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Agenda: Children and Families Commission 12-2017

735 East Carnegie Drive, Suite 150, San Bernardino, California 92408

Meeting date, time, and place	December 20, 2017 3:30 p.m. to 5:00 p.m. Commission Conference Center
Pledge of Allegiance	Chair or designee will lead the Pledge of Allegiance
SPECIAL PRESENTATION	None
Conflict of Interest Disclosure	Commission members shall review agenda item contractors, subcontractors, and agents, which may require member abstentions due to conflict of interest and financial interests. A Commission member with conflicts of interests shall state their conflict under the appropriate item. A Commission member may not participate in or influence the decision on a contract for which their abstention has been recorded.
Consent Items	The following consent items are expected to be routine and non-controversial and will be acted upon by the Commission at one time unless any Commissioner directs that an item be removed from the Consent Agenda for discussion.

Item No.	CONSENT
1	Approve Minutes of November 1, 2017 Commission Meeting. (Presenter: Ann M. Calkins, Executive Assistant, 252-4252)
2	Approve Amendment A2 to Contract Number IC029 with Vavrinek, Trine, Day & Co., LLP (VTD) to update the timeline for the Fiscal Year 2016-2017 audit report. (Presenter: Debora Dickerson, Administrative Supervisor II, 252-4269)

The agenda and supporting documents are available for review during regular business hours at First 5 San Bernardino, 735 East Carnegie Drive, Suite 150, San Bernardino, California 92408.

Interpreters for hearing impaired and Spanish speaking individuals will be made available with forty-eight hours notice. Please call Commission staff (909) 386-7706 to request the service. This location is handicapped accessible.

Item No.	DISCUSSION
3	Conduct Public Hearing for the Children and Families Commission for San Bernardino County Annual Audit for Fiscal Year 2016-2017. (Presenter: Debora Dickerson-Sims, Administrative Supervisor II, 252-4269)
4	Conduct Public Hearing of the Children and Families Commission for San Bernardino County Annual Report for Fiscal Year 2016-2017. (Presenter: Scott McGrath, Evaluation Supervisor, 252-4259)
5	Authorize First 5 San Bernardino (F5SB) as a Co-Lead to enter into Contract 188800 LDP with First 5 Riverside (F5R) (Lead) to receive Dental Transformation Initiative – Local Dental Pilot Project funding from F5R to improve dental services in the Inland Empire region strengthening the child health system for Fiscal Years 2017 – 2020. (Presenter: Mary Jaquish, Program Supervisor, 252-4254)

Public Comment

Persons wishing to address the Commission will be given up to three minutes and pursuant to Government Code 54954.2(a)(2) "no action or discussion will be undertaken by the Commission on any item NOT on the agenda."

Commissioner Roundtable

Open to comments by the Commissioners.

Next Meeting at First 5 San Bernardino

NO MEETING IN JANUARY 2018

Wednesday, February 7, 2018
3:30 p.m. to 5:00 p.m.

The agenda and supporting documents are available for review during regular business hours at First 5 San Bernardino, 735 East Carnegie Drive, Suite 150, San Bernardino, California 92408.

Interpreters for hearing impaired and Spanish speaking individuals will be made available with forty-eight hours notice. Please call Commission staff (909) 386-7706 to request the service. This location is handicapped accessible.

CHILDREN AND FAMILIES COMMISSION
for San Bernardino County
AGENDA: DECEMBER 20, 2017

Subject: Information Relative to Possible Conflict of Interest

Instructions: Contractors, subcontractors, principals and agents are listed below for each applicable agenda item. Commissioners are asked to review the items for possible conflicts of interest and to notify the Commission secretary prior to the Commission meeting of conflicts concerning items on the meeting's agenda. This procedure does not relieve the Commissioner of his or her obligations under the Political Reform Act.

Background: The Political Reform Act of 1974 (Government Code section 87100 et. Seq.) prohibits public officials from making, participating in making or in any way attempting to use their official position to influence a governmental decision in which they have reason to know they have a "financial interest." Additionally, Government Code section 1090 et seq. prohibits public officers and employees from being financially interested in any contract made by them in their official capacity or by the board of which they are members. A limited exception is allowed for County Children's and Families Commissions. (See Government Code section 1091.3)

Item No.	Contractor	Principals & Agents	Subcontractors; Principals & Agents	Commissioner Abstentions
1	N/A	N/A	N/A	N/A
2	Vavrinek, Trine, Day & Co., LLP	David Showalter Partner and CPA	N/A	N/A
3	N/A	N/A	N/A	N/A
4	N/A	N/A	N/A	N/A
5	First 5 Riverside	Tammi Graham Executive Director	N/A	N/A

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Minutes: Children and Families Commission Meeting

735 East Carnegie Drive, Suite 150, San Bernardino, California 92408

Meeting Date, Time and Location	Commission Meeting November 1, 2017 - 3:30 p.m. First 5 San Bernardino
Pledge of Allegiance	The Pledge of Allegiance was led by Chair Ohikhuare
SPECIAL PRESENTATION	None
Conflict of Interest Disclosure	Commission members shall review agenda item contractors, subcontractors, and agents, which may require member abstentions due to conflict of interest and financial interests. A Commission member with conflicts of interests shall state their conflict under the appropriate item. A Commission member may not participate in or influence the decision on a contract for which their abstention has been recorded.
Attendees	**Commissioners Present** • Margaret Hill • Maxwell Ohikhuare, M.D. • CaSonya Thomas • Paul Vargas • Elliot Weinstein, M.D. **Staff Present** • Karen Scott, Executive Director • Cindy Faulkner, Operations Manager • Mary Jaquish, Supervisor • Ann Calkins, Executive Assistant • Staci Scranton, Supervising Office Assistant • Sophie Akins, Commission Counsel • Greg Sellon, Accountant III • Ronnie Thomas, Staff Analyst II

Changes to the Agenda

Items 4 and 5 were pulled from the agenda and are scheduled for presentation at the December 6th meeting.

Report – Advisory Committee Chair, Margaret Hill

The Committee met on September 28th. The following actions and discussions took place:

- Members elected James Moses as the new Vice Chair.
- Members reviewed bylaws and upon further discussion and correction, the bylaws were approved.
- Information items on Help Me Grow, Systems Trajectory, and AmeriCorps Home Visitation were presented.

A new meeting has not yet been scheduled, however, once finalized, the meeting date will be posted on the First 5 website.

Report – Executive Director, Karen Scott

Talk, Read, Sing

F5SB will again host the annual Talk, Read, Sing event on Saturday, November 4th from 9 am – 2 pm at the San Bernardino County Museum. A free event for children and their families focused on the importance of early literacy skills. Taking the time to talk, read, sing (and play) with a young child sparks learning curiosity and increases their exposure and familiarity with words. Thank you to Leonard Hernandez, Melissa Russo and staff from the museum for collaborating with F5SB to make this event possible.

The Talk, Read, Sing Initiative, spearheaded by First 5 CA, aligns with San Bernardino County's Vision2Read campaign. The goal of the campaign is to see our children's reading levels excel by the 3rd grade. Currently, 69% of children in San Bernardino County do not meet new California English language arts/literacy standards. Join us for free books, exploration of the museum and family entertainment. Together we can improve literacy competence and early learning for all children.

"Papa-Palooza" - A Celebration of Fatherhood in San Bernardino County"

Planning is underway for F5SB's annual event held in January, scheduled for Friday, January 5, 2018 Cal State San Bernardino or San Bernardino County Department of Behavioral Health's Auditorium in Rialto. This year's theme is "Papa-Palooza - A Celebration of Fatherhood in San Bernardino County". After all, fathers are 50% of the equation when it comes to improving the health and well-being of our children ages prenatal through 5.

"Papa-Palooza" is a major awareness event to share information on services, resources and support available for fathers as well as recognize wonderful accomplishments by fathers throughout the County. The program is being planned to run from 9 am to noon, with speakers, presentations and a showing of the film "Daddy Don't Go" which follows the lives of four young fathers as they struggle to navigate parenthood. The film shows viewers how men can still be "present" as fathers despite having limited means and facing certain obstacles. The running time for the film is 1 hour and 38 minutes.

Consent Motion to approve Consent Items by Commissioner Hill and seconded by Commissioner Vargas. With Commissioners Garrett and Ramos absent and without further comment or objection, motion carried by unanimous vote.

Item No.	CONSENT
1	Approve Minutes of September 6, 2017 Commission Meeting. (Presenter: Ann M. Calkins, Executive Assistant, 252-4252)
2	Approve Commission Meeting Schedule for Calendar Year 2018. (Presenter: Ann M. Calkins, Executive Assistant, 252-4252)
3	A. Ratify one (1) year contract previously executed by the Executive Director for the contract term of October 1, 2017 through September 30, 2018 with Prevent Child Abuse California (PCA CA) for the First 5 Service Corps Prevent Child Abuse Through Home Visitation (PATH) program for Fiscal Year 2017-2018 for four (4) AmeriCorps service member positions to provide home visitation program services not to exceed $56,000 in matching funds. B. Ratify the Memorandum of Understanding (MOU) with PCA CA for Fiscal Year 2017-2018 for AmeriCorps service member mileage reimbursement in an amount not to exceed $12,000. C. Execute Service Agreements with host sites for supporting the PATH program in a total amount for all hosts, not to exceed $30,000 for Fiscal Year 2017-2018. (Presenter: Cindy Faulkner, Operations Manager, 252-4253)

Item No.	DISCUSSION
4	Conduct Public Hearing for the Children and Families Commission for San Bernardino County Annual Audit for Fiscal Year 2016-2017. (Presenter: Debora Dickerson-Sims, Administrative Supervisor II, 252-4269) ***Item pulled from agenda. Scheduled for presentation at December meeting.***
5	Conduct Public Hearing of the Children and Families Commission for San Bernardino County Annual Report for Fiscal Year 2016-2017. (Presenter: Scott McGrath, Evaluation Supervisor, 252-4259) ***Item pulled from agenda. Scheduled for presentation at December meeting.***
6	Approve Amendment A2 for Contract EC030 with San Bernardino County Superintendent of Schools for $71,794 for a total contract amount of $326,544 for system coordination staff for continued Quality Start San Bernardino (QSSB) implementation in accordance with the San Bernardino County's QRIS Strategic Plan for Fiscal Year 2017-2018. (Presenter: Cindy Faulkner, Operations Manager, 252-4253) **Discussion** Commissioner Hill asked what happens to the funding after 2017-18. Ms. Faulkner answered the funding will continue until 2020. Unspent funds will be carried over from 2015-16 and 2016-17. Ms. Faulkner explained that other county commissions work with their respective county's Office of Education and it was determined that for eventual alignment and connection with the K through 12 system, SBCSS was the ideal partner to make this happen. **Public Comment** None

	Motion to approve Item 6 by Commissioner Weinstein and seconded by Commissioner Hill. With Commissioners Garrett and Ramos absent and without further comment or objection, motion carried by unanimous vote.
7	A. Approve commitment of funding to Department of Behavioral Health (DBH) of $26,250,000 for a five-year contract term from July 2018 through June 2023. This commitment of continued support from the Commission to DBH for the established early childhood mental health services system guarantees that a contract will be forthcoming in the listed amount. This commitment enables DBH to immediately release a Request for Proposal (RFP) seeking interested and qualified organizations and agencies to provide services to children ages 0 – 5 and families for the Screening, Assessment, Referral and Treatment (SART) and Early Identification and Intervention (EIIS) programs. B. Authorize the Executive Director to negotiate a contract with the Department of Behavioral Health not to exceed $26,250,000 for the SART and EIIS services to be provided from July 2018 through June 2023. (Presenter: Ronnie S. Thomas, Staff Analyst II, 252-4255) **Discussion** Commissioner Vargas expressed his appreciation for staff taking on more responsibility, such as presenting agenda items to the Commission, and for the mentoring taking place at First 5. Commissioner Hill asked if the needs of the 0 to 5 population are being met in San Bernardino County. Executive Director Karen Scott answered that there will never be enough money to meet all the needs of children in the 0 to 5 population that fall within our mission. First 5 is working towards identifying all partners and organizations that operate within a "system" to help build capacity within that system and accomplish the task. First 5 will never be able to do this alone. Programs such as Quality Start which focuses on early education but includes components of childhood mental health; Help Me Grow which focuses on early screening and identification of socio-emotional and developmental delays; continued discussions related to ACE (Adverse Childhood Experiences) and working with Dr. Powell and others within the school system – these are opportunities to expand the reach to children in need. There will be ways to utilize SART funding to reach and provide greater services for those children. Ms. Scott stated First 5 feels successful in preventing children from getting to SART's door by the Commission's investment in other preventative measures. Dr. Tim Hougen added that DBH is currently working on a pilot program with Dr. Powell in the High Desert with an integration of three different funding sources. The mental health portion of that is EIIS (Early Identification and Intervention Services). **Public Comment** None Commissioner Thomas abstained due to her position as appointing authority over the Department of Behavioral Health. Motion to approve Item 7 by Commissioner Hill and seconded by Commissioner Weinstein. With Commissioners Garrett and Ramos absent, an abstention by Commissioner Thomas, and without further comment or objection, motion carried by unanimous vote.

Public Comment	None
Commissioner Roundtable	None
Adjournment	Motion to adjourn made by Commissioner Vargas and seconded by Commissioner Weinstein. With Commissioners Garrett and Ramos absent and without further comment or objection, motion carried by unanimous vote. Chair Ohikhuare adjourned the meeting at 4:04 p.m.
Next meeting at First 5 San Bernardino	**Wednesday, February 7, 2018** **3:30 p.m.**
Attest	

Maxwell Ohikhuare, M.D., Chair

Ann M. Calkins, Commission Clerk

AGENDA ITEM 2
DECEMBER 20, 2017

Subject	Contract Amendment to update timeline for Fiscal Year 2016-20/17 audit report with Vavrinek, Trine, Day & Co., LLP (VTD).
Recommendations	Approve Amendment A2 to Contract Number IC029 with Vavrinek, Trine, Day & Co., LLP (VTD) to update the timeline for the Fiscal Year 2016-2017 audit report. (Presenter: Debora Dickerson, Administrative Supervisor II, 252-4269)
Financial Impact	None.
Background Information	On June 1, 2016, the Commission approved a contract with Vavrinek, Trine, Day & Co., LLP (VTD) to conduct and prepare an Annual Audit and Report and render an opinion of the Commission's financial statements. Currently, in the contract Section II (2)(B) and Section 2 (C) of Exhibit "A" states. "The Commission requires five (5) copies of the draft audit report to be submitted to the Commission Office no later than October 1 and twenty-five (25) bound copies of the final audit report to be submitted to the Commission Office no later than October 7." Due to mitigating circumstances, VTD determined that they needed to complete expanded "tests" of the Commission's procurement process, focused review of Commission policies and interview of Commission members, causing a delay in the completion beyond October 7, 2017. This amendment will update the timeline to Section II(2)(B) and Section 2 (C) of Exhibit "A" by adding the following: "Notwithstanding anything to the contrary herein, the Contractor shall submit to the Commission Office twenty-five (25) bound copies of the final audit report for Fiscal Year 2016-2017 no later than December 15, 2017."
Review	Sophie Akins, Commission Counsel

Report on Action as taken	
Action:	
Moved:	**Second:**
In Favor:	
Opposed:	
Abstained:	
Comments:	
Witnessed:	

CHILDREN AND FAMILIES COMMISSION FOR SAN BERNARDINO COUNTY

STANDARD CONTRACT

FOR COMMISSION USE ONLY

	New	Vendor Code	SC	Dept.	A	Contract Number
X	Change	4100001938		903		IC029 A2
	Cancel					

Organization	Dept.	Orgn.	Contractor's License No.
Children and Families Commission	903	PROG	California CPA License No. 2376

Commission Representative	Telephone	Total Contract Amount
Cindy Faulkner, Operations Manager	909-386-7706	$84,660

Contract Type

☐ Revenue ☒ Encumbered ☐ Unencumbered ☐ Other:

If not encumbered or revenue contract type, provide reason:

Commodity Code	Contract Start Date	Contract End Date	Original Amount	Amendment Amount
95200	July 1, 2016	October 31, 2018		

Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No.	Amount
			200			
Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No.	Amount
Fund	Dept.	Organization	Appr.	Obj/Rev Source	GRC/PROJ/JOB No.	Amount

Abbreviated Use: Annual Audit and Report

Estimated Payment Total by Fiscal Year

FY	Amount	I/D	FY	Amount	I/D
16-17	20,900				
17-18	31,400				
18-19	32,360				

THIS CONTRACT is entered into in the State of California by and between the Children and Families Commission for San Bernardino County, hereinafter called the Commission, and

Legal Name (hereinafter called the Contractor)

Vavrinek, Trine, Day & Company, LLP

Department/Division

Address

10681Foothill Boulevard, Sutie 300

Rancho Cucamonga, CA 91730

Program Address (if different from legal address):

Phone

(909) 466-4410

Federal ID No.

95-264-8289

IT IS HEREBY AGREED AS FOLLOWS:

AMENDMENT NO. 2

1. Paragraph 2(B) Reports of Section II, SCOPE OF WORK AND DUE DATES, and Section 2 (C) of Attachment A, are amended by adding the following sentence:

   Notwithstanding anything to the contrary herein, the Contractor shall submit to the Commission Office twenty-five (25) bound copies of the final audit report for Fiscal Year 2016-2017 no later than December 15, 2017.

continued on next page

Auditor-Controller/Treasurer Tax Collector Use Only

☐ Contract Database	☐ FAS
Input Date	**Keyed By**

ATTACHMENTS

Attachment A – Scope of Work

All other terms and conditions of this contract remain in full force and effect.

CHILDREN & FAMILIES COMMISSION FOR SAN BERNARDINO COUNTY	VAVRINEK, TRINE, DAY & COMPANY, LLP
	Legal Entity
►	►
Authorized Signature	Authorized Signature
Maxwell Ohikhuare, M.D.	
Printed Name	Printed Name
Commission Chair	
Title	Title
Dated	Dated

Official Stamp

Reviewed for Processing	Approved as to Legal Form	Presented to Commission for Signature
►	►	►
Cindy Faulkner	Sophie Akins	Karen E. Scott
Operations Manager	Commission Counsel	Executive Director
Date	Date	Date

Section 2 – Description of Services

A. Complete Work Plan/Project Description

Overview of the Audits

As required by the Request for Qualifications our audit plan covers the engagements for:

- Audit of the Commission's Financial Statements
- A report on compliance with applicable laws, regulations and requirements contained with the applicable provisions of the California Health and Safety Code (Report on State Compliance)
- A report on the Commission's compliance and internal control as required by *Government Auditing Standards*
- Meeting with Commission staff prior to public hearing
- Presence at the public meeting
- Issue a management letter, as applicable
- Technical assistance with the implementation of accounting and compliance matters

The audits will be conducted in accordance with generally accepted auditing standards issued by the American Institute of Certified Public Accountants (AICPA), *Governmental Auditing Standards* published by the Comptroller General of the United States.

B. Our Proposed Audit Approach/Plan

Our engagement approach for the Commission audit has well-detailed goals by which the engagement partner can measure progress. Our audit plan includes frequent contact between the partner and the engagement team to assure that objectives are attained according to the audit schedules and problems are communicated and dealt with on a timely basis. Our engagement approach benefits from our long accumulated experience during which our firm has identified key areas of financial and accounting concern in the audit process. More importantly, the approach provides for a complete reassessment of the management and control environment in each year's audit and thus is capable of responding to changes and will ensure that deadlines are met in issuing the annual financial statements.

The key characteristics of our engagement approach are:

- *Knowledge of the Commission and similar entities.* We have extensive experience auditing governmental entities, including First 5 Commissions. This experience enables us to perform a more efficient audit and identify key audit risks.
- *Cost-effectiveness*. Our experienced auditor's low percentage of turnover reduce your cost
- *Timeliness*. We take deadlines, both yours and ours, seriously.
- *Partner-manager involvement.* Deciding on audit strategies requires seasoned judgment. Our partners and managers have been heavily and continuously involved in governmental audits. Furthermore, you will be able to consult with senior team members whenever needed throughout the year. We are available during the year for any additional consultation that may arise.

Project Management – Overall Audit

Our audit plan involves six (6) stages for each audit. These stages are:

Stage 1, Planning
Stage 2, Risk Assessment
Stage 3, Preparation of the Overall Audit Plan
Stage 4, Conducting the Interim Audit
Stage 5, Conducting the Final Audit
Stage 6, Reporting

Section 2 – Description of Services

B. Our Proposed Audit Approach/Plan, (Continued)

Stage 1, Planning

VTD will meet with key staff of the Commission to plan the audit services for the year. These meetings will discuss all audit issues and the proposed interim work plan. During this phase, we will accomplish:

- Identifying the key personnel and contacts in the Finance Department and other departments.
- Identify the Commission's significant classes of transactions and business processes.
- Obtain an understanding of audit risk areas.
- Developing an understanding of unusual transactions or events that have occurred during the fiscal year.
- Formalizing logistics.
- Finalizing the timeframes for interim fieldwork.

Stage 2, Risk Assessment

Based upon the information obtained in the planning meetings VTD will perform a risk assessment as required by Statements on Auditing Standards (SAS) to be used in the preparation of the overall audit plan.

Stage 3, Preparation of the Overall Audit Plan

Once the planning and risk assessment process are complete an overall audit plan will be prepared. The plan will specify each audit task, staffing assignments, timelines, and due dates. The plan will also break down the work assignments between interim and final audit timelines. The audit plan will include the transaction cycles which have been selected for internal control testing and those for which only the detailed walk through will be performed.

Stage 4, the Interim Audit

The specific dates will be determined during the planning meeting and preparation of the audit plan process. Our interim work will include the following:

1. Defining the Commission's objectives and strategies and related business risks.
2. Obtaining an understanding of the Commission's internal control environment (tone at the top):
   - Communication and enforcement of integrity and ethical values
   - Commitment to competence
   - Participation of those charged with governance
   - Management's philosophy and operation style
   - Organizational structure
   - Assignment of authority and responsibility
   - Human resource policies and practices
3. Reviewing the Commission's risk assessment process.
4. Understanding the internal control communication process.
5. Understanding the internal control monitoring process.
6. Testing compliance with the *Standards and Procedures for Audits of Local Entities Administering the California Children and Families Act*, issued by the California State Controller's Office.

Section 2 – Description of Services

B. Our Proposed Audit Approach/Plan, (Continued)

Stage 5, the Final Audit

We will commence our final fieldwork as soon as the Commission has sufficiently closed their accounting records.

