plan will be more extensive for those children who are classified as high or extreme risk. Based on our needs assessment data we have selected three focus populations: children 0-12, children residing in tribal communities, and children residing in remote regions to prioritize enrollment in the pilot program.

For our innovative strategies around medical and dental integration, we are proposing to work with the clinics that serve as the medical home for the vast majority of this population. We know that about 6,000 of our 16,878 Medi-Cal eligible children have FQHC's as their medical home, and another approximately 7,000 have one of two private clinics as their medical home. We propose to work with the FQHCs in Years 1 and 2 of the LDPP and then share those strategies with the two Rural Health Clinic pediatric offices that work with a large majority of local children on Medi-Cal.

Our needs assessment work and a thorough review of DTI materials has been the foundation for the selection of key strategies for this pilot project. The needs assessment has been an ongoing process that has included: review of secondary data, one-on-one key informant interviews with stakeholders, a survey with local school staff, focus groups with parents on Medi-Cal, and a series of meetings with **the Dental Advisory Group (DAG)** and the **Pediatric Oral Health Initiative Leadership Team (POHILT)**.

The Humboldt County Department of Health & Human Services Public Health Branch has worked with the California Center for Rural Policy at Humboldt State University (CCRP) to conduct a community needs assessment focused on children's oral health. The first of these efforts was a *Children's Dental*

Strategic Plan (CDSP) for Humboldt County which was completed in 2012. Utilizing community input and research around best practices for children's oral health, five focus areas were identified for the county: 1) address the lack of comprehensive oral health data available, 2) improve oversight, coordination, and advocacy, 3) improve access to dental services for those at highest risk of decay, 4) create a culture shift about the importance of preventive care through education and social marketing, and 5) increase the amount and quality of networking between new and current partners. The strategic plan also included a SWOT analysis which identified strengths, weaknesses, opportunities, and threats.

This 2012 strategic plan was followed by the creation of the **Pediatric Oral Health Initiative Leadership Team** in January 2014 to provide high level leadership and advocacy to address the focus areas identified in the strategic plan. The **Dental Advisory Group (DAG)** had already been meeting since 1999, when the first children's oral health initiative was launched in the county under a Circle of Smiles grant from the California Endowment. Both the POHILT and the DAG are vital, active groups with a number of community partners from a variety of agencies (See Figure 1 in Section 1.4 for more details).

In response to focus area #1, the lack of comprehensive oral health data, Public Health and CCRP completed a collaborative project to gather and analyze population-based data on children's oral health in Humboldt County. The findings for this project were articulated in a report titled *Healthy Teeth for Life.* We discovered that our county had a high response rate (60.3%) to the optional Kindergarten Oral Health Assessment, and we took a deep dive into the data to better understand trends around children's oral health status when they enter kindergarten.

The average percentage of kindergarten students with untreated decay was 27.2% over a five-year period (2009-2014). Seven school districts in the county had more than 30% of students with untreated decay, and two districts had more than 50% of students with untreated decay. Our data clearly shows that there are a significant percentage of our children entering kindergarten with preventable yet untreated decay.
We also found geographic clusters of high decay, particularly in areas where they were high percentages of students enrolled in free and/or reduced lunch through their school district. The eastern region of our county was particularly impacted, and that is also where many of our tribal residents reside. These findings are one of the reasons we are prioritizing children who reside in tribal communities. Findings also showed high rates of untreated decay in remote areas that are not in close proximity to a provider that accepts Denti-Cal. This data informed the Collaborative's decision to target children in remote rural regions of the county.

The following recommendations were made based on the *Healthy Teeth for Life* report: 1) prioritize future oral health-related outreach, education, and service delivery based on geographic regions of need highlighted by the Kindergarten Oral Health Assessment data, 2) increase the focus on 0-5/pre-K oral health, 3) focus on filling data gaps related to children's oral health, and 4) continue to explore innovations in cross-sector collaboration amongst providers and organizations working on children's oral health.

In planning for the DTI opportunity, Public Health & CCRP have conducted key informant interviews and small group discussions with all of our Federally Qualified Health Care Clinics (FQHC- the only local

providers willing to see children on Denti-Cal). We have also facilitated conversations with seven of our local private dentists. We have had discussions with our State Assemblymember Jim Wood (former DDS and current Chair, State Assembly Health Committee), our DAG and POHILT members, and our local community action agency. We have learned a great deal during these exploratory conversations, and we developed our pilot program design based on feedback received during these exchanges. We have discussed DTI with over 30 of our community partners, and it has been a repeating item on the agenda for both DAG and POHILT since we first learned of the opportunity.

In terms of local context, Humboldt County has had similar experiences to other rural counties in California. We have no private providers who are willing to accept children or any patient enrolled in Denti-Cal. When we discussed this with the private dentists, the following reasons emerged: 1) an onerous process to enroll in Denti-Cal, 2) inadequate reimbursement rates, 3) regular refusal of and excess scrutiny of claims for reimbursement, 4) a high no show rate for this population, and 5) extensive treatment needs for the Medi-Cal population Essentially, the private dentists said that they lose money when they serve this population, which is highly problematic for any private practice. Additionally, there are barriers other than reimbursement that de-incentivize private dentists from serving patients who have Denti-Cal.

A 2010 report, *Specialty Access on the North Coast: Mental, Dental, and Medical Access,* cited 41 adjusted full-time equivalent (FTE) general dentists, but **only 5.2 FTE dentists to serve low-income patients. This translated to 4,808 low-income patients per dentist, a ratio that qualifies the county as a Dental Health Professional Shortage Area.**

The overall goals of Domain 4 align very closely with the current agenda and focus of our county-wide children's oral health initiative. For example, the POHILT decided in 2015 that they wanted to set three main data targets for their work: 1) to increase the number of children who receive a caries risk assessment, 2) to reduce the percentage of students entering kindergarten with untreated decay, and 3) to reduce our local dependence on hospital-based dentistry to meet the extensive treatment needs of children on Denti-Cal.

CCRP and Public Health have also worked collaboratively to conduct focus groups with parents of children on Medi-Cal. To date we have conducted three focus groups with 32 parents and what we have heard is that they feel they have very limited access to preventive oral health services as well as limited access to treatment services. Parents cared very much about their children's oral health but felt as though they were not meeting their children's needs, which created shame and embarrassment for parents. We heard statements such as "I never went to the dentist until I was 21 and pregnant."

Many parents had grown up in homes where tooth brushing was not a daily habit. We also heard of the fear that many parents have of going to the dentist, and frustration around long waiting times for appointments. For example, 29% (n=9) of participants reported that they had to wait 2-3 months for a dental appointment. Almost 70% (n=21) felt that all children develop tooth decay. About 36% (n=11) reported that their child did not regularly see a dentist, despite all participants having dental insurance. Additionally, 32% (n=10) of participants said their child had not seen a dentist in the past 12 months.

Our hope is that the Local Dental Pilot Program will provide our county with an opportunity to make progress on some of these very complex issues, and to shift the focus more to prevention for this population. In terms of our additional focus on integrating medical and dental care, we know that only 33% of California community clinics have co-located dental and primary care. According to the UCLA Center for Health Policy Research, the degree of oral and primary care integration in these organizations is unknown. We will look at the UCLA-First 5 LA 21st Century Dental Homes Project (DHP) model and other innovative models to assist our FQHCs and two private pediatric providers in developing and measuring strategies to integrate medical and dental prevention in the clinic setting.

Section 3 Services, Interventions, Care Coordination and Data Sharing:

3.1 Services and Care Coordination:

Figure 3

Describes the community linkages and ongoing efforts of local partners that align with the goals of the LDPP. All of the county-wide initiatives listed below are focused on goals that align with the DTI Domains.

Through education, outreach, early intervention, prevention, and treatment, these ongoing efforts aim to:

1) Reduce the overall risk for caries for children on Medi-Cal (DTI Domain 2)
2) Increase continuity of care for children on Medi-Cal (DTI Domain 3)
3) Increase the utilization of preventive services for children on Medi-Cal (DTI Domain 1)

Figure 3: Community Linkages Focused on Children's Oral Health, Humboldt County

Agency	LDPP	Oral Health Services for Children on Medi-Cal	Mobile Dental Van	Well Child Dental Visit	TOOTH Education & Outreach Program	HRSA Education & Outreach Grant
DHHS Public Health (LDPP Lead Entity)	X	X		X		X
Open Door Community Health Centers-Burre Dental Center	X	X	X	X		
First 5 Humboldt					X	
Redwood Community Action Agency	X	X			X	X
Northcoast Children's Services		X			X	X
Humboldt County Office of Education			X		X	X
Redwoods Rural Health Center	X	X	X	X		
California Center for Rural Policy	X					X
Public Health WIC	X	X		X		
Humboldt Network of Family Resource Centers	X		X			
United Indian Health Services		X		X		
Changing Tides Family Services					X	X

Using an agreed upon, standardized Caries Risk Assessment (CRA) form across our 3 FQHC's as well as our WIC Program and our education and place based outreach through Redwood Community Action Agency, we will create a triaged system of care based upon a low, moderate, high and extreme risk scale within our target population of 0-12.

After a CRA is completed, clients will then be triaged based upon the above scale and referred through our LDPP Care Coordination Hub in a warm hand off to assigned Oral Health Care Coordinators under the umbrella of Public Health.

These Care Coordinators will at first engage referred families in a ***Patient Activation Measure (PAM)*** specifically designed to assess their oral health knowledge, confidence and skills. After the PAM, Care Coordinators will work with the family to create a ***Family Dental Plan (FDP)*** based upon their PAM level and the CRA results and will work directly with these clients to determine appointment compliance and other potential barriers to receiving care as well as basic oral health literacy utilizing a motivational interviewing approach. All of these interventions will be tracked through an **LDPP Data Tracking System** which will allow us to adequately measure over time a child/family's progress as well as identify the need for quality improvement interventions.

Another component of the LDPP will be provider and community-based trainings to increase the capacity of individuals and agencies to provide preventive oral health services in a variety of settings. We will also be utilizing a motivational interviewing approach to the care coordination and system change work integral to LDPP. Through the "Smiles for Life" or similar curriculum, along with motivational interviewing trainings/tools, we hope to raise the level of oral health literacy and increase the community-level response to high rates of untreated decay for children in our county.

This training and education will be provided by staff and has been included in the 4-year budget. Costs for printing materials and local mileage to provider locations are folded into each year's budget. The training curriculum itself is available at no cost. Provider training and education will be coordinated and conducted by LDPP staff. CCRP will design and administer training evaluations (if the training selected does not include an evaluation component). In addition to training community-based organizations, there will be a specific focus on recruiting and training medical providers to conduct oral health assessments (CRAs) and apply fluoride varnish.

Through larger, collective oral health work that has occurred in the last 3 years, Redwood Community Action Agency (RCAA) has been the recipient of two recent grants solely directed at working on the children's oral health landscape in Humboldt and adding to our future effort towards sustainability. RCAA's work aligns with the DTI Domains, specifically Domains 1 and 3, and with the strategic direction of our county-wide *Children's Dental Strategic Plan (CDSP)*.

In May of 2015, RCAA received a 3-year HRSA grant called *TOOTH Plus Rural Health Care Services Outreach Program*. This grant encompasses an expansion of community-based early intervention tactics that include preventative education, screenings and fluoride varnish in preschool as well as a county-wide public campaign to increase oral health literacy entitled "Smile Humboldt."

A second grant, just received in early spring also by RCAA, is an AmeriCorps Planning Grant for 2017, in which we will be creating an Oral Health Corps that will work in concert with our LDPP Design. Our collective and collaborative oral health work, specifically over the last 2 years with a more concentrated focus on pediatric oral health needs helped to position RCAA to receive both the HRSA and AmeriCorps grants.

Our FQHC's will deal with the extreme cases including hospital based dentistry referrals in cooperation with our Oral Health Care Coordinators and in partnership with the RCAA Oral Health Corps members, who will work on the more daily issues clients may have in accessing services, getting appointments, interfacing with providers on behalf of a client and basic oral health literacy questions as part of our LDPP Care Coordination System. OH Care Coordinators will track clients and their progress through the PAM and rework the Family Dental Plan as needed to continue to ensure that those who are in the high and extreme risk categories get the care they require as well as the follow up preventive services needed to maintain their oral health.

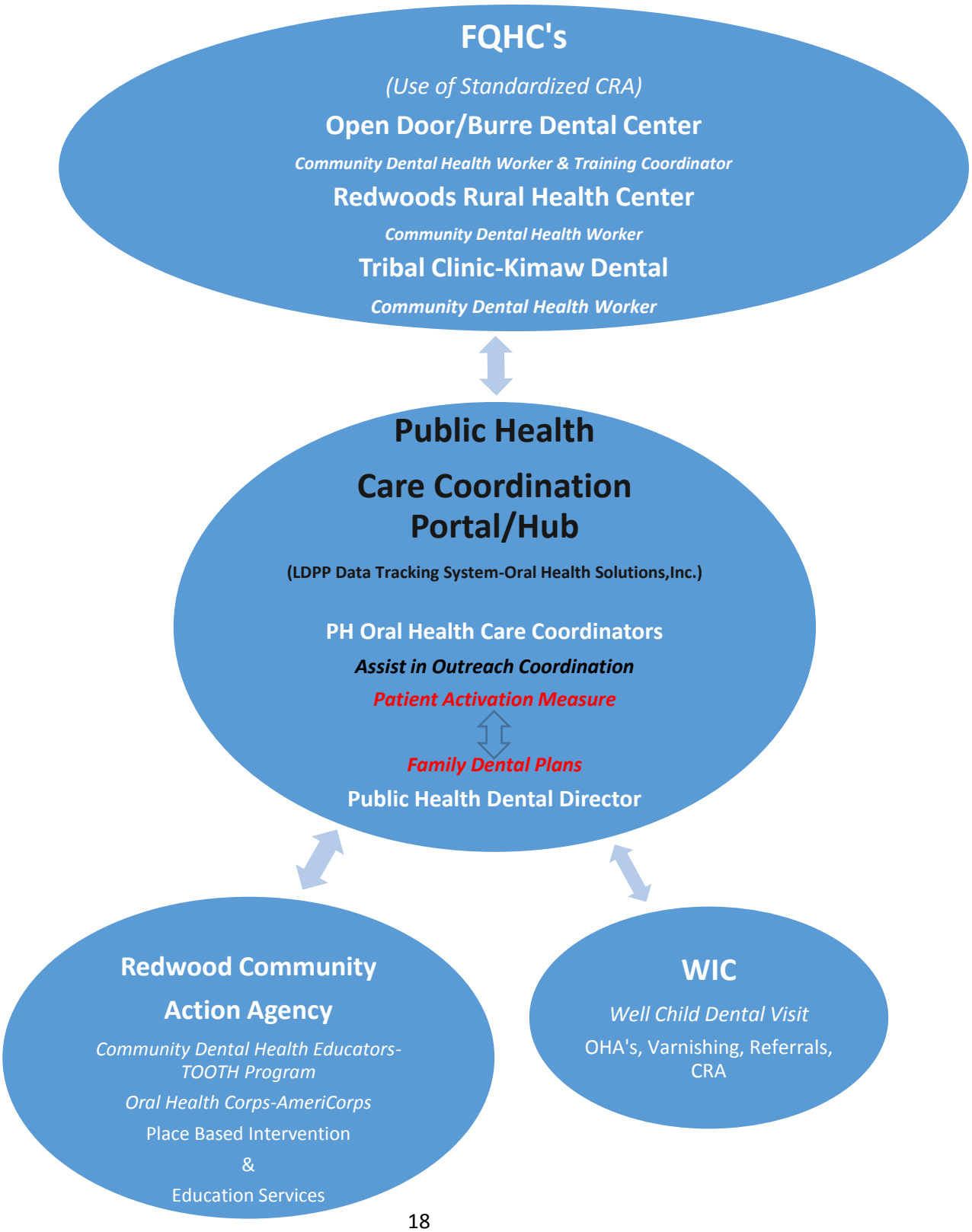
As part of this new LDPP care coordination infrastructure, those involved in direct care coordination will meet monthly under the leadership of Public Health, as an **LDPP Care Coordination Team**. **This is a new, innovative approach for our county, in essence creating a formal oral health case management team working across government, clinics and nonprofit entities.**

This team will work on quality improvement strategies that address their on-going work with clients, how the intervention and care coordination infrastructure is working, what challenges are being presented, how collaboration and linkages are being established and whether those are successful from both a case management perspective as well as the client perspective. Strategies will also address the client experience and will include regular evaluations by clients of their interactions with the care coordination infrastructure. Part of this work will also be the deliberation of incentivizing success and what that might look like in the form of oral health supplies to support needs. Focus groups with participants will also provide us with vital feedback about the experience of project participants.

We are also proposing to work with Oral Health Solutions, Inc. (OHS) to develop the **LDPP Data Tracking System.** The core of the system will consist of a smart device App used to support electronic forms hosted on tablet computers. The App will be completely customized to support the specific data collection/management needs of the LDPP.

As part of Year 1, Open Door/ Burre Dental Clinic, Redwoods Rural Health Center and Kimaw Dental Clinic will incorporate CRA modules into their respective EMR systems for data tracking purposes. The Team will continually address these shared interventions and work to make sure that the system is working for all including the CRA data module within the pilot FQHC's. Additionally, OHS will be assisting us in this process as part of their work with the LDPP.