During this phase, we will perform substantive audit procedures on the year-end statement of net position, fund balances, revenue and expenditure/expense accounts. We will use a variety of audit procedures which may include outside confirmations, statistical sampling, detailed testing of schedules, analytical review, inquiry, and observation.

Stage 6, the Reporting Phase

At the end of the audit process we will meet with key staff to cover the following:

- Discuss improvements for subsequent years audit plan,
- Meet with the appropriate level of management to present the results of the audit,
- Communicate with those charged with Governance.

Communication

We do not believe in surprises. Although the reporting phase involves a recap of the process we will be in constant communication regarding each aspect of the audit throughout the entire process. You will not have any surprises at the end of the audit.

Management letters

The results of our understanding of internal control serve as a basis for our recommendations to management. We also consider any weaknesses noted during our substantive testing and other audit procedures. Upon completion of the audit, the findings and recommendations we consider to be of value to you are summarized and presented as management comments.

We will meet with management to discuss these comments prior to finalizing the letter to ensure that our management letter will contain no surprises. The purpose of our management comments is to direct your attention to:

- Significant deficiencies and material weaknesses (if any) identified during the course of the audit. Auditing Standards require written communication to management and those charged with governance, of significant deficiencies or material weaknesses, identified during the audit.
- Other matters that we believe to be of potential benefit to the management of the City, such as recommendations for operational or administrative efficiency, or for improving existing internal controls.

In our view, management letters can serve the Commission on two distinct levels. The first is when we, the auditors, determine that there are material deficiencies in internal controls. These should be communicated at once to the highest level of management so that corrective action can be taken. The other level is the more routine operational improvement and control enhancement comments which are communicated to management on a timely basis such that appropriate action can be taken.

Section 2 – Description of Services

C. Work Timeline

Audit Milestones	Audit of Financial Statements
Planning Meeting (Stage 1)	March - April
Audit Planning (Stage 2)	April - May
Interim Fieldwork (Stage 3)	June - July
Fiscal Year-End Work (Stage 4)	August - September
Deliver Draft Auditors' Report (Stage 5)	September 30, 2016
Deliver Final Reports (Stage 6)	October 7, 2016

D. Subcontractors

Based upon the experience of our Team that we have assigned to this engagement VTD will not be using subcontractors to assist with this project.

E. Sample Invoice

VTD prepares invoices on a monthly basis based on the time incurred in a format that is customary. VTD maintains the ability to prepare invoices in the format necessary for the Commission.

F. License to Practice in California

VTD is licensed to practice public accounting in the State of California and has complied with all applicable California State Board of Accountancy requirements. In addition, all of the key professional staff that will be assigned to the audit are also licensed to practice in the State of California and have complied with all applicable State Board of Accountancy standards.

G. Independence

VTD independent of the Commission as defined by auditing standards generally accepted in the United States of America and the U.S. General Accounting Office's Governmental Auditing Standards.

The firm will not enter into any relationships that would impair our independence during the term of the contract if awarded.

H. Descriptions of work performed for other First 5 Commissions

VTD has provided similar audit services for several other jurisdictions similar to that which is requested by the Commission. We have provided a listing of Commissions with the various types of services performed for each. Please refer to "Section 5 – References" starting on page 18 of this proposal.

AGENDA ITEM 3
DECEMBER 20, 2017

Subject	Annual Audit for Fiscal Year 2016-2017
Recommendations	Conduct Public Hearing for the Children and Families Commission of San Bernardino County Annual Audit for Fiscal Year 2016-2017. (Presenter: Debora Dickerson-Sims, Administrative Supervisor II, 252-4269)
Financial Impact	None
Background Information	The California Children and Families Act of 1998 ("Act") was passed as Proposition 10 by California voters in November 1998 and enacted by the State Legislature through California Health and Safety Code Sections 130100-130155 and Revenue and Taxation Code Section 30131. Section 130150 of the Act requires every County Commission, on or before October 15th of each year, to "conduct an audit of, and issue a written report on the implementation and performance of, its functions during the preceding fiscal year." Section 130140 (a) (1) (G) additionally requires the County Commission to "conduct at least one public hearing prior to adopting any annual audit …". Vavrinek, Trine, Day & Co. LLP (VTD) conducted an audit of the First 5 San Bernardino Commission encapsulating all fiscal activity of the Commission for Fiscal Year 2016-2017 and developed an audit report as required by Section 130150. Audit findings, if applicable, will include auditor's recommendation and First 5 staff's response to the findings.
Review	Sophie Akins, Commission Counsel

Report on Action as taken	
Action:	
Moved:	**Second:**
In Favor:	
Opposed:	
Abstained:	
Comments:	
Witnessed:	

AGENDA ITEM 4
DECEMBER 20, 2017

Subject	Annual Report for Fiscal Year 2016-2017
Recommendations	Conduct Public Hearing of the Children and Families Commission for San Bernardino County's Annual Report for Fiscal Year 2016-2017. (Presenter: Scott McGrath Supervisor, 252-4259)
Financial Impact	None
Background Information	The California Children and Families Act of 1998 ("Act") was passed as Proposition 10 by California voters in November 1998 and enacted by the State Legislature through California Health and Safety Code Sections 130100 -130155 and Revenue and Taxation Code Section 30131. Section 130150 of the Act requires every County Commission, on or before November 1st of each year, to submit to the state commission its audit and written report on the "implementation and performance of, its functions during the preceding fiscal year." Section 130140 (a) (1) (G) additionally requires the County Commission to "conduct at least one public hearing prior to adopting any . . . report". The 2016-2017 Annual Report has been compiled and includes number of children and families served, priorities, activities, program highlights and overall accomplishments. The report also includes program and fiscal information and an analysis of services delivered based on the State's Desired Results Areas – Improved Family Functioning, Improved Child Development, Improved Health and Improved Systems of Care.
Review	Sophie Akins, Commission Counsel

Report on Action as taken	
Action:	
Moved:	**Second:**
In Favor:	
Opposed:	
Abstained:	
Comments:	
Witnessed:	

AGENDA ITEM 5
DECEMBER 20, 2017

Subject	Dental Transformation Initiative – Local Dental Pilot Project Funding
Recommendations	Authorize First 5 San Bernardino (F5SB) as a Co-Lead to enter into Contract 188800 LDP with First 5 Riverside (F5R) (Lead) to receive Dental Transformation Initiative – Local Dental Pilot Project funding from F5R to improve dental services in the Inland Empire region strengthening the child health system for Fiscal Years 2017 – 2020. (Presenter: Mary Jaquish, Program Supervisor, 252-4254)
Financial Impact	$1,021,119 for Fiscal Years 2017-2020.
Background Information	On June 1, 2016, the California Department of Health Care Services (DHCS) released the Dental Transformation Initiative (DTI) grant opportunity to increase dental care for Medi-Cal recipients. The goals of the DHCS, through this funding opportunity address the following domains: 1) increase dental prevention services; 2) incorporate caries risk assessment and disease management; 3) establish continuity of care among Medi-Cal children and 4) present projects to include innovative interventions and/or strategies that, when shown successful, could be implemented or scaled statewide. On September 7, 2016, the Commission authorized the F5SB Executive Director to negotiate and submit a joint proposal with F5R for the Dental Transformation Initiative – Local Dental Pilot Project, using a collaborative and regional approach, by utilizing existing resources, partners and providers. F5SB and F5R elected to apply for Domain 4 of the funding. The funding for each LDPP was awarded based upon the LDPP application cost allocations, comparisons to similarly size pilot projects, target population demographics, project designs, and an assessment of available funding relative to the number of applications received. F5R and F5SB applied for and were successful in the application for a total funded amount of $12,114,979. Although F5R and F5SB applied together as co-leads, the State is not set up to award and communicate with more than one entity for a grant funded project, so F5R has been designated the Lead. As a Co-Lead for LDPP-IE, F5SB will retain a great deal of responsibility in implementation of the pilot project. Per Contract 188800 LDP and the Scope of Work (Attachment A), the allocation for F5SB is $1,021,119 for Fiscal Years 2017-2020. Pending Commission approval, this contract will allow F5SB to dedicate staff positions to ensure goals within the LDPP-IE Scope of Work are met. Identified staff include an accountant, contract analyst, data analyst and a portion of supervisory oversight. In addition, operational costs incurred by this project will be reimbursed through this contract. F5R and F5SB formed a consortium of key stakeholders to develop a regional dental pilot project to integrate and coordinate innovative oral health interventions by creating an integrated system involving community health centers, early care and education centers, schools, and home visitors. Using a collective impact approach, the LDPP-IE will lead to systems change in the region creating an

integrated oral health system of care.

The LDPP-IE project will test and implement two community-based strategies. The primary strategy is the implementation of the Virtual Dental Home (VDH) through ten (10) community health clinics to expand dental services in community settings. VDH oral health delivery system provides risk based preventative and early intervention therapeutic services in community settings such as schools and preschool sites where there is no dental care. It utilizes tele-health technology connecting a dentist in a community clinic to allied dental personnel, which includes a hygienist providing education, triage, case management, preventative procedures, and Interim Therapeutic Restorations (ITR). When complex dental treatment is required, the VDH connects patients through care coordination efforts back to the community clinic.

The second strategy is to create, test, and implement an Early Childhood Oral Health Assessment (ECHOA) for non-dental providers to screen children for risk of oral health disease in community settings resulting in the establishment of dental homes.

There are 38 agencies agreeing to participate in the LDPP-IE project (Pages 4-8 of LDPP Application). Twenty-three (23) are supporting agencies, fourteen (14) are sub-contractor agencies and 1 vendor, Riverside-San Bernardino County Indian Health, Incorporated who will be paid per performance utilizing the ECHOA risk assessment tool. The LDPP-IE builds upon long standing commitments to children's oral health and strengthens the capacity of community partners both in funded and unfunded roles.

The following agencies are participating sub-contractors who will provide services through the LDPP-IE funded pilot project (Page 54 of LDPP Application):

1) The Children's Partnership - $104,651
2) University of the Pacific - $925,509
3) Center for Oral Health - $431,813
4) Social Interest Solutions - $340,108
5) SAC Health Systems - $1,516,599
6) Park Tree Community Health Center - $409,625
7) Borrego Community Health Foundation - $1,365,619
8) Bear Valley Community Healthcare District - $304,080
9) Vista Community Clinic - $743,283
10) Riverside University Health Systems, Medical Services Office - $309,591
11) North County Health System - $626,895
12) Neighborhood Health Clinic - $513,562
13) Clinicas De Salud - $233,130
14) Morongo Basin Healthcare District - $531,720

Pending Commission approval, F5SB together with F5R will ensure needed resources are available that address families' socio-economic and cultural barriers. Through this innovative partnership, the region will be in a better position build upon existing resources and improve children's oral health outcomes.

	As per our Strategic Plan, SPA 2: Systems and Networks, F5SB is providing leadership in the development of this DTI-LDPP – a system that supports children prenatal through age 5 and results in sustainable and collective impact of health services for children.
Review	Sophie Akins, Commission Counsel

Report on Action as taken	
Action:	
Moved:	**Second:**
In Favor:	
Opposed:	
Abstained:	
Comments:	
Witnessed:	

CONTRACTOR AGENCY CONTACT INFORMATION

Instructions:
1) Complete one form for **EACH** First 5 Riverside Contract; **2)** Form **MUST** be submitted with signed contract; **3)** Form **MUST** be updated and resubmitted to First 5 Riverside **whenever** the program makes changes to the address or personnel listed on this document.

Effective Date	12/01/17	**First 5 Contract #**	18800DTI
Agency Name	First 5 San Bernardino		

Preferred Mailing Address for CONTRACTS and CONTRACT CORRESPONDENCE:

Street Address or PO Box	City	State	Zip
735 East Carnegie Drive, Ste. 150	San Bernardino	CA	92408

Attn	Mary Jaquish	**Title**	Program Supervisor	**Email**	mjaquish@cfc.sbcounty.gov
Agency Telephone #	(909) 252-4254			**Agency Fax #**	(909) 386-7703

Preferred Mailing Address for CONTRACTS PAYMENTS (if different than above):

Street Address or PO Box	City	State	Zip
Same as above			

Agency's Funded Program Site Address(es)
(Attach additional sheets as necessary for multiple site addresses)

Location Name	First 5 San Bernardino		
Street Address (no PO Box)	**City**	**State**	**Zip**
735 East Carnegie Drive, Ste. 150	San Bernardino	CA	92408

Location Name			
Street Address or PO Box	**City**	**State**	**Zip**

Executive Director: (and/or individual AUTHORIZED to execute contracts)

Name	Title	Telephone Number	Email address
Karen Scottt	Executive Director	(909) 252-4251	kscott@cfc.sbcounty.gov

Other Authorized:

Name	Title	Telephone Number	Email address
Cindy Faulkner	Operations Manager	(909) 252-4253	cfaulkner@cfc.sbcounty.gov

Agency Staff Contact Information

Program Manager (will have PERSIMMONY access and must complete a separate PERSIMMONY user form)

Name	Title	Telephone Number	Email address

Program Data Entry Person (will have PERSIMMONY access and must complete a separate PERSIMMONY user form)

Name	Title	Telephone Number	Email address
Scott McGrath	Evaluation Supervisor	(909) 252-4259	smcgrath@cfc.sbcounty.gov

Fiscal Data Entry Person (will have PERSIMMONY access and must complete a separate PERSIMMONY user form)

Name	Title	Telephone Number	Email address
Debora Dickerson	Administrative Supervisor II	(909) 252-4269	Debora.Dickerson-Sims@cfc.sbcounty.gov

Fiscal Accountant (will NOT have PERSIMMONY access)

Name	Title	Telephone Number	Email address

Special Instructions:
(Complete this section ONLY if there are additional communication channels other than those noted above)

Name	Title	Telephone Number	Email address

RIVERSIDE COUNTY CHILDREN AND FAMILIES COMMISSION
CONTRACT
INVESTMENT OF FUNDS
Local Dental Pilot Project – Inland Empire
585 Technology Court
Riverside, California 92507

COMMISSION AWARD:	**18800 LDP**
CONTRACTOR:	**Children and Families Commission for San Bernardino County (First 5 San Bernardino)**
CONTRACT TERM:	**12/01/2017 – 12/31/2020**
MAXIMUM REIMBURSABLE AMOUNT:	**$1,021,119.00**

The CONTRACTOR designated above is hereby certified for an investment of funds in an amount not to exceed the amount listed above.

Compensation: The maximum reimbursable amount over the life of the Contract for Investment of Funds (hereinafter the "Contract") is **$1,021,119.00** as awarded by the Riverside County Children and Families Commission (COMMISSION), also known as First 5 Riverside, provided pursuant to the Department of Health Care Services (DHCS), Contract No. 16-93569, to provide services and results as set forth in Attachments A, through I attached hereto as incorporated herein by reference, subject to the following terms and conditions:

IN WITNESS, WHEREOF, Commission and CONTRACTOR have executed this Contract.

Authorized Signature for Commission:	**Authorized Signature for CONTRACTOR:**
Printed Name of Person Signing: Tammi Graham	Printed Name of Person Signing:
Title: Executive Director	Title: Commission Chair
Address: 585 Technology Court Riverside, CA 92507-2423	Address: 735 E. Carnegie Drive, Suite 150 San Bernardino, CA 92408
Date:	Date:
Attest:	Attest:
Name and Title: Lynn M. Stephens Commission Coordinator	Date:

RIVERSIDE COUNTY CHILDREN AND FAMILIES COMMISSION

Local Dental Pilot Project – Inland Empire

CONTRACT TERMS AND CONDITIONS

Contents

Followed by:

Terms and Conditions

1. NOTICES

All correspondence and notices required or contemplated by this Contract shall be delivered to the respective parties at the addresses set forth below and are deemed submitted one day after their deposit in the United States mail, postage prepaid:

COMMISSION:	CONTRACTOR:
Tammi Graham, Executive Director First 5 Riverside 585 Technology Court Riverside, California 92507	Karen Scott, Executive Director Children and Families Commission for San Bernardino County (First 5 San Bernardino) 735 E. Carnegie Drive, Suite 150 San Bernardino, CA 92408

Or to such other addresses as the parties may hereafter designate in writing.

2. SOURCE AND SCOPE OF CONTRACT

A. This Contract award is valid and enforceable only if sufficient funds are available to the COMMISSION from DHCS (Contract No. 16-93569) for the total term of the Contract. It is mutually agreed that if the State does not appropriate sufficient DHCS funds, this Contract shall be amended to reflect any reduction in funds.

B. In addition, this Contract is subject to any additional restrictions, limitations, or conditions enacted by the State of California, which may affect the provisions, terms, or funding of this Contract in any manner.

C. This Contract award is designated for an investment of funds to provide Health, Education, Child Care services or System Change in accordance with the current Commission Strategic Plan. Services are to be provided to benefit individuals 0-20 years of age (may also be abbreviated as “0-20”) who reside in Riverside or San Bernardino County.

3. DEFINITIONS

The following are terminology included within the Terms and Conditions of the Contract and defined by the Riverside County Children & Families Commission as stated below:

Commission: The Riverside County Children & Families Commission, an assembly of Commissioners, appointed by the Riverside County Board of Supervisors and responsible for establishing policy and directing Proposition 10 and Dental Transition Initiative funds at the county level. For purposes of this Contract, the COMMISSION administers the Dental Transformation Initiative funds for Riverside and San Bernardino Counties.

Contractor: The government or other legal entity to which a contract is awarded and which shall be accountable to the COMMISSION for the use of funds provided.

County: The Riverside County Children & Families Commission, the County of Riverside, its agencies, districts, special districts and departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives.

Data Management System: An online data management system used to collect and analyze client demographics, services and target accomplishments.

Executive Director: The designated lead director of the COMMISSION or his or her designee.

Fiscal Year: The fiscal year for the terms under this Contract are from January 1 through December 31.

Performance Target: The specific results that a CONTRACTOR will commit to achieve. CONTRACTOR will be contractually responsible to achieve these specific targets as outlined in Scope of Work (SOW), (See Attachment A).

Performance Target Accomplishment Schedule: The specific timeline that a CONTRACTOR will commit to adhere to, (See Attachment A).

Probationary Status: CONTRACTOR is given notice of non-compliance and, after failure to correct deficiencies, has been placed in a status that may require additional monitoring, announced and unannounced visits, additional reporting by CONTRACTOR, an evaluation by Commission staff and a report to the COMMISSION inclusive of recommendations regarding the disposition of the Contract.

Scope of Work (SOW): A documented qualitative and quantitative description of the project's deliverables (i.e. what the CONTRACTOR is funded to do), (See Attachment A).

Please see Attachment E for additional LDPP-IE specific definitions.

4. TERM

The term of this Contract shall be from **12/01/2017** through **12/31/2020** unless sooner terminated by the provisions herein by either party. Funds shall not be automatically renewed by the COMMISSION upon or after the term of the Contract except by formal amendment approved by the COMMISSION.

5. COMPLIANCE, DISALLOWANCE, WITHHOLDING

If CONTRACTOR fails to comply with any conditions contained within this Contract, the COMMISSION may place the CONTRACTOR in a probationary status, temporarily withhold payments until the deficiency is corrected, deny funds for all or part of the cost of activity not in compliance, and/or request repayment to the COMMISSION if any disallowance is rendered after audit findings. Written notification of non-compliance will be sent to the identified contact person and the CONTRACTOR's executive director or other lead staff authorized by the CONTRACTOR's governing board or ownership within twenty (20) working days.

6. TERMINATION

A. By Commission: The COMMISSION may, by written notice to CONTRACTOR terminate this Contract in whole or in part at any time for the reasons as set forth below. Upon receipt of notice, CONTRACTOR shall immediately discontinue all services affected (unless the notice directs otherwise).

1. Termination for cause:

a. Due to Default or Breach of Contract. Upon default by the CONTRACTOR in the performance of this Contract or material breach of any of its provisions which include but are not limited to; change in status or delegation, assignment or alteration of the services outlined in Attachment A of this Contract, the COMMISSION may immediately terminate this Contract by written notice, which shall be effective upon receipt by CONTRACTOR, unless Commission provides CONTRACTOR the opportunity to cure breach within twenty (20) working days of receipt of notice, and CONTRACTOR does so to Commission's satisfaction.

b. Due to Health and Safety Concerns of Clients. The COMMISSION may immediately terminate this Contract, at the sole discretion of the COMMISSION when the CONTRACTOR has been accused and found to be in violation of any county, state,

or federal law and/or regulation related to the health and safety of clients. Contract may also be immediately terminated at the sole discretion of the COMMISSION if the CONTRACTOR fails to provide for the health and safety of clients served under this Contract where the health and safety of clients are placed at risk by CONTRACTOR.

c. Due to Non-Appropriation. It is mutually agreed that if either the federal or state budget of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the COMMISSION shall have no liability to pay any funds whatsoever to the CONTRACTOR or to furnish any other considerations under this Agreement and CONTRACTOR shall not be obligated to perform any provisions of this Agreement. If funding for any fiscal year is reduced or deleted by the federal or state budgetary process for purposes of this program, the COMMISSION shall have the option to either cancel this Agreement with no liability occurring to the COMMISSION, or offer an agreement amendment to CONTRACTOR to reflect the reduced amount.

d. Due to Non-Compliance. Termination may occur if CONTRACTOR fails to provide the COMMISSION with any reports, data and/or information as required in this Contract. CONTRACTOR may be placed in a probationary status until compliance with the terms of the Contract has been met. CONTRACTOR will be given thirty (30) calendar days to cure the deficiency. If compliance is not met within the thirty (30) calendar days, the COMMISSION may move forward with termination of the Contract.

B. By CONTRACTOR: CONTRACTOR may terminate this Contract in whole or in part upon thirty (30) calendar days written notice to the COMMISSION.

7. REQUIREMENT OF SUPPLEMENTING PROGRAM

Funds received pursuant to this Contract shall not be used to supplant any program of the CONTRACTOR. DHCS Funds shall ONLY be used to supplement a CONTRACTOR's program. The COMMISSION endorses the California Children and Families Commission's interpretation of supplanting: The definition of "supplement" is to add to or augment something that currently exists, while "supplant" is defined as taking the place of something currently in existence. As defined in Health and Safety Code sections 130100 et seq., all monies raised shall be appropriated and expended by CONTRACTOR only to supplement existing levels of services.