The following graphic, next page, illustrates our intervention and care coordination strategy and the design of the LDPP Care Coordination Team:


FQHC's
(Use of Standardized CRA)
Open Door/Burre Dental Center
Community Dental Health Worker & Training Coordinator
Redwoods Rural Health Center
Community Dental Health Worker
Tribal Clinic-Kimaw Dental
Community Dental Health Worker
Public Health
Care Coordination Portal/Hub
(LDPP Data Tracking System-Oral Health Solutions,Inc.)
PH Oral Health Care Coordinators
Assist in Outreach Coordination
Patient Activation Measure
Family Dental Plans
Public Health Dental Director
Redwood Community Action Agency
Community Dental Health Educators-TOOTH Program
Oral Health Corps-AmeriCorps
Place Based Intervention
&
Education Services
WIC
Well Child Dental Visit
OHA's, Varnishing, Referrals, CRA

3.2 Innovations, Interventions, and Strategies:

With a long standing group of committed stakeholders, including funders, providers, CBOs, and government who understand the challenges around children's oral health, we continue to work together to provide more effective and efficient services to improve the oral health of low-income children in Humboldt County. In order to work more effectively and efficiently, there is a desire to work "upstream" and put more emphasis on those most at risk of decay, use evidenced-based prevention practices, and work together to share best practices and provide integrated care coordination.

Figures *4* and *5* show the current membership of both our Dental Advisory Group (DAG) and Pediatric Oral Health Initiative Leadership Team (POHILT). These partners will have varying levels of involvement with the LDPP which is described in Figure 1 in Section 1.4.

Figure 4: Humboldt County Dental Advisory Group (DAG) Current Membership as of January 2017	
Agency/Organization	**Name/Title of Participating Member**
Redwood Community Action Agency	Kathy Carterby-TOOTH Educator Maire Dodd-TOOTH Educator Carla Avila-TOOTH Educator
DHHS- Community Health Outreach	Dawn Rossman-Community Health Outreach Worker
DHHS- Field Nursing	Andrea Armin-Public Health Nurse
DHHS- Maternal Child & Adolescent Health	Emily Adams-Perinatal Services Coordinator
California Center for Rural Policy	Dawn Arledge-Director of Health
Open Door Community Health Center/Burre Dental Clinic	Brandy Boone-Case Manager Barbara Davis-Mobile Dental Van Coordinator
St Joseph Health / Loleta Community Resource Center	Marina Cortez-Hash-Coordinator
Changing Tides Family Services	Pam Manning-Resource & Referral Director
DHHS-Mobile Medical	Linda Souza-Outreach Worker
Humboldt Area Foundation	Lynn Langdon-Grants Administrator
DHHS-Public Health	Teo Salas-Meza-Translator/Interpreter
Smullin Foundation	Laura Olson-Executive Director
DHHS-Public Health	Catherine DeSantis-Program Coordinator
DHHS-MCAH	Jeanne Vaudiau-Medical Office Assistant Helen Luther-CHDP-Health Manager Holly Baker-Medical Office Assistant
DHHS-Community Health Outreach	Emily Shears-Community Health Outreach Worker
DHHS-WIC	Irene Gil-Director of Nutrition
Union Labor Health Foundation/Angel Fund	Robert Berg, Retired DDS
Redwood Regional Center	John Sullivan, MD
Paso a Paso	Jessica Eusebiol-Community Health Worker
Humboldt County Office of Education	Tess Ives-Director of Health Services

Figure 5: Humboldt County Pediatric Oral Health Initiative Leadership Team (POHILT) Current Membership as of January 2017	
Agency/Organization	**Name/Title of Participating Member**
Public Health	Lara Weiss-Deputy Director of Public Health
North Coast Clinics Network	Tim Rine-Executive Director
Open Door Community Health Centers/ Burré Dental	Hermann Spetzler-CEO Cheyenne Spetzler-Chief of Operations
First 5 Humboldt	Mary Ann Hansen-Executive Director
St. Joseph Health	Martha Shanahan-Director of Community Benefit
Union Labor Health Foundation	Amy Jester-Program Manager
Redwood Community Action Agency /TOOTH	Lorey Keele-Program Director
Changing Tides Family Services	Kerry Venegas-Executive Director
Northcoast Children's Services-Head Start	Kathy Montagne-Executive Director
Humboldt County Office of Education	Tess Ives-Director of Health Services
Redwoods Rural Health Center	Tina Tvedt-Executive Director
California Center for Rural Policy-Humboldt State University	Dawn Arledge-Director of Health Connie Stewart-Executive Director
MCAH/Public Health	Megan Blanchard-Supervising Public Health Nurse
MCAH/Public Health (WIC)	Irene Gil-Director of Nutrition
Humboldt Network of Family Resource Centers	Taffy Stockton-Network Coordinator
Smullin Foundation	Laura Olson-Executive Director

Based upon the work that has occurred as a result of the CDSP and the POHILT, the opportunity that the DTI/LDPP presents is in line with our own strategic direction to significantly address the silo work and create a better system of intervention, coordination and service delivery.

Our proposed prevention based service delivery will work across disparate organizations that include our FQHC's (including a tribal clinic), our local Community Action Agency (a nonprofit), County Government (Public Health) and our school based family resource centers which will ensure a non-duplication of services. This delivery will include the commitment of all entities to use a standardized Caries Risk Assessment (CRA) tool.

We are also proposing a greater volume of place-based services as an intervention/prevention based strategy in partnership with 2 of our local, school-based family resource centers as well as other sites where families can have easy access to these services including Public Health, WIC and schools, particularly those identified in our assessment work that show a high rate of kindergarten oral health decay. Those place-based services will include education/oral health literacy, oral health assessments, fluoride varnishing to be conducted by our Community Dental Health Educators through RCAA.

Targeted Geographic Areas & Schools for Oral Health Placed Based Services 4 Times a Year

Region	% of county pop.*	% of PDI Referrals	School Districts	Untreated Decay Rate	Response Rate	% Eligible for FRPM*	Nearest FQHC*
Eastern Humboldt	**4%**	**29%**	**Klamath-Trinity Joint Unified**	**56.3%**	**43.1%**	**94.1%**	**K'ima:w Dental Clinic, Hoopa**
Eel River Valley	**13.5%**	**16.5%**	**Scotia Union**	**55.5%**	**83.8%**	**65%**	**Open Door Burre, Eureka**
			Rio Dell	**39.7%**	**59%**	**72.8%**	
			Fortuna Union	**35.7%**	**91%**	**63.7%**	
			Loleta Union	**30.6%**	**60.4%**	**80%**	
Eureka	**22.5%**	**29%**	**Eureka City Unified**	**36.9%**	**47.8%**	**74.2%**	**Open Door Burre, Eureka**
Arcata/McKinleyville	**24.4%**	**12.9%**	**Arcata School District**	**35.8%**	**50.8%**	**52.7%**	**Burre & UIHS, Arcata**
Southern Humboldt	**3.4%**	**9.3%**	**Southern Humboldt Joint Unified****	**6.5%**	**36%**	**52.2%**	**Redwoods Rural, Redway**

We intend to work on greater integration of oral health care delivery on the medical side by piloting Community Dental Health Worker positions at all 3 of our FQHC's. Open Door will also employ a Training Coordinator position within the clinic setting with one of our partner FQHC's, Open Door-Burre Dental Center. That position will work to improve care and support the idea of integrating oral health education, screening, and varnish application during pediatric appointments. They will also train ODCHC dental assistants to apply fluoride varnish to children ages 6 months to 12 years old who present to ODCHC's pediatric clinic for medical and behavioral health visits. We will then seek to replicate this in our 2 larger, local, pediatric clinics that see a disproportionate amount of Medi-Cal children.

Our 2 other FQHC sites, Redwoods Rural Health Center and K'ima:w Dental Clinic will both pilot Community Dental Health Worker positions designed to promote cross referrals and case management between the medical and dental sides of those organizations as well as work directly in their respective, remote-based communities to integrate place-based services and interventions, connect them to needed services and promote general oral health literacy.

While WIC has a previously identified Well Child Dental Visit (WCDV) program, it has continued to underperform with a low turnout and appointment compliance issues, but Public Health WIC leadership clearly acknowledges that it is the perfect place to capture the population we are trying to reach. By enhancing that visit with the availability of more experienced oral health staff while providing the ability to do oral health assessments and varnishing, we hope to raise the use of these visits by creating a more professional experience for WIC clients while also creating a stronger referral and support mechanism for potentially "at risk" children and their families.

As we have previously outlined, we are building an integrated care coordination and prevention/intervention model. We feel strongly that this multi-faceted approach is absolutely not redundant of existing approaches but instead, we anticipate that the efficacy of a greater frequency and access to things like fluoride varnish, basic cleanings and oral health assessments as well as wrap around case management will provide the likelihood of greater success in lowering the decay rate, particularly in some parts of the County that we have determined through our Kindergarten Oral Health Assessment (KOHA) data analysis, have a continual and unusually high rate of decay. We have already demonstrated though this local needs assessment that greater case management will lead to better outcomes for these kids in our target population.

And finally, we will be contracting with a local, retired dentist to serve as our Public Health Dental Director to assist the **LDPP Care Coordination Team** in ensuring the quality and efficacy of the services we are providing out it in the community.

We anticipate that the totality of the model we are proposing can make a case that early intervention, prevention, and case management will reduce the risk for caries, and improve the overall dental health of our target population. Also we envision that the potential for engaging the medical community in the integration of oral health into the primary care and place-based settings will also make preventive services more accessible, which in the long term will reduce the treatment needs of the target population.

Because we already have data that clearly shows where our higher risk children reside we have a much higher likelihood of reaching them, particularly in this more formal structure of referrals, more refined support through education and intervention and ensuring appointment compliance and frequency of care for those at highest risk. Open Door's proposed model in their pediatric setting including overseeing the development of patient/family-facing scripts, educational and outreach materials, and curriculum development for ODCHC's pediatric departments will help us develop a training model that we can then essentially integrate into our 2 larger, pediatric practices.

In terms of our innovation around the integrating medical and dental care, we know that only 33% of California community clinics have co-located dental and primary care. According to the UCLA Center for Health Policy Research, the degree of oral and primary care integration in these organizations is unknown. We will look at the UCLA-First 5 LA 21st Century Dental Homes Project (DHP) model and other innovative models to assist our FQHCs and two private pediatric providers in developing and measuring strategies to integrate dental prevention in the clinic setting. We also hope to model the integration of dental prevention into school-based and other place-based settings such as family resource centers to

increase the ability of our remote rural residents on Medi-Cal to access preventive services

All locations at which LDPP services are provided will be tracked in the LDPP Tracking System so that we are able to compare results across sites. For example, we will be able to compare results from school-based locations with community-based locations such as the Family Resource Centers. We will also be able to look at LDPP prevention services delivered in clinic-based settings and compare results to place-based settings.

A prevention focused care coordination model describes our overall approach to the LDPP. We intend to prioritize risk through the CRA tool and create treatment plans for participants that prioritize dental prevention for this population. We acknowledge that for many Denti-Cal families, prevention is not typically the priority and children are seen when they are in pain or when extensive treatment is needed. We intend to shift this traditional dynamic to help LDPP families access prevention services on a regular basis based on their assessed risk level.

We will utilize intensive case management and motivational interviewing approaches to identify barriers to accessing care, both preventive care and needed treatment. Care coordination will be accomplished through strategic, intentional case management that links LDPP participants to a dental and medical home. LDPP Community Dental Health Workers, Public Health Care Coordinators and our Community Dental Health Educators will be working as a team to discuss barriers that arise for multiple participants and working with our community partners to address barriers to care for the population as a whole. **There are no current efforts focused on care coordination that bridge the gap across diverse agencies that provide a variety of services to this population.**

In addition, our proposed approach will ensure that LDPP participants in remote rural areas are able to access care through place-based services in the areas that they live. This will require innovative partnerships that allow dental prevention to be accessed in a variety of school-based, community-based, and health clinic settings.

The purpose of the caries risk assessment (CRA) in this setting will be the following: We will use the CRA as the first step to assess LDPP participants' oral health status when they enter the LDPP. Based on the CRA results, LDPP participants will be categorized into four risk levels: low, moderate, high, and extreme. Based on the assessed risk level identified, LDPP participants will be tracked into a pre-determined set of preventive services. We are willing to adjust to any DHCS requirements to use a particular CRA, though our preference would be to use the one proposed above-*see attached examples of CRA tool we will be using*.

The CRA tool we intend to use is the CRA that was developed and is currently in use by our largest FQHC- Open Door Community Health Centers. There are two versions of the CRA: one for children 0-5 and one for children 6+. The back of the CRA includes frequently asked questions by parents so that providers can explain the CRA. The back of the CRA also includes information about the risk levels and what they mean.

The pre-determined set of preventive services was also developed by the dentist and staff at the Burre Dental Clinic, which is the dental clinic for Open Door.

The following set of preventive services will be provided:

Low Risk

- No preventive services required, 6-month check-ups

Moderate Risk

- Preventive Services: Plaque disclosure, Basic education around brushing and flossing techniques, 6-month check-ups

High Risk

- Preventive Services: Fluoride varnish, Basic education around brushing and flossing techniques, Plaque disclosure, Bathroom plaque disclosure training, case management to ensure dental visits/facilitate care, 3-6 month check-ups

Extreme Risk

- Preventive Services: Fluoride varnish on a monthly basis, Basic education around brushing and flossing techniques, Plaque disclosure, Bathroom plaque disclosure training, case management to ensure dental visits/facilitate care, 3-month check-ups

Our LDPP partners have all agreed to use this tool, which is the first time that consistency across providers will be implemented. Services will be reimbursed through the providers' established billing system.

All preventive services will be tracked through the LDPP Data Tracking System. We will also track whether or not restorative services were provided to the LDPP participants. All of these details will be included and specified in the data sharing agreements.

A final innovative strategy is the incorporation of Hygienist advanced practice scholarships into our LDPP. We are doing this for the following reasons:

1) Humboldt County is a designated Dental Health Professional Shortage Area.
2) We have no private dental providers that currently accept Medi-Cal.
3) Advanced practice hygienists have the ability to practice in non-traditional settings as well as the option to open their own practice.
4) Advanced practice hygienists have the ability to become Medi-Cal providers.
5) In order for a local resident to complete their education for advanced practice hygienist, he or she must travel **at least** 6 hours to the nearest accredited educational institution.
6) We believe that a critical component to increasing the number of providers that accept Denti-Cal, we must build the capacity for mid-level professionals to provide preventive services.
7) We want to increase our local workforce of advanced practice hygienists.
8) We will have an agreement in place with scholarship recipients where they state their commitment to serve either as LDPP staff or as a local Denti-Cal provider.

By providing scholarships we are making soft gains in workforce investment in a community that is underserved and has inadequate dental providers willing to take patients on Denti-Cal. As we have already demonstrated, almost 60% of children in our county are enrolled in Medi-Cal and there is a far greater need than the current providers can handle.

Figure 6, next page, gives a quick summary of all our aforementioned Innovations, Interventions & Strategies:

Figure 6: Humboldt County Local Dental Pilot Program Summary of Innovations, Interventions & Strategies				
Goals	**Strategies**	**Key Activities**	**Outcomes**	**Data Source**
Reduce the overall risk for caries for children participating in the care coordination model ***(DTI Domain 2/STC 107)***	Implement a place-based prevention focused care coordination model	1. Pilot program referral from partners 2. Caries risk assessment (CRA) baseline 3. Patient Activation Measure (PAM) tool and development of shared Family Dental Plan (FDP) with goals based on risk level 4.LDPP Community Dental Health Workers and Educators provide CRA, preventive services, and care coordination based on PAM & FDP 5. Annual CRA & review/updating of PAM & FDP 6. Provide 3 scholarships for local hygienists to obtain advanced practice licenses to increase local provider capacity to provide preventive services for children on Medi-Cal through LDPP (Years 2-4)	**1**. Increase provision and utilization of annual caries risk assessment & preventive services in place-based settings	Standardized Caries Risk Assessment (CRA) from EHR
Increase continuity of care for children on Medi-Cal ***(DTI Domain 3/STC 108)***			**2**. Increase provision of care coordination components identified in FDPs	Patient Activation Measure (PAM) & Family Dental Plans (FDP) LDPP Data Tracking System (Oral Health Solutions)
Increase the utilization of preventive services for children on Medi-Cal ***(DTI Domain 1/STC 106)***	Integrate dental prevention into primary care and community-based settings	1. Work with FQHCs to implement and evaluate model strategies to integrate dental care into primary care settings 2. LDPP Community Dental Health Workers and Educators provide assessments and preventive services at clinic and community-based settings 3. Community Dental Health Worker positions at FQHCs 4. Provide "Smiles for Life" or similar training for medical providers and school and community professionals that work with children	**3**. Identify model strategies appropriate for rural communities at FQHCs and other primary care settings	Implement plans with evaluation metrics
Increase the provision of dental prevention services in primary care and community-based settings ***(DTI Domains 1&3/STCs 106 & 108)***			**4**. Increase provision of preventive services for children on Medi-Cal in primary care and community-based settings	Clinic and site-specific records Training evaluations

In addition to the outcomes listed in **Figure 6**, the LDPP will measure the number of LDPP participants who receive an annual CRA and we will be tracking where those services were delivered so that we may compare the effectiveness of preventive service provision in both health and dental clinic setting as well as community-based settings. We will also measure the completion of preventive services delivered to participants based on their CRA risk level. Each service will have a unique code as well as other components such as goals for the home setting identified in the Family Dental Plans. These will be self-reported by families when they complete the annual update of the FDP.