8. DATA MANAGEMENT

CONTRACTOR agrees to participate in a comprehensive, internet-based evaluation and management process as defined by the COMMISSION. Participation shall include, but is not limited to, monthly input of program and financial data, submission of quarterly and annual Program Progress Reports, utilization of the COMMISSION developed reporting systems and Administrative Review formats and required training to familiarize and implement the results-based accountability framework.

The COMMISSION continues to refine its evaluative processes that will assist the COMMISSION, its CONTRACTORS and the community to successfully increase and measure the impact of the Dental Transformation Initiative in Riverside and San Bernardino Counties. Where appropriate, CONTRACTOR agrees to participate in the ongoing development of these evaluative processes. Specific areas may include, but are not limited to, the development of outcomes for programmatic performance, standards for service delivery and assessment tools.

9. SCOPE OF WORK (SOW)

A. CONTRACTOR will be required to submit and adhere to a Scope of Work (SOW) approved by as Attachment A to this Contract. The SOW will accurately reflect measurable results of services provided through DHCS funding. The SOW will provide a qualitative and quantitative description of the program(s) objectives to be achieved in connection with DHCS funding.

B. SOW revisions that are considered relatively minor adjustments that do not affect the overall deliverables of this Contract shall be accepted for consideration in the month of July of each fiscal year. Requests for these types of SOW adjustments must be submitted to the COMMISSION office in writing or via e-mail and shall not be implemented by CONTRACTOR prior to receipt of written approval from authorized Commission personnel. Upon approval, CONTRACTOR will receive either written or e-mail verification from the COMMISSION Executive Director (or designee).

SOW revisions that are considered significant changes to Program Performance Targets and affect the overall deliverables of this Contract include the following: changes that result in the type or number of customers served, new staff positions or major staff changes, or significant changes in the Performance Targets. Requests for these types of SOW changes shall be accepted for consideration one time each fiscal year during the month of July. SOW revisions shall be submitted to the COMMISSION Executive Director (or designee), via the COMMISSION's contract analyst assigned to the CONTRACTOR. The COMMISSION Executive Director (or designee) will respond to the proposed request for SOW revisions within thirty (30) calendar days after receipt at the COMMISSION office. Final approval of any proposed revisions to the SOW shall require the written approval of the COMMISSION Executive Director (or designee) and DHCS. All changes will be incorporated into the Contract and shall become effective on the date of written approval from the COMMISSION Executive Director and/or the COMMISSION and DHCS.

C. CONTRACTOR agrees to obtain consent using the COMMISSION Consent Form for any customer information entered into the data management system. CONTRACTOR also agrees to maintain the original signed Consent Form on file for the COMMISSION to review as necessary. Each customer is to receive a copy of the signed Consent Form.

10. REIMBURSEMENT OF COSTS

Payment will not be provided for services performed and/or expenditures accrued prior to the full execution of this Contract unless previously authorized by COMMISSION action. Reimbursement of costs shall be made upon CONTRACTOR's satisfactory performance, based upon the Scope of Work (Attachment A) and methodology contained in Attachment A as determined by the COMMISSION. The COMMISSION shall allocate the funds to CONTRACTOR as follows:

A. All funds provided pursuant to this Contract shall be expended by CONTRACTOR in accordance with the budget, as set forth in Attachment B hereto.

B. All funds will be distributed as detailed in the Payment Provisions, as set forth in Attachment C hereto.

11. FISCAL AND PROGRAM REPORTING REQUIREMENTS

A. Fiscal Reporting

Fiscal expenditures are required to be input into the Data Management System on a monthly basis and input must be completed by the 15th of the month following contract performance. CONTRACTOR is required to report expenditures on a monthly basis and apply accruals at year end. Accruals show costs for services that have occurred but have not yet been paid. If the reporting due date falls on a weekend or County, State or nationally recognized holiday, the due date will be on the following business day. Any changes that occur with expenditures must be reported to Commission staff and adjusted within the data management system before

the end of the Quarter following the expense occurrence. Example: Changes to expenditures in the first quarter of performance must be adjusted and reconciled before the end of the 2nd quarter (December 31, as reported in the January 31 report). **A change in CONTRACTOR staff, or other difficulties, does not absolve the CONTRACTOR from this monthly fiscal reporting responsibility.**

In rare and justifiable circumstances, an extension may be requested by the CONTRACTOR. Such requests are to be submitted in writing prior to the due date and shall be directed through the COMMISSION's contract analyst assigned to the CONTRACTOR.

If applicable, CONTRACTOR shall provide copies of the claim report submitted monthly for Medi-Cal and/or any other state or federal reimbursements. In addition, the CONTRACTOR will provide the subsequent revenue reports that will reconcile the claim reports.

Costs may be allowed and reviewed for reimbursement up to the time of the Final Fiscal Expenditure Report, which is due January 15th. All reimbursement costs not submitted by January 15th will be disallowed.

Payment information, including amount, payment reduction or payment withheld may be obtained by the CONTRACTOR via the data management system. Changes in the mailing address or remit to address must be submitted in writing on CONTRACTOR letterhead and signed by an authorized representative.

B. **Program Reporting**

Program data must be entered on a monthly basis and input must be completed by the 15th of the following month. If the reporting due date falls on a weekend or holiday, the due date will be on the following business day. Additionally, Quarterly Program Progress Reports must be submitted to the COMMISSION within thirty (30) calendar days after the end of the quarter. Any changes that occur with program data input must be reported to COMMISSION staff and adjusted within the data management system before the end of the Quarter following the change. Example: Changes to program data in the first quarter must be adjusted and reconciled before the end of the 2nd quarter. **A change in contract staff, or other difficulties, does not absolve the CONTRACTOR from this monthly program data input and quarterly Program reporting responsibility.**

In rare and justifiable circumstances, an extension may be requested by the CONTRACTOR. Such requests are to be submitted in writing prior to the due date and shall be directed through the COMMISSION's contract analyst assigned to the CONTRACTOR.

Quarterly Program Reporting due dates for each Contract period:

- QUARTER 1 ending March 31: Report Due April 30
- QUARTER 2 ending June 30: Report Due July 31
- QUARTER 3 ending September 30: Report Due October 31:
- QUARTER 4 ending December 31: Report Due January 31 (Final Cumulative Program Progress Report)

If the due date falls on a weekend or County, State or nationally recognized holiday, the due date will be on the following business day. The first quarterly report is due **April 30, 2018**.

12. REIMBURSEMENT OF FUNDS TO THE COMMISSION

If CONTRACTOR has been overpaid in the previous fiscal year, the COMMISSION will, in instances where the Contract is renewed, reduce subsequent payment(s) to recover the amount overpaid.

Notwithstanding any other provision herein, CONTRACTOR agrees to reimburse, in full, any and all funds received from the COMMISSION, upon request of the COMMISSION, where such funds as determined by the COMMISSION are not, or have not been utilized by CONTRACTOR for their purpose as intended by the COMMISSION. The terms and conditions of reimbursement shall be at the sole discretion of the COMMISSION. This provision is not terminated upon termination of this Contract.

13. COMMISSION FISCAL REQUIREMENTS

A. Budget Revisions

Budget revisions are requests to transfer funds from one approved budget category to another. The Executive Director, or designee, will accept proposed budget revisions along with written justification from CONTRACTOR during the month of July of each fiscal year. Any unused funding from each fiscal year within the Contract Term may be considered for "roll over" into the next fiscal year for allowable and preapproved budget revisions, contingent on approval of the COMMISSION Executive Director (or designee) and DHCS. The COMMISSION Executive Director (or designee), will respond to budget revisions within thirty (30) calendar days after receipt at the COMMISSION office.

B. Amendments

Necessity for budget amendments to this Contract will be determined by the COMMISSION Executive Director (or designee) and/or DHCS, and may include, but are not limited to contract increases or decreases and significant changes to the Scope of Work (SOW). All budget amendments to the Contract shall require formal approval of the COMMISSION Executive Director acting on behalf of the COMMISSION, as provided herein, before they are effective. Major budget amendments, as determined by the COMMISSION Executive Director, in consultation with County legal counsel and approved by DHCS, may require formal approval of the COMMISSION. Contract budget amendments will be considered until July 31 of each fiscal year.

D. Cost Allocation

CONTRACTOR shall have or establish a cost allocation plan to identify prorated costs shared by multiple funding sources, including DHCS funds. CONTRACTOR shall identify any other funding sources and organizations whose cooperation/participation is necessary to ensure the success of the project. CONTRACTOR's Cost Allocation Plan must be approved by CONTRACTOR's appropriate governing body and submitted with the executed Contract.

A Cost Allocation Plan (CAP) is defined as a written summarization that documents the methods and procedures that the CONTRACTOR will use to allocate costs between two or more programs or funding sources. The goal is to ensure that each program or funding source bears its fair share, and only its fair share, of the total costs. The CONTRACTOR must have a method of identifying and distributing program costs that are comprehensive, well documented, and defensible under the Generally Accepted Accounting Principles (GAAP).

A written CAP is required if <u>any</u> of the conditions below are met:

- Funded staff members share their time between a First 5 Commission funded program and one or more other grant funded programs.
- A single-funded staff member shares their time between two or more First 5 Commission funded programs.
- The same facilities and/or resources are utilized by more than one funded program.

E. Overhead/Indirect Costs

1. Overhead/Indirect costs are defined as costs incurred for a common or joint purpose benefiting more than one cost objective and cannot be readily identified with a particular final cost objective. These costs do not provide a measurable, direct benefit to a particular program or activity, unlike direct costs. Indirect cost percentage rate is based on salaries only..

2. Indirect costs shall be based on the CONTRACTOR's official governing board approved Cost Allocation Plan. State/federal approved rates in excess of the approved twenty percent (20%) indirect cost rate percentage will be reviewed and approved on a case-by-case basis.

F. Revenues Received

Any and all revenue received by the CONTRACTOR (except funds received from the COMMISSION) to operate the program funded pursuant to this Contract shall be reported as revenue received within the monthly fiscal report. All such revenues shall be used to fully compensate expenses within the program funded and/or to provide additional services within the program funded pursuant to this Contract. Any unused revenues shall be deducted from Contract reimbursement.

G. Payroll Taxes

The COMMISSION shall not be directly responsible for the payment of any taxes on the CONTRACTOR's behalf. In the event that the COMMISSION is required to do so by state, federal or local taxing agencies, CONTRACTOR agrees to promptly reimburse the COMMISSION for the full value of such paid taxes plus interest and penalty, if any. These taxes shall include, but are not limited to the following: FICA (Social Security), unemployment insurance contributions, income tax, disability insurance and workers' compensation insurance.

14. CONTRACTOR AUDIT REQUIREMENTS

A. All CONTRACTORS are required to have an annual financial audit. Each CONTRACTOR shall provide a copy of their annual audited financial statements to the COMMISSION, covering the fiscal year that funds are received for services provided pursuant to this Contract. The audited financial statements will cover the CONTRACTOR's fiscal year and will include a statement of internal controls over financial reporting and on compliance and other matters in accordance with general accepted auditing standards (GAAS). All audits shall be performed by a Certified Public Accountant (CPA) who possesses a valid license to practice within the State of California.

B. Audited financial statements are to be submitted to the Executive Director, or designee, within one hundred and eighty (180) calendar days after the close of the CONTRACTOR's fiscal year for every year covered under this Contract. If the audited financial statements are not received on or before the required due date and an extension has not been granted, the audited financial statements shall be considered delinquent and immediate corrective action is required. If the CONTRACTOR fails to produce or submit acceptable audited financial statements, the COMMISSION has the authority to withhold funding, and if necessary, secure an Auditor, and the CONTRACTOR shall be liable for all Commission costs incurred in obtaining an independent audit. The cost of the audit will be applied against the Contract encumbered amount, thereby reducing the amount of funding available to the program.

15. INVENTORIABLE EQUIPMENT

A. Inventoriable equipment includes equipment/fixed assets with a unit cost of one thousand dollars ($1000) or more or if the aggregate cost of integral components required to fully operate the assembled equipment (i.e. computer processing unit, keyboard, monitor) total one

thousand dollars ($1,000) or more. Inventoriable equipment derived from approved purchases funded by DHCS funds shall be maintained by the CONTRACTOR. CONTRACTOR shall use such capitalized equipment only for the purposes for which they were granted for children 0-20 years of age.

B. The CONTRACTOR shall inventory and report any and all equipment purchases meeting this criterion, on the COMMISSION Inventory Record Form. This record must be submitted within forty-five (45) calendar days of purchase to the COMMISSION's contract analyst assigned to the CONTRACTOR. Applicable receipts must be maintained by the CONTRACTOR to validate expenditures and shall be submitted as invoice back-up documentation and uploaded to the data management system, and made available as requested during the COMMISSION Administrative review. It is understood that the CONTRACTOR is liable for any/all liability and damages resulting from the use and/or misuse of equipment purchased with DHCS funds. Equipment shall not be used for personal use by the CONTRACTOR, and/or their employees, agents, subcontractors and/or collaborating partners.

C. Any remaining non-inventoriable items, material and supplies with a value of less than one thousand dollars ($1000) will be used for individuals ages 0-20 years of age by a program serving this population, or returned to the COMMISSION. If Contractor is no longer serving this population, all remaining items will be returned to the COMMISSION within thirty (30) calendar days of the program ceasing operations.

16. REVERSION OF ASSETS

Real or Personal Property Assets. Any real property or moveable or immovable personal property under CONTRACTOR's control or ownership that was acquired or improved in whole or in part with DHCS funds disbursed under this Contract, or under any previous Contract between the COMMISSION and CONTRACTOR, where the original cost exceeded one thousand dollars ($1,000.00) shall either be: (1) used by CONTRACTOR for the services described in the Scope of Work (Attachment A) for a period of five (5) years after termination or expiration of this Contract, unless a different period is specified in the Scope of Work (Attachment A); or (2) disposed of and proceeds paid to the Commission in a manner that results in the COMMISSION being reimbursed in the amount of the current fair market value (assuming depreciation in accordance with customary business practices) of the real or personal property less any portion of the current value attributable to CONTRACTOR's out of pocket expenditures using non-commission funds for acquisition of, or improvement to, such real or personal property and less any direct and reasonable costs of disposition.

A. In furtherance of the foregoing, if the COMMISSION selects continued use of the capital asset, the CONTRACTOR hereby agrees that it will confirm in writing that it will continue to use the capital asset for purposes congruent with the intent of the this Contract. This provision shall survive the termination or expiration of this Contract and shall be actionable by law or in equity by the COMMISSION against CONTRACTOR and its successors in interest.

B. In the event the COMMISSION selects disposition of the subject real or personal property, the CONTRACTOR shall exercise due diligence to dispose of such property in conformity with applicable laws and regulations and in accordance with customary business practices. The net proceeds of such disposition shall be disbursed directly to and be payable to the COMMISSION upon the close of the applicable disposition transaction, such as close of escrow for the sale of real property, transfer of a motor vehicle "Certificate of Title" in accordance with applicable California Vehicle Code requirements, or completion of sale of personal property by bill of sale in accordance with Uniform Commercial Code (UCC) requirements.

17. TOBACCO CONTROL POLICY

CONTRACTOR shall abide by the Comprehensive Tobacco Control Policy, incorporated herein by reference, and as may be amended from time to time. CONTRACTOR shall have tobacco

education and cessation materials visibly available and accessible to clients participants and to staff funded from the COMMISSION funded activities. The Comprehensive Tobacco Control Policy is set forth through Attachment D hereto.

18. CONDUCT OF BUSINESS

CONTRACTOR shall comply with all references listed below. Failure to comply may place the CONTRACTOR in a Probationary Status or result in a Termination of Contract.

A. CONTRACTOR shall be in compliance, and shall remain in compliance with all applicable state and/or federal laws, regulations or requirements during the term of the Contract.

B. CONTRACTOR shall conduct its business, pursuant to this Contract, in compliance with all applicable state, and/or federal laws, regulations or requirements.

C. CONTRACTOR shall obtain and shall maintain all applicable business and/or professional licenses, insurances, and/or accreditations, in good standing, which are required under the laws of the State of California or the federal government at all times while performing services under this Contract.

D. CONTRACTOR shall notify the COMMISSION Executive Director (or designee) verbally and in writing their intent to cease operations of the facility or program within sixty (60) calendar days, but no less than thirty (30) calendar days, of the event.

E. CONTRACTOR shall notify the COMMISSION Executive Director (or designee) in writing within seventy-two (72) hours of a change of key personnel funded under this Contract. Key personnel are defined as individuals who have a direct bearing on the outcome of the project, who have substantive responsibility for developing or achieving the scope or objectives of the project, and who possess the reputation, knowledge, or skills on which the work of the project is based. This includes, but is not limited to the Director, Chief Executive Officer (CEO), Chief Financial Officer (CFO), Program Manager, or Project Lead.

F. CONTRACTOR shall notify the COMMISSION Executive Director (or designee) verbally and in writing of any condition that could interfere with CONTRACTOR's ability to perform required services and/or meet material Contract requirements within thirty (30) calendar days of the learning of such a condition.

G. Agencies that are governed by a regulatory or licensing entity shall advise and forward to the COMMISSION Executive Director any and all documentation of regulatory/licensing violations, findings and responses to such violations and/or findings within twenty-four (24) hours of receipt of notice of violation from the governing entity. Agencies shall promptly submit to Commission Executive Director a copy of the response sent to the governing entity.

H. CONTRACTOR shall immediately notify the COMMISSION upon the intent to file or filing of any action of bankruptcy.

I. CONTRACTOR shall immediately notify the COMMISSION upon the commencement of any litigation, whether CONTRACTOR is the plaintiff or defendant, where such litigation may interfere with the ability of CONTRACTOR to perform its duties under this Contract, and where the COMMISSION is not a party to such litigation.

J. CONTRACTOR shall immediately notify the COMMISSION upon the commencement of any investigation, and/or activity by a regulatory agency against CONTRACTOR, which may interfere with the ability of CONTRACTOR to perform its duties under this Contract.

K. CONTRACTOR shall provide a grievance policy system, approved by the COMMISSION, through which participants of services shall have an opportunity to express their views and

complaints regarding the delivery of service. Grievance procedures must be posted prominently in English and Spanish at service sites for participants to review.

19. RECORDS MANAGEMENT AND MAINTENANCE

A. The CONTRACTOR shall make reports to the COMMISSION in the required format and containing information as required by the COMMISSION.

B. The CONTRACTOR shall provide additional reports or information if required by the State or the local COMMISSION not reasonably anticipated at the time the Contract was entered into.

C. CONTRACTOR shall input all data required on a monthly basis by the 15th day of the month following the end of the reporting period **and** submit quarterly reports within thirty (30) calendar days following the end of the quarter, and at the end of the term of the Contract. This requirement includes:

1. All the monthly data necessary to generate demographic, service utilization, results and aggregate activity reports;

2. Submission of the Program Progress Report on a quarterly basis;

D. CONTRACTOR shall retain such reports, and all records associated with this Contract for at least five (5) years following the close of the fiscal year in which this Contract is in effect. This obligation is not terminated upon termination of this Contract, whether by recessions or otherwise. CONTRACTOR agrees to require any subcontractors to retain all records associated with the Contract for the same time period.

E. Accounting information and transactions shall be recorded and reported in accordance with generally accepted accounting principles (GAAP).

F. Where medical records, and/or client records are generated under this Contract, CONTRACTOR shall safeguard the confidentiality of the records in accordance with all state and federal laws, and all regulations promulgated hereunder, including the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-91, enacted August 21, 1996, and the laws and regulations promulgated subsequent thereto.

G. Each CONTRACTOR must maintain a written customer confidentiality policy and maintain a written protocol to ensure CONTRACTOR staff is aware of and abide by said policy.

20. PUBLIC DISCLOSURE OF DOCUMENTS

CONTRACTOR acknowledges and agrees that information, communications, and documents given by or to the COMMISSION and meetings involving the COMMISSION members, staff, finance or advisory committee members may be subject to applicable law on public disclosures and/or public meetings. CONTRACTOR shall cooperate with the COMMISSION in order that it may fully comply with the requirements of such laws and regulations.

21. INSPECTIONS, PROGRAM MONITORING AND CONTRACT ADMINISTRATIVE REVIEW BY COMMISSION

A. Commission representatives shall review and inspect the CONTRACTOR through mandatory periodic Administrative Review visits for compliance with the terms of this Contract. During the Administrative Review visits, CONTRACTOR representatives from both fiscal and program areas **must** be present. All books, financial records and program records including verification of target(s) and other documents relating to the performance of this Contract must be open to inspection, examination, or copying during normal business hours by the COMMISSION staff or duly authorized representatives from the state or federal government. Records shall be

made available at reasonable times at CONTRACTOR's place of business or at such other mutually agreeable location in the County of Riverside or San Bernardino, State of California.

B. Upon completion of the Program Monitoring and Administrative Review visit, the CONTRACTOR will be mailed a report summarizing the results of the Administrative Review visit within forty-five (45) calendar days of the visit. The CONTRACTOR may be required to respond to concerns or requests as specified in the Administrative Review report within thirty (30) calendar days of receipt.

22. GOVERNING LAW AND VENUE

A. CONTRACTOR agrees to, and shall also require and ensure its subcontractors agree to, comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code, and any applicable rules or regulations promulgated by DHCS pursuant to these chapters. CONTRACTOR agrees to, and shall also require its subcontractors to, comply with all federal laws and regulations governing and regulating the Medicaid program.

B. CONTRACTOR agrees, and shall also require its subcontractors to agree, that it shall not ingage in or commit fraud or abuse. "Fraud" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program or in reimbursement for services that are not medically necessary or that fail to meet professional recognized stands for health care.

C. This Contract, and its construction and interpretation as to validity, performance and breach shall be construed under the laws of the State of California. In the event any provision in this Contract is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will nevertheless continue in full force without being impaired or invalidated in any way.

D. The provision of the Government Claims Act (Government Code Section 900 et seq.) must be followed first for any disputes under this Contract.

E. All actions and proceedings arising in connection with this Contract shall be tried and litigated exclusively in state or federal (if permitted by law and a party elects to file an action in federal court) courts located in the County of Riverside, State of California.

23. PROHIBITION OF POLITICAL/RELIGIOUS ACTIVITY

CONTRACTOR agrees that it shall not require client participation in political or religious activities in order to receive services for programs funded by the COMMISSION. Furthermore, DHCS funds shall be used only for the purposes specified in this Contract and in any attachments, hereto. No DHCS funds shall be used for any political activity, or to further the election or defeat of any candidate for political office. No DHCS funds shall be used for purposes of religious worship, instruction or proselytizing.