Our LDPP intends to identify and test 2-4 model strategies appropriate for rural communities at FQHCs and other primary care settings. We will be working initially with the Open Door Community Health Centers and will apply lessons learned to our work with the pediatric offices in Years 3 & 4.

Also measured will be the provision of preventive services for LDPP participants in primary care and community-based settings through the LDPP Data Tracking System. At the end of Year 1 we will establish a baseline for Outcomes 1, 2, and 3 which we will compare to subsequent years.

The data that will be used to measure whether strategies are having the intended impact will come from the LDPP Data Tracking System. All requirements around entering data and the type of data required will be clearly outlined in the data sharing agreements. Our primary data sources will be: Clinic and place-based records of service delivery, CRA, the Patient Activation Measure (PAM), and the Family Dental Plans.

Performance metric measurements will be entered by LDPP staff on a weekly basis and CCRP will produce quarterly reports that reflect the status of performance metrics identified in the Special Terms and Conditions (STC) for Dental Transformation Initiative. We have proposed to work with three of the DTI domains and we will include all metrics outlined by DHCS in the STCs.

For clarification, we have identified the following organizations as key partners. Their specific roles are identified in **Figure 1**. The partner organizations include: DHHS Public Health (Lead Entity), Open Door Community Health Centers, First 5 Humboldt, Humboldt Area Foundation, Redwood Community Action Agency, Northcoast Children's Services, Humboldt County Office of Education, Redwoods Rural Health Center, K'ima:w Medical Center, California Center for Rural Policy, DHHS Public Health WIC, Humboldt Network of Family Resource Centers, Smullin Foundation, United Indian Health Services, St. Joseph Health- Humboldt, and Changing Tides Family Services.

For some of these organizations, their roles will not fall directly within LDPP scope of work but they will be strategically supporting the work of the LDPP with a focus on increasing long-term sustainability of the project. For example, the Humboldt Area Foundation and the Smullin Foundation will be thought partners and active participants in our efforts to identify long-term funding sources for this work. These are all partners who participated in the Children's Dental Strategic Plan and they are all concerned with long-term sustainability of the work proposed in the LDPP.

While Oral Health Solutions and Partnership Health Plan are listed in our proposal, they were not listed in Figure 1 as they are new partnerships that will only be pursued if funding is received. For all other organizations listed, we have both a historical relationship and will continue to work with those organizations regardless of whether or not LDPP funding is received.

3.3 Accountability:

The LDPP will be monitored on an ongoing basis. Project monitoring will be a section in the CCRP quarterly and annual reports for the LDPP, so it will be formally addressed on an ongoing basis throughout the grant period. The draft project monitoring plan can be found in Figure 7 in Section 3.4.

The **LDPP Coordinator** and the Lead Agency have reviewed and will ensure compliance with the DHCS agreements and any requirements of STC 109 and Attachment JJ. Public Health will work with CCRP to ensure that performance metrics mirror metrics delineated in the STC document, and Public Health will ensure that all DHCS oversight, monitoring, and reporting requirements are met.

The **LDPP Coordinator** will work closely with CCRP to identify parameters around the frequency and type of monitoring with the first three months of the grant period. The **LDPP Coordinator** and CCRP Director of Health will meet with the **LDPP Advisory Team** and will closely review all grant-related requirements to set a monitoring schedule that meets both the needs of the local stakeholders as well as the needs of the funder.

All of these timelines and details will be integrated into the *LDPP Quality Improvement Plan*. The LDPP Quality Improvement Plan will be a living and working document that the **LDPP Advisory Team** will utilize on an ongoing basis throughout the pilot project. Our target would be to complete the first iteration of the LDPP Quality Improvement Plan by the sixth month of the first year of the grant.

The **LDPP Coordinator** will assure compliance with all agreements with DHCS that relate to LDPP requirements and with STC109 and Attachment JJ of the Medi-Cal 2020 Waiver Special Terms and Conditions. The **LDPP Coordinator**, CCRP, and the **LDPP Advisory Team** will be responsible for ensuring that the targeted population receives timely preventive care. Oral Health Solutions, Inc. (OHS) will develop the **LDPP Data Tracking System** for all participating individuals and CCRP will provide regular reports to the **LDPP Advisory Team** for both quality improvement and quality assurance purposes.

As is illustrated in the table in Section 4.2, we have set targets for our strategy areas so part of the project monitoring process will be to assess, on both a quarterly and annual basis, our progress towards meeting those targets. We will be meeting regularly with our **LDPP Care Coordination Team** as well as our DAG and POHILT members, and any issues with project monitoring will be identified and discussed within six months of being identified in a CCRP report. We will also conduct an annual focus group with project staff where we can discuss possible modifications to address any monitoring/progress issues that arise.

When needed project adjustments and/or modifications emerge, CCRP will assist the LDPP by documenting all discussions and facilitating a collaborative process where the timeframe and

expectations for proposed modifications are agreed upon by LDPP partners.

In addition, attached to our application is a draft Memorandum of Understanding (MOU) that we will ask all of our funded partners to sign if our LDPP is awarded. This document sets a clear standard for accountability for each of the funded partners. Should DTI funding be received, this document will be modified to meet DHCS's requirements including those listed in STC 109 and Attachments JJ.

In terms of accountability systems that assure that our target population receives timely, medically necessary care, the **LDPP Data Tracking System** will include date, location, service provider and type of service provided for every participant in the pilot program. These data points will be analyzed and reported on in the project monitoring section of CCRP's quarterly and annual reports.

All funded partners will sign a memorandum of understanding and a data sharing agreement that will specifically outline all expectations and requirements for their participation in the LDPP. These agreements have been drafted but will not be finalized until funding has been received.

The Public Health Dental Director will be responsible for oversight of the place-based and other non-traditional settings in which LDPP services are delivered.

All funded partners will submit agreed upon data and DTI performance metrics on a monthly basis, by the 5th day following the end of each month. CCRP will monitor the LDPP Tracking System by the 10th day of each month for the preceding month and will notify the LDPP Coordinator immediately if data is not submitted in a timely manner. Funded partners will provide narrative with justification any time they are not able to submit data in a timely manner and in accordance with the MOUs and data sharing agreements.
In terms of the complete QI plan, our first priority will be to set up the LDPP Data Tracking System. Data from the tracking system will be necessary to complete the QI plan.

Some sections of the QI plan will be developed upon receipt of LDPP funding. Those sections include:
1) Description of LDPP mission, program goals, and objectives,
2) Description of key quality terms/concepts,
3) Description of how QI projects will be selected and monitored,
4) Description of communication plan for QI activities and processes, and how updates will be communicated to partners.

The sections of the plan that will be developed after the LDPP Tracking System is in place will be the
1) Proposed QI projects and activities for each year of the LDPP, and
2) The description of the evaluation/quality assurance activities that will be utilized to determine the effectiveness of the QI plan's implementation.

We intend to develop part of the QI plan in collaboration with LDPP partners, and that process cannot start until the project has been funded. We will also utilize the results from the first round of focus groups with LDPP parents to help guide the QI work as well.

We do intend to utilize the Plan-Do-Study-Act (PDSA) cycle to test changes in real work settings. Key questions that we will ask are: 1) What are we trying to accomplish? 2) How will we know that a change is an improvement, and 3) What change can we make that will result in improvement? DHHS Public Health has already utilized and is familiar with PDSA due to efforts around Public Health Accreditation.

3.4 Data Sharing:

Data sharing will be an immediate priority area for the LDPP to address if funding is received. A sustainable infrastructure to support data sharing between entities will be explicit in the MOU (see draft MOU attached- also referenced in Section 3.3). Data sharing guidelines including the existing resources and gaps for partner agencies will be discussed with each of the funded LDPP partners. Public Health and CCRP will develop individualized additional data sharing guidelines with each of the funded partners that will address any gaps or resources that the partner agency identifies. Though these guidelines will be individualized for each funded partner, there will be consistency across the funded partners in terms of what they will be asked to report.

All partners participating in the LDPP pilot project will adhere to data sharing guidelines with Public Health and CCRP. The exact parameters around what data will be shared will be clarified upon receipt of DTI funding. At a minimum all LDPP data related to the CRA, delivery of preventive oral health services, care coordination and case management including education will be shared between partner agencies. One of the key roles of the **LDPP Advisory Team** will be to monitor and assure the ongoing sharing of data.

Our providers will be given a unique code for LDPP participants so that they are uniquely tracked in their systems. This coding requirement will be included in the data sharing agreements. The LDPP will only be open to currently enrolled Medi-Cal children.

Data sharing guidelines will address 1) the type of data that will be shared, 2) the personnel responsible for data sharing at each partner agency, 3) the frequency of reporting that data to Public Health, 4) data sharing needs, concerns, and issues raised by the partner agency, 5) how data will be shared with the public and/or the funder, and 6) any training or technical assistance needs related to data sharing that can be met by Public Health or CCRP.

Public Health and CCRP propose to work with Oral Health Solutions, Inc. (OHS) to develop and deploy the **LDPP Data Tracking System**. The core of the system will consist of a smart device App used to support electronic forms hosted on tablet computers. Initially, the App will be based on the iForm/ES App from Zerion Software. The iForm/ES App will be completely customized to create the app to support the specific data collection/management needs of the project. OHS will use iForm/ES administrative tools to create/update project tools (such as the caries risk assessment, Family Dental Plan, and the Patient Activation Measure) and manage users (authorized data entry personnel only).

CCRP will seek approval from the Humboldt State University Institutional Research Board (IRB) for this project. Sharing of personal health information (PHI) will be minimized to protect project participants, and the IRB approval process will clarify and vet all of the details of any data sharing that is done for the pilot project. CCRP is a part of Humboldt State University and HSU requires that any project that

includes humans or data on humans in any way must submit a proposal to the Committee for the Protection of Human Subjects in Research, also known as the Institutional Review Board. CCRP will not have access to PHI and the only direct contact that CCRP will have with clients will be through the focus groups. CCRP regularly submits IRB proposals for focus groups and other similar work and no project has been denied. CCRP does not anticipate that the IRB would be denied. There is no risk for the human subjects that will be participating in the LDPP, which is the primary concern for IRB. If there were concerns from the IRB, CCRP will address those concerns and obtain approval. Typically this process takes about one month

All data sharing processes, expectations, and IRB status will be shared with partners, **LDPP Coordinator** and CCRP Director of Health will work together to ensure that timelines and implementation plans for data sharing are reasonable and achievable for project partners. Public Health and CCRP will assure that data sharing guidelines are being followed and that data is being shared in a timely manner.

Public Health and CCRP will assure that data sharing occurs with the following LDPP partners: Redwood Community Action Agency, Humboldt County Department of Health & Human Services, the three participating FQHCs, and the two pediatric Rural Health Clinics that participate in the medical-dental integration strategy in Years 3 & 4.

CCRP will be available on an ongoing basis to provide technical assistance and support to any funded partner that is not sharing data in a timely manner. The MOU signed by partners provides contractual leverage to assure compliance. CCRP will also provide training to funded partners to help them streamline their processes for sharing and reporting data to Public Health.

All of the LDPP funded partners will be responsible for entering data into the LDPP Data Tracking System on a monthly basis, by the 5th of each month after services are delivered. Data sharing specifics will be described in detail in the data sharing agreement that each funded partner will sign. Because LDPP will be a pilot program, the exact type of data that will be shared will be determined after funding is received. All data specific to the performance metrics identified in the STCs for DTI will be collected and reported on. We have also included Figure 7 (which is also in Section 4.1) to provide additional detail on our data sharing plan and specifics.

In terms of timelines, LDPP funded partners will submit data on a monthly basis into the LDPP Data Tracking System. CCRP will monitor the tracking system and ensure that data is being entered. CCRP will in turn produce quarterly and annual reports summarizing the data from the tracking system. All data that is shared will be de-identified; no PHI will be included in reports and CCRP will not have access to PHI for the LDPP. CCRP and DHHS Public Health will comply with all DHCS evaluation timelines.

In terms of anticipated challenges, we will need to set up the LDPP Data Tracking System before data can be entered. We will also need to complete the data sharing agreements before data sharing can begin. We are not entirely sure how long this process will take but we will begin immediately if funding is received, and we would hope to have the tracking system in place within three months of the start of the grant. We will also aim to have the data sharing agreements in place within three months of the start of the grant. The primary ongoing challenge we can anticipate is compliance with the data sharing

agreement. Training will be provided to LDPP staff who are entering data in the tracking system. New employees to the LDPP will be trained if there are changes in LDPP personnel.

Data sharing challenges that arise during the project will be identified by CCRP through monthly monitoring of the tracking system, and they will be brought to the attention of the LDPP Coordinator immediately. Because there will be both an MOU and data sharing agreement for each funded partner, those agreements will be used as leverage should serious issues arise, and funded partners may lose funding if they are unable to comply with the data sharing agreement.

Funded LDPP partners will assign a lead person responsible for entering LDPP data into the tracking system. Those identified users will have access to enter data in the system, but they will not have the ability to change data once it has been submitted, nor will they have access to the data that is submitted by other partners.

In terms of data governance structure and approach, the LDPP Data Tracking System will be designed by Oral Health Solutions, Inc. (OHS) as they have the expertise and prior experience in creating oral health-focused databases. CCRP and DHHS Public Health will work in collaboration with OHS during the development phase. The LDPP Data Tracking System will reside within and be considered the property of the lead agency, DHHS Public Health. CCRP will be responsible for monitoring the tracking system, extracting data, analyzing data, and producing data reports on a quarterly and annual basis.

Data related to the PAM and Family Dental Plans (treatment) is central to the goals of LDPP. The Data Tracking System will provide an extremely efficient means to collect and consolidate this data. Data will be collected in electronic form as it is generated by multiple providers/community dental health workers/care coordinators across multiple sites. Paperless, direct-to-electronic-format data collection will not only improve efficiency, it should also reduce data entry errors. The LDPP will also implement a metric to establish, and improve, the efficacy of the Data Tracking System by incorporating User Quality surveys to measure usability and suitability of the system.

The system will include:
1) A customized electronic form for capturing client data (PAM survey, treatment data, and care coordination information). This form can be used on iPad or Android tablets via the iForm/ES App from Zerion Software.

2) Access to a database containing consolidated raw form data. This is the iForm Builder Control Panel from Zerion Software. The Control Panel provides simple analytical tools. Data can be downloaded at anytime for analysis in other tools (spreadsheets, local database, etc.) or automatically transferred securely to another internet accessible database.

3) Access to an online database containing the collected data organized by patient. This is the OHS Dental Data Manager (DDM). The DDM includes patient views consistent with commercial Electronic Dental Record systems and supports custom reports based on relational database queries for analysis purposes.
All components are HIPAA compliant.

iForm/ES is a well-regarded commercial platform for hosting electronic forms. An annual subscription is required for use of the App and platform (approximately $200/App User). This subscription will be covered by OHS during the project.

Section 4 Progress Reports and On-Going Monitoring:

4.1 LDPP Monitoring:

The **LDPP Coordinator** and CCRP will work together to ensure that project activities and outcomes are being met, and they in turn will report to the **LDPP Advisory Team**.

Performance measure for each participating entity will be set based on the outcomes and targets listed in the table in Section 4.2. We have set annual target benchmarks for the project as a whole and each funded partner will have a specific role to play and specific data to share. As was discussed in Section 3.4, if funding is received Public Health and CCRP will be creating individualized data sharing guidelines with each funded partner and the following components will be common to each partner: Short-term process measures, ongoing outcome measures, and annual target benchmarks.

The project monitoring plan is discussed in detail in Section 3.3, and the comprehensive plan for collecting, tracking and documenting metrics is explicit in Section 4.2. The project monitoring plan will be adjusted as needed to meet any requirements outlined in STC 109 and Attachment JJ.

Should poor performance or other issues be identified, the following steps will be taken. The **LDPP Coordinator** will first have a conversation with the project partner and technical assistance and/or training will be identified and provided to ensure compliance with pilot project requirements. The **LDPP Coordinator** will also consult with the Public Health Branch Director during this process.

If the first phase of meeting and discussing the issue is not effective, the **LDPP Coordinator** and CCRP will bring the issue to the attention of the **LDPP Advisory Team** to collectively analyze the problem and identify the corrective action that needs to be taken.

If that is not effective, the **LDPP Coordinator** will have a one-on-one conversation with the leader of the partner organization with the likely outcome of termination from the LDPP, unless there is some guarantee of corrective action at that time. Accountability and monitoring of project partners will also be explicit in the MOU (see attached draft) and in the data sharing agreement, so those documents will make all expectations clear as well as consequences for non-compliance. The first choice for corrective action will always be to identify and meet training and technical assistance needs for any agency that is struggling to meet data sharing requirements, process and outcome measures, and partner-specific benchmarks.

Figure 7, next page, summarizes our monitoring plan including the performance measures (both short-term and ongoing) and annual target benchmarks for all LDPP partners.

Figure 7: Monitoring Plan **Agency**	**LDPP Core Components**	**Process Measures & Annual Targets**	**Outcome Measures & Annual Targets**
Open Door Community Health Center-Burre Dental Center	Referrals to LDPP	Create LDPP referral guidelines *(Year 1)*	Open Door will refer 150-210 children per year to LDPP *(Years 2-4)*
	Data sharing* with LDPP partners	Work with LDPP partners to design data sharing guidelines *(Year 1)*	Utilize the LDPP database for all LDPP participants *(Years 2-4)*
	Integrate Community Dental Health Worker and Training Coordinator into medical clinic practice	Create an implementation plan *(Year 1)*	Community Dental Health Worker provides caries risk assessment and preventive services to LDPP participants with Open Door as their medical home Training Coordinator improve care and support the idea of integrating oral health education, screening, and varnish application during pediatric appointments Implementation plan and results shared with two pediatric clinics *(Years 2-4)*
Redwoods Rural Health Center	Referrals to LDPP	Create LDPP referral guidelines *(Year 1)*	Redwoods Rural will refer 25-50 children per year to LDPP *(Years 2-4)*
	Data sharing with LDPP partners	Work with LDPP partners to design data sharing guidelines *(Year 1)*	Utilize the LDPP database for all LDPP participants *(Years 2-4)*
	Integrate Community Dental Health Worker into medical and dental practice	Create an implementation plan *(Year 1)*	Community Dental Health Worker provides care coordination to LDPP participants with Redwoods Rural as their medical home *(Years 2-4)*
K'ima:w Medical Center-Dental Clinic	Referrals to LDPP	Create LDPP referral guidelines *(Year 1)*	K'ima:w will refer 25-50 children per year to LDPP *(Years 2-4)*
	Data sharing with LDPP partners	Work with LDPP partners to design data sharing guidelines *(Year 1)*	Utilize the LDPP database for all LDPP participants *(Years 2-4)*

	Integrate Community Dental Health Worker into medical and dental practice	Create an implementation plan *(Year 1)*	Community Dental Health Worker provides care coordination to LDPP participants with Kimaw as their medical home *(Years 2-4)*
Redwood Community Action Agency	Referrals to LDPP	Create LDPP referral guidelines *(Year 1)*	RCAA will refer 75-150 children per year to LDPP *(Years 2-4)*
	Data sharing with LDPP partners	Work with LDPP partners to design data sharing guidelines *(Year 1)*	Utilize the LDPP database for all LDPP participants *(Years 2-4)*
	Community Dental Health Educators to provide place-based assessments, preventive services and education/oral health literacy	Create a service delivery/outreach plan to ensure place-based services are available county-wide *(Year 1)*	Provide assessments, education and preventive services for at least 50% of the LDPP participants *(Years 2-4)*
Public Health WIC	Referrals to LDPP	Create LDPP referral guidelines *(Year 1)*	WIC will refer 75-150 children per year to LDPP *(Years 2-4)*
	Data sharing with LDPP partners	Work with LDPP partners to design data sharing guidelines *(Year 1)*	Utilize the LDPP database for all LDPP participants *(Years 2-4)*
	PH Dental Care Coordinators to provide place-based assessments & preventive services	Create a service delivery/outreach plan aligned with WIC Well Child Dental Visits *(Year 1)*	Provide assessments, education and preventive services for at least 50% of the LDPP participants *(Years 2-4)*
California Center for Rural Policy	Developing, collecting, tracking and documenting LDPP metrics	Ensure all data guidelines are established *(Year 1)*	Ensure all data guidelines are followed *(Years 2-4)*
	Ongoing project monitoring and evaluation	Produce quarterly and annual reports document progress to date *(Year 1)*	Produce quarterly, annual, and final reports *(Years 2-4)*

Note: Data sharing includes all LDPP-related tools, including the standardized caries risk assessment, the Family Dental Plan and the Patient Activation Measure (for those doing care coordination only) Additionally, all LDPP funded partners will assist with, refer to, and participate in all LDPP-related trainings.

Performance metrics shall mirror the metrics delineated in the STC document. Each of these metrics will be included in the LDPP Data Tracking System.

There are three metrics outlined in the **STCs for Domain 1** which will be incorporated into our LDPP.

1) Percentage of beneficiaries who received any preventive dental service during the measurement period.

Number of unduplicated children ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days who received any Medi-Cal covered preventive service (D1000-D1999) in the measurement period. (Numerator)

Number of unduplicated children ages one (1) through twenty (20) enrolled in Medi-Cal for at least ninety (90) continuous days during the measurement period. (Denominator)

2) Number of service office locations that are providing preventive dental services to children, compared to the number of these locations in the baseline year. Claims data will be utilized to calculate this metric.

3) Number and percentage change of Medicaid participating dentists providing preventive dental services to at least (10) Medicaid-enrolled children in the baseline year, and in each subsequent year. *Please note that we do not have any private dentists in our county who are willing to accept Medi-Cal, and that this is not an explicit goal of our pilot*. However, we will track this metric and will be working with a group of local private dentists and the local Dental Society to identify the concerns and barriers at the state level that are prohibiting their participation in this program.

In regards to **Domain 2**, Humboldt County's LDPP will incorporate the following performance metrics listed in the STC document:

1) Number of, and percentage change in, restorative services
2) Number of, and percentage change in, preventive dental services
3) Utilization of CRA CDT codes and reduction of caries risk levels
4) Change in use of emergency room for dental related reasons among the targeted children for this domain
5) Change in number and proportion of children receiving dental surgery under general anesthesia
6) Utilization rates for restorative procedures against preventive services to determine if the LDPP has been effective in reducing the number of restorations being performed. This performance measure will be collected at annual intervals.

   Note: Metrics 1-5 will be broken down by age ranges under one (1), one (1), through two (2), three (3) through four (4), and five (5) through six (6).
7) Utilization of CRA and treatment plan service to monitor utilization and domain participation.

There is one metric outlined in the **STCs for Domain 3** which will be incorporated into our LDPP.

1) Number of beneficiaries who have remained with their same service office location for two (2), three (3), four (4), five (5), and six (6) year continuous periods.

Number of children age twenty (20) and under who received an examination from the same service office location with no gap in service for two (2), three (3), four (4), five (5) and six (6) year continuous periods. (Numerator)

Number of children age twenty (20) and under enrolled in the delivery system during the measurement periods. (Denominator)

Note: Humboldt County's LDPP will only be able to guarantee collection of these metrics for the period of LDPP funding, which is four years.

The evaluation of Humboldt County's LDPP will be conducted by DHCS. CCRP is responsible for monitoring data (performance measures consistent with the performance metrics of the three DTI domains) at appropriate frequencies. CCRP is responsible for measuring whether the project is having the intended impact and implementing quality improvement plans.

Most performance metrics listed in the STCs will be included in the LDPP Data Tracking System. Results from the PAM and CRAs will also be included in the tracking system, as will results from the Family Dental Plans. The PAM and the Family Dental Plan will be administered by the LDPP Care Coordinators with participating LDPP families every six months. The CRA will be administered by the LDPP oral health care coordinators every six months. Performance metrics will be collected in accordance with DHCS requirements. LDPP funded partners will be submitting data on a monthly basis and quarterly summary data reports will be produced and shared. LDPP funded partners will assign a lead person for data entry at their organization and training will be provided as well as any technical assistance that partners may need. Training will be provided before data is entered and technical assistance will be provided upon request or in cases where data sharing is not in accordance with the data sharing agreement.

DHHS Public Health and CCRP will work with Oral Health Solutions during the development phase of the tracking system and will ensure that all relevant performance metrics are tracked. For any metrics that fall outside the scope of the tracking system (such as Domain 2 Metrics #4 & #5) will be collected by CCRP. Both DHHS Public Health and CCRP have accessed emergency room data as well as data related to children receiving dental surgery under general anesthesia in the past. CCRP collected and analyzed data for Medi-Cal enrolled children who had received dental surgery under general anesthesia for a five-year period in the 2014 *Healthy Teeth for Life* report and that data will be available for comparison purposes.

4.2 Data Analysis and Reporting:

CCRP will be responsible for monitoring data (performance measures consistent with the performance metrics of the three DTI domains) at appropriate frequencies. CCRP will be collecting, analyzing, and reporting data regarding clients' progress in the pilot program. CCRP will also design outcome measures to track progress on the medical and dental integrations strategies implemented at local health clinics.

Additionally, CCRP will measure the collaborative efficacy- how well partners are working together- of the LDPP partners as well as the POHILT and DAG partners. On an annual basis, CCRP will conduct either focus groups or key informant interviews with a randomly selected group of pilot program participants to assess their satisfaction with the pilot program.

CCRP will also conduct an annual focus group with LDPP staff to elicit their thoughts about successes, challenges and needed improvements in the LDPP work. CCRP will design and deploy a training evaluation form for participants in all LDPP-related trainings. Finally, CCRP will produce a sustainability plan in the final year of the pilot program.

The first step will be for CCRP to develop the LDPP database to track pilot program outcomes and to create a pilot program logic model. The goal will be to design a user-friendly interface for funded LDPP staff to track and monitor progress of children enrolled in the pilot program. Public Health and CCRP propose to work with Oral Health Solutions, Inc. (OHS) to develop and deploy the **LDPP Data Tracking System**.

The core of the system will consist of a smart device App used to support electronic forms hosted on tablet computers. Initially, the App will be based on the iForm/ES App from Zerion Software. The iForm/ES App will be completely customized to create the app to support the specific data collection/management needs of the project. OHS will use iForm/ES administrative tools to create/update project tools (such as the caries risk assessment, Family Dental Plan, and the Patient Activation Measure) and manage users (authorized data entry personnel only).

In addition to basic demographics (such as age, gender, insurance status, town of residence, school the child attends, etc., we will also collect data using the following tools: Caries Risk Assessment-CRA (to be administered on annual basis), Family Dental Plan (to be administered twice a year and will include all prevention and care coordination component for each child based on assessed risk level), and the Patient Activation Measure-PAM (to be administered twice a year to assess parent engagement in their child's oral health care).

The Patient Activation Measure (PAM) is a tool currently in use and created by Insignia Health in 2012 to measure a patient's level of activation in managing their health needs. We will create, with permission and/or in cooperation with Insignia Health, an oral health version of this tool focused on parent/caregiver level of activation in managing their children's oral health. The PAM will give care coordinators insight to more effectively support each family. Twice a year administration of the tool will allow us to measure changes in parents/caregivers' level of activation over time.

All data entry will be completed at the LDPP Public Health Hub by LDPP Public Health staff. For services that may be delivered in clinic settings, school settings, or other place-based locations, LDPP staff will provide raw data to the Public Health Hub for data entry. All instructions around data collection and data sharing will be outlined in partner agreements.

Data will be reported to CCRP on a quarterly basis. CCRP will in turn provide quarterly data summary reports that will be shared with the **LDPP Advisory Team**. These data reports will assist the **LDPP Advisory Team** in program monitoring and in quality improvement and assurance throughout the pilot program. Data collection protocol and expectations will be outlined in the data sharing agreements with all LDPP partners. CCRP will also generate an annual progress report that will include all of the evaluation results. The question of program sustainability will be addressed in each annual evaluation plan, and in the final year of the grant we will bring all of that information together to create a formal collaborative sustainability plan.

The basic steps for children and families who participate in the LDPP will be the following: 1) Referral to LDPP, 2) Determine eligibility and complete intake form, 3) Caries Risk Assessment, 4) Creation of Family Dental Plan and completion of Patient Activation Measure, and 5) Completion of components of prevention and care coordination plan.

CCRP will work with the **LDPP Coordinator** to ensure timely submission of all DHCS-required quarterly and annual progress reports. CCRP will also support the LDPP Lead Entity-Public Health by reporting and submitting timely and complete data to DHCS in a format specified by the state. CCRP will additionally support the LDPP Lead Entity-Public Health in any statewide program evaluation activities and will provide data to measure the success of key activities of the work plan through the duration of the project.

Once a referral is made, the parent(s) or guardian(s) will complete the LDPP Intake form, which will be developed by the **LDPP Coordinator** and CCRP. The LDPP intake form will include patient demographics and outline the next steps for the child/family. The child will then receive a caries risk assessment (which will be provided by either the clinic or can be done by pilot project staff). Individuals will be classified into four risk categories: low, medium, high, and extreme. Each risk category will trigger a pre-identified set of oral health preventive services and/or case management activities which will be outlined in the Family Dental Plan. CCRP will track the caries risk assessment data and the provision of services identified for each risk category. A caries risk assessment will be provided for individuals participating in the program on a twice a year basis to track changes in risk status over time.

For each service we will track the type of service, date of service, location of service, and who provided that service. For case management activities we will track key points in the process through which a case manager listens to a family, identifies their barriers to care, and provides support to lessen those challenges. CCRP will work with the **LDPP Advisory Team** to identify a quality improvement process to keep close tabs on the case management and care coordination components to understand which case management activities are most effective for participants who are classified as high or extreme risk

through the CRA.

CCRP will provide training to all **LDPP Care Coordination Team** members to ensure that expectations and requirements around data collection and reporting are clear to all partners. CCRP will provide technical assistance to any project partner who needs additional training to successfully collect and share data for the pilot project.

CCRP will work with the **LDPP Coordinator** & FQHC leadership during Year 1 to incorporate evaluation and performance measures into their site-specific implementation plans. CCRP will provide best practice research and evidence to help teams explore innovative strategies for integrating oral health into their medical clinics.

CCRP will also work with the **LDPP Advisory Team** to identify measures and/or indicators that help the team to assess the effectiveness of CRA utilization, particularly for children ages 6 and under. The CRA will be a critical tool and one of our FQHCs already has in place an excellent CRA that our partners have all agreed to use. However, if the DHCS requires use of a standardized CRA across the state, CCRP will adapt any evaluation tools including the CRA if directed by DHCS.

Data analysis and reporting will be used for sustainability planning. At each annual focus group conducted with LDPP staff, CCRP will elicit partner feedback on what is working, what is not working, and how our county can sustain the pilot program work beyond the scope of the grant. Humboldt County oral health partners successfully sustained multiple components of the original Circle of Smiles grant from the California Endowment in 1999, so our county already has some experience in sustaining children's oral health work with or without grant funding. After Circle of Smiles, the oral health collaborative successfully sustained: 1) a county-wide Oral Health Coordinator, 2) financial support for children who require hospital-based dentistry, and 3) the TOOTH (Teaching Oral Health Optimism throughout Humboldt) school-based education program. The TOOTH program was originally funded by an AmeriCorps grant with the California Conservation Corps and was then transitioned to the Redwood Community Action Agency. It has since become a program funded by local partners including First 5 Humboldt and now with federal grant support from HRSA.

The **LDPP Advisory Team**, DAG and POHILT partners will bring their collective expertise to bear on the question of how we sustain this work beyond the grant. One of the key questions we will ask ourselves is- What is it that we want to sustain? Sustainability is often talked about in broad terms and we intend to get to specifics. CCRP will also produce a sustainability plan during the final year of the pilot program, which will bring the four years of partner input and research around best practices together.

Our current thinking around sustainability is focused on strategies that will increase the number of private providers willing to serve residents with Medi-Cal. Initial conversations have included the model of paying a "flat fee" or "fee for service" that adequately compensates the private provider for care through a mutual agreement with a local FQHC. Our local FQHCs have indicated that they are interested in this approach. Additionally, because we have developed relationships with many of the local providers that serve the Medi-Cal population, we believe that additional collaboration and innovation around preventive service delivery and care coordination will build confidence around future innovation

and multi-agency approaches to address the needs of this population. Additionally, by strengthening these partnerships between private and public providers, our community will be better positioned to respond to improvements that the State will be making in the near future to reform Denti-Cal.

Figure 8, **next page, summary of our Data Collection Plan**

Figure 8: Humboldt County Local Dental Pilot Program Draft Data Collection Plan			
Outcome	**Target**	**Data Sources**	**Data Collection Method**
Reduce the overall risk for care for children participating in the pilot program *DTI Domain 2/STC 107*	1. Reduce overall caries risk level for participants 2. Reduce individual-level caries risk level for participants 3. Adoption of sustainability plan in final year of pilot program	~Caries Risk Assessment ~Sustainability plan	Administered twice a year to participants Targets 1&2: Quarterly report done by CCRP Target #3: Sustainability plan done by CCRP in Year 4
Increase continuity of care for children on Medi-Cal *DTI Domain 3/STC 108*	1. 35-50% of pilot program participants classified as high or extreme will complete care coordination plan 2. Participants will increase level of engagement in their children's oral health care 3. Partners will report enhanced collaboration around continuity of care	~Family Dental Plan ~Patient Activation Measure ~Focus groups/key informant, interviews with parents ~Focus group with LDPP partners	Administered twice a year to participants and partners Target 1: Quarterly report done by CCRP Targets #2&3: Annual report done by CCRP
Increase the utilization of preventive services for children on Medi-Cal *DTI Domain 1/STC 106*	1. 50% of pilot program participants (all risk levels) will receive the preventive services outlined in the FDP 2. 50-100 LDPP and medical and community partners will participate in "Smiles for Life" training each year	~Family Dental Plan ~Training evaluations	Twice a Year Target #1: Quarterly reports done by CCRP Target #2: Annual report done by CCRP
Increase the provision of dental prevention services in primary care and community-based settings *DTI Domains 1&3/ STC 106 & 108*	1. Preventive & education services will be delivered in school and/or place-based settings and will increase over the pilot program period 2. FQHCs & 2 pediatric offices implement strategies to integrate dental prevention into primary care	~Family Dental Plan ~Clinics implementation & evaluation plan	4 times a year completion by participants and partners Annual report done by CCRP

Data analysis and reporting will be a major component of our plan for sustainability since the data will help us to determine if LDPP strategies are effective and if performance metrics reflect success. In addition to data analysis and reporting, we will continue to facilitate dialogue with the local funders that are currently supportive of children's oral health. These include: Humboldt Area Foundation, Smullin Foundation, and First 5 Humboldt. We will also utilize these existing relationships to connect with other potential future local and federal funding sources.