24. WORK PRODUCT

A. The COMMISSION shall be the owner of the following items incidental to this Contract upon production, whether or not completed: all data collected, all documents of any type whatsoever, and any material necessary for the practical use of the data and/or documents from the time of collection and/or production whether or not performance under this Contract is completed or terminated prior to completion. CONTRACTOR shall not release any materials under this section except after prior written approval of the COMMISSION.

B. Material produced in whole or in part under this Contract shall not be subject to copyright in the United States or in any other country except as determined at the sole discretion of the COMMISSION. The COMMISSION will have the unrestricted authority to publish, disclose, distribute, and use in whole or in part, any reports, data, documents or other materials prepared under this Contract.

C. Notwithstanding paragraphs A and B of this section, any information technology application or other software solution developed in conjunction with this contract shall be the property of DHCS.

25. NON-DISCRIMINATION

Pursuant to the Affordable Care Act section 1557 (42 U.S.C. section 18116), during the performance of this Contract, CONTRACTOR shall not, and shall also require and ensure its subcontractors, providers, agents, and employees to not, cause an individual, beneficiary, or applicant to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or subject to any other applicable State and Federal Laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through DHCS. This Contract hereby incorporates by reference the provisions of Title 2, CCR. Section 11105 et seq., as may be amended from time to time. CONTRACTOR agrees to comply with the provisions of Title 2, CCR, Section 11105 et seq. and further agrees to include this Non-Discrimination clause in any and all subcontracts to perform services under this Contract.

26. INDEPENDENT CONTRACTOR

It is understood and agreed that CONTRACTOR is an independent contractor and that no relationship of employer-employee exists between the CONTRACTOR and the COMMISSION. The CONTRACTOR, nor CONTRACTOR's officers, agents, employees or subcontractors, shall not be entitled to any Commission paid employee benefits, including Workers' Compensation.

27. HOLD HARMLESS/INDEMNIFICATION

CONTRACTOR shall indemnify and hold harmless the COMMISSION, the County of Riverside, its agencies, districts, special districts and departments, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (individually and collectively hereinafter referred to as Indemnitees or COUNTY) from any and all liability whatsoever, including wrongful death, based or asserted upon any services of CONTRACTOR, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to this Contract, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever arising from the performance of CONTRACTOR, its officers, employees, subcontractors, agents or representatives from this Contract. CONTRACTOR shall defend, at its sole expense, all costs and fees including, but not limited to, attorney fees, cost of investigation, defense and settlements or awards, the Indemnitees in any claim or action based upon such alleged acts or omissions.

With respect to any action or claim subject to indemnification herein by CONTRACTOR, CONTRACTOR shall, at their sole cost, have the right to use counsel of their own choice and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of COUNTY; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes CONTRACTOR's indemnification to Indemnitees as set forth herein.

CONTRACTOR's obligation hereunder shall be satisfied when CONTRACTOR has provided to COUNTY the appropriate form of dismissal relieving COUNTY from any liability for the action or claim involved.

The specified insurance limits required in this Contract shall in no way limit or circumscribe CONTRACTOR's obligations to indemnify and hold harmless the Indemnitees herein from third party claims.

In the event there is conflict between this clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code 2782. Such interpretation shall not relieve the CONTRACTOR from indemnifying the Indemnitees to the fullest extent allowed by law.

A. If CONTRACTOR is a public entity, as defined by applicable law, the COMMISSION and CONTRACTOR, to the extent that liability may be imposed on the COMMISSION by the provisions of Government Code Section 895.2, shall be liable for their own acts or omissions, including all claims, liabilities, injuries, suits, and demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect, caused or alleged to have been caused by either the COMMISSION or CONTRACTOR, their employees or representatives, performance or omission of any act or responsibility of either party under this Contract. In the event that a claim is made against both the COMMISSION and CONTRACTOR, both parties shall cooperate in the defense of said claim and to cause their insurers to do likewise.

B. CONTRACTOR agrees to indemnify the COMMISSION for all federal/state withholding or state retirement payments, which the COMMISSION may be required to make by the federal or state government as a result of this Contract. If for any reason, CONTRACTOR is determined not to be an independent contractor to the COMMISSION in carrying out the terms of the Contract, such indemnification shall be paid in full to the COMMISSION upon sixty (60) calendar days written notice to CONTRACTOR if a federal and/or state determination is made that such payment is required.

28. INSURANCE

Without limiting or diminishing the CONTRACTOR'S obligation to indemnify or hold the County harmless, CONTRACTOR shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this Contract.

Workers' Compensation:
If the CONTRACTOR has employees as defined by the State of California, the CONTRACTOR shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than one million dollars ($1,000,000) per person per accident. The policy shall be endorsed to waive subrogation in favor of the County of Riverside, and, if applicable, to provide a Borrowed Servant/Alternate Employer Endorsement.

Commercial General Liability:
Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury, and cross liability coverage, covering claims which may arise from or out of CONTRACTOR's performance of its obligations hereunder. Policy shall name the County of Riverside, its agencies, districts, special districts, and departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insureds. Policy's limit of liability shall not be less than one million dollars ($1,000,000) per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this Contract or be no less than two (2) times the occurrence limit.

Vehicle Liability:
If vehicles or mobile equipment are used in the performance of the obligations under this Contract, then CONTRACTOR shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than one million dollars ($1,000,000) per

occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this Contract or be no less than two (2) times the occurrence limit. Policy shall name the County of Riverside, its agencies, districts, special districts, and departments, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insureds.

Professional Liability Insurance:
CONTRACTOR shall maintain Professional Liability Insurance providing coverage for the CONTRACTOR's performance of work included within this Contract, with a limit of liability of not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) annual aggregate. If CONTRACTOR's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such insurance shall continue through the term of this Contract and CONTRACTOR shall purchase at his sole expense either 1) an Extended Reporting Endorsement (also known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Contract; or 3) demonstrate through Certificates of Insurance that CONTRACTOR has Maintained continuous coverage with the same or original insurer. Coverage provided under items; 1), 2) or 3) will continue for a period of five (5) years beyond the termination of this Contract.

General Insurance Provisions - All lines:

1. Any insurance carrier providing insurance coverage hereunder shall be admitted to the State of California and have an A M BEST rating of not less than A: VIII (A:8) unless such requirements are waived, in writing, by the County risk manager. If the County's risk manager waives a requirement or a particular insurer such waiver is only valid for that specific insurer and only for one (1) policy term.

2. The CONTRACTOR's insurance carrier(s) must declare its insurance self-insured retentions. If such self-insured retentions exceed five hundred thousand dollars ($500,000) per occurrence such retentions shall have the prior written consent of the County risk manager before the commencement of operations under this Contract. Upon notification of self-insured retention unacceptable to the County, and at the election of the Country's risk manager, CONTRACTOR's carriers shall either; 1) reduce or eliminate such self-insured retention as respects this Contract with the County, or 2) procure a bond which guarantees payment of losses and related investigations, claims administration, and defense costs and expenses.

3. CONTRACTOR shall cause CONTRACTOR's insurance carrier(s) to furnish the County of Riverside with either 1) a properly executed original Certificate(s) of Insurance and certified original copies of Endorsements effecting coverage as required herein, and 2) if requested to do so orally or in writing by the County risk manager, provide original Certified copies of policies including all Endorsements and all attachments thereto, showing such insurance is in full force and effect. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that thirty (30) working days' written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. In the event of a material modification, cancellation, expiration, or reduction in coverage, this Contract shall terminate forthwith, unless the County of Riverside receives, prior to such effective date, another properly executed original Certificate of Insurance and original copies of endorsements or certified original policies, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect. CONTRACTOR shall not commence operations until the COUNTY has been furnished original Certificate (s) of Insurance and certified original copies of endorsements and if requested, certified original policies of insurance including all endorsements and any and all other attachments as required in this Section. An individual authorized by the insurance carrier to do so on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.

4. It is understood and agreed to by the parties hereto that the CONTRACTOR's insurance shall be construed as primary insurance, and the County's insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

5. If, during the term of this Contract or any extension thereof, there is a material change in the scope of services; or, there is a material change in the equipment to be used in the performance of the scope of work which will add additional exposures (such as the use of aircraft, watercraft, cranes, etc.); or, the term of this Contract, including any extensions thereof, exceeds five (5) years the County reserves the right to adjust the types of insurance required under this Contract and the monetary limits of liability for the insurance coverage's currently required herein, if; in the County risk manager's reasonable judgment, the amount or type of insurance carried by the CONTRACTOR has become inadequate.

6. CONTRACTOR shall pass down the insurance obligations contained herein to all tiers of subcontractors working under this Contract.

7. The insurance requirements contained in this Contract may be met with a program(s) of self-insurance acceptable to the County.

8. CONTRACTOR agrees to notify County of any claim by a third party or any incident or event that may give rise to a claim arising from the performance of this Contract.

Adjustment and/or Waiver of Requirements:
The COMMISSION Executive Director (or designee), in consultation with the COMMISSION's risk manager, may adjust the insurance requirements set forth herein as deemed necessary for the Contract, and/or may waive insurance requirements where not applicable to the Contract. Insurance endorsements shall be submitted to the COMMISSION upon submission of the fully executed Contract, but no later than when contract work commences.

29. ASSIGNMENT

This Contract shall not be assigned by CONTRACTOR, either in whole or in part, without prior written consent of the COMMISSION, as approved and authorized by formal action of the COMMISSION.

30. ALTERATION AND/OR AMENDMENT

No alteration, amendment, or variation of the terms of this Contract shall be valid unless made in writing and signed by the parties hereto. Oral understandings or Contract not incorporated herein shall not be binding on any of the parties hereto. As provided herein, the COMMISSION Executive Director, acting on behalf of the COMMISSION, may alter or revise this Contract on behalf of the COMMISSION. Material alterations and/or amendments, as determined by the COMMISSION Executive Director in consultation with County legal counsel, will require formal approval of the COMMISSION. Except as provided herein, the parties expressly recognized that individual Commission members, advisory committee members, or staff to the COMMISSION is without authorization to either change or waive any material requirements of this Contract without formal action of the COMMISSION.

31. CONFLICT OF INTEREST

CONTRACTOR shall have no economic interest, and shall not acquire any economic interest, direct or indirect, which will conflict in any manner or degree with the performance of services required under this Contract.

32. WAIVER AND SEVERABILITY

Any waiver by the COMMISSION of any breach of any one (1) or more terms of this Contract shall not be construed to be a waiver of any subsequent or other breach of the same term of any other term herein. In the event, any provision in this Contract is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will nevertheless continue in full force without being impaired or invalidated in any way.

33. DISALLOWANCE

In the event CONTRACTOR receives payment for services under this Contract, which is later disallowed for nonconformance with the terms and conditions herein, CONTRACTOR shall promptly refund the disallowed amount to the COMMISSION upon request. The COMMISSION retains the option to offset the amount disallowed from any payment due to the CONTRACTOR under this Contract, or under any other Contract, or Contract between CONTRACTOR and the COMMISSION.

34. OFFICIAL DOCUMENTS

Upon the Contract approval by the COMMISSION, one (1) completed set of this document will be sent to the CONTRACTOR. Such copy shall be the officially approved Contract for the conduct of the approved project.

35. ENTIRE CONTRACT

This Contract, inclusive of all attachments and exhibits, constitutes the entire Contract between the parties hereto with respect to the subject matter hereof and all prior or contemporaneous Contract of any kind of nature relating to the same shall be deemed to be merged herein. Any modifications to the terms of this Contract shall be by the provisions of the section entitled "alteration and/or amendment" herein.

36. NONEXCLUSIVE CONTRACT

CONTRACTOR understands that this is not an exclusive Contract and that the COMMISSION shall have the right to negotiate with and enter into Contracts with others providing the same or similar services as those provided by CONTRACTOR as the COMMISSION desires, and at the sole discretion of the COMMISSION.

37. CERTIFICATION OF AUTHORITY TO EXECUTE THIS CONTRACT

CONTRACTOR certifies that the individual signing herein has authority to execute this Contract on behalf of CONTRACTOR, and may legally bind CONTRACTOR to the terms and conditions of this Contract, and any attachments hereto.

38. COMPLIANCE WITH LAW

CONTRACTOR shall, at its sole cost and expense, comply with all County, State, and Federal law now in force or which may hereafter be in force with regard to this Contract. The judgment of any court of competent jurisdiction, or the admission of CONTRACTOR in any action against CONTRACTOR, whether the COMMISSION be a party thereto or not, that CONTRACTOR has violated any such ordinance or statute, shall be conclusive of that fact as between CONTRACTOR and the COMMISSION.

39. CONFLICTS IN INTERPRETATION

In the event of conflict in interpretation by the parties of the provisions contained in the numbered sections of this Contract and the provisions contained in the Attachments hereto, the provisions of the attachments in the Contract shall prevail over those in numbered sections.

Agency Name: The Children and Families Commission for San Bernardino County (dba First 5 San Bernardino) **Contract #:** 18800 LDP

Program Name: Local Dental Pilot Project – Inland Empire (LDPP-IE) **Contract Years:** 2017 – 2020

Service Area: Riverside and San Bernardino Counties

Program Overview:
The Local Dental Pilot Project – Inland Empire (LDPP-IE) brings together resources from two of the largest counties in southern California to leverage strengths and achieve greater impact for the region. First 5 Riverside (F5R) and First 5 San Bernardino (F5SB) formed a consortium of key stakeholders to develop a regional dental pilot project to integrate and coordinate innovative oral health interventions by creating an integrated system involving community health centers, early care and education centers, schools, and home visitors. Using a collective impact approach, the LDPP-IE will lead to systems change in the region creating an integrated oral health system of care resulting in improved health of Medi-Cal children served. The First 5 consortia are partnering with the University of the Pacific, The Children's Partnership, and the Center for Oral Health to support the testing and implementation of the virtual dental home (VDH) and/or the newly developed early childhood oral health assessment (ECOHA) for non-dental providers through ten (10) Community Health Centers, Riverside-San Bernardino County Indian Health, Inc., and committed supporting agencies. The participating entities will demonstrate the proposed interventions are achievable and successful in improving health outcomes for the target population.

Major Objectives
First 5 San Bernardino (F5SB) will co-lead the LDPP-IE along with First 5 Riverside (F5R). The aim of the project is to incorporate oral health practices into all areas of health and social support systems, build and expand professional capacity of oral health providers, educate parents/caregivers of Medi-Cal enrolled/eligible children implementing the VDH and ECOHA. F5SB will ensure compliance with the DHCS agreement and requirements of the Medi-Cal 2020 Special Terms and Conditions (STC) 109 (pages 68-80) and Attachment JJ (pages 412-434).

Major Functions, Tasks, and Activities	Data Source and Verification	Frequency of Reporting	Completion Date
1. First 5 San Bernardino will lead the data collection coordination efforts in collaboration with subcontractors for the project to respond to DHCS evaluation requirements,[i] including data[1] from VDH and ECOHA mobile application imported to the appropriate data system(s).	Persimmony data report MEDS Utilization Report ECOHA mobile app DHCS data portal EHR/DHR	Quarterly 2018 - 2020	Continuous through project period
2. Participate in the monthly DHCS LDPP teleconference to ensure DHCS compliance; confirming evaluation requirements are consistent with the performance metrics of Domain 4, VDH and ECOHA strategies.	Participation in DHCS teleconference	Quarterly 2018 - 2020	Continuous through project period
3. Responsible for data collection (quantitative and qualitative) and data analysis to identify trends in reported data. Collaborate with subcontractors and comply with DHCS data reporting requirements as defined in F5SB contract, Attachments G & H, of which are consistent with the performance metrics of Domain 4. Submit timely data to F5R in accordance with the timelines required under the terms of the LDPP-IE DHCS.[ii]	Persimmony data report MEDS Utilization Report ECOHA mobile app DHCS data portal EHR/DHR	Quarterly 2018 - 2020	Continuous through project period
4. Responsible for contract monitoring of designated subcontracts, ensuring programmatic and fiscal compliance with F5R contract terms and conditions, DHCS monitoring requirements, and Scope of Work for Analyst, Evaluation and Fiscal staff.	Persimmony data report MEDS Utilization Report ECOHA mobile app DHCS data portal EHR/DHR	Quarterly 2018 - 2020	Continuous through project period

Major Functions, Tasks, and Activities	Data Source and Verification	Frequency of Reporting	Completion Date
5. Ensure that quality improvement efforts are informed by evaluation data and practices to meet DHCS requirements to further goals of the domain(s) of the respective strategy (Attachment H). F5SB will Identify what is working, adjustments needed, and lessons learned to ensure that success is measured against the desired outcomes. [iii]	Persimmony data reports MEDS Utilization Report ECOHA mobile app DHCS data portal EHR/DHR	Quarterly 2018 - 2020	Continuous through project period
6. Collaborate with Social Interest Solutions, University of the Pacific, The Children's Partnership and the LDPP-IE Program Director to provide input and expertise around data collection for the development of the ECOHA mobile application and its use.[iv]	Meeting agendas calendar appointments correspondence	Quarterly 2018 - 2020	Continuous through project period

[1]Early Childhood Oral Health Assessment (ECOHA), Medi-Cal Electronic Data System (MEDS), Electronic Dental Record (EDR), Electronic Health Record (EHR) Department of Health Care Services (DHCS) designated data portal, Persimmony.

Provided for informational use:

[i] Riverside County Children & Families Commission Local Dental Pilot Project Application, November 9, 2017., p.26.
[ii] Ibid., p.34., p.46.
[iii] Ibid., p.33.
[iv] Ibid., p. 30.

Children and Families Commission for San Bernardino County
(First 5 San Bernardino)
18800 LDP

Attachment B.1
Year 1
12/01/17 through 12/31/17

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Contract Analyst	1.0	$6,165.47	100%	$	6,165		
Accountant	1.0	$4,655.73	20%	$	931		
Supervisor, Data and Community Engagement	1.0	$6,243.47	20%	$	1,249		
Data Analyst	1.0	$6,165.47	100%	$	6,165		
			Total Salary	**$**	**14,511**		
		Fringe Benefits	**51.08%**	$	7,412		
					Total Personnel	**$**	**21,923**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	129	
County Services	$	303	
Office Supplies	$	401	
Rent Expense	$	760	
Data Management System and Monitoring	$	6,000	
		Total Operating Expenses	**$ 7,593**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

None	$	-	
		Total Travel	**$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Total Subcontracts **$ -**

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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) **20%** **Indirect Costs** **$ 2,902**

Annual Budget Total **$ 32,418**

Children and Families Commission for San Bernardino County
(First 5 San Bernardino)
18800 LDP

Attachment B.2
Year 2
01/01/18 through **12/31/18**

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Contract Analyst	1.0	$6,319.60	100%	$	75,835		
Accountant	1.0	$4,772.13	20%	$	11,453		
Supervisor, Data and Community Engagement	1.0	$6,399.55	20%	$	15,359		
Data Analyst	1.0	$6,319.60	100%	$	75,835		
			Total Salary	**$**	**178,482**		
		Fringe Benefits	**51.08%**	$	91,169		
					Total Personnel	**$**	**269,651**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	774	
County Services	$	1,820	
Office Supplies	$	4,809	
Rent Expense	$	9,120	
Data Management System and Monitoring	$	-	
		Total Operating Expenses	**$ 16,523**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

None	$	-	
		Total Travel	**$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Total Subcontracts **$ -**

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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) **20%** **Indirect Costs** **$ 35,696**

Annual Budget Total **$ 321,870**

Children and Families Commission for San Bernardino County
(First 5 San Bernardino)
18800 LDP

Attachment B.3
Year 3
01/01/19 through **12/31/19**

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost
Contract Analyst	1.0	$6,477.59	100%	$	77,731
Accountant	1.0	$4,891.43	20%	$	11,739
Supervisor, Data and Community Engagement	1.0	$6,559.54	20%	$	15,743
Data Analyst	1.0	$6,477.59	100%	$	77,731
			Total Salary	**$**	**182,944**
		Fringe Benefits	**51.08%**	$	93,448
				Total Personnel	**$ 276,392**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	774
County Services	$	1,820
Office Supplies	$	4,809
Rent Expense	$	9,120
Data Management System and Monitoring		
Total Operating Expenses	**$**	**16,523**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-
Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

None	$	-
Total Travel	**$**	**-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None		
Total Subcontracts	**$**	**-**

Other Costs [Itemize each expense]

None	$	-
Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$ 36,589**
		Annual Budget Total	**$ 329,504**

Children and Families Commission for San Bernardino County
(First 5 San Bernardino)
18800 LDP

Attachment B.4

Year 4
01/01/20 through **12/31/20**

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Contract Analyst	1.0	$6,639.53	100%	$	79,674		
Accountant	1.0	$5,013.72	20%	$	12,033		
Supervisor, Data and Community Engagement	1.0	$6,723.53	20%	$	16,136		
Data Analyst	1.0	$6,639.53	100%	$	79,674		
			Total Salary	**$**	**187,517**		
		Fringe Benefits	**51.08%**	$	95,784		
					Total Personnel	**$**	**283,301**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	774	
County Services	$	1,820	
Office Supplies	$	4,809	
Rent Expense	$	9,120	
Data Management System and Monitoring	$	-	
		Total Operating Expenses	**$** **16,523**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$** **-**

Travel (At CalHR reimbursement rates)

None	$	-	
		Total Travel	**$** **-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Total Subcontracts **$** **-**

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$** **-**

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) **20%** **Indirect Costs** **$** **37,503**

Annual Budget Total **$** **337,327**

Attachment B-5
BUDGET NARRATIVE AND JUSTIFICATION
Year 1 - 12/01/17 through 12/31/17
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

Accountant - This position will be responsible for fiscal oversight of the contract between First 5 San Bernardino and First 5 Riverside. Year one has been allocated at one month and is at 20% effort to this program for the term of the contract.

Contract Analyst - This position will be tasked with budget development, contract negotiation, compliance, and monitoring to ensure performance requirements are aligned with agreed upon contractual obligations. One FTE has been allocated to this position. Year one has been allocated at one month, and is at 100% effort to this program for the term of the contract.

Data Analyst - This position will be tasked as the co-lead liaison between partner agencies to compile, analyze and report on the data generated from the participating entities. One FTE has been allocated to this position. Year one has been allocated at one month, and is at 100% effort to this program for the term of the contract.

Supervisor, Data and Community Engagement – This position will be responsible for the supervision of the Contract and Data Analysts. Year one has been allocated at one month, and is at 20% effort for the term of the contract.

OPERATIONAL EXPENSES

Communication / Mobile Devices – This budget line will pay for Webinar/Conference call costs and the portion of the phone system allocated to staff under this program.

County Services – This line will pay for a portion of the MOU with the County of San Bernardino for payroll processing, IT services, human resources, and legal services.

Office Supplies – Exclusively for use by the staff associated with this program and include generic office supplies such as pens, paper, staples, paperclips, paper.

Contract Data Management System – Cost related to the establishment of a separate stand-alone module within current electronic data management system (Persimmony) for the LDPP-IE program to monitor contract compliance, and for subcontractors to report fiscal expenses.

EQUIPMENT

None

TRAVEL

None

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, and other costs.

ATTACHMENT C: PAYMENT PROVISIONS

A. FISCAL

The maximum reimbursable amount over the life of this Contract is **$1,021,119.00** as awarded by the Riverside County Children and Families Commission (COMMISSION), also known as First 5 Riverside, provided pursuant to the California Department of Health Care Services (DHCS), Contract No. 16-93569.

CONTRACT PERIOD: **12/01/2017 - 12/31/2020**

1. Method, Time and Schedule Conditions of Payment

   a. The COMMISSION will disburse funds on a reimbursement payment process based on the Contract Budget (Attachment B) amount for the applicable fiscal year and monthly report submissions. Payment will be rendered thirty (30) business days from submission of all required documentation and/or the reporting deadline.

   b. Disbursement of any payment of funds to Contractor shall be made so long as all of the following conditions have been met:

      1. The Contract has been approved by the COMMISSION;

      2. The Contract has been fully executed by all parties;

      3. All applicable licenses in order to comply with the terms of the Scope of Work (Attachment A) are current and valid;

      4. The CONTRACTOR submits monthly itemized invoices, via the data management system to include the supporting documentation separated by a cover sheet in front of each expense category. Documentation shall include; payroll register or report, time & activity report and/or, timesheets, statement of costs, copy of invoice or receipt, mileage report(s), copy of check(s) or proof of payment; and,

      5. Commission staff has reviewed and approved Cost Allocation Plan (if applicable).

   c. Under special circumstances, CONTRACTOR may request advance disbursements. A supplemental disbursement request along with justification must be submitted, in writing, to the Executive Director or designee. Discretion to grant advance disbursements rest exclusively with the Executive Director or designee.

   d. The COMMISSION Executive Director, or designee, reserves the right to withhold or reduce disbursement of funds if CONTRACTOR fails to 1): comply with monthly and/or quarterly reports by the indicated due date as set forth in Section 11 of the Contract, 2) if results achieved are not as projected and no COMMISSION approved plan is in place for improvement, or 3) if the CONTRACTOR is not in compliance with any provision contained within this Contract.

   e. The final funding period amount approved for the applicable fiscal year will be paid based on final expenditures as of December 31 and reported as of January 20, which is the final deadline to submit program expenditures. Expenditures made after December 31 will not be accepted.

ATTACHMENT D:
COMPREHENSIVE TOBACCO CONTROL POLICY

As a material condition of the Contract, the CONTRACTOR shall agree that the CONTRACTOR and the CONTRACTOR's employees, while receiving funding from the COMMISSION:

1. Shall not use tobacco products while using the CONTRACTOR's property e.g., vehicle, equipment;

2. Shall not sell, offer or provide tobacco products on CONTRACTOR 's premises;

3. Shall have tobacco education and cessation materials visibly available and accessible to clients participating in activities funded by DHCS funds;

4. Shall assure that the CONTRACTOR and its employees have no current business association or relationship with the tobacco industry, and further agrees to neither accept nor solicit financial contributions, sponsorships, gifts, or services from any tobacco company, executive, or tobacco-related function; and

5. Shall make a reasonable effort to divest of all investments in companies that derive fifteen percent (15%) or more of their revenues from tobacco.

The COMMISSION may terminate for default or breach of this Contract and any other Contract the CONTRACTOR has with the COMMISSION, if the CONTRACTOR or CONTRACTOR 's employees, are determined by the COMMISSION Executive Director (or designee), not to be in compliance with the conditions set forth herein.

If the CONTRACTOR or CONTRACTOR's employees, are determined by the COMMISSION Executive Director (or designee), not to be in compliance with the conditions set forth herein, the COMMISSION may terminate for default or breach of this Contract and any other Contract the COMMISSION has with the CONTRACTOR.

In instances where the CONTRACTOR is part of a larger entity, and where the entity has an investment policy set by governance officials other than the CONTRACTOR, and the CONTRACTOR is not directly involved in such investment decisions, CONTRACTOR agrees to the provisions herein as required in the programs and activities under the direct control of the CONTRACTOR to the satisfaction of the COMMISSION Executive Director (or designee). Activities of the larger entity other than investment decisions, which are not under the direct control of CONTRACTOR, shall not be considered to be in violation of CONTRACTOR's activities pursuant to the policy.

ATTACHMENT E:
LOCAL DENTAL PILOT PROGRAM – INLAND EMPIRE
COMPREHENSIVE DEFINITIONS

Accessibility: Ease of obtaining services, measured by addressing geographical, travel and other barriers.

AAPD: American Academy of Pediatric Dentistry

AAPHD: American Association of Public Health Dentistry

ADA: American Dental Association

Affordable Care Act (ACA): Health care reform law enacted in March 2010. Affordable Care Act (ACA) refers to the final amended version of the law.

CalHR Reimbursement Rate: California Department of Human Resources mileage reimbursement rate as established by the current Memorandum of Understanding for specific Bargaining Units.

Care Coordinator (VDH – Strategy 1): This position is a key component for the Virtual Dental Home (VDH) and Early Care Oral Health Assessment (ECOHA) strategies to reach the target population. This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialities, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy.

Caries: A biofilm (plaque)-induced acid demineralization of enamel or dentin, mediated by saliva.

CDHCS: California Department of Health Care Services

Center for Oral Health (COH): An organization that supports collaboration and communication, building from existing systems, the Center for Oral Health is the convener of the Oral Health Action Coalition – Inland Empire (OHAC-IE), composed of more than 30 organizations united by the common goal of improving the oral health of underserved residents in the Inland Empire.

Community Health Worker: This is a key component for the ECHOA strategy to reach the target population. This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will link Medi-Cal children to community-based dental services including newly established VDH hubs across the County.

Cost Effectiveness: Achieving the desired goal with minimal expenditure.

Demonstrated Outcomes: Data supported evidence that indicators addressed through the program show marked improvement.

Dental Assessment Mobile Application: A mobile-friendly caries risk assessment tool (i.e., a mobile-application) for use by early childhood home visitors (those funded by First 5 Riverside, First 5 San Bernardino), Quality Start early learning provider sites, and WIC sites who are located or work with families in the geographic community of the clinics that are implementing the VDH, except the Tribal Family Program. This application will be available in English and Spanish and is downloadable to IOS and Android.

Dental Home: Ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated, and family-centered way.

Dental Screening: A visual assessment of the child's oral health, done without instrumentation or the use of x-rays or any other diagnostic equipment. The provider observes, provides fluoride varnish and notes the condition of the teeth, surrounding soft tissues, simple jaw relationships and overall oral hygiene.

Dental Transformation Initiative (DTI): Within the Medi-Cal 2020 Waiver, the Dental Transformation Initiative (DTI) represents a critical mechanism to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform.

Dental Services, Treatment and Prevention: Includes a thorough dental examination with the use of x-rays and proper instruments to diagnose the condition of the teeth and other oral structures. A full scope of treatment may include preventative services, such as cleaning and oral hygiene instruction for parent and/or child, as well as restoration or removal of damaged teeth and proper space maintenance. Complete treatment results in the proper function and comfort of the child's mouth in a developmentally appropriate way. It anticipates the best possible outcome for healthy permanent teeth.

Dosage: The frequency and level of exposure to services offered to the participant.

Early Childhood Oral Health Assessment (ECOHA): The process of screening children 0 through 5 for the current condition of their teeth and other oral structures.

Evidence-Based: Refers to the use of research and scientific studies as a base for determining best practices.

Full-Time Equivalent (FTE): A measurement equal to one staff person employed in a full-time work schedule and which is, for purposes relating to this contract, calculated at 2,080 hours in a year. FTEs provide a common unit of measurement for positions budgeted. The number of FTEs is the cumulative value expressed, using the full-time equivalent measurement as a baseline, as a total percentage of time or as a total percentage of funds related to a classification.

Federally Qualified Health Center (FQHC): Entities as defined by the Social Security Act at section 1905(l)(2) which, is receiving a grant under section 330 of the Public Health Service Act. Programs meeting the FQHC requirements commonly include the following (but must be certified and meet all requirements stated above): Community Health Centers, Migrant Health Centers, Healthcare for the Homeless Programs, Public Housing Primary Care Programs, Federally Qualified Health Center Look-Alikes, and Tribal Health Centers.

HIPAA: Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").

IT Support (VDH – Strategy 1): Minimal support is required for data collection support through internal IT staff.

Local Dental Pilot Project (LDPP): Part of the State of California's Medi-Cal 2020 Section 1115 waiver, intended to target Medi-Cal child beneficiaries, ages twenty (20) and under, in need of dental services.

LDPP-IE: Local Dental Pilot Project, Inland Empire

Medi-Cal: The California Medical Assistance Program (Medi-Cal) is California's Medicaid program serving low-income individuals, including: families, seniors, persons with disabilities, children in foster care, pregnant women, and childless adults with incomes below 138% of federal poverty level. Individuals enrolled in one of the following programs can also get Medi-Cal: CalFresh, SSI/SSP, CalWorks (AFDC), Refugee Assistance, Foster Care or Adoption Assistance Program.

Navigator (VDH – Strategy 1): The position is a key component for the VDH strategy to reach the target population. The navigator assists the registered dental hygienist in many aspects of patient care and treatment in community settings. The navigator's key responsibilities may include assisting with patient care activities to include scheduling, confirmation telephone calls, retriving/dispensing electronic charts, data input, arranging and following up on referrals and providing oral health education as directed by the registered dental hygienist.

OHAC-IE: Oral Health Action Coalition, Inland Empire

Outcome: The result, which the Commission seeks (as outlined in the Strategic Plan) and to which all performance targets must contribute to a measurable change.

Project Lead (VDH – Strategy 1): This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted at .10 FTE for each FTE navigator and care coordinator across all participating VDH teams.

Project Lead (ECOHA – Strategy 2): Salary for a portion of this position across all participating ECHOA teams is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted at .10 FTE for each FTE community health worker across all participating ECOHA teams.

Ready4K: Through text messaging, Ready4K breaks down the complexity of engaged parenting into small steps that are easy to achieve. In addition, the program provides continuous encouragement and support to parents over an entire school year. Each week, parents receive three text messages to help them build their children's skills by maximizing existing family routines in fun and easy ways.

Researched Based: See evidence-based: Using research as the basis for determining best practices.

Reasonable Rate of Success: Total number of program participants expected to complete the program meeting the outcome targets.

Resource Center: A facility to which children, prenatal through age five, and families access services needed. Two basic program elements must be present at a Resource Center for it to meet the minimal definition: (i) referrals and linkages to critical services and programs, not represented physically at the center, and (ii) case management (see definition for Case Management).

Rural Health Clinic (RHC): Clinics that are certified under section 1861(aa)(2) of the Social Security Act to provide care in underserved areas, and therefore, to receive cost-based Medicare and Medicaid reimbursements.

Social Interest Solutions (SIS): An organization that helps national, state, county, and individual program stakeholders to effectively leverage technology solutions to automate and improve screening, eligibility, and enrollment processes.

Special Needs: Children having an identified disability, health, or mental health condition(s) that require early interventions, special education services, or other specialized supports.

Strengthening Families™: A framework for working with children and families. The approach allows for consistency across child- and family-serving systems and acknowledges the interdependent factors affecting families every day. The foundation of this framework is built upon five research-based Protective Factors. When these Protective Factors are present and robust, families are less likely to experience child abuse or neglect and are more equipped to create environments for young children's optimal development.

Subcontractor: Agencies contracted by the primary Contractor to provide direct services for which they will be responsible for achieving the performance targets for the portion of services they are providing. Contractor shall be responsible for the performance of any subcontractor.

The Children's Partnership (TCP): California—based national children's advocacy organization committed to improving the lives of underserved children where they live, learn, and play with breakthrough solutions at the intersection of research, policy, and community engagement.

Unduplicated Clients: Clients who are counted as receiving service for the first time in a fiscal year.

Uninsured: Individuals not covered by health insurance.

Virtual Dental Home (VDH): Using tele-health technology the VDH creates a community-based oral health delivery system in which children 0-20 years of age receive preventive and simple therapeutic services in community settings.

Verification: Validates that something represented to happen does, in fact, take place. The verification tools must be approved by the Commission.

Women, Infants, and Children (WIC): The Special Supplemental Nutrition Program for Women, Infants, and Children - better known as the WIC Program - serves to safeguard the health of low-income pregnant, postpartum, and breastfeeding women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating including breastfeeding promotion and support, and referrals to health care. Is maintained by the Food and Nutrition Service (FNS), a Federal agency of the U.S. Department of Agriculture, responsible for administering the WIC Program at the national and regional levels.

Attachment F
HIPAA Business Associate Addendum

I. Recitals

A. This Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").

B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal information ("PI") under state law.

C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act, and the Final Omnibus Rule as well as the Alcohol and Drug Abuse patient records confidentiality law 42 CFR Part 2, and any other applicable state or federal law or regulation. 42 CFR section 2.1(b)(2)(B) allows for the disclosure of such records to qualified personnel for the purpose of conducting management or financial audits, or program evaluation. 42 CFR Section 2.53(d) provides that patient identifying information disclosed under this section may be disclosed only back to the program from which it was obtained and used only to carry out an audit or evaluation purpose or to investigate or prosecute criminal or other activities, as authorized by an appropriate court order.

E. The terms used in this Addendum, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

II. Definitions

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and Final Omnibus Rule.

D. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

Initial_____ Date_____

E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

G. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.

H. Personal Information shall have the meaning given to such term in California Civil Code section 1798.29.

I. Protected Health Information means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

J. Required by law, as set forth under 45 CFR section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.

M. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.

N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. section 17932(h), any guidance issued pursuant to such Act, and the HIPAA regulations.

III. Terms of Agreement

A. Permitted Uses and Disclosures of PHI by Business Associate

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for,

Initial_____ Date_____

or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, the HIPAA regulations, the Final Omnibus Rule and 42 CFR Part 2.

1. ***Specific Use and Disclosure Provisions.*** Except as otherwise indicated in this Addendum, Business Associate may:

   a. ***Use and disclose for management and administration.*** Use and disclose PHI for the proper management and administration of the Business Associate provided that such disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

   b. ***Provision of Data Aggregation Services.*** Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of DHCS.

B. Prohibited Uses and Disclosures

1. Business Associate shall not disclose PHI about an individual to a health plan for payment or health care operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).

2. Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. Responsibilities of Business Associate

Business Associate agrees:

1. ***Nondisclosure.*** Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

2. ***Safeguards.*** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of PHI other than as provided for by this Agreement. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other

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3. requirements of 45 CFR section 164, subpart C, in compliance with 45 CFR section 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

4. ***Security***. To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

   a. Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;

   b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;

   c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

   d. In case of a conflict between any of the security standards contained in any of these enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

   Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.

D. ***Mitigation of Harmful Effects***. To mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate or its subcontractors in violation of the requirements of this Addendum.

E. Business Associate's Agents and Subcontractors.

1. To enter into written agreements with any agents, including subcontractors and vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business associates are directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health

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information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or sub-award to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.

2. In accordance with 45 CFR section 164.504(e)(1)(ii), upon Business Associate's knowledge of a material breach or violation by its subcontractor of the agreement between Business Associate and the subcontractor, Business Associate shall:

   a. Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by DHCS; or

   b. Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

F. ***Availability of Information to DHCS and Individuals****.* To provide access and information:

1. To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR section 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

2. If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. section 17935(e).

3. If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents of its subcontractors and agents.

G. ***Amendment of PHI.*** To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR section 164.526, in the time and manner designated by DHCS.

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H. ***Internal Practices****.* To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.

I. ***Documentation of Disclosures****.* To document and make available to DHCS or (at the direction of DHCS) to an Individual such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR section 164.528 and 42 U.S.C. section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

J. ***Breaches and Security Incidents.*** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

1. ***Notice to DHCS.*** (1) To notify DHCS **immediately** upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration. This notification will be **by telephone call plus email or fax** upon the discovery of the breach. (2) To notify DHCS **within 24 hours by email or fax** of the discovery of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI or PI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Business Associate as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.

   Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves data provided to DHCS by the Social Security Administration, notice shall be provided by calling the DHCS EITS Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website

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(www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link:
http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

Upon discovery of a breach or suspected security incident, intrusion, or unauthorized access, use or disclosure of PHI or PI, Business Associate shall take:

a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

2. ***Investigation and Investigation Report.*** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. If the initial report did not include all of the requested information marked with an asterisk, then within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:

3. ***Complete Report.*** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. If all of the required information was not included in either the initial report, or the Investigation Report, then a separate Complete Report must be submitted. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve or disapprove the determination of whether a breach occurred, is reportable to the appropriate entities, if individual notifications are required, and the corrective action plan.

4. ***Notification of Individuals.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its subcontractors, agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

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5. ***Responsibility for Reporting of Breaches.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, subcontractors or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.

6. ***DHCS Contact Information.*** To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

DHCS Program Contract Manager	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: EITS Service Desk (916) 440-7000 or (800) 579-0874

K. ***Termination of Agreement.*** In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

1. Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or

2. Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

L. ***Due Diligence.*** Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Addendum.

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M. ***Sanctions and/or Penalties***. Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

IV. Obligations of DHCS

DHCS agrees to:

A. ***Notice of Privacy Practices***. Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR section 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/default.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the left column and "Notice of Privacy Practices" on the right side of the page).

B. ***Permission by Individuals for Use and Disclosure of PHI***. Provide the Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect the Business Associate's permitted or required uses and disclosures.

C. ***Notification of Restrictions***. Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR section 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

D. ***Requests Conflicting with HIPAA Rules***. Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

A. From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS inspects, or fails to inspect, or has the right to inspect, Business Associate's facilities, systems and procedures does not relieve Business Associate of its responsibility to comply with this Addendum, nor does DHCS':

1. Failure to detect or

2. Detection, but failure to notify Business Associate or require Business Associate's remediation of any unsatisfactory practices constitute acceptance of such practice or a waiver of DHCS' enforcement rights under this Agreement and this Addendum.

B. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate

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provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

A. ***Term.*** The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).

B. ***Termination for Cause****.* In accordance with 45 CFR section 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by DHCS; or
2. Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.

C. ***Judicial or Administrative Proceedings****.* Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

D. ***Effect of Termination****.* Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate.

VII. Miscellaneous Provisions

A. ***Disclaimer****.* DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

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B. ***Amendment.*** The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon thirty (30) days written notice in the event:

1. Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or

2. Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

C. ***Assistance in Litigation or Administrative Proceedings.*** Business Associate shall make itself and any subcontractors, employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its subcontractor, employee or agent is a named adverse party.

D. ***No Third-Party Beneficiaries.*** Nothing express or implied in the terms and conditions of this Addendum is intended to confer, nor shall anything herein confer, upon any person other than DHCS or Business Associate and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

E. ***Interpretation***. The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.

F. ***Regulatory References.*** A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.

G. ***Survival.*** The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.

H. ***No Waiver of Obligations***. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

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Attachment F
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Attachment F.1
Business Associate Data Security Requirements

I. Personnel Controls

A. ***Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. ***Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. ***Confidentiality Statement.*** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. ***Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

A. ***Workstation/Laptop encryption.*** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. ***Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. ***Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. ***Removable media devices.*** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

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E. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. ***Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

G. ***User IDs and Password Controls.*** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. ***Data Destruction.*** When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.

I. ***System Timeout.*** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. ***Warning Banners.*** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. ***System Logging*****.** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. ***Access Controls.*** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

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M. ***Transmission encryption.*** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. ***Intrusion Detection***. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

III. Audit Controls

A. ***System Security Review.*** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. ***Log Reviews.*** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. ***Change Control.*** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

A. ***Emergency Mode Operation Plan.*** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. ***Data Backup Plan.*** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls

A. ***Supervision of Data.*** DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

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B. ***Escorting Visitors.*** Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

C. ***Confidential Destruction.*** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. ***Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

E. ***Faxing.*** Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. ***Mailing.*** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

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C. Dental Transformation Initiative

104. Special Terms and Conditions for Dental Transformation Initiative Under the Medi-Cal program, dental services are provided to approximately 5.5 million child Medi-Cal beneficiaries ages twenty (20) and under. Services are provided via two (2) delivery systems – Fee-for-Service (FFS) and Dental Managed Care (DMC). The Department of Health Care Services (DHCS, Department) conducts oversight of the FFS contractor(s) and six (6) dental managed care contracts in the DMC system.

DHCS facilitates access to oral health services for the FFS and DMC delivery systems in multiple ways, including through telephone service centers and correspondence controls for beneficiaries and providers; conducting beneficiary and provider outreach and education; implementing strategies for monitoring and augmenting provider network adequacy and beneficiary utilization; and providing regular reports to the Legislature, stakeholders, and federal and State government entities. All data and measurement reporting associated with the Dental Transformation Initiative (DTI) will be based on an annual reporting period by Program Year (PY).

The Medi-Cal Dental program aims to improve the beneficiary's experience so individuals can consistently and easily access high quality dental services supportive of achieving and maintaining good oral health; to implement effective, efficient, and sustainable health care delivery systems; to maintain effective, open communication, and engagement with our stakeholders; and to hold DHCS and our providers, plans, and partners accountable for performance and health outcomes. The Department employs performance measures in both delivery systems to gauge the effectiveness of contractor and State efforts. To aid in this performance monitoring, the Department utilizes a public Medi-Cal dental dashboard populated with performance measures posted on the Department's website, regular system reports, and ad hoc queries to the various databases. Benchmarks and quality and access criteria for the DMC and FFS delivery systems are designed to provide programmatic goals and expectation levels for contractors. Additionally, there are contractual checks targeted at ensuring access to care for the beneficiaries, encouraging provider participation, and holding the contractor(s) responsible for being active and proactive participants in ensuring the delivery of medically necessary dental services to the Medi-Cal beneficiary population.

105. DTI PROGRAM and FUNDING OVERVIEW The DTI will be funded at a maximum of $148 million annually, except as provided below, for five (5) years totaling a maximum of $740 million (DTI Pool). To the extent any of the funds associated with the DTI are not fully expended in a given PY, those remaining prior PY funds may be available for DTI payments in subsequent years, notwithstanding the annual limits stated above. The program will include three (3) domains: preventive services, caries risk assessment and management, and continuity of care, in addition to making funding available for local pilots that address one (1) or more of these three (3) domains. Specific incentive payments within each domain will be furnished to qualified providers, along with messaging and education to providers and beneficiaries about programs and efforts in their local communities. The Department intends to allow DTI participation from providers in both the FFS and DMC delivery systems beginning in PY 1 and as outlined in these STCs. The Department will make DTI

incentive payments directly to contracted service office locations that participate in the FFS and/or DMC delivery systems that qualify for DTI incentive payments. The service office location is the business or pay-to address where services are rendered by the provider (which may be an individual, partnership, group, association, corporation, institution, or entity that provides dental services). Incentive payments shall be issued to the service office location based on the services rendered at the location and compliance with the criteria enumerated in the STCs.

Incentive payments from the DTI Pool are intended to support and reward participating service office locations for achievements within one (1) or more of the project domains set forth herein. The incentive payments are not considered direct reimbursement for dental services under the State Plan. The non-federal share for DTI incentive payments shall be derived from expenditures associated with those Designated State Health Programs set forth in STC 31.

106. Domain 1: Increase Preventive Services Utilization for Children

In alignment with the CMS Oral Health Initiative, this program aims to increase the statewide proportion of children ages one (1) through twenty (20) enrolled in Medi-Cal who receive a preventive dental service in a given year. The Department's goal is to increase the utilization amongst children enrolled in the FFS and DMC dental delivery systems by at least ten (10) percentage points over a five (5) year period. The Department will commit to re-assessing the goal after PY 2 and increase said percentage, if appropriate, based on the success of the domain. For example, the 2014 rate for the state using the Form CMS-416 methodology was 37.84 percent of children. Thus, if this rate remained the same for the demonstration baseline year, the ten (10) percentage point improvement goal for this five (5) year demonstration would be to increase this rate to 47.84 percent of children statewide. DHCS will use the CMS 416 methodology for reporting purposes, but will pay out incentives using unrestricted eligibility criteria.

DHCS will offer payments as financial incentives for dental service office locations to increase delivery of preventive oral care to Medi-Cal children, and to maintain preventive oral care for children who previously received that service. As of September 2015, there are 5,370 service office locations across California that participate in the Medi-Cal Dental Program. DHCS will stage a messaging campaign to explain the new incentive program to the provider community and to generate interest among beneficiaries. DHCS will leverage existing contract provisions specific to provider and beneficiary outreach to operationalize the commitments of these STCs.

a. Program Criteria. The incentive program will provide semi-annual incentive payments to dental provider service office locations that provide preventive services to an increased number of Medi-Cal children, as determined by the Department. Eligible providers will receive payments based on them achieving an increased number of Medi-Cal children who received eligible preventive dental services, as compared to a baseline pre-determined by the Department. Providers who render preventive services to a number of children that meets or exceeds a Department pre-determined number of beneficiaries, by service office location, would qualify for the incentive payment.

Further, the program will also disburse incentive payments to providers who were not previously participating in Medi-Cal and rendering preventive services, but who do so during the demonstration, on the condition that they meet or exceed the provision of services based on the Department pre-determined number of beneficiaries, by county, needed to be served to achieve the goal. The new service office location's pre-determined number will be the average number of beneficiaries among all existing service office locations in the county needed to increase the statewide goal of two (2) percentage points. In subsequent demonstration years, the Department will re-evaluate the new service office location and develop a benchmark using the same methodology as described above for existing dental providers in the program.

Safety net clinics would also be eligible for these incentives and would be supplied with incentive payments separate and apart from their Prospective Payment System (PPS) or Memorandum of Agreement (MOA) rates for Federally Qualified Health Centers/Rural Health Centers and Tribal Health Centers, respectively. Each safety net clinic office location would be considered a dental service office location for purposes of this domain.

To illustrate, if a service office location provided preventative services to 1,000 beneficiaries for the selected benchmark year, its baseline benchmark is 1,000. In the first year, the annual target benchmark will be to increase by two percentage points over 1,000 thus, this service office location would need to provide preventive services to an additional 20 new beneficiaries (1,000 x 0.02 = 20).

The Department will determine the number of additional beneficiaries to be served in order to achieve the goal of ten (10) percentage point utilization increase statewide.

Incentive payments will be based on each service office location that meets or exceeds the Department pre-determined goal for increases in preventive services provided to every child within frequency limitations regardless of whether that child is a previously established patient of that service office location.

b. Responsibilities of Providers Service office locations are expected to continue to follow claiming and billing guidelines of the Medi-Cal Dental Program and to adhere to requirements of this incentive program**.**

c. Performance Metrics The Department will calculate a baseline measure of the rate of children's utilization of preventive services statewide and for each service office location, within the Medi-Cal FFS and DMC dental delivery systems, with a goal of increasing the statewide utilization of preventive services for children by at least ten (10) percentage points over five (5) years. The Department will also calculate the number of service locations that are providing preventive services to an increased number of children. The baseline year will consist of data from the most recent complete year preceding implementation of the waiver. Beneficiary utilization and service office location participation will be reassessed after PY 2.

The first metric that will be used for monitoring domain success is the percentage of beneficiaries who received any preventive dental service during the measurement period,

which is calculated as follows:

i. Numerator: 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 dental service (D1000-D1999) in the measurement period.
ii. Denominator: 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.
iii. The second metric that will be used is claims data to determine the number of service office locations in each county that are providing preventive dental services to children, compared to the number of these locations in the baseline year.
iv. A third metric will track statewide the number and percentage change of Medicaid participating dentists providing preventive dental services to at least ten (10) Medicaid-enrolled children in the baseline year, and in each subsequent measurement year.

d. State Oversight, Monitoring, and Reporting
i. Program Integrity: To ensure program integrity, the Department will perform annual assessments of service utilization, billing patterns and shifts in enrollment for anomalies that may be indicators of fraud, waste or abuse. The Department is required to ensure that all claims submitted for adjudication are handled in a timely manner. Any suspicious claim activity is tracked through the program's Surveillance Utilization Review System (SURS) to prevent fraud and abuse.
ii. Monitoring Plan/Provisions: To measure the impact on the utilization of preventive services, there will be monitoring of actively participating service office locations and monitoring of preventive services utilization statewide and by county via claims utilization.
iii. Reporting of Activity: The Department will be responsible for reporting on data and quality measures to CMS on an annual basis in the demonstration annual report. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable PY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable PY. Content will include, but not be limited to:
    i. A detailed description of how DHCS has operationalized this domain, including information about which entities (DHCS, MCOs, dental vendor, others) have responsibility for the components of this domain;
    ii. The number of individual incentives paid, and the total amount expended, under this domain in the current PY;
    iii. A plan (awareness plan) that describes (a) how the Department has generated awareness of the availability of incentives for providing preventive dental services to children, including steps taken to increase awareness of the DTI among dental as well as primary care providers, and (b) how the Department has generated awareness among enrollees of the availability of, the importance of, and how to access preventive dental services for children. Specific approaches will break out for example, age groupings, rural and urban residents, or primary language and should be developed in

conjunction with interested dental and children's health stakeholders.

iv. An annual analysis of whether the awareness plan has succeeded in generating the necessary utilization, by subgrouping, to meet the goals of this domain, and a description of changes to the awareness plan to address any identified deficiencies;
v. Data describing the use of preventive dental services and, separately, other dental services, and expenditures on preventive dental services and, separately, other dental services;
vi. A discussion of the extent to which the metrics described for this domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain;
vii. An analysis of changes in cost per capita;
viii. A descriptive analysis of any program integrity challenges generated by this domain and how those challenges have been, or will be, addressed; and
ix. A descriptive analysis of the overall effectiveness of the activities in this domain in meeting the intended goals, any lessons learned, and any adjustments recommended.

e. Incentives DHCS may earn additional demonstration authority, up to a maximum of $10 million, to be added to the DTI Pool for use in paying incentives to qualifying providers under DTI, by achieving higher performance improvement, as indicated in the below table:

PY	Target	$1 million in additional demonstration authority for achieving:	$2 million in additional demonstration authority for achieving:
1	+ two (2) percentage points over baseline year	Not Applicable	+ three (3) or more percentage points over baseline year
2	+ four (4) percentage points over baseline year	+5 or more percentage points over the baseline	+ six (6) or more percentage points over baseline year
3	+ six (6) percentage points over	+7.5 or more percentage points over the baseline	+ nine (9) or more percentage points over baseline year
	baseline year		
4	+ eight (8) percentage points over baseline year	+10 or more percentage points over the baseline	+ twelve (12) or more percentage points over baseline year

5	+ ten (10) percentage points over baseline year	+12.5 or more percentage points over the baseline	+ fifteen (15) or more percentage points over baseline year

f. Financing The incentive payment for preventive services will equate to a payment of approximately seventy-five (75) percent above the Schedule of Maximum Allowances (SMA) if the 2 percentage point benchmark increase is achieved or thirty-seven and a half (37.5) percent above the SMA if an increase of at least 1 percentage point but less than 2 percentage points is achieved. To the extent that the projected funding limit is reached for the Domain, a pro-rata share payment amount will be determined based on remaining funds. These payments are subject to annual funding limits contained herein and any annual limit applicable to this specific domain. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in STC 105.

g. Evaluation The results of this project will be used to determine if provider incentive payments are an effective method by which to encourage service office locations to provide preventive dental services to more Medi-Cal children and to what extent an incentive payment is an effective method for increasing Medi-Cal provider participation which could then impact better access to care for children.

107. Domain 2: Caries Risk Assessment and Disease Management Pilot

This four (4) year domain will only be available initially to dentists in pilot counties that elect and are approved by the Department to participate in the program. The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of PY 2. Through this effort, Medi-Cal dentists voluntarily participating in the domain will be eligible to receive incentive payments for performing pre-identified treatment plans for children based upon the beneficiary's risk level as determined by the dentist via a caries risk assessment (CRA) which will include motivational interviewing and use of antimicrobials, as indicated. The pre-identified treatment plans will be generated by the Department, and will correspond to the varying degrees of caries risk — low, moderate, and high. Pilot counties will be identified and selected by the Department through an analysis of counties with a high percentage of restorative services, a low percentage of preventive services, and indication of likely participation by enrolled service office locations.

Dentists must first complete a CRA to determine the appropriate treatment plan for a child, and report the results of the CRA to DHCS on a claim. Once the risk level and the treatment plan have been determined, the beneficiary may be eligible for increased frequency limitations on prophylaxis, topical fluoride varnish, and exams.

The key elements of this model are to formally assess and manage caries risk, and to emphasize the provision of preventive services in lieu of more invasive and costly procedures.

a. Program Criteria The incentive program will only be available for services performed on child beneficiary's age six (6) and under. The pre-identified treatment plans will be composed of the following procedures: CRA (which will globally include support for behavior change through motivational interviewing and nutritional counseling, and for disease management through use of interim carries arresting medication application), application of topical fluoride varnish, prophylaxis, and exams will be permitted for children evaluated and determined to be a particular caries risk level with frequency limitations in a twelve (12) month period, as follows: "high risk" children will be authorized to visit their provider four (4) times; "moderate risk" children will be authorized to visit three (3) times; and "low risk" children two (2) times. Dentists will receive payment for completion of a CRA and the corresponding treatment plan within the designated time frame.

b. Responsibilities of Providers Dentists participating in the domain must opt-in by completing a no-cost Department recognized training program (which could be developed in partnership with California Dental Association, as an example) and submitting verification documentation. Authorized training programs and acceptable documentation will be posted on the Medi-Cal Dental website. The Department will have an annual "open enrollment" for the domain in pilot counties and in additional counties when and if this domain is expanded beyond the pilot counties.

c. Performance Metrics The following procedures will be incorporated in the Department-determined treatment plans for child beneficiaries: CRA (which will globally include behavior modification through motivational interviewing and nutritional counseling, as well as antimicrobials), application of topical fluoride varnish, toothbrush prophylaxis, and exams. Increased frequencies for toothbrush prophylaxis, fluoride varnish, and exams will be permitted for children evaluated and determined to be at a particular caries risk level with frequency limitations in a twelve (12) month period, as follows: "high risk" will be authorized to visit their provider four (4) times; "moderate risk" children will be authorized to visit three (3) times; and "low risk" children two (2) times.

   The baseline year will consist of collecting data statewide for the most recent state fiscal year preceding implementation of the domain. The Department will collect data and report on the following performance measures, broken down by age ranges under one (1), one (1) through two (2), three (3) through four (4), and five (5) through six (6):

   i. Number of, and percentage change in, restorative services;
   ii. Number of, and percentage change in, preventive dental services;
   iii. Utilization of CRA CDT codes and reduction of caries risk levels (not

available in the baseline year prior to the Waiver implementation);

iv. Change in use of emergency rooms for dental related reasons among the targeted children for this domain (use of the ER for dental trauma will be excluded from this analysis if a claims-based methodology for doing so is identified); and

v. Change in number and proportion of children receiving dental surgery under general anesthesia.

The Department will also track and report on, for children in age ranges under one (1), one (1) through two (2), three (3) through four (4), and five (5) through six (6), the utilization rates for restorative procedures against preventive services to determine if the domain has been effective in reducing the number of restorations being performed. Because preventive services do not yield immediate effects, the Department will be required to collect data on these performance measures at annual intervals for a number of years to determine correlation and statistical significance. The Department will inform CMS of the number of additional years this data will be collected and reported no later than the end of PY 1.

The Department will also track and report on the utilization of CRA and treatment plan service to monitor utilization and domain participation.

d. State Oversight, Monitoring, and Reporting

i. Program Integrity: To ensure program integrity, the Department will perform annual assessments of service utilization, billing patterns and shifts in enrollment for anomalies that may be indicators of fraud, waste or abuse. The Department is required to ensure all claims submitted for adjudication are handled in a timely manner. Any suspicious claim activity is tracked through the program's SURS to prevent fraud and abuse.

ii. Monitoring Plan/Provisions: To measure the impact on the utilization of CRA and management of childhood caries, there will be quarterly monitoring of actively participating service office locations and monitoring of CRA and treatment plans in each participating county.

iii. Reporting of Activity: The Department will be responsible for reporting on data and quality measures to CMS on an annual basis in the demonstration annual report. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable PY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable PY. Content will include, but not be limited to:

A. A detailed description of how DHCS has operationalized this domain, including information about which entities (DHCS, MCOs, dental vendor, others) have responsibility for the components of this domain;
B. The number of individual incentives paid and the total amount expended under this domain, by county, in the current DY;
C. A descriptive assessment of the impact of this domain on the targeted

children (broken out by age ranges under one (1), one (1) through two (2), three (3) through four (4), and five (5) through six (6)) for the following:

1) Provision of CRAs;
2) Provision of dental exams;
3) Use of preventive dental services;
4) Expenditures on preventive dental services;
5) Use of dental treatment services;
6) Expenditures on dental treatment services;
7) Use of dental-related general anesthesia; and
8) Expenditures on dental-related general anesthesia and facility costs.

D. A discussion of the extent to which the metrics described for this domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain;
E. An analysis of changes in cost per capita;
F. A descriptive analysis of any program integrity challenges generated by this domain and how those challenges have been, or will be, addressed; and
G. A descriptive analysis of the overall effectiveness of the activities in this domain in meeting the intended goals, any lessons learned, and any adjustments recommended.

e. Financing Dentists participating in the domain will be authorized to perform an increased number of services per year in accordance with the pre-identified treatment plan options based upon caries risk level, and are eligible to receive an incentive payment under this program for each additional service not currently covered under the California State Plan and frequency limitations listed in the Manual of Criteria. Subject to the annual funding limits contained herein and any annual limit applicable to this specific domain, qualifying service office locations will receive an incentive payment for providing each of these additional services. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in STC 105.

f. Evaluation The results of this project will be used to determine if this provider incentive program is effective in encouraging providers to perform a CRA for the targeted population and to ensure completion of the appropriate treatment plan for the management of childhood caries, if the utilization of emergency room visits for dental issues among the targeted children declines, if expenditures of emergency room visits non-traumatic dental issues among targeted children declines, and if the utilization of and expenditures (including anesthesia and facility fees) for the targeted children receiving dental related general anesthesia declines.

108. Domain 3: Increase Continuity of Care

To encourage the continuity of care within the beneficiary population, an incentive payment

would be paid to service office locations who have maintained continuity of care through providing examinations for their enrolled child beneficiaries, age twenty (20) and under over the course of this Waiver. The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of PY 2.

a. Program Criteria This incentive program will be available to service office locations that provide examinations (D0120, D0150, or D0145) to an enrolled Medi-Cal child for two (2), three (3), four (4), five (5), and six (6) year continuous periods. The incentive will be a flat payment for providing continuity of care to the beneficiary. Incentive payments will be made annually.

b. Responsibilities of Providers Service office locations are expected to continue to follow claim and billing guidelines of the Medi-Cal Dental Program and to adhere to requirements of this incentive program.

c. Performance Metrics The baseline year will be based on data from the most recent complete state fiscal year. Using claims data, DHCS will determine the 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 following the establishment of the baseline year throughout the demonstration period. The metric described above is calculated as follows:
    i. Numerator: 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 from the baseline.
    ii. Denominator: Number of children age twenty (20) and under enrolled in the delivery system during the measurement periods.
    iii. This measure is similar to the Dental Quality Alliance measure Usual Source of Services, with the exception that the Department would incent over a longer continuous period.

d. State Oversight, Monitoring, and Reporting
    i. Program Integrity: To ensure program integrity, the Department will perform annual assessments of service utilization, billing patterns, and shifts in enrollment for anomalies that may be indicators of fraud, waste or abuse. The Department is required to ensure all claims submitted for adjudication are handled in a timely manner. Any suspicious claim activity is tracked through the program's SURS to prevent fraud and abuse.
    ii. Monitoring Plan/Provisions: To measure the impact on the continuity of care, there will be annual monitoring of the performance measure, usual source of care by service office location.
    iii. Reporting of Activity: The Department will be responsible for reporting on data and quality measures to CMS on an annual basis in the demonstration annual report. A preliminary report will be delivered only to CMS for internal review six

(6) months following the end of the applicable PY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY. Content will include, but not be limited to:

A. A detailed description of how DHCS has operationalized this domain, including information about which entities (DHCS, MCOs, dental vendor, others) have responsibility for the components of this domain;
B. The number of individual incentives paid and the total amount expended under this domain, by county, in the current DY;
C. A descriptive assessment of the impact of this domain on provision of the following to targeted children
    1. Dental exams;
    2. Use of and expenditures on preventive dental services; and
    3. Use of and expenditures on other dental services.
D. A discussion of the extent to which the metrics described for this domain are proving to be useful in understanding the effectiveness of the activities undertaken in the domain;
E. An analysis of change in cost per capita;
F. A descriptive analysis of any program integrity challenges generated by this domain and how those challenges have been, or will be, addressed; and
G. A descriptive analysis of the overall effectiveness of the activities in this domain in meeting the intended goals, any lessons learned, and any adjustments recommended.

e. Financing Subject to the annual funding limits contained herein and any annual limit applicable to this specific domain, incentive payment amounts will be made available in tiers based on the length of time a beneficiary maintains continuity of care with the same service office location. Tier one (1) payments will be provided on a per-child basis for beneficiaries who receive at least two (2) examinations from the same service office location for two (2) consecutive years. In each subsequent year, the dollar amount of the incentive payment for an exam of the same child within that period would be increased. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in STC 105.

f. Evaluation The results of this project will be used to determine if incentive payments are effective in promoting continuity of care for the targeted children under this domain.

109. Local Dental Pilot Program

Local dental pilot projects (LDPPs) will address one (1) or more of the three (3) domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships. DHCS will require local pilots to have broad-based provider and community support and collaboration including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of the Department in any of the domains specified above. DHCS will solicit proposals once at the beginning of the demonstration and shall review,

approve, and make payments to LDPPs in accordance with the requirements outlined in Attachment JJ; a maximum of fifteen (15) LDPPs shall be approved. DHCS will work in collaboration with the CMS in the development of evaluation criteria for the LDPPs.

The Department will begin this effort as pilots in select counties and will then, subject to the availability of funding under the DTI Pool, seek to implement on a statewide basis any pilot that is determined to be successful. DHCS will evaluate the pilots and consider expansion no sooner than nine (9) months following the end of PY 2.

a. Program Criteria. DHCS intends to review, approve, and make incentive payments available to pilots that target an identified population of Medi-Cal eligible child beneficiaries in accordance with the requirements established jointly by the Department and CMS and deemed appropriate to fulfill specific strategies linked to one (1) or more of the domains delineated above. The specific strategies, target populations, payment methodologies, and participating entities shall be proposed by the entity submitting the application for participation and included in the submission to the Department. DHCS shall approve only those applications that meet the requirements to further the goals of one (1) or more of the three (3) dental domains. Each pilot application shall designate a responsible county, Tribe, Indian Health Program, UC or CSU campus as the entity that will coordinate the pilot. DHCS reserves the right to suspend or terminate a pilot at any time if the enumerated goals are not met. The application process is outlined in Attachment JJ.

b. Responsibility of Providers. The responsibility of the providers would be contingent upon the design of the pilot program being proposed as outlined in Attachment JJ.

c. Performance Metrics. Performance metrics for each pilot shall mirror the metrics delineated in this STC document.

d. State Oversight, Monitoring, and Reporting
    i. The Department shall designate someone within the Department as the person with primary responsibility for oversight of the pilots.
    ii. The Department shall routinely monitor the progress made by the responsible county of the accepted dental pilot proposal.
    iii. Reporting requirements shall be delineated in the submitted proposals.
    iv. The Department will ensure that the terms of the proposal are abided by. The Department will be responsible for reporting on the pilots to CMS on an annual basis in the demonstration annual report.
    v. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY.
    vi. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY. Content will include, but not be limited to:
        A. A detailed description of how DHCS has operationalized this aspect of the demonstration, including the solicitation and selection process;
        B. The number of pilot projects funded and the total amount expended

under this domain in the current DY;

C. A description of the pilot projects selected for award; including but not limited to their specific strategies, target populations, payment methodologies, annual budget, and expected duration, the performance metrics with which they will be measured; as well as the goals they intend to achieve;
D. An assessment of the pilot projects selected for award, including their performance and outcomes, replicability, any challenges encountered, actions undertaken to address those challenges, as well as information on payments made to each pilot project by the Department;
E. A descriptive assessment of the impact of this aspect of the demonstration on achieving the goals in domains one (1) through three (3); and
F. A descriptive analysis of any program integrity challenges generated by this aspect of the demonstration, and how those challenges have been, or will be, addressed.

e. Financing. DHCS will to make available funding to the LDPP only on the basis of an approved application pursuant to (a) above. Total funding for LDPPs is limited to a maximum of twenty-five (25) percent of the annual funding amounts listed in STC 105. The incentive funding available for payments will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in STC 105.

f. Evaluation Local dental pilot projects will be evaluated consistent with the performance metrics of the aforementioned dental domains and the goals outlined in the individual proposals. DHCS reserves the right to suspend or terminate a pilot at any time if the enumerated goals are not met.