One of the primary LDPP partners, the Open Door Community Health Center, has already begun to explore the possibility of working with local private dentists on a contractual basis to address the shortage of providers willing to see children on Medi-Cal. By providing a flat fee or fee per hour, Open Door has expressed both the interest and the capacity to hire private dentists to deliver preventive and treatment services to the Medi-Cal population.

Additionally, our proposal to provide annual scholarships to local hygienists to pursue the advanced practice license is **integral** to our sustainability efforts. We hope to build our local workforce, particularly mid-level professionals who can open a practice and become Medi-Cal providers. We will be working closely with the scholarship recipients to ensure their commitment to working in Humboldt County, and we will connect them to existing local advanced practice hygienists to provide mentorship and advice to new advanced practice hygienists. We will also include a community service requirement focused on DTI activities for all scholarship recipients. We have a strong, existing relationship with the local Hygienists Association which will be valuable for our sustainability work.

In early 2016 we began convening local private dentists for Friday lunches where we have discussed the shortage of dental providers for the Medi-Cal population. We have gained a much clearer understanding of the barriers they are facing with regards to serving the Medi-Cal population. In addition to the state-level barriers with Denti-Cal, many of which are described in the Little Hoover Commission report entitled "Fixing Denti-Cal", we were able to identify some of the challenges with serving the Medi-Cal population such as low appointment compliance and high treatment needs. We are sponsoring a leading Public Health dentist to speak to the local Dental Society in November 2016 and we will be continuing the Friday lunches to keep the dialogue going and to facilitate connections between the local FQHCs and the private providers.

Finally, when we reviewed our county's current *Standard Agreement Amendment* with DHCS for Medi-Cal Administrative Activities (MAA), we discovered that dental prevention is considered Not-Allowable Medi-Cal Outreach (p.3). **An amendment to the Standard Agreement that changes this restriction on dental prevention activities would allow us the ability to retain Care Coordinators under the umbrella of Public Health beyond the DTI project and build sustainability into this work going forward.**

Data will be tracked in the LDPP Data Tracking System developed by Oral Health Solutions and will be extracted by CCRP on a quarterly basis. Quantitative data will be analyzed using IBM SPSS Statistics. SPSS is a widely used software package used for statistical analysis. CCRP already owns this software so there will no associated cost to the LDPP.

Quantitative data that will be analyzed includes the performance metrics outlined in the STCs as well as results from the CRA, PAM, and Family Dental Plans. The full quantitative analysis plan will be completed after the LDPP Data Tracking System is developed.

Qualitative data will be analyzed using Atlas.ti. Atlas.ti is widely used for qualitative analysis. The program provides tools that locate, code, and annotate findings in primary data to evaluate its importance, and to visualize complex relationships between and across findings.

Qualitative analysis of the focus group and components of the Family Dental Plan will be based on a modified method of constant comparison used in naturalistic theory. Naturalistic inquiry is a form of qualitative research where social issues are looked at in their natural settings.

Data will be analyzed on a quarterly basis and summarized in quarterly reports that will first be shared with DHHS Public Health. Both quantitative and qualitative data will be included in CCRP reports. DHHS Public Health and CCRP will then share the findings with the LDPP Advisory Team and the LDPP Care Coordination Team. At each meeting in which findings are shared, the LDPP Coordinator and CCRP Director of Health will facilitate planned discussions around barriers, successes and challenges. These data reports will also be integral to designing QI activities for LDPP.

Section 5 Financing:

5.1 Financing Structure and Budget:

It is our understanding that the Lead Entities will not receive any advance funds for this project. Therefore, the County of Humboldt will be covering the first quarter's expenses of the LDPP until reimbursement from DHCS is received. All funded collaborating partners and subcontractors will agree, per the MOU, to submit invoices for payment on a quarterly basis, within fifteen (15) days of the end of the quarter. Invoices will be submitted to the LDPP Coordinator for initial review, then submitted to DHHS – Public Health's Financial Services department for further review and processing. The Fiscal Assistant and Senior Fiscal Assistant will review each invoice for accuracy and appropriateness of expenses in relation to the LDPP, as well as ensuring funds budgeted for each category and collaborating partner are not in excess of what was anticipated.

The Financial Services department will then process each invoice for payment to the collaborating partners. Payment will be disbursed to the collaborating partners and subcontractors within thirty (30) days of receipt of invoice. The Financial Services department will also be responsible for creating and submitting a quarterly invoice for LDPP to DHCS for reimbursement of expenses incurred by both collaborating partners and DHHS - Public Health. The Financial Services department will use any required form(s) provided by DHCS as necessary for submittal of quarterly invoices, and adhere to invoice-related guidelines and deadlines as instructed by DHCS. Once reimbursement from DHCS is received, the revenue will be deposited into the grant's specific budget revenue line for reimbursement of future quarterly invoices from collaborating partners and subcontractors, and to ensure future expenses are covered within DHHS-Public Health.

Expenses will be accounted for within a software program that the County of Humboldt uses as a general ledger. The LDPP budget will be integrated into the software as a budget separate from other funded programs to allow the Financial Services staff to easily track and reconcile expenses against revenue received. Reconciliation will take place on a quarterly basis at minimum while the Fiscal Assistant and Senior Fiscal Assistant prepare the quarterly invoice to submit to DHCS. At the end of each grant Year period, an additional reconciliation will take place to ensure that revenue received or anticipated match the expenses of the project.

This proposal aligns with and leverages existing funding sources including:

- Redwood Community Action Agency's (RCAA) *TOOTH Plus Rural Health Care Services Outreach Program*, providing outreach and education.
- RCAA *AmeriCorps Planning Grant* to build an Oral Health Corps.
- *First 5 Humboldt* support for implementation of the Children's Dental Strategic Plan (CDSP).
- *Smullin Foundation* support for oral health coordination at Humboldt County Public Health.
- *North Coast Grantmaking Partnership* (consortium of local funders) support for oral health supplies and prevention programming.
- *California Dental Association Foundation's Henry Schein Cares Program* support for oral health supplies.

Please see **Attachment 3** for a visual *Flow Chart* representing the flow of funding**.**
Please see **Attachment 4** for the *Budget Narrative***.**

5.2 Funding Request:

Please see **Next Page** for *LDPP Lead Entity Budgets* and **Attachment 5** for the *Subcontractor Budgets*.

Year 1 **County of Humboldt**
(7/1/2017 through 12/31/2017)

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
LDPP Coordinator	1	$6,238 - $7,395	100%	$ 37,430
Care Coordinators	2	$2,767 - $4,083	100%	$ 33,197
Administrative Analyst	1	$3,463 - $5,239	50%	$ 10,390
Senior Fiscal Assistant	1	$2,952 - $3,860	50%	$ 8,856
Fiscal Assistant	1	$2,419 - $3,361	50%	$ 6,901
Program Planner	1	$5,425 - $6,030	80%	$ 27,271
			Total Salary	$ 124,045
			Fringe Benefits (64%)	$ 78,867

Total Personnel $ 202,912

Operating Expenses

Printing and Postage	$1,250
Communication	$1,200
Two (2) iPad Pro Tablets	$2,130
Office Supplies	$805
Computers/Software (2)	$2,390

Total Operating Expenses $ 7,775

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates) **Total Travel** $ 11,128
19,353 miles @ .575

Subcontracts

Humboldt State University – California Center for Rural Policy (HSU-CCRP, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 47,913	$ 1,000	$ 375	$ 0	$6,657	$55,945

Redwoods Rural Health Center (RRHC, Participating Entity)

Personnel	Operating Expenses	Equipment	Travel	Indirect Costs	Total Costs
$ 24,535	$1,065	$12,100	$863	$ 3,803	$ 42,366

Open Door Community Health / Burre Dental Center (Participating Entity)

Personnel	Operating Expenses	Equipment	Travel	Indirect Costs	Total Costs
$33,268	$ 1,065	$ 25,000	$ 345	$ 5,213	$ 65,251

Redwood Community Action Agency (RCAA, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 50,317	$ 4,530	$ 3,450	$ 0	$ 7,454	$ 65,751

Oral Health Solutions, Inc.

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 15,000	$ 3,200	$2,000	$ 0	$ 1,500	$ 21,700

K'im:aw Medical Center

Personnel	Operating Expenses	Equipment	Travel	Indirect Costs	Total Costs
$ 21,053	$ 1,065	$25,000	$863	$ 3,264	$ 51,245

Dr. Robert Berg, DDS Public Health Dental Director	$21,600		
		Total Subcontracts	$ 323,858
Other Costs			
Hygienist Scholarships for RDHAP Certification	$15,000		
Humboldt Network of Family Resource Centers – Stipends	$5,000		
Family Starter Kits	$5,000		
		Total Other Costs	$ 25,000
Indirect Costs			
		Indirect Costs	$ 24,809
		Annual Budget Total	**$ 595,004**

*** DHHS - Public Health fringe benefits vary slightly based on level of benefits received (i.e. insurance costs based on plan chosen) and salary.**

Year 2 **County of Humboldt**
(1/1/2018 through 12/31/2018)

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
LDPP Coordinator	1	$6,238 - $7,395	100%	$ 80,259
Care Coordinators	2	$2,767 - $4,083	100%	$ 72,626
Administrative Analyst	1	$3,463 - $5,239	50%	$ 22,277
Senior Fiscal Assistant	1	$2,952 - $3,860	50%	$ 20,987
Fiscal Assistant	1	$2,419 - $3,361	50%	$ 15,561
Program Planner	1	$5,425 - $6,030	80%	$ 55,633
			Total Salary	$ 267,343
			Fringe Benefits (60%)	$ 160,885

Total Personnel $ 428,228

Operating Expenses

Printing and Postage	$2,500
Office Supplies	$1,500

Total Operating Expenses $ 4,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates) **Total Travel** $ 22,256
38,706 miles @ .575

Subcontracts

Humboldt State University – California Center for Rural Policy (HSU-CCRP, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 97,745	$ 2,000	$ 750	$ 0	$ 13,582	$ 114,077

Redwoods Rural Health Center (RRHC, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 52,504	$ 8,500	$1,725	$ 0	$ 8,140	$ 70,869

Open Door Community Health / Burre Dental Center (Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 70,618	$ 1,000	$ 690	$ 0	$ 10,948	$ 83,256

Redwood Community Action Agency (RCAA, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 105,666	$ 4,800	$ 6,900	$ 0	$ 15,654	$ 133,020

Oral Health Solutions, Inc.

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 8,000	$ 2,000	$1,000	$ 0	$ 800	$ 11,800

K'im:aw Medical Center

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 44,210	$ 1,000	$1725	$ 0	$ 6,854	$ 53,789

Dr. Robert Berg, DDS Public Health Dental Director	$43,200		
		Total Subcontracts	$ 510,011
Other Costs			
Hygienist Scholarships for RDHAP Certification	$ 5,000		
Humboldt Network of Family Resource Centers – Stipends	$ 5,000		
Family Starter Kits	$ 10,000		
		Total Other Costs	$ 20,000
Indirect Costs			
		Indirect Costs	$ 53,469
		Annual Budget Total	**$ 1,037,964**

*** DHHS - Public Health fringe benefits vary slightly based on level of benefits received (i.e. insurance costs based on plan chosen) and salary.**

Year 3 **County of Humboldt**
(1/1/2019 through 12/31/2019)

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
LDPP Coordinator	1	$6,238 - $7,395	100%	$ 84,376
Care Coordinators	2	$2,767 - $4,083	100%	$ 76,378
Administrative Analyst	1	$3,463 - $5,239	50%	$ 24,207
Senior Fiscal Assistant	1	$2,952 - $3,860	50%	$ 22,059
Fiscal Assistant	1	$2,419 - $3,361	50%	$ 16,035
Program Planner	1	$5,425 - $6,030	80%	$ 56,746
			Total Salary	$ 279,801
			Fringe Benefits (59%)	$ 164,105

Total Personnel $ 443,906

Operating Expenses

Printing and Postage	$2,500
Office Supplies	$1,500

Total Operating Expenses $ 4,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates) **Total Travel** $ 22,256
38,706 miles @ .575

Subcontracts

Humboldt State University – California Center for Rural Policy (HSU-CCRP, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$99,697	$ 2,000	$ 750	$ 0	$ 13,853	$ 116,300

Redwoods Rural Health Center (RRHC, Participating Entity)

Personnel	Equipment	Travel	Subcontracts	Indirect Costs	Total Costs
$ 56,179	$ 8,500	$ 1,725	$ 0	$ 8,710	$ 75,114

Open Door Community Health / Burre Dental Center (Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 74,148	$ 1,000	$ 690	$ 0	$ 11,495	$ 87,333

Redwood Community Action Agency (RCAA, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 110,949	$ 4,800	$ 6,900	$ 0	$ 16,437	$ 139,086

Oral Health Solutions, Inc.

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 4,000	$ 2,000	$ 0	$ 0	$ 400	$ 6,400

K'im:aw Medical Center

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 46,421	$ 1,000	$ 1,725	$ 0	$ 7,197	$ 56,343

Dr. Robert Berg, DDS Public Health Dental Director	$43,200		
		Total Subcontracts	$ 523,776
Other Costs			
Hygienist Scholarships for RDHAP Certification	$ 5,000		
Humboldt Network of Family Resource Centers – Stipends	$ 5,000		
Family Starter Kits	$ 10,000		
		Total Other Costs	$ 20,000
Indirect Costs			
		Indirect Costs	$ 55,961
		Annual Budget Total	**$ 1,069,899**

*** DHHS - Public Health fringe benefits vary slightly based on level of benefits received (i.e. insurance costs based on plan chosen) and salary.**

Year 4 **County of Humboldt**
(1/1/2020 through 12/31/2020)

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
LDPP Coordinator	1	$6,238 - $7,395	100%	$ 88,683
Care Coordinators	2	$2,767 - $4,083	100%	$ 80,270
Administrative Analyst	1	$3,463 - $5,239	50%	$ 25,628
Senior Fiscal Assistant	1	$2,952 - $3,860	50%	$ 23,162
Fiscal Assistant	1	$2,419 - $3,361	50%	$ 16,856
Program Planner	1	$5,425 - $6,030	80%	$ 57,881
			Total Salary	$ 292,480
			Fringe Benefits (57%)	$ 167,387

Total Personnel $ 459,867

Operating Expenses

Printing and Postage	$2,500
Office Supplies	$1,500

Total Operating Expenses $ 4,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates) **Total Travel** $ 22,256
38,706 miles @ .575

Subcontracts

Humboldt State University – California Center for Rural Policy (HSU-CCRP, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$101,691	$ 2,000	$ 750	$ 0	$ 14,130	$ 118,571

Redwoods Rural Health Center (RRHC, Participating Entity)

Personnel	Equipment	Travel	Subcontracts	Indirect Costs	Total Costs
$ 60,111	$ 8,500	$ 1,725	$ 0	$9,319	$79,655

Open Door Community Health / Burre Dental Center (Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 77,855	$ 1,000	$ 690	$ 0	$ 12,070	$91,615

Redwood Community Action Agency (RCAA, Participating Entity)

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 116,497	$ 4,800	$ 6,900	$ 0	$ 17,258	$ 145,455

Oral Health Solutions, Inc.

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 1,750	$ 2,000	$ 0	$ 0	$ 175	$ 3,925

K'im:aw Medical Center

Personnel	Operating Expenses	Travel	Subcontracts	Indirect Costs	Total Costs
$ 48,743	$ 1,000	$ 1,725	$ 0	$ 7,557	$ 59,025

Dr. Robert Berg, DDS Public Health Dental Director	$43,200		
		Total Subcontracts	$ 541,446
Other Costs			
Hygienist Scholarships for RDHAP Certification	$ 5,000		
Humboldt Network of Family Resource Centers – Stipends	$ 5,000		
Family Starter Kits	$ 10,000		
		Total Other Costs	$ 20,000
Indirect Costs			
		Indirect Costs	$ 58,496
		Annual Budget Total	**$ 1,106,065**

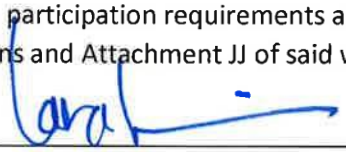
*** DHHS - Public Health fringe benefits vary slightly based on level of benefits received (i.e. insurance costs based on plan chosen) and salary.**

Section 6: Attestations and Certification

6.1 Attestation I certify that, as the representative of the LDPP Lead Entity, the Lead Entity agrees to the following conditions:

- ☑ The LDPP Lead Entity will assure appropriate participation in regular Learning Collaboratives to share best practices among participating entities, in accordance with STC 109.
- ☑ The LDPP Lead Entity will enter into an agreement with DHCS that specifies the requirements of the LDPP with STC109 and Attachment JJ of the Medi-Cal 2020 Waiver Special Terms and Conditions. The agreement with DHCS will include a data sharing agreement. See Exhibit A "HIPAA Business Associate Addendum (BAA)" of this Application. The provisions in the DHCS boilerplate BAA apply only to BAA-covered information that is shared by DHCS with the LDPP specifically for the purpose of LDPP operations and evaluation. DHCS does not anticipate that BAA-covered information will be shared for the purpose of LDPP operations or evaluation. DHCS anticipates limited, or no, BAA-covered information sharing from the LDPP to DHCS. However, DHCS will include a BAA in the event that data needs to be shared. The BAA will apply to the transfer of BAA-covered information should the need arise.
- ☑ The LDPP Lead Entity shall submit quarterly and annual reports in a manner specified by DHCS and CMS. Continuation of the LDPP may be contingent on timely submission of the quarterly and annual reports.
- ☑ The LDPP Lead Entity will report and submit timely and complete data to DHCS in a format specified by the State and as defined in the LDPP's individual agreement with the State. Incomplete and/or untimely data submissions may lead to a financial penalty after multiple occurrences and technical assistance is provided by the State.
- ☑ The LDPP Lead Entity will assure participation in program evaluation activities and will agree to provide data to measure the success of key activities of the work plan throughout the duration of the project.

I hereby certify that all information provided in this application is true and accurate to the best of my knowledge, and that this application has been completed based on a thorough understanding of program participation requirements as specified in the Medi-Cal 2020 Waiver Special Terms and Conditions and Attachment JJ of said waiver.



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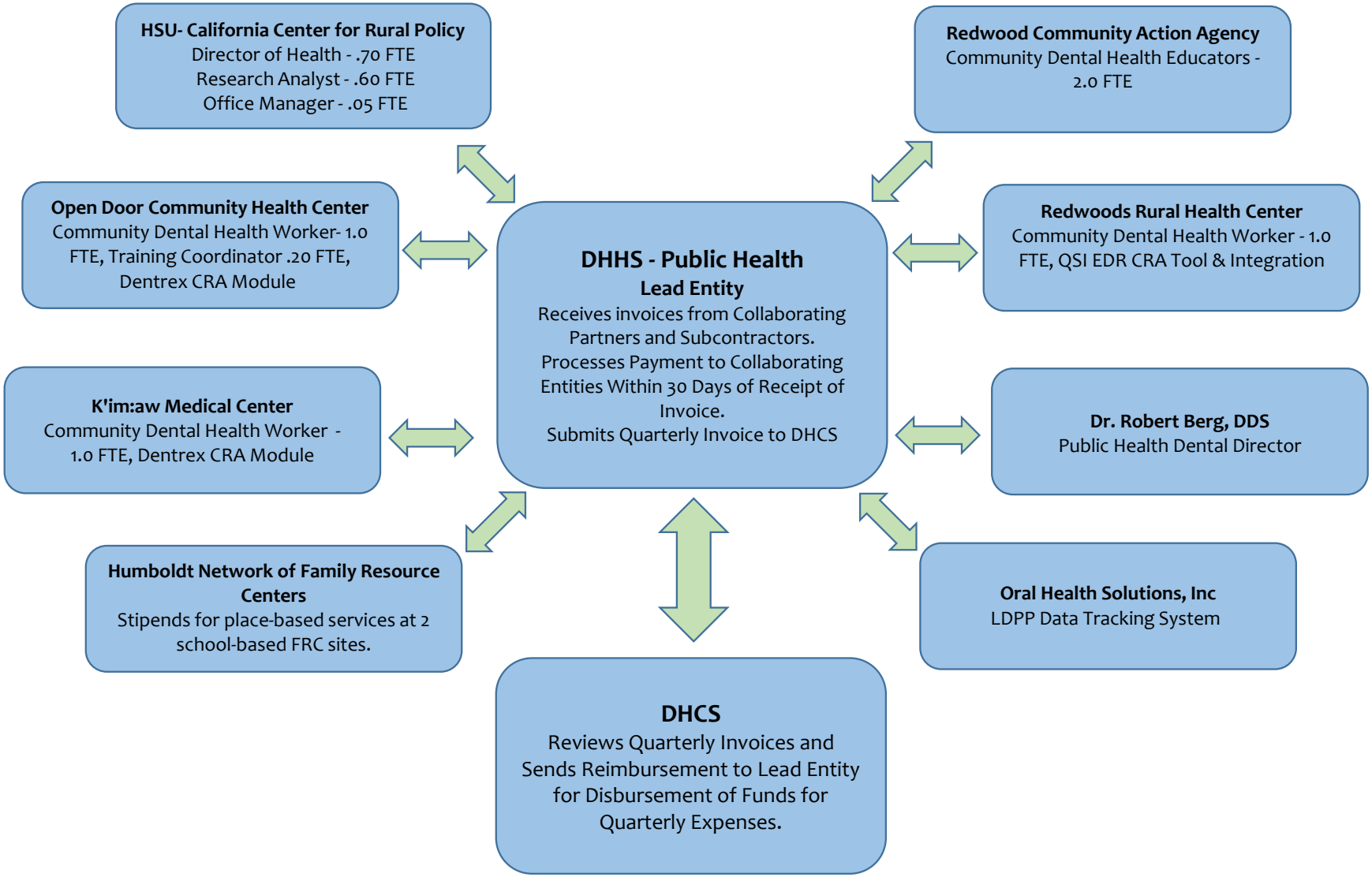
Signature of LDPP Lead Entity Representative **Date**

Attachment 3

Humboldt County Department of Health and Human Services Local Dental Pilot Project Funding Diagram



Attachment 4 Budget Narrative
Dental Transformation Initiative - Local Dental Pilot Project
Humboldt County
Year 1

I. PERSONNEL EXPENSES

Position Title		Description	FTE	Expected Value or Impact
LDPP Coordinator - Department of Health and Human Services (DHHS) - Public Health		LDPP Coordinator will oversee all activities of the grant including the direct supervision of two Public Health-Oral Health Care Coordinators, partial supervision of a Public Health Program Planner and supervisorial consulting with a contracted Public Health Dental Director position as part of the grant. • Monitoring the activities and performance of all collaborating community partners, subcontractors for DHHS as part of this grant, and serving as the main point of contact including trouble shooting issues and ensuring the careful implementation of the LDPP strategies; • Coordination and planning of meetings of both the LDPP Advisory Team as well as the LDPP Care Coordination Team; • Creation and implementation of an oral health care coordination infrastructure that aligns with the pilot's model including the creation of a family dental plan and instituting a patient activation measure; • Revamping of the WIC Well Child Dental Visit program to boost appointment compliance and provide enhanced services as well as integrate and align LDPP work into other DHHS programs as appropriate; • Creation and implementation in partnership with Oral Health Solutions and the California Center for Rural Policy (CCRP), to develop a LDPP Data Tracking System and software program to track and measure outcomes of project; • Work directly with CCRP to create QI protocols for DHCS evaluative purposes; • Direct liaison to DHCS on behalf of the DTI LDPP and networking with the other statewide funded LDPP entities as part of the DTI *Year 1 is calculated for 6 months due to anticipated start date.*	1.00	Oversee all activities of the LDPP including the direct supervision of two Public Health-Oral Health Care Coordinators, partial supervision of a Public Health Program Planner and supervisorial consulting with a contracted Public Health Dental Director position. Direct oversight of creation of infrastructure, protocols, QI and LDPP model implementation.

Care Coordinators - DHHS - Public Health		Assisting in the implementation of an oral health care coordination infrastructure/hub at Public Health that aligns with the pilot's model including the creation and use of a family dental plan and instituting a patient activation measure; scheduling place-based services and other oral health related activities including working with WIC's Well Child Dental Visit program to boost appointment compliance and providing enhanced services; working directly with the other oral health care coordinators in our LDPP funded partner organizations to accept referrals, track clients and eliminate barriers to care; working directly with Medi-Cal children 0-12 years of age and their families who are assessed "at risk" or "extreme risk" for dental disease and are referred into the pilot program to coordinate services and provide support so that barriers to care are reduced for these children including the use of a patient activation measure to assess a family's oral health knowledge, confidence and skills followed by the creation of a family dental plan to assist the Coordinator and the family in setting goals to improve their child's oral health care; serving as part of the LDPP Care Coordination Team and attending these monthly meetings to coordinate efforts to assist children and families in the pilot program with other LDPP funded partners; working in alignment with other DHHS programs where appropriate either with referrals or other needed support services as it relates to oral health; input and assist in managing the LDPP Data Tracking System and software program to track and measure over time a child/family's progress; attending quarterly Dental Advisory Group meetings. *Year 1 is calculated for 10.5 months due to anticipated start date.*	2.00	Key members of the Care Coordination Team, who will assist in developing Family Dental Plans aligned with the Patient Activation Measure. Scheduling place-based services and other oral health related activities, maintenance and data entry into LDPP Data Tracking System.
Administrative Analyst - DHHS - Public Health		Assist in creation and processing of contracts and MOUs with collaborating partners and subcontractors, including proclamations, Agenda Items to take to the Board of Supervisors and processing any contract amendments as necessary. Also assists in evaluating performance measures. Will attend LDPP Advisory Team Meetings. *Year 1 is calculated for 6 months due to anticipated start date*	0.50	Assist in creation & maintenance of contracts, MOUs and amendments with collaborating partners including proclamations. Assist in evaluating data and performance measures.
Senior Fiscal Assistant - DHHS - Public Health		Oversee and assist Fiscal Assistant in processing invoices from collaborating partners and internal invoices related to LDPP and monitoring of budget. Also create and process quarterly invoices to the state for reimbursement. Main fiscal point of contact for state and collaborating partners. *Year 1 is calculated for 6 months due to anticipated start date*	0.50	Oversight of Fiscal Assistant activities surrounding LDPP and creation of quarterly invoices for submittal to DHCS.
Fiscal Assistant - DHHS - Public Health		Processing of invoices from collaborating partners and subcontractors - checking for accuracy and appropriateness of expenses, ensuring accurate salary splits of DHHS - Public Health staff, monitoring of DTI budget, assist Senior Fiscal Assistant in creating quarterly invoices to the state and checking for accuracy. Also processes reimbursement payment from the state. Secondary fiscal point of contact. *Year 1 is calculated for 6 months due to anticipated start date*	0.50	Process invoices from collaborating partners for payment, monitoring of LDPP budget, assist in quarterly invoices to DHCS, and process reimbursement from DHCS.

Program Planner - DHHS - Public Health			Planning and coordination of LDPP in conjuction with and under the supervision of the LDPP Coordinator to ensure performance measures are being met, assist in coordination and communication with collaborating partners and Care Coordinators, as well as other duties as identified.Will attend LDPP Care Coordination Team meetings. *Year 1 is calculated for 6 months due to anticipated start date*	0.80	Assist LDPP Coordinator in planning and coordination of program including coordination with collaborating partners and Care Coordinators, assist in evaluation of performance measures.
Total Salaries:	**$ 124,045.00**		**Total FTE**	**5.30**	
Total Fringe Benefits:	**$ 78,867.00**		Benefits are projected to be 64% of gross wages. This figure includes employee health insurance, dental insurance, FICA, SUI and Retirement. *Fringe Benefit percentages vary dependent on which insurance and retirement options are chosen by staff as well as the salary rate. Fringe Benefits are per Humboldt County's MOU with their employee union representative AFSCME*		
Total Personnel Expenses:	**$ 202,912.00**				

II. OPERATING EXPENSES

Printing & Postage	$ 1,250.00		Printing and postage costs for DHHS-Public Health include program-specific mailers such as formal correspondence to subcontractors and Participating Entities, correspondence to clients, fliers, posters & brochures for trainings/meetings/events (such as place-based services in school settings) surrounding LDPP work, mailing of invoices to LDPP & state, etc.	It is expected the ability to correspond with families via USPS will expand the reach our program has. Not all clients in our area have regular access to internet or e-mail. Posters and fliers for events would inform the community of events surrounding LDPP activities such as place-based services. Printed brochures include educational materials for parents and children with expectation of increasing the knowledge and encouraging families to prioritize attention to preventive oral health activities.
Communication	$ 1,200.00		Includes purchase of 3 cell phones at $400 each with wifi, texting and data capabilities (totaling $1200) - one for each (2) Care Coordinators and the LDPP Coordinator employed by DHHS - Public Health. Based on recent costs for other, similar DHHS-Public Health purchases.	3 cell phones purchased in Year 1 for new staff positions of 2 Care Coordinators and LDPP Coordinator in order to be able to communicate with Participating Entities, other staff, and clients while working out on the field.

Two (2) iPad Pro Tablets	$ 2,130.00		Two iPad Pro tablets at $979 each, plus .0875 sales tax totalling $2,130. 12.9" screen with 256 GB & WiFi capability, priced at Apple's government discount rate. For use by DHHS - Public Health Care & LDPP Coordinators and Participating Entities staff members out in the field while performing place-based services or attending events	iPads, in conjunction with the cloud-based app to be developed by Oral Health Solutions, would provide DHHS-Public Health staff working in place-based services and out in the field the ability to update records and create new records in the field in real time as opposed to needing to dedicate additional time in the office doing so. This increases staff efficiency. See Oral Health Solutions subcontract narrative for more information.
Office Supplies	$ 805.00		Miscellaneous office supplies anticipated as necessary for operating the LDPP in DHHS-Public Health. Such Office Supplies would include, but not limited to; supplies needed for new Care Coordinators to set up their desks (staplers, pens, tape, post-its, chairs for their desks, envelopes, folders, desk organizers, paper clips, etc.) By analyzing the office supplies expenses in programs with similar FTEs in DHHS-Public Health it was determined this is a conservative estimate of office expenses, especially given start-up costs for 2 full new employees.	Expected value would be that DHHS staff is able to perform the duties assigned to them surrounding LDPP successfully and efficiently with the appropriate office supplies.
Computers/Software	$ 2,390.00		2 computers and operating software for the Care Coordinator positions in DHHS-Public Health. The Care Coordinator positions would be hired to perform activities solely for the LDPP as their FTE is dedicated to the program. DHHS-Public Health does not currently have any extra computers, creating the necessity to purchase 2 computers in order for the Care Coordinators to perform their duties specific to the LDPP, such as e-mail correspondence, data entry, creation and maintenance of documents surrounding the LDPP. Computer costs based on fiscal year 16-17 replacement costs of computers in DHHS-Public Health, at approximately $950 x 2, or $1900, and software expense of $245 x 2, or $490, totalling $2390.	Expected value would be that newly hired DHHS Care Coordinators are able to perform the duties assigned to them surrounding LDPP successfully and efficiently with the appropriate computers and software.
Total Operating Expenses:	**$ 7,775.00**			

III. EQUIPMENT

N/A	$ -			
Total Equipment:	**$0**			

IV. TRAVEL

Travel	$ 11,128.00		Local mileage for LDPP Coordinator, LDPP Program Planner, and DHHS Care Coordinators. Anticipated each staff member (4 total) to travel to outlying rural areas 2 times a week at approximately 100 miles round-trip x 26 weeks at current CalHR rate.	Local mileage allows the Care Coordinators and LDPP Program Coordinator to visit outlying clinics such as Redwoods Rural Health Center and K'im:aw Medical Center to collaborate with other Community Dental Health Workers and provide outreach to patients by coming to them as opposed to traveling into town.
Total Travel	**$ 11,128.00**			

V. SUBCONTRACTS

Humboldt State - California Center for Rural Policy (CCRP, Participating Entity			CCRP is the primary, participating entity working in conjunction with DHHS - Public Health on data collection and monitoring, establishment of performance measures and repsonsible for the Quality Improvement Plan for the LDPP.	
CCRP Personnel			*Personnel costs in Year 1 reflect 6 month time frame.*	
Director of Health, .70 FTE	$ 20,297.00		Responsibilities: Research oversight, project monitoring, development and oversight of Quality Improvement Plan, attend LDPP Advisory Team meetings and LDPP Care Coordination Team meetings, oversight of data collection, analysis and grant reporting, sharing program data with identified audiences including Participating Entities. Employee cost is based on hourly rate of $27.88 x 728 hours	
Research Analyst, .60 FTE	$ 12,000.00		Responsibilities: Creation and implementation of all data collection protocols, monitor ongoing data collection, conduct quarterly data analysis and produce summary reports, assist with coordination of Quality Improvement efforts, conduct focus groups and key informant interviews.Employee cost is based on hourly rate of $19.23 x 1092 hours.	
Office Manager, .05 FTE	$ 988.00		Responsibilities: Monitor LDPP expenses, process payroll for LDPP staff, and other administrative responsibilities surrounding LDPP activities. Employee cost is based on hourly rate of $19.00 x 91 hours.	
CCRP Salary Total	$ 33,285.00			

CCRP Fringe Benefits	$ 14,628.00		Benefits are projected to be 44% of gross wages. This figure includes employee health insurance, dental insurance, FICA, SUI and Retirement. Fringe Benefit percentages vary dependent on which insurance and retirement options are chosen by staff as well as the salary rate.	
CCRP Personnel Total	**$ 47,913.00**			
CCRP Operating Expenses	$ 1,000.00		Printing costs of $2,000 annually to cover the cost of printing reports, data protocols, data collection tools, etc.	Printing costs allow CCRP to provide printed performance measures and data summaries at LDPP meetings to DHHS-Public Health, Participating Entities, and possibly DHCS.
CCRP Travel	$ 375.00		Local mileage based on esimate of approximately 100-120 miles per month at $.54/mile to LDPP-related meetings. Year 1 travel is anticipated to be higher as start-up of program will involve more meetings and collaboration.	Local mileage allows CCRP the ability to attend LDPP Advisory and Care Coordination Team meetings.
CCRP Indirects	$ 6,657.00		Indirects include the following expenses: Estimated A-87 Overhead, Insurance, I-S, Communication, utility costs. Rated at 20% of the personnel salary.	
CCRP Total	**$ 55,945.00**		***Sole Source Justification:*** The California Center for Rural Policy (CCRP) at Humboldt State University (HSU) is the only entity with the knowledge and expertise in Humboldt County to provide data collection and analysis services. The California Center for Rural Policy conducts research to inform policy, build community, and promote the health and well-being of rural people and environments. CCRP accomplishes this by using innovative research methods tailored to the study of rural people, environments, and their interactions	