D. Whole Person Care Pilots

110. Whole Person Care Pilots. The overarching goal of the Whole Person Care (WPC) Pilots is the coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources. WPC Pilots will provide an option to a city, county, a city and county, a health or hospital authority, or a consortium of any of the above entities serving a county or region consisting of more than one county, or a health authority, to receive support to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. Through collaborative leadership and systematic coordination among public and private entities, WPC Pilot entities will identify target populations, share data between systems, coordinate care real time, and evaluate individual and population progress – all with the goal of providing comprehensive coordinated care for the beneficiary resulting in better health outcomes.

The investment in this localized effort will build and strengthen relationships, and improve collaboration among participating WPC Pilot entities. The results of these

Program Purpose and Goals

Within the Medi-Cal 2020 waiver, the Dental Transformation Initiative (DTI) represents a critical mechanism to improve dental health for Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this strategy aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Given the importance of oral health to the overall health of an individual, California views improvements in dental as critical to achieving overall better health outcomes for Medi-Cal beneficiaries, particularly children. The dental strategies implemented in this pool would be developed and operated by the Department and our Fee-For-Service (FFS) and Dental Managed Care (DMC) contractors.

The DTI will be funded at a maximum of $148 million annually, except as provided below, for five (5) years totaling a maximum of $740 million (DTI Pool). To the extent any of the funds associated with the DTI are not fully expended in a given DY, those remaining prior DY funds may be available for DTI payments in subsequent years, notwithstanding the annual limits stated above. The program will include three (3) domains: preventive services, caries risk assessment and management, and continuity of care, in addition to making funding available for local pilots that address one (1) or more of these three (3) domains. Specific incentive payments within each domain will be available to qualified providers, along with messaging and education to providers and beneficiaries about programs and efforts in their local communities. The Department also intends to have participation from providers in both the FFS and DMC delivery systems beginning in DY 1. The Department will make incentive payments directly to contracted service office locations that participate in the FFS and/or DMC delivery systems that qualify for incentive payments. The service office location is the business or pay-to address where services are rendered by the provider (which may be an individual, partnership, group, association, corporation, institution, or entity that provides dental services). Incentive payments shall be issued to the service office location based on the services rendered at the location and compliance with the criteria enumerated in the STCs.

Dental Program Background

The Medi-Cal Dental Program provides services to 5.5 million Medi-Cal child beneficiaries age twenty (20) and under. Dental services are provided through two (2) delivery systems: Medi-Cal Dental FFS, referred to as Denti-Cal, and DMC. Most beneficiaries are served through the dental FFS delivery system. The Department of Health Care Services (DHCS, Department) conducts oversight of the FFS contractor(s) and six (6) DMC contracts. As the expansion of dental benefits continues to cover more Californians, increased monitoring of beneficiary utilization and provider participation is crucial for identifying any access to dental care issues for children enrolled in the Medi-

Cal Dental Program.

DHCS facilitates access to oral health services for the FFS and DMC delivery systems in multiple ways, including through telephone service centers and correspondence controls for beneficiaries and providers; conducting beneficiary and provider outreach and education; strategies for monitoring and augmenting provider network adequacy and beneficiary utilization; and providing regular reports to the Legislature, stakeholders, and Federal and State government entities. All data and measurement reporting associated with the DTI will be based on an annual reporting period by Demonstration Year (DY).

Project 1: Increase Preventive Service Utilization for Children
Required Project

Project Domain	Increase Preventive Services Utilization for Children
Rationale (Evidence base and reasoning behind project idea)	
Based on reports produced by the Department of Health Care Services (DHCS), as of September 2015 the Denti-Cal provider network had 5,370 service office locations across California. DHCS is proposing to incentivize dental provider service office locations to increase preventive oral care to Medi-Cal children.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	

- Increase the statewide proportion of children ages one (1) through twenty (20) and under enrolled in the Medi-Cal Dental Program and who receive a preventive dental service by ten (10) percentage points over a five (5) year period
- Maintain preventive oral care for children who previously received this service

The incentive program will provide semi-annual incentive payments to dental provider service office locations that provide preventive services to an increased number of Medi-Cal children, as determined by the Department. Eligible providers will receive payments based on them achieving an increased number of Medi-Cal children who received eligible preventive dental services, as compared to a baseline pre-determined by the Department. Providers who render preventive services to a number of children that meets or exceeds a Department pre-determined number of beneficiaries, by service of location, would qualify for the incentive payment.

Further, the program will also disburse incentive payments to providers who were not previously participating in Medi-Cal and rendering preventive services, but who do so during the demonstration, on the condition that they meet or exceed the provision of services based on the Department pre- determined number of beneficiaries, by county, needed to be served to achieve the goal. The new service office location's pre-determined number will be the average number of additional beneficiaries among all existing service office locations in the county needed to increase the statewide goal of two (2) percentage points. In subsequent demonstration years, the Department will re-evaluate the new service office location and develop a benchmark using the same methodology as described above for existing dental providers in the program.

Safety net clinics would also be eligible for these incentives and would be supplied with incentive payments separate and apart from their Prospective Payment System (PPS) or Memorandum of Agreement (MOA) rates for Federally Qualified Health Centers/Rural Health Centers and Tribal Health Centers, respectively. Each safety net clinic office location would be considered a dental service office location for purposes of this domain.

The Department will determine the number of additional beneficiaries to be served in order to achieve the goal of ten (10) percentage point utilization increase statewide. To illustrate, if a service office location provided preventative services to 1,000 beneficiaries for the selected benchmark year, its baseline benchmark is 1,000. In the first year, the annual target benchmark will be to increase by two (2) percent of 1,000; thus this service office location would need to provide preventive services to an additional 20 new beneficiaries (1,000 x 0.02 = 20).

DHCS may earn additional demonstration authority, up to a maximum of $10 million, to be added to the DTI Pool for use in paying incentives to qualifying providers under DTI, by achieving higher performance improvement, as indicated in the below table:

DY	Target	$1 million in additional demonstration authority for achieving:	$2 million in additional demonstration authority for achieving:
1	+ two (2) percentage points over baseline year	Not Applicable	+ three (3) or more percentage points over baseline year
2	+ four (4) percentage points over baseline year	+5 or more percentage points over the baseline	+ six (6) or more percentage points over baseline year
3	+ six (6) percentage points over baseline year	+7.5 or more percentage points over the baseline	+ nine (9) or more percentage points over baseline year
4	+ eight (8) percentage points over baseline year	+10 or more percentage points over the baseline	+ twelve (12) or more percentage points over baseline year
5	+ ten (10) percentage points over baseline year	+12.5 or more percentage points over the baseline	+ fifteen (15) or more percentage points over baseline year

Incentive payments will be based on each service office location that meets or exceeds the Department pre-determined goal for increases in preventive services provided to every child within frequency limitations regardless of whether that child is a previously established patient of that service office location.

The incentive payment for preventive services will equate to a payment of approximately seventy-five (75) percent above the Schedule of Maximum Allowances (SMA) incentive payment for service office locations that meet or exceed a 2 percentage point increase in number of children receiving a preventive dental service on an annual basis, above the predetermined baseline number of children receiving a preventive dental service in the previous year. Alternatively, incentive payments for preventive services will equate to a payment of approximately thirty-seven and a half (37.5) percent above the SMA incentive payment for service office locations that meet at least a 1 percentage point increase, but less than 2 percentage point increase in number of children receiving a preventive dental service on an annual basis above the predetermined baseline number of children served with a preventive dental service in the previous year. To the extent that the projected funding limit would be reached for this Domain, incentive payment amounts will be reduced for each claim by the percentage by which incentive payments would otherwise exceed the annual limit. These payments are subject to annual funding limits contained herein and any annual limit applicable to this specific domain. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable PY, except as provided for in the Medi-Cal 2020 Waiver Special Terms and Conditions (STCs).

The results of this project will be used to determine if provider incentive payments are an effective method by which to encourage service office locations to provide medically necessary preventive dental services to more Medi-Cal children and to what extent an incentive payment is an effective method for increasing Medi-Cal provider participation

and improving access to care for children. The Department anticipates that increased preventive services will result in decreased long term costs for more invasive procedures, one of the core tenants of the Triple Aim concept.

A reassessment of this Domain and the applicable benchmarks will take place between years two and three in order to evaluate program effectiveness, increases in preventive services, adjustments for population growth or decline throughout the state, and other factors as may be appropriate.

Core Components

The baseline year will consist of data from the most recent complete year preceding implementation of the waiver. Beneficiary utilization and service office location participation will be reassessed on an annual basis thereafter. The metrics that will be used for monitoring domain success are:

1. Percentage of beneficiaries who received any preventive dental service during the measurement period, which is calculated as follows:

   Numerator: 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 dental service (D1000-D1999) in the measurement period.

   Denominator: 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.

2. Claims data to determine the number of service office locations in each county that are providing preventive dental services to children, compared to number of these locations in the baseline year.

3. Statewide the number and percentage change of Medicaid participating dentists providing preventive dental services to at least ten (10) Medicaid-enrolled children in the baseline year, and in each subsequent measurement year.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.

Projects Metrics

Clinical Event Outcomes	1. Prevention • Increase the utilization of children ages one (1) through twenty (20) enrolled in Medi-Cal who receive any preventive dental service, by at least ten (10) percentage points over a five (5) year period. 2. Access to Care Increase the number of actively participating providers in each county who provide preventive services.

Project 2: Caries Risk Assessment and Disease Management Pilot
Required Project

Project Domain	Caries Risk Assessment and Disease Management Pilot
Rationale (Evidence base and reasoning behind project idea)	
Dentists today are embracing a philosophy of prevention and taking proactive measures to prevent and mitigate oral disease. The key elements of this model are to formally assess and manage caries risk and to emphasize the provision of preventive services in lieu of more invasive and costly procedures for Medi-Cal children age six (6) and under enrolled in the Medi-Cal Dental Program. Caries Risk Assessment (CRA) incorporates an evidence-based philosophy which focuses on preventive and intervention therapy based on an individual patient's caries risk through prevention, intervention, education, and identification. Ultimately, this will enable DHCS to work toward the achievement of the CMS Triple Aim goals by implementing provider incentives based on performing a CRA to identify a child's risk level, and developing and completing a beneficiary specific treatment plan. Additionally, it will enable the Medi-Cal Dental Program to improve the overall oral health of the enrolled beneficiary population.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	

- Diagnose early childhood caries and treat it as a chronic disease
- Introduce a model that proactively prevents and mitigates oral disease through the delivery of preventative services in lieu of more invasive and costly procedures, aimed at improving the population's oral health
- Track the target population's utilization of preventive and restorative services

This four (4) year domain will only be available initially to dentists in pilot counties that elect and are approved by the Department to participate in the program. The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of DY 2. Through this effort, Medi-Cal dentists voluntarily participating in the domain will be eligible to receive incentive payments for performing pre-identified treatment plans for children based upon the beneficiary's risk level as determined by the dentist via a caries risk assessment which include motivational interviewing and use of antimicrobials, as indicated. Pilot counties will be identified and selected by the Department through an analysis of counties with a high percentage of restorative services, a low percentage of preventive services, and indication of likely enrolled service office location participation. The incentive program will only be available for services performed on child beneficiaries age six (6) and under.

Dentists participating in the domain will be authorized to perform an increased number of services per year in accordance with the pre-identified treatment plan options based

upon caries risk level, and are eligible to receive an incentive payment under this program for each additional service not currently covered under the California State Plan and frequency limitations listed in the Manual of Criteria. Subject to the annual funding limits contained herein and any annual limit applicable to this specific domain, qualifying service office locations will receive an incentive payment for providing each of these additional services. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable DY, except as provided for in the Medi-Cal 2020 Waiver STCs.

The results of this project will be used to determine if this provider incentive program is effective in encouraging providers to perform a CRA for the targeted population and to ensure completion of the appropriate treatment plan for the management of childhood caries, if the utilization of emergency room visits for dental issues among the targeted children declines, if expenditures of emergency room visits non-traumatic dental issues among targeted children declines, and if the utilization of and expenditures (including anesthesia and facility fees) for the targeted children receiving dental related general anesthesia declines.

Core Components

Dentists must first complete a CRA to determine the appropriate treatment plan for a child, and report the results of the CRA to DHCS on a claim. Once the risk level and the treatment plan have been determined, the beneficiary may be eligible for increased frequency limitations on prophylaxis, topical fluoride varnish, and exams. The pre-identified treatment plans will be composed of the following procedures: CRA (which will globally include motivational interviewing, behavior modification/nutritional counseling, and interim caries arresting medication application), application of topical fluoride varnish, prophylaxis, and exams. Increased frequencies for prophylaxis, fluoride varnish, and exams will be permitted for children evaluated and determined to be at a particular caries risk level with frequency limitations in a twelve (12) month period, as follows: “high risk” will be authorized to visit their provider four (4) times; “moderate risk” children will be authorized to visit three (3) times; and “low risk” children two (2) times. Dentists will receive payment for completion of a CRA as well as each of the following services: application of topical fluoride varnish, toothbrush prophylaxis, and exams at their respective appropriate increased frequency limitations.

The Department will collect data and report on the following performance measures:

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 (not available in the baseline year prior to the Waiver implementation);
4. Change in use of emergency rooms for dental related reasons among the targeted children for this domain; and
5. Change in number and proportion of children receiving dental surgery under general anesthesia.

The Department will also track and report on, for children in age ranges under one (1), one (1) through two (2), three (3) through four (4), and five (5) through six (6), the utilization rates for restorative procedures against preventive services to determine if the domain has been effective in reducing the number of restorations being performed. Because preventive services do not yield immediate effects, the Department will be required to collect data on these performance measures at annual intervals for a number of years to determine correlation and statistical significance. The Department will inform CMS of the number of additional years this data will be collected and reported no later than the end of DY 1.

The Department will also track and report on the utilization of CRA and treatment plan service to monitor utilization and domain participation.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.

Project Metrics	
Clinical Event Outcomes	1. <u>Caries Risk Assessment</u> • Increase utilization of CRA CDT codes and monitor movement between risk levels 2. <u>Caries Management</u> • Increase ratio of utilization of preventive services versus restorative • Decrease utilization of use of emergency room and oral surgery for dental related reasons among children

Project 3: Increase Continuity of Care
Required Project

Project Domain	Increase Continuity of Care
Rationale (Evidence base and reasoning behind project idea)	
Maintaining a consistent relationship with a primary care dental provider can encourage children and their families to receive regular preventive care and to actively manage their care.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	
➢ Increase dental continuity of care among Medi-Cal children enrolled in the Medi-Cal Dental Program The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of DY 2. The results of this project will be used to determine if incentive payments are effective in promoting continuity of care, consistent with the enumerated Triple Aim goals.	
Core Components	

To encourage the continuity of care within the beneficiary population, an incentive payment would be paid to dental provider service office locations who have maintained continuity of care through providing examinations for their enrolled child beneficiaries, age twenty (20) and under for two (2), three (3), four (4), five (5), and six (6) year continuous periods. The incentive will be a flat payment for providing continuity of care to the beneficiary. Incentive payments will be made annually.

The baseline year will be based on data from the most recent complete state fiscal year. Using claims data, DHCS will determine the 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 following the establishment of the baseline year throughout the demonstration period. This will be calculated as follows:

Numerator: 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.

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

This measure is similar to the Dental Quality Alliance measure Usual Source of Services, with the exception that the Department would incent over a longer continuous period.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.	
Project Metrics	
Clinical Event Outcomes	1. Continuity of Care • Increase utilization of children continuously enrolled in the Medi-Cal Dental Program who received services performed by the same provider in two (2), three (3), four (4), five (5), and six (6) consecutive year periods.

Project 4: Local Dental Pilot Programs
Optional Project

Project Domain	Pediatric Oral Disease Prevention, Caries Risk Assessment and Management, and Dental Health Homes
Project Title	Local Dental Pilot Programs (LDPPs)
Rationale (Evidence base and reasoning behind project idea)	
LDPPs shall address one (1) or more of the three (3) domains through alternative programs, potentially using strategies focused on rural areas including local case management initiatives and education partnerships. DHCS will require LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of the Department in any of the domains specified above.	
Goals/Objectives (Project-specific Triple Aim goals and expected project outcomes)	

Increase dental prevention, caries risk assessment and disease management, and continuity of care among Medi-Cal children.

DHCS will solicit proposals once at the beginning of the demonstration and shall review, approve, and make payments to LDPPs in accordance with the requirements as outlined below; a maximum of fifteen (15) LDPPs shall be approved. DHCS will work in collaboration with the CMS in the development of evaluation criteria for the LDPPs.

a. LDPPs should include the potential for statewide expansion.

b. LDPPs shall include specific strategies to meet one (1) or more of the three (3) DTI domains.
   i. Increase preventive services utilization for children;
   ii. Increase caries risk assessment and disease management; and
   iii. Increase continuity of care

c. LDPPs are intended to target individuals in need of dental services. LDPPs will identify the needs of their population and proposed interventions that would be supported through the LDPP in their application. LDPPs must be complementary and not redundant with the efforts describe in the aforementioned domains.

d. The specific strategies, target populations, payment methodologies, and participating entities shall be established by the entity submitting the application. DHCS shall approve applications that meet the requirements as outlined by CMS and the Department established criteria and that further the goals of the DTI. Each LDPP is intended to be in operation from the date of approval through the end of the demonstration. However, DHCS reserves the right to suspend or terminate a LDPP at any time if the enumerated goals are not met, corrective

action has been imposed, and/or poor performance continues.

e. Financing for LDPPs is contingent upon the structure and design of approved proposals and is limited to a maximum of twenty-five (25) percent of the annual funding limits contained herein and any annual limit applicable to this specific domain. The incentive funding available for payments within this domain will not exceed the amount apportioned from the DTI pool to this domain for the applicable DY, except as provided for in the Medi-Cal 2020 Waiver STCs.

Lead and Participating Entities.

a. DHCS will accept applications for LDPPs from a county, a city and county, a consortium of counties serving a region consisting of more than one (1) county, a Tribe, an Indian Health program, UC or CSU campus. Each LDPP application shall designate a "lead entity" that will be a county, Tribe, Indian Health Program, UC or CSU campus that will coordinate the LDPP and be the single point of contact for DHCS and CMS.
b. The LDPP application shall identify other entities that shall participate in the project.

Application Process.

a. *Timing.* Lead entities shall submit LDPP applications to DHCS no later than 60 days after the applicable protocols are approved.

b. *Application Contents*. LDPP applications must include:
   i. identification of a LDPP lead entity;
   ii. a collaboration plan that includes local partners and details how decisions will be made;
   iii. a description of the needs assessment that was conducted to identify the target population(s), including the data used;
   iv. a description of services and care coordination that will be available to beneficiaries under the LDPP;
   v. a description of how the lead entity and participating providers will be accountable for ensuring that the patient's receive timely, medically necessary care;
   vi. detail of the specific interventions, including how a process improvement plan will be incorporated to modify and learn from the interventions during the LDPP;
   vii. a description of how data sharing will occur between the entities, including what data will be shared with which entities;
   viii. a description of other strategies and outreach efforts that will be implemented to achieve the goals of the LDPP in the form of an awareness plan;
   ix. a plan for the lead entity to conduct ongoing monitoring of the LDPP and make subsequent adjustments when issues are identified;
   x. letters of support from participating providers and other relevant

stakeholders indicating their agreement to participate in or support the

LDPP;

xi. a financing structure including a description of how and to whom LDPP payments will be distributed; and

xii. a total requested annual dollar amount, which shall be based on budgeted costs for infrastructure and overall LDPP support and the expected value or impact of the LDPP. Budgets shall exclude costs for services reimbursable with Medi-Cal Dental or other federal funding resources.

c. *DHCS Review Process*. DHCS will review all LDPP applications according to the guidelines to be established by DHCS and CMS.

i. DHCS shall review each application for projects to verify that they conform to the relevant requirements and meet the selection criteria as established by DHCS and CMS. DHCS will complete its review of the application, and will respond to the LDPP lead entity in writing with any questions, concerns, or problems identified. The lead entity will respond to DHCS' questions and concerns in writing within five (5) business days.

ii. Following the submission of final responses to questions about the application, DHCS will take action on the application and promptly notify the applicant and CMS of that decision.

Termination. DHCS reserves the right to suspend or terminate a LDPP at any time if the enumerated goals are not met, corrective action has been imposed, and/or poor performance continues.

Progress Reports. The LDPP shall submit quarterly and annual reports as agreed upon by DHCS and CMS upon acceptance of the LDPP. Continuation of the LDPP shall be contingent on timely submission of all the required reports.

The Department will begin this effort as a pilot in select counties and will then seek to implement on a statewide basis if the pilot is determined to be successful and subject to the availability of funding under the DTI Pool. If successful, DHCS will consider expansion no sooner than nine (9) months following the end of DY 2.