Redwoods Rural Health Center (RRHC, Participating Entity			RRHC will pilot a Community Dental Health Worker position for the LDPP. They will promote cross referrals and case management between the medical and dental sides of RRHC as well as work directly in their respective, remote-based community to integrate place-based services and interventions, and promote general oral health literacy.	RRHC will work with LDPP partners to design data sharing guidelines and create an implementation plan to integrate Community Dental Health Worker in Year 1. Years 2-4 RRHC will refer 25-50 children a year to LDPP.
RRHC Personnel			*Personnel costs in Year 1 reflect 6 month time frame.*	
Community Dental Health Worker, 1.0 FTE	$ 19,019.00		Schedule school-based and mobile van dental services, collaboration with school staff, partner with other Participating Entities to ensure children are directly connected to RRHC for preventive and restorative services, assist parents of Medi-Cal eligible children in integrating medical and dental services. Will attend LDPP Care Coordination Team meetings.	
RRHC Salary Total	$ 19,019.00			

RRHC Fringe Benefits	$ 5,516.00		Benefits are projected to be 29% of gross wages. This figure includes employee health insurance, dental insurance, FICA, SUI and Retirement.	
RRHC Personnel Total	**$ 24,535.00**			
RRHC Operating Expenses	$ 1,065.00		Annual maintenance cost of QSI - EDR CRA Tool to be implemented by RRHC for the LDPP. One iPad Pro tablet at $979, plus .0875 sales tax totalling $1,065. 12.9" screen with 256 GB & WiFi capability, priced at Apple's government discount rate. For use by Community Dental Health Worker out in the field while performing place-based services or attending events.	The QSI-EDR CRA Tool will document the patient's caries risk in the QSI electronic dental record. Data can be extracted and reports of high risk patients will be used for focused care coordination and case management.
RRHC Equipment	$ 12,100.00		The QSI EDR CRA Tool is a module that RRHC does not currently have in place. Their current electronic health record system does not include software that links medical records to dental records. This software will allow RRHC to link the medical and dental records. Equipment includes a $3,600 integration fee and an $8,500 Annual Maintenance fee, for a total in Year 1 of $12,100.	Utilized to improve case management by simplifying data retrieval of patients as well as the ability to track patients for treatment. This software will allow them to collect and extract the data necessary for the LDPP Data Tracking System. It will support data sharing by enhancing the capacity of RRHC to collect the required performance metrics listed in the STCs.
RRHC Travel	$ 863.00		Local mileage estimated at 250-300 miles monthly at current CalHR mileage reimbursement rates.	Mileage allows RRHC to participate in LDPP Care Coordination Team and LDPP Advisory Team meetings as well as Community Dental Health Worker's travel to place-based services as necessary.
RRHC Indirects	$ 3,803.00		20% of Total Personnel Salary excluding Fringe Benefits.	
RRHC Total	**$ 42,366.00**		***Sole Source Justification:*** *RRHC is the only Denti-Cal providing entity in remote Southern Humboldt County.*	

Open Door Community Health / Burre Dental Center (Participating Entity)				Open Door Community Health Centers (ODCHC) recognizes the benefits of integrated care and supports the idea of integrating oral health education and screening during pediatric appointments. These visits will have the following 4 objectives: Conduct a caries risk assessment; Provide oral health education for patients/families and serve as a resource to medical and behavioral health team regarding their patient's oral health status; Assist the patient/family in establishing a dental home, including ensuring an enhanced referral to dental care for high-risk pediatric patients via the Community Dental Health Worker – Dental Treatment Plan Coordinator. Open Door is a Medi-Cal provider and able to bill Medi-Cal for any eligible services	Will assist in designing data sharing guidelines in Year 1. Open Door will refer 150-210 children per year to LDPP in Years 2-4. Assist in training to integrate medical and dental with 2 other local pediatric clinics who serve Medi-Cal clients in Years 2-4.
Training Coordinator - .20 FTE	$	9,748.00		Training Coordinator will oversee project implementation, including oversight for other program staff. Will oversee development of paitent/family-facing scripts, educational and outreach materials and curriculum development for Open Door's pediatric departments. Will meet regularly with the LDPP Care Coordination Team to learn about best practices and strategize on ways to improve oral health care services for high risk populations.	
Community Dental Health Worker - 1.0 FTE	$	16,320.00		Community Dental Health Worker will identify patients who need urgent care due to multiple diagnoses and health issues, and assist in expediting care. Will assess social needs of each patient/family and their coping/adaptive abilities, formal and informal support-system and self-care abilities. Will determine barriers unique to each patient (literacy, language, income, etc) and help the patient develop a plan to overcome them. Will facilitate and promote effective communication between patient and dental provider, collaborating with the provider in the development of an effective patient education program. Will meet regularly with patients and assist them in fulfilling recommendations for their dental treatment plan such as transportation assistance, translation, etc. and attend and coordinate chart review and case management with provider and other involved staff members.	
Open Door Salary Total	**$**	**26,068.00**			
Open Door Fringe Benefits	$	7,560.00		Benefits are projected to be **29**% of gross wages. This figure includes employee health insurance, dental insurance, FICA, SUI and Retirement.	
Open Door Personnel Total	**$**	**33,628.00**			

Open Door Operating Costs	$ 1,065.00		One iPad Pro tablet at $979, plus .0875 sales tax totalling $1,065. 12.9" screen with 256 GB & WiFi capability, priced at Apple's government discount rate. For use by DHHS - Public Health Care & LDPP Coordinators and Participating Entities staff members out in the field while performing place-based services or attending events.	iPads, in conjunction with the cloud-based app to be developed by Oral Health Solutions, would provide DHHS-Public Health staff and Hygienists working in place-based services and out in the field the ability to update records and create new records in the field in real time as opposed to needing to dedicate additional time in the office doing so. This increases staff efficiency. See Oral Health Solutions subcontract narrative for more information.
Open Door Equipment - Dentrex CRA Module	$ 25,000.00		Cost of the Dentrex CRA Module, which is a software module meant to be utilized to improve Case Management by simplyfing data retrieval for patients as well as the ability to track patients for treatment. Supports oral health interventions for Open Door's Burre Dental Center and is a module that works with their existing EHR system.	Utilized to improve case management by simplifying data retrieval for patients as well as the ability to track patients for treatment.
Open Door Travel	$ 345.00		Local Mileage rated at approximately 100-120 miles a month rated at current CalHR reimbursement rates..	Mileage allows Open Door to participate in LDPP Care Coordination Team and LDPP Advisory Team meetings.
Open Door Indirects	$ 5,213.00		Indirects include fiscal support and other administrative services in support of the LDPP. (20% of personnel costs less benefits)	
Open Door Total	**$ 65,251.00**		***Sole Source Justification:*** *Open Door's Burre Dental Center is the only Denti-Cal providing entity in the Northern area of Humboldt County, serving the majority of the county's Denti-Cal children.*	

Redwood Community Action Agency (RCAA, Participating Entity)		Identify and conduct oral health assessments for approximately 1,200 children as well as identifying approximately 75-150 high-risk children via those assessments and assisting them in establishing a dental home and facilitating a treatment plan with the dental home. Assessing and referring those children considered “high risk” or “extreme risk” into the LDPP through the Public Health Care Coordination Hub and working in conjunction with the PH Oral Health Care Coordinators, and attending LDPP Care Coordination Team Meetings.	RCAA will assist in designing data sharing guidelines, creating a service/delivery outreach plan to ensure place-based services are available county-wide in Year 1. RCAA will refer 75-150 children per year in Years 2-4.
RCAA Personnel		*Personnel costs in Year 1 reflect 6 month time frame.*	

Community Dental Health Educators, 2.0 FTE	$ 37,272.00		Oral Health Educators will schedule dates and times with schools and Family Resource Centers within the county in order to provide CRAs, plaque indexing and flouride varnish treatments to approximately 1,200 children ages 3-12. Educators will work with RCAA or other Registered Dental Assistants to identify children with parental permission in conducting a CRA, plaque indexing and flouride varnish treatments.	
RCAA Salary Total	**$ 37,272.00**			
RCAA Fringe Benefits	$ 13,045.00		Benefits are projected to be 35% of gross wages. This figure includes employee health insurance, dental insurance, FICA, SUI and Retirement.	
RCAA Personnel Total	**$ 50,317.00**			
RCAA Operating Costs	$ 4,530.00		$100/month for miscellaneous office supplies, and $300/month for printing costs of outreach and educational brochures, average cost for full-color brochures of $2/each. (Office SUpplies and Printing total for Year 1 is $2,400) Includes two iPad Pro tablet at $979 each, plus .0875 sales tax totalling $2,130. 12.9" screen with 256 GB & WiFi capability, priced at Apple's government discount rate. For use by DHHS - Public Health Care & LDPP Coordinators and Participating Entities staff members out in the field while performing place-based services or attending events.	Office supplies allow staff to perform duties assigned to them surrounding the LDPP. Educational brochures are expected to promote and educate families around the importance of oral health and regular dentist visits for children. iPads, in conjunction with the cloud-based app to be developed by Oral Health Solutions, would provide DHHS-Public Health staff and Hygienists working in place-based services and out in the field the ability to update records and create new records in the field in real time as opposed to needing to dedicate additional time in the office doing so. This increases staff efficiency. See Oral Health Solutions subcontract narrative for more information.
RCAA Travel	$ 3,450.00		Local mileage at a total of 1,000-1,100 miles/month for the Oral Health Educators at current CalHR rates. Travel to outlying clinic areas and schools, LDPP meetings and LDPP Care Coordination team meetings	Local mileage for Community Dental Health Educators allows staff to travel to outlying clinic areas and schools for outreach and to conduct oral health assessments, as well as LDPP meetings and Care Coordination team meetings.
RCAA Indirects	$ 7,454.00		RCAA Indirects include fiscal support and other administrative services in support of the LDPP. (20% of personnel costs less benefits)	
RCAA Total	**$ 65,751.00**		***Sole Source Justification:*** *RCAA is a long-standing partner with DHHS-Public Health in oral health activities. As Humboldt County is a rural, small-populated county, they are one of the few entities that has the expertise and capacity to collaborate in the LDPP.*	

Oral Health Solutions, Inc.	**$ 21,700.00**		Provide technical assistance and consulting services for the development and deployment of a HIPAA-compliant, cloud-based, easy-to-use data collection system to be utilized by the collaborating partners and Care Coordinators to coordinate oral health services within the LDPP. This system consists of a smart device app to manage the LDPP-specific Patient Activation Measure, Caries Risk Assessments, care coordination and treatment in the field. Includes training sessions for staff using the system as well as ongoing system maintenance and assistance with data analysis. Travel includes local mileage at CalHR rate for 2 OHS staff members and lodging, meal per diems, and other travel expenses for required onsite training of LDPP staff.	Development, deployment and technical assistance of the LDPP Data Tracking System, the main data collection system to be developed and utilized by the Care Coordination Team and our FQHC's to manage the Caries Risk Assessments, Patient Activation Measure and Family Dental Plans as part of our care coordination model.
Oral Health Solutions, Inc. Total	**$ 21,700.00**		***Sole Source Justification:*** *Oral Health Solutions is the only company that has the expertise and experience specific to DHHS-Public Health's LDPP needs having developed similar public helath based programs to support oral health data collection as well as the ability meet short deadlines and provide in-person training and ongoing technical support.*	

K'im:aw Medical Center				K'im:aw Medical Center is a Tribal FQHC providing oral health services to the tribal population in Eastern Humboldt County, primarily Hupa.	K'ima:w Medical Center will refer 25-50 children per year to LDPP. Community Dental Health Worker will provide care coordination to LDPP participants with K'ima:w as their medical home. Will also create LDPP referral guidelines and work with LDPP partners to design data sharing guidelines in Year 1.
K'im:aw Personnel				*Personnel costs in Year 1 reflect 6 month time frame.*	
Community Dental Health Worker - 1.0 FTE	$	16,320.00		Community Dental Health Worker will provide care coordination and education primarily for tribal families to improve oral health services to the tribal community. Will attend LDPP Care Coordination Team meetings.	K'ima:w Medical Center will refer 25-50 children per year to LDPP. Community Dental Health Worker will provide care coordination to LDPP participants with K'ima:w as their medical home. Will also create LDPP referral guidelines and work with LDPP partners to design data sharing guidelines in Year 1.
K'im:aw Salary Total	**$**	**16,320.00**			
K'im:aw Fringe Benefits	$	4,733.00		Benefits are projected to be 29% of gross wages. This figure includes employee health insurance, dental insurance, FICA, SUI and Retirement. Fringe Benefit percentages vary dependent on which insurance and retirement options are chosen by staff as well as the salary rate.	
K'im:aw Personnel Total	**$**	**21,053.00**			
K'im:aw Medical Center Operating Costs	$	1,065.00		One iPad Pro tablet at $979, plus .0875 sales tax totalling $1,065. 12.9" screen with 256 GB & WiFi capability, priced at Apple's government discount rate.	For use by Community Dental Health Worker to enter data into the LDPP tracking system while performing place-based services or attending events.
K'im:aw Equipment	$	25,000.00		Cost of the Dentrex CRA Module, which is a software module meant to be utilized to improve Case Management by simplyfing data retrieval for patients as well as the ability to track patients for treatment.	Utilized to improve case management by simplifying data retrieval for patients as well as the ability to track patients for treatment.
K'im:aw Travel	$	863.00		Local mileage estimated at 250-300 miles monthly at current Federal mileage reimbursement rates.	Mileage allows K'im:aw to participate in LDPP Care Coordination Team and LDPP Advisory Team meetings as well as Community Dental Health Worker's travel to place-based services as necessary.
K'im:aw Indirects	$	3,264.00		20% of Total Personnel Salary excluding Fringe Benefits.	
K'im:aw Medical Center Total	**$**	**51,245.00**		***Sole Source Justification:*** *K'im:aw Medical Center is the only Denti-Cal providing entity in the Eastern area of Humboldt County, serving the population in their remote area with a focus on local Native tribes.*	

Dr. Robert Berg, Consulting Dentist	**$ 21,600.00**		Dr. Berg, retired DDS, will service as the LDPP's supervising Public Health Dental Director and assist in supervising and maintaining a high quality of preventive services and providing general expertise in the field. Will attend LDPP Care Coordination Team meetings. $180/hour at approximately 240 hours annually. Monthly hours will vary dependent on need. Not to exceed $43,200 per calendar year.*Year 1 total adjusted to reflect a July 1 start date.*	Dr. Berg will act as the LDPP's supervising Public Health Dental Director and assist in supervising and maintaining a high quality of preventive services and providing general expertise in the field. It is anticipated his expertise, direction and contributions will result in a solid infrastructure for the LDPP and will be essential in problem-solving throughout the program.
Dr. Robert Berg, Consulting Dentist Total	**$ 21,600.00**		***Sole Source Justification:*** *Dr. Berg has a long history in Humboldt County of supporting public health dental needs and lending his 48+years of experiene in the field as well as being highly respected by his peers. He is active in the local dental society and serves on a local advisory board that supports local oral health grants to individuals in need.*	
Total Subcontracts:	**$ 323,858.00**			

VI. OTHER COSTS

Hygienist Scholarships	$ 15,000.00		As a Dental Health Professional Shortage Area, Humboldt County relies on hygienists in advanced practice to meet dental needs.Three scholarships at $5,000 each in Year 1 to assist in students achieving their RDHAP Certification. This scholarship, intended as an investment tool for the community, will cover the approximate cost of obtaining certification.	Scholarships would be used to increase the amount of certified hygienists in our community. This would help ensure the sustainability of the project in future years by establishing a network of providers who are dedicated to expansion of dental care. This would be an investment tool to create greater access to prevention services in a dental health professional shortage area.
Humboldt Network of Family Resource Center Stipends	$ 5,000.00		We are proposing to partner with two local school-based Family Resource Center to 1) provide referrals to LDPP, and 2) to provide a space and staff support for place-based preventive service delivery. The purpose of the stipend is to incentivize and compensation FRC staff for their assistance with coordinating these activities. Their assistance will include: identifying eligible LDPP participants, linking those families to the LDPP Care Coordinators, and working with RCAA's Community Dental Health Educators.These services would be scheduled at 2 school-based locations for a one-day event on a quarterly basis or 4 times a year.	The effectiveness of the FRC stipends will be evaluated by monitoring the participation rate at each FRC. Pilot place-based services at school-based specific Family Resource Center sites around prevention-related activities. Aimed at improving access to prevention-related activities to at-risk children.
Family Starter Kits	$ 5,000.00		The Family Starter Kits will be provided to LDPP families to encourage brushing and flossing at home. In addition to including toothbrushes, toothpaste and floss, we will also provide a timer so that children can brush for two minutes. Smile Humboldt educational materials will be included. LDPP Care Coordinators and Community Dental Health Workers will be responsible for distributing the kits to families upon completion of the Family Dental Plan. The Family Dental Plan will included goal setting and tracking for home-based oral health behaviors. In order to evaluate the effectiveness of the Family Starter Kits, the Family Dental Plan results will be assessed. LDPP Care Coordinators and Community Dental Health Workers will be monitoring families' completion of home-based oral health behaviors. In addition, there will be a question on the Family Dental Plan that asks the family if they used the supplies and materials and we will ask focus group participants to discuss their use of these kits as well. Cost of Family Starter Kits is $1.25 per unit with the anticipation to hand out 8,000 per year.	Incentivize families with desirable outcome being a shift in culture to have a stronger focus on their child's oral health, and increase possibility that child will return to dentist for prevention treatment.
Total Other Costs:	**$ 25,000.00**			

VII. INDIRECT COSTS

Total Indirects	**$ 24,809.00**		Indirects include the following expenses: Estimated A-87 Overhead, Insurance, I-S, Purchasing and Communication expenses from the County of Humboldt, Program share of building expenses estimated by FTE (includes building utility costs such as PG&E, phone system, shared printer lease, alarm system and miscellaneous maintenance expenses). 20% of Total Personnel Salary excluding Fringe Benefits.	