Core Components

DHCS intends to review, approve, and make incentive payments available to pilots that target an identified population of Medi-Cal eligible child beneficiaries in accordance with the requirements established by the Department and deemed appropriate to fulfill specific strategies linked to one (1) or more of the domains delineated above. The specific strategies, target populations, payment methodologies, and participating entities shall be proposed by the entity submitting the application for participation and included in the submission to the Department. DHCS shall approve only those applications that meet the requirements to further the goals of one (1) or more of the three (3) dental domains. Each pilot application shall designate a responsible county who will coordinate the pilot. DHCS reserves the right to suspend or terminate a pilot at

any time if the enumerated goals are not met, corrective action has been imposed, and/or poor performance continues. A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.	
Project Metrics	
Clinical Event Outcomes	Local dental pilot projects will be evaluated consistent with the performance metrics of the aforementioned dental domains and the goals outlined in the individual proposals. DHCS reserves the right to suspend or terminate a pilot at any time if the enumerated goals are not met. Any of the following, or other measures that are closely tied the DTI domains. **Increase Preventive Services Utilization for Children** 1. Prevention • CMS Oral Health Initiative Goal: To increase the utilization of children ages twenty (20) and under enrolled in Medicaid or CHIP who receive any preventive dental service, by ten (10) percentage points over a five (5) year period. 2. Access to Care • Increase the number of actively participating providers in each county who provide preventive services. **Caries Risk Assessment and Disease Management Pilot** 1. Caries Risk Assessment • Increase utilization of CRA CDT codes and monitor movement between risk levels 2. Caries Management • Increase ratio of utilization of preventive services versus restorative • Decrease utilization of use of emergency room and oral surgery for dental related reasons among children **Increase Continuity of Care** 1. Continuity of Care • Increase utilization of children continuously enrolled in the Medi-Cal Dental Program who received services performed by the same provider in two (2), three (3), four (4), five (5), and six (6) consecutive year periods.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

SEP 12 2017

Ms. Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Ms. Cantwell:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved the attached evaluation design for the Dental Transformation Initiative (DTI) Program, authorized under the section 1115(a) demonstration entitled "Medi-Cal 2020" (11-W-00193/9), as submitted by the state and as modified through our discussions. A copy of the approved DTI evaluation design is enclosed.

We look forward to continuing to work with you and your staff on the California Medi-Cal 2020 Demonstration. If you have any questions, please contact your project officer, Mrs. Heather Ross, at either 410-786-3666, or by email at Heather.Ross@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

[redacted]

Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosures

cc: Henrietta Sam-Louie, ARA Region IX

I. Introduction

Within the Medi-Cal 2020 Waiver, the Dental Transformation Initiative (DTI) represents a critical strategy to improve dental health for eligible Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this initiative aims to increase the number of children receiving preventive dental services, prevent and treat more early childhood caries, and increase continuity of care for children, within the waiver's five program years from January 1, 2016 through December 31, 2020. In addition, to help accomplish these aims the Department of Health Care Services (DHCS) is also undertaking efforts to increase the number of Medi-Cal dental providers, and is engaging with stakeholders, Safety Net Clinics, Fee-For-Service providers and Dental Managed Care Plans and providers. Given the importance of oral health to the overall health of an individual, California views improvements in dental care as critical to achieving better health outcomes overall for Medi-Cal children.

The DTI covers four Domains:

Domain 1: Increase Preventive Services Utilization
This domain aims to increase preventive dental service utilization among children ages 1 through 20 by ten percentage points over the five-year duration of DTI (two percentage points per program year), through incentive payments made to providers in addition to reimbursement under the DHCS Dental Schedule of Maximum Allowances (SMA) for provider payments. Utilization is defined as the percent of eligible beneficiaries who receive preventive dental services. An increased number of beneficiaries receiving preventive services, rather than an increase in the total preventive services provided demonstrates increased utilization.

Incentive payments are made to providers based on whether the service office location meets or exceeds State-predetermined goals for the number of beneficiaries to receive any preventive service. Service office locations are eligible to earn full incentive payments of 75 percent of the SMA when meeting a benchmark that represents a 2-percentage point increase in beneficiaries receiving preventive services, or partial incentive payments at 37.5 percent of the SMA reflecting achievement of a 1 to 1.99 percentage point increase in beneficiaries receiving preventive services. The incentive payment of 75 percent of SMA for the 11 eligible preventive services varies from $3.00 to $86.25.

Because dental providers have up to 12 months from the date of service to submit claims and the waiver requires the most recent year of complete data, DHCS uses calendar year 2014 (January 1, 2014 to December 31, 2014) preventive services utilization by beneficiaries with at least 90 continuous days eligibility as the baseline for Domain 1. A benchmark is calculated based on the number of beneficiaries who visited a service office location in the baseline year plus a two percent increase in each

program year. The benchmark for a new service office location, without 2014 baseline claims data, is a two percent increase above the average number of beneficiaries who visited existing service office locations in the same county.

Domain 2: Caries Risk Assessment and Disease Management Pilot

Under this four-year domain, dental providers in selected pilot counties will be eligible to receive incentive payments for performing pre-defined caries risk assessments (CRAs), developing treatment plans, and providing nutritional and motivational counseling for Medi-Cal children ages 6 and under based upon the child's risk. This domain seeks to prevent and mitigate oral disease through the delivery of preventive services in lieu of more invasive and costly procedures (restorative services). Claims data and number of beneficiaries with no more than a one-month gap of eligibility for State Fiscal Year (SFY) 2013-2014 and SFY 2014-2015 were collected and analyzed to select pilot counties and project the fiscal impact of this domain. Pilot counties were selected by the department through an analysis identifying counties with a high percentage of restorative services, a low percentage of preventive services, and an indication of likely participation by enrolled service office locations. Instead of having a baseline year, Domain 2 uses a control group to determine the effectiveness of CRA and treatments. The control group is defined in paragraphs below.

Aim one of this domain is to decrease caries risk levels among CRA utilized children from the pilot counties over the four years of domain 2 implementation. This goal is based on a research article (Ng, 2014) which showed 28 percent lower rates of new cavitation lesions compared to baseline historical controls over two and half years in seven participating hospitals. DHCS proposes a goal of 20 percent of the CRA utilized children age six and under from the pilot counties will have lowered their level of caries risk.

Aim two is to decrease the number of emergency room (ER) visits for dental related reasons, excluding dental trauma, among the targeted children for this domain. The goal is based on the same research article (Ng, 2014) which showed pain related to untreated decay compared to baseline historical controls, which had 27 percent improvement over two and a half years in the seven participating hospitals. DHCS proposes a goal of a 20 percent decrease in ER visits among CRA utilized children age six and under from the pilot counties compared to the control group – Medi-Cal beneficiaries with same age group, caries risk levels and counties of residency who do not receive CRA treatment.

Aim three is to decrease the number of children receiving dental surgery under general anesthesia (GA). The goal is based on the same research article (Ng, 2014) which showed the referrals for restorative treatment under GA in the operating room had 36 percent improvement over two and half years in the seven participating hospitals, compared to baseline historical controls. DHCS proposes a goal of a 20 percent decrease in use of GA among CRA utilized children ages six and under from the pilot counties compared to the control group mentioned above.

The CRA reimbursement amount is $126.00, which includes procedure codes D0601, D0602, and D0603 - Caries risk assessment – Low, Moderate, and High respectively, D1310 - Nutritional counseling and D9993 - Motivational interview. Provider frequency limitations allow low risk beneficiaries to receive a CRA every six months, moderate risk beneficiaries to receive a CRA every four months, and high risk beneficiaries to receive a CRA every three months. The CRA reimbursement amount for D1354-Interim caries arresting medication is $35.00 for high risk beneficiaries every six months. Cost-benefit ratios, also known as costs per capita based on the Medi-Cal 2020 Special Terms and Conditions (STCs), are $252.00 for low risk, $441.00 for moderate risk and $700.00 for high risk beneficiaries.

Domain 3: Continuity of Care

This domain seeks to increase continuity of care for the targeted population over 2, 3, 4, 5, and 6 continuous year periods by making available incentive payments to dental service office locations in selected pilot counties who have maintained continuity of care through providing recall examinations to their enrolled Medi-Cal children ages 20 and under. Continuity of care means the targeted population re-visits the same dental service office locations over two, three, four, five, and six continuous years over the domain demonstration period (January 1, 2016 through December 31, 2020). The goal of Domain 3 is to improve the continuity of care for targeted children in participating counties, through annual examinations (D0120, D0150, or D0145) with their established dental provider, with a goal of at least a 5 percentage point improvement over the course of the domain years. The baseline period for Domain 3 is calendar year 2015.

Incentive payments are calculated for each beneficiary by year(s) of continuity of care, on a tiered schedule, based on the number of years a service office location maintains continuity of care with the same beneficiary. The incentive payment by beneficiary by continuity of care in tier year 1 is $40.00 per person, in tier year 2 is $50.00 per person, in tier year 3 is $60.00 per person, in tier year 4 is $70.00 per person and in tier year 5 is $80.00 per person.

The calculation of two-year continuity of care is same as the performance metrics defined in the STCs. The numerator is the number of children age twenty and under who received an examination from the same service office location with no gap in service for two continuous years. The denominator is the number of children age twenty and under enrolled in the delivery system during the measurement periods. To be consistent with Domain 1 and 2, the baseline year continuity of care is calculated by children age twenty and under received an examination from the same service office location in both calendar year 2014 and 2015.

Domain 4: Local Dental Pilot Programs (LDPPs)

Local Dental Pilot Projects (LDPPs) will address the above-described domains through pilot programs aimed at increasing preventive services, CRAs and disease management and continuity of care through alternative programs and potentially use of

strategies focused on rural areas, including local case management initiatives and education partnerships. The LDPPs are not to be duplicative of the efforts undertaken by DHCS in the aforementioned domains.
DHCS intends to make incentive payments to pilots that target an identified population of Medi-Cal eligible children and are deemed appropriate to fulfill specific strategies linked to one (1) or more of the domains delineated above. The specific strategies, target populations, payment methodologies, and participating entities are to be proposed by the entity submitting the application for participation and included in the submission to DHCS. Each LDPP application designates a "lead entity" that is a county, Tribe, Indian Health Program, UC or CSU campus and will coordinate the LDPP and be the single point of contact for DHCS and the Centers for Medicare and Medicaid Services (CMS). Each LDPP shall identify the lead and participating entities, target populations, collaboration plans, services and care coordination, pilot project innovations, interventions and/or strategies, data sharing, monitoring and reporting, financing structure, funding request, and budget for the LDPP.

The approved 15 LDPPs are as follows:

- Alameda County
- California Rural Indian Health Board, Inc.
- California State University, Los Angeles
- First 5 Kern
- First 5 San Joaquin
- First 5 Riverside
- Fresno County
- Humboldt County
- Northern Valley Sierra Consortium
- Orange County
- Sacramento County
- San Luis Obispo County
- San Francisco City and County Department of Public Health
- Sonoma County
- University of California, Los Angeles

II. Demonstration Goals and Objectives

The primary goal of the DTI is to improve dental health for eligible Medi-Cal children by focusing on high-value care, improved access, and utilization of performance measures to drive delivery system reform. More specifically, this initiative aims to increase the use of preventive dental services, prevent and treat more early childhood caries, and increase continuity of care for children. The evaluation will examine progress toward each of these goals.

The aim of the evaluation is to determine the causal impacts of the DTI Demonstration on how incentive payments influence:

- The utilization of preventive services amongst Medi-Cal children ages 1 through 20, with the goal of increasing utilization rates by at least 10 percentage points over a five-year period. (Domain 1 & Domain 4)
- Provider participation in a program to treat early childhood caries with the following goals to be achieved:
    1. A 20 percent decrease in CRA risk level among CRA utilized children age six and under from the pilot counties compared to the control group – Medi-Cal beneficiaries with same age group, caries risk levels and counties of residency who do not receive CRA treatment.
    2. A 20 percent decrease in use of ER visits among CRA utilized children age six and under from the pilot counties compared to the control group – Medi-Cal beneficiaries with same age group, caries risk levels and counties of residency who does not receive CRA treatment.
    3. A 20 percent decrease in use of GA among CRA utilized children ages six and under from the pilot counties compared to the control group mentioned above.

- The continuity of care for targeted children age twenty and under in participating counties, through annual examinations with their established dental provider, with a goal of at least a 5 percentage point improvement in two-year continuity of care over the demonstration period. (Domain 3 & Domain 4)

A. Research Questions and Hypotheses

Evaluation questions and related hypotheses are as follows:

Domain 1 & 4:

- Question: Will the payment incentives lead to higher utilization rates for preventive services?
- Hypothesis: The participating service office locations will increase the number of Medi-Cal children to whom they provide preventive dental services by at least ten percentage points over a five-year period.

- Question: Will incentive payments lead to an increase in Medi-Cal provider participation?
- Hypothesis: At least a five percent increase in the number of providers will be motivated to enroll as Medi-Cal providers within five years as a result of the availability of incentive payments.

- Question: Will an increase in the number of providers participating in Medi-Cal lead to an increase in the number of children receiving preventive dental services?

- Hypothesis: To the extent that provider incentive payments are an effective method of increasing provider participation in Medi-Cal, an increase in the number of providers will result in an increase in the number of children receiving preventive dental services by 10 percentage points over a five-year period.

Domain 2 & 4:

- Question: Do provider incentive payments lead providers to perform CRA for the targeted population?
- Hypothesis: Provider incentive payments are effective in encouraging providers to perform CRA for the targeted population.

- Question: Do provider incentive payments lead providers to ensure completion of appropriate treatment modalities for the management of early childhood caries?
- Hypothesis: Provider incentive payments ensure completion of appropriate treatment modalities for the management of early childhood caries by requesting a bundle submission of CRA procedures in one claim to receive incentive payments. This will result in a 20 percent of children ages six and under from the pilot counties to reduce their level of caries risk by the end of the demonstration of Domain 2.

- Question: Does adhering to DTI demonstration protocols lead to a decline in the number of ER services for non-traumatic dental emergencies for children ages six and under in Domain 2 pilot counties?
- Hypothesis: The number of ER services for non-traumatic dental emergencies among the CRA utilized beneficiaries will be lower than the control group by 20 percent.

- Question: Does adhering to DTI demonstration protocols lead to a decline in the use of dental related GA for children ages six and under in Domain 2 pilot counties?
- Hypothesis: The use of dental related GA among the CRA utilized beneficiaries will be lower than the control group by 20 percent.

Domain 3 & 4:

- Question: Are incentive payments effective in promoting continuity of care for targeted children?
- Hypothesis: Incentive payments are an effective method of promoting continuity of care for targeted children in participating counties and will achieve at least a 5 percentage point improvement in two-year continuity of care, over the demonstration period.

Domain 1, 2, 3, & 4:

- Question: Will the provider incentive payments for preventive services and continuity of care have a more favorable cost benefit ratio than that of CRA?

- Hypothesis: The provider incentive payments for preventive services and continuity of care provide a more favorable cost benefit ratio than that of CRA. Cost benefit ratio is measured as cost per capita, meaning the amount of incentive payments divided by number of beneficiaries who contributed to the payment of a year.

B. Evaluation Design and Approach

Determination of the best approach to evaluate the causal effects of the DTI demonstration is challenging. When considering alternative evaluation designs, the implementation of some DTI Domains in select counties versus statewide, uncertainty regarding participation of dental providers and variation among strategies implemented among LDPP awardees must be taken into account. All dental providers in a select county and/or LDPPs may not be ready to participate in the Domains immediately. It is likely that Domain implementation will not be tightly tied to stated implementation dates. As a result, the start dates used in data collection or analyses will in some instances be based on an individual dental provider's implementation start dates, rather than California's stated implementation dates.

The proposed evaluation will use an interrupted time series design that, under a multiple baseline design, allows implementation of the respective Domains at multiple points staggered over time with a hypothetical outcome of measurement of treatment access or quality of care. Changes in outcomes following Domain implementation, coupled with the absence of changes in other counties that were not selected for the Domain may suggest that the change observed resulted from the implementation of the demonstration. A multiple baseline design can be used to study the changes created by the demonstration.

To determine whether incentive payments have been effective in meeting the goals of the DTI demonstration, the evaluation will examine the availability of services along the full continuum of dental care, dental services provided to eligible Medi-Cal children and target populations, performance metrics for each of the Domains and any health care cost offsets resulting from appropriate use of dental services using a logic model.

To determine the cost benefits of the DTI, a cost-benefit analysis of the DTI and each of the Domains, as well as any health care cost offset resulting from the appropriate use of dental services, will be conducted.

C. Performance Measures

Domain 1 & 4

The baseline year will consist of data from the most recent complete year preceding implementation of the waiver. The metrics that will be used for monitoring domain success are:

1. Percentage of beneficiaries who received any preventive dental service during the measurement period, which is calculated as follows:

Numerator: 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 dental service (D1000-D1999) in the measurement period.

Denominator: 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.

2. Claims data to determine the number of service office locations in each county that are providing preventive dental services to children, compared to number of these locations in the baseline year.

3. Statewide, the number and percentage change of Medicaid participating dentists providing preventive dental services to at least ten (10) Medicaid-enrolled children in the baseline year, and in each subsequent measurement year.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY

Domain 2 & 4

The Department will collect data and report on the following performance measures:

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 (not available in the baseline year prior to the Waiver implementation);

4. Change in use of emergency rooms for dental related reasons among the targeted children for this domain; and

5. Change in number and proportion of children receiving dental surgery under general anesthesia.

The Department will also track and report on, for children in age ranges under one, one through two, three through four, and five through six, the utilization rates for restorative procedures (D2000-D2999) and all dental treatment procedures (D2000-D9999) vs preventive services (D1000-D1999) to determine if the domain has been effective in reducing the number of restorations and other dental treatments being performed.

To measure the goals of this domain, ICD codes for non-traumatic ER, dental procedure codes for GA and oral surgery will also be collected and analyzed to give a more complete picture of the services and make it helpful to evaluate the effect of the intervention.

Because preventive services do not yield immediate effects, the Department will be required to collect data on these performance measures at annual intervals for many years to determine correlation and statistical significance.

The Department will also track and report on the utilization of CRA and treatment plan service to monitor utilization and domain participation.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.

Domain 3 & 4

The baseline year will be based on data from the most recent complete state fiscal year.

Using claims data, DHCS will determine the 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 following the establishment of the baseline year throughout the demonstration period. This will be calculated as follows:

Numerator: Number of children age twenty (20) and under who received an examination from the same service office location with no gap of calendar year in service for two (2), three (3), four (4), five (5), and six (6) year continuous periods. A recall visit must take place within the second calendar year no matter the number of months between the two visits in two calendar years. For example, if a beneficiary first visited a dental service office location in January 2015 and then visited the same location for the second time in December 2016, the location who treated this beneficiary will still receive a unit of incentive payment due to this beneficiary's return in 2016.

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

This measure is similar to the Dental Quality Alliance measure Usual Source of Services, with the exception that the Department would incent over a longer continuous period.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DY.

Domain 4

DHCS intends to review, approve, and make incentive payments available to pilots that target an identified population of Medi-Cal eligible child beneficiaries in accordance with the requirements established by the Department and deemed appropriate to fulfill specific strategies linked to one (1) or more of the domains delineated above. The specific strategies, target populations, payment methodologies, and participating entities shall be proposed by the entity submitting the application for participation and included in the submission to the Department. DHCS shall approve only those applications that meet the requirements to further the goals of one (1) or more of the three (3) dental domains. Each pilot application shall designate a responsible county who will coordinate the pilot. DHCS reserves the right to suspend or terminate a pilot at any time if the enumerated goals are not met, corrective action has been imposed, and/or poor performance continues.

A preliminary report will be delivered only to CMS for internal review six (6) months following the end of the applicable DYPY. An updated report will be delivered to CMS and published publicly twelve (12) months following the end of the applicable DYPY.

D. Data Collection ([or Data Sources] by performance measure)

The data sources included in this section are described in greater detail in the Appendix 1.

1. **Administrative Data Sources**

a. Medi-Cal Eligibility Data System (MEDS): MEDS contains data on all Medi-Cal beneficiaries statewide, including demographic information and residential addresses.
b. Medi-Cal Claims and Encounter Data (DHCS data warehouse): The DHCS data warehouse, known as the Medi-Cal Management Information System/Decision Support System (MIS/DSS) contains data for Medicaid claims, which provides

identifying information on Medi-Cal eligible beneficiaries that can be linked to other datasets.

c. Medi-Cal Provider Master File (PMF): The PMF contains data for enrolled Medi-Cal dental providers and safety net clinic providers, including service office locations, pay-to addresses and delivery system details.
d. Surveillance Utilization Review System (SURS): Suspicious claim activity is tracked through SURS to prevent fraud, waste, and abuse.

In addition to the above datasets, data from any other dataset that may become available during the evaluation will be assessed to determine whether the data would add substantially to the planned analyses. If so, these datasets will be incorporated into the evaluation to the extent possible.

2. New Data Collection Activities

a. Stakeholder Surveys: Stakeholder surveys will address multiple needs. For example, Medi-Cal beneficiary and dental provider surveys may include questions on access to care, quality of care, and/or whether provider incentive payments are an effective method to encourage service office locations to provide preventive dental services and continuity of care to more Medi-Cal children or enroll as a Medi-Cal dental provider.
b. Chart Review: Beneficiary dental records at dental provider service office locations may be reviewed to inform evaluation activities.
c. Document Review: The evaluation may consider other relevant data points such as enrollment data, provider audits or grievance reports, in order to inform evaluation activities. These activities will complement but not duplicate planned review processes, which are intended to ensure that baseline requirements from the STCs are met.

III. Data Analysis Strategy (including discussion of challenges and proposed solutions)

The proposed strategy can be divided into three broad areas: Access, Quality, and Cost. The measures proposed for each of the areas are described below.

A. Access Measures

Hypotheses:

1. Provider incentive payments are an effective method to encourage dental service office locations to provide preventive dental services to targeted Medi-Cal children. Progress will be measured across all Domains by conducting a comparative analysis of the before and after utilization measures. This will entail the measurement of provider participation figures for actual number of providers, as well as number of claims received in the fee for service and managed care delivery systems. Utilization will also be measured by age stratifications consistent with CMS 416 methodology to gauge the extent of success within each Domain. Comparative analysis for proximate counties prior to the

demonstration with similar population and/or utilization that were not selected for participation will be conducted and as provided in Appendix 1, Evaluation Methodology Models.

2. Provider incentive payments are an effective method for increasing Medi-Cal provider participation, which could improve access to care for children. Progress will be measured across all Domains by conducting a comparative analysis of the before and after utilization measures. This will entail the measurement of provider participation figures for actual number of providers, as well as number of claims received in the fee for service and managed care delivery systems. Utilization will also be measured by age stratifications consistent with the CMS 416 methodology to gauge the extent of success within each Domain. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted and as provided in Appendix 1, Evaluation Methodology Models.
3. Provider incentive payments are effective in encouraging providers to perform CRA for the targeted population. Progress will be measured by comparing the utilization trends for CRA treatment plan and assessments by the CDTs within this domain. As CRA is not a covered benefit statewide, there are specific challenges imposed in this Domain as there is not a control county in which to compare. Rather, a study of the progress through all counties will be conducted.
4. Conducting CRA and initiation of treatment planning yields earlier diagnosis of caries and dental disease in children. Early diagnosis can reduce a child's risk level in the future years and lead to increased compliance