YEAR 1 GRAND TOTAL **$ 595,482.00**

Attachment 5

Subcontractor Budget

Humboldt State University Sponsored Programs Foundation –
California Center for Rural Policy
Year 1
07/01/2017 through 12/31/2017

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Director of Health	1	$4,833 - $5,129	70 %	$ 20,297
Research Analyst	1	$3,333 - $3,538	60 %	$ 12,000
Office Manager	1	$3,293 - $3,495	5 %	$ 988
			Total Salary	$ 33,285
			Fringe Benefits (44%)	$ 14,628

Total Personnel $ 47,913

Operating Expenses

Printing $1,000

Total Operating Expenses $ 1,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)
652 miles @ .575

Total Travel $ 375

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 6,657

Annual Budget Total **$ 55,945**

Subcontractor Budget

Humboldt State University Sponsored Programs Foundation –
California Center for Rural Policy
Year 2
01/01/2018 through 12/31/2018

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Director of Health	1	$4,833 - $5,129	70 %	$ 41,409
Research Analyst	1	$3,333 - $3,538	60 %	$ 24,486
Office Manager	1	$3,293 - $3,495	5 %	$ 2,016
			Total Salary	$ 67,911
			Fringe Benefits (44%)	$ 29,834

Total Personnel $ 97,745

Operating Expenses

Printing $2,000

Total Operating Expenses $ 2000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)
1,305 miles @ .575

Total Travel $ 750

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 13,582

Annual Budget Total **$** 114,077

Subcontractor Budget

Humboldt State University Sponsored Programs Foundation –
California Center for Rural Policy
Year 3
01/01/2019 through 12/31/2019

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Director of Health	1	$4,833 - $5,129	70 %	$ 42,238
Research Analyst	1	$3,333 - $3,538	60 %	$ 24,972
Office Manager	1	$3,293 - $3,495	5 %	$ 2,056
			Total Salary	$ 69,266
			Fringe Benefits (44%)	$ 30,431

Total Personnel $ 99,697

Operating Expenses

Printing $2,000

Total Operating Expenses $ 2000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)
1,305 miles @ .575

Total Travel $ 750

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 13,853

Annual Budget Total **$** 116,300

Subcontractor Budget

Humboldt State University Sponsored Programs Foundation –
California Center for Rural Policy
Year 4
01/01/2020 through 12/31/2020

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Director of Health	1	$4,833 - $5,129	70 %	$ 43,083
Research Analyst	1	$3,333 - $3,538	60 %	$ 25,472
Office Manager	1	$3,293 - $3,495	5 %	$ 2,097
			Total Salary	$ 70,652
			Fringe Benefits (44%)	$ 31,039

Total Personnel $ 101,691

Operating Expenses

Printing $2,000

Total Operating Expenses $ 2000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)
1,305 miles @ .575

Total Travel $ 750

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 14,130

Annual Budget Total **$** 118,571

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Subcontractor Budget

Redwoods Rural Health Center
Year 1
07/01/2017 through 12/31/2017

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720 - $3,884	100 %	$ 19,019

Total Salary	$	19,019
Fringe Benefits (29%)	$	5,516
Total Personnel	$	24,535

Operating Expenses

iPad Pro	$1,065	
Total Operating Expenses	$	1,065

Equipment

QSI EDR CRA Tool	$3,600	
QSI EDR Annual Maintenance Fee	$8,500	
Total Equipment Expenses	$	12,100

Travel (At CalHR reimbursement rates) 1,500 miles @ .575	**Total Travel**	$ 863

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)	**Indirect Costs**	$ 3,803
	Annual Budget Total	**$** $42,366

Subcontractor Budget

Redwoods Rural Health Center
Year 2
01/01/2018 through 12/31/2018

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720 - $3,884	100 %	$ 40,701

Total Salary	$	40,701
Fringe Benefits (29%)	$	11,803
Total Personnel	$	52,504

Operating Expenses

Total Operating Expenses	$ 0

Equipment

QSI EDR Annual Maintenance Fee	$8,500	
Total Equipment Expenses		$ 8,500

Travel (At CalHR reimbursement rates) 3,000 miles @ .575	
Total Travel	$ 1,725

Subcontracts

Total Subcontracts	$ 0

Other Costs

Total Other Costs	$ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)	
Indirect Costs	$ 8,140
Annual Budget Total	**$** 70,869

Subcontractor Budget

Redwoods Rural Health Center
Year 3
01/01/2019 through 12/31/2019

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720 - $3,884	100 %	$ 43,550

Total Salary	$	43,550
Fringe Benefits (29%)	$	12,629

Total Personnel $ 56,179

Operating Expenses

Total Operating Expenses $ 0

Equipment

QSI EDR Annual Maintenance Fee	$8,500

Total Equipment Expenses $ 8,500

Travel (At CalHR reimbursement rates)
3,000 miles @ .575

Total Travel $ 1,725

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 8,710

Annual Budget Total **$** 75,114

Subcontractor Budget

Redwoods Rural Health Center
Year 4
01/01/2020 through 12/31/2020

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720 - $3,884	100 %	$ 46,599

Total Salary	$	46,599
Fringe Benefits (29%)	$	13,512
Total Personnel	$	60,111

Operating Expenses

Total Operating Expenses	$ 0

Equipment

QSI EDR Annual Maintenance Fee	$8,500	
Total Equipment Expenses		$ 8,500

Travel (At CalHR reimbursement rates) 3,000 miles @ .575	
Total Travel	$ 1,725

Subcontracts

Total Subcontracts	$ 0

Other Costs

Total Other Costs	$ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)	
Indirect Costs	$ 9,319
Annual Budget Total	**$** 79,655

Subcontractor Budget

Open Door Community Health Center
Year 1
07/01/2017 through 12/31/2017

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720- $3,300	100 %	$ 16,320
Training Coordinator	1	$8,123- $9,404	20%	$ 9,748
			Total Salary	$ 26,068
			Fringe Benefits (29%)	$ 7,560
			Total Personnel	$ 33,628

Operating Expenses

iPad Pro	$1065	
	Total Operating Expenses	$ 1065

Equipment

Dentrex CRA Module	$25,000.00	
	Total Equipment Expenses	$ 25,000

Travel (At CalHR reimbursement rates)
600 miles @ .575

Total Travel $ 345

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 5,213

Annual Budget Total **$** 65,251

Subcontractor Budget

Open Door Community Health Center
Year 2
01/01/2018 through 12/31/2018

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720- $3,300	100 %	$ 34,272
Training Coordinator	1	$8,123- $9,404	20%	$ 20,471
			Total Salary	$ 54,743
			Fringe Benefits (29%)	$ 15,875

Total Personnel $ 70,618

Operating Expenses

Dentrex CRA Module Annual Maintenance Fee $1,000

Total Operating Expenses $ 1,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)
1,200 miles at .575

Total Travel $ 690

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 10,948

Annual Budget Total **$** 83,256

Subcontractor Budget

Open Door Community Health Center
Year 3
01/01/2019 through 12/31/2019

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720- $3,300	100 %	$ 35,985
Training Coordinator	1	$8,123- $9,404	20%	$ 21,494
			Total Salary	$ 57,479
			Fringe Benefits (29%)	$ 16,669

Total Personnel $ 74,148

Operating Expenses

Dentrex CRA Module Annual Maintenance Fee	$1,000

Total Operating Expenses $ 1,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)
1,200 miles @ .575

Total Travel $ 690

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 11,495

Annual Budget Total **$** 87,333

Subcontractor Budget

Open Door Community Health Center
Year 4
01/01/2020 through 12/31/2020

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720- $3,300	100 %	$ 37,784
Training Coordinator	1	$8,123- $9,404	20%	$ 22,569
			Total Salary	$ 60,353
			Fringe Benefits (29%)	$ 17,502

Total Personnel $ 77,855

Operating Expenses

Dentrex CRA Module Annual Maintenance Fee $1,000.00

Total Operating Expenses $ 1,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)
1,200 miles @ .575

Total Travel $ 690

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 12,070

Annual Budget Total **$** 91,615

Subcontractor Budget

Redwood Community Action Agency
Year 1
07/01/2017 through 12/31/2017

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Educator	2	$3,106 - $3,700	100 %	$ 37,272

Total Salary	$	37,272
Fringe Benefits (35%)	$	13,045
Total Personnel	$	50,317

Operating Expenses

iPad Pro	$ 2,130
Office Supplies & Printing	$ 2,400

Total Operating Expenses	$	4,530

Equipment

Total Equipment Expenses	$	0

Travel (At CalHR reimbursement rates)
6,000 miles @ .575

Total Travel	$	3,450

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs	$	7,454
Annual Budget Total	**$**	65,751

Subcontractor Budget
Redwood Community Action Agency
Year 2
01/01/2018 through 12/31/2018

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Educator	2	$3,106 - $3,700	100 %	$ 78,271

Total Salary	$	78,271
Fringe Benefits (35%)	$	27,395

Total Personnel $ 105,666

Operating Expenses
Office Supplies & Printing

Total Operating Expenses $ 4800

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)
12,000 miles @ .575

Total Travel $ 6,900

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs $ 15,654

Annual Budget Total **$** 133,020

Subcontractor Budget
Redwood Community Action Agency
Year 3
01/01/2019 through 12/31/2019

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Educator	2	$3,106 - $3,700	100 %	$ 82,185

Total Salary	$	82,185
Fringe Benefits (35%)	$	28,764
Total Personnel	$	110,949

Operating Expenses
Office Supplies & Printing

Total Operating Expenses	$	4,800

Equipment

Total Equipment Expenses	$	0

Travel (At CalHR reimbursement rates)
12,000 miles @ .575

Total Travel	$	6,900

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs	$	16,437
Annual Budget Total	**$**	139,086

Subcontractor Budget
Redwood Community Action Agency
Year 4
01/01/2020 through 12/31/2020

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Educator	2	$3,106 - $3,700	100 %	$ 86,294

Total Salary	$	86,294
Fringe Benefits (35%)	$	30,203
Total Personnel	$	116,497

Operating Expenses
Office Supplies & Printing

Total Operating Expenses	$	4,800

Equipment

Total Equipment Expenses	$	0

Travel (At CalHR reimbursement rates)
12,000 miles @ .575

Total Travel	$	6,900

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs	$	17,258
Annual Budget Total	**$**	145,455

Subcontractor Budget

Oral Health Solutions, Inc.
Year 1
02/15/2017 through 12/31/2017

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Project Director	1	$12,500 - $12,500	5 %	$ 7,500
Software Technician	1	$4,166.67 - $4,166.67	15 %	$ 7,500
			Total Salary	$ 15,000
			Fringe Benefits (0%)	$ 0
			Total Personnel	$ 15,000

Operating Expenses

iOS tablet for development	$700
Android tablet for development	$500
Dental Data Manager Subscription	$2,000
Total Operating Expenses	$ 3,200

Equipment

Total Equipment Expenses	$ 0

Travel (At CalHR reimbursement rates)

Total Travel	$ 2,000

Subcontracts

Total Subcontracts	$ 0

Other Costs

Total Other Costs	$ 0

Indirect Costs (10% of salary)

Indirect Costs	$ 1,500
Annual Budget Total	**$** 21,700

Subcontractor Budget

Oral Health Solutions, Inc.
Year 2
01/01/2018 through 12/31/2018

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Project Director	1	$12,500 - $12,500	2 %	$ 3,000
Software Technician	1	$4,166.67 - $4,166.67	10 %	$ 5,000
			Total Salary	$ 8,000
			Fringe Benefits (0%)	$ 0

Total Personnel $ 8,000

Operating Expenses

Dental Data Manager Subscription	$2,000

Total Operating Expenses $ 2,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)

Total Travel $ 1,000

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (10% of salary)

Indirect Costs $ 800

Annual Budget Total **$** 11,800

Subcontractor Budget

Oral Health Solutions, Inc.
Year 3
01/01/2019 through 12/31/2019

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Project Director	1	$12,500 - $12,500	1.5 %	$ 2,250
Software Technician	1	$4,166.67 - $4,166.67	3.5 %	$ 1,750
			Total Salary	$ 4,000
			Fringe Benefits (0%)	$ 0

Total Personnel $ 4,000

Operating Expenses

Dental Data Manager Subscription	$2,000	

Total Operating Expenses $ 2,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)

Total Travel $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (10% of salary)

Indirect Costs $ 400

Annual Budget Total **$** 6,400

Subcontractor Budget
Oral Health Solutions, Inc.
Year 4
01/01/2020 through 12/31/2020

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Project Director	1	$12,500 - $12,500	0.5 %	$ 750
Software Technician	1	$4,166.67 - $4,166.67	2 %	$ 1,100
			Total Salary	$ 1,750
			Fringe Benefits (0%)	$ 0

Total Personnel $ 1,750

Operating Expenses
Dental Data Manager Subscription $2,000

Total Operating Expenses $ 2,000

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)

Total Travel $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (10% of salary)

Indirect Costs $ 175

Annual Budget Total **$** 3,925

Subcontractor Budget

K'im:aw Medical Center
Year 1
7/1/2017 through 12/31/2017

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720 - $3,149	100 %	$ 16,320

Total Salary	$	16,320
Fringe Benefits (29%)	$	4,733
Total Personnel	$	21,053

Operating Expenses

iPad Pro	$1,065	
Total Operating Expenses	$	1,065

Equipment

Dentrex CRA Module	$25,000	
Total Equipment Expenses	$	25,000

Travel (At CalHR reimbursement rates)
1,500 miles @ .575

Total Travel	$	863

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs	$	3,264
Annual Budget Total	**$**	51,245

Subcontractor Budget

K'im:aw Medical Center
Year 2
1/1/2018 through 12/31/2018

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720 - $3,149	100 %	$ 34,272

Total Salary	$	34,272
Fringe Benefits (29%)	$	9,938
Total Personnel	$	44,210

Operating Expenses

Dentrex CRA Module Maintenance Fee	$1,000	
Total Operating Expenses	$	1,000

Equipment

Total Equipment Expenses	$	0

Travel (At CalHR reimbursement rates)
3,000 miles @ .575

Total Travel	$	1,725

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs	$	6,854
Annual Budget Total	**$**	53,789

Subcontractor Budget

K'im:aw Medical Center
Year 3
1/1/2019 through 12/31/2019

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720 - $3,149	100 %	$ 35,986

Total Salary	$	35,986
Fringe Benefits (29%)	$	10,435
Total Personnel	$	46,421

Operating Expenses

Dentrex CRA Module Maintenance Fee	$1,000	
Total Operating Expenses	$	1,000

Equipment

Total Equipment Expenses	$	0

Travel (At CalHR reimbursement rates)
3,000 miles @ .575

Total Travel	$	1,725

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs	$	7,197
Annual Budget Total	**$**	56,343

Subcontractor Budget
K'im:aw Medical Center
Year 4
1/1/2020 through 12/31/2020

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Community Dental Health Worker	1	$2,720 - $3,149	100 %	$ 37,785

Total Salary	$	37,785
Fringe Benefits (29%)	$	10,958
Total Personnel	$	48,743

Operating Expenses
Dentrex CRA Module Maintenance Fee $1,000

Total Operating Expenses	$	1,000

Equipment

Total Equipment Expenses	$	0

Travel (At CalHR reimbursement rates)
3,000 miles @ .575

Total Travel	$	1,725

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)

Indirect Costs	$	7,557
Annual Budget Total	**$**	59,025

Subcontractor Budget

Dr. Robert Berg, DDS
Year 1
07/01/2017 through 12/31/2017

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Consulting Dentist; LDPP Director	1	$180 per hour	N/A	$ 21,600
			Total Salary	$ 21,600

Total Personnel $ 21,600

Operating Expenses

Total Operating Expenses $ 0

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)

Total Travel $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs

Indirect Costs $ 0

Annual Budget Total **$** 21,600

Subcontractor Budget

Dr. Robert Berg, DDS
Year 2
01/01/2018 through 12/31/2018

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Consulting Dentist; LDPP Director	1	$180 per hour	N/A	$ 43,200
			Total Salary	$ 43,200

Total Personnel $ 43,200

Operating Expenses

Total Operating Expenses $ 0

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)

Total Travel $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs

Indirect Costs $ 0

Annual Budget Total **$** 43,200

Subcontractor Budget

Dr. Robert Berg, DDS
Year 3
01/01/2019 through 12/31/2019

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Consulting Dentist; LDPP Director	1	$180 per hour	N/A	$ 43,200
			Total Salary	$ 43,200

Total Personnel $ 43,200

Operating Expenses

Total Operating Expenses $ 0

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)

Total Travel $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs

Indirect Costs $ 0

Annual Budget Total **$** 43,200

Subcontractor Budget
Dr. Robert Berg, DDS
Year 4
01/01/2020 through 12/31/2020

Personnel

Position Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
Consulting Dentist; LDPP Director	1	$180 per hour	N/A	$ 43,200
			Total Salary	$ 43,200

Total Personnel $ 43,200

Operating Expenses

Total Operating Expenses $ 0

Equipment

Total Equipment Expenses $ 0

Travel (At CalHR reimbursement rates)

Total Travel $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs

Indirect Costs $ 0

Annual Budget Total **$** 43,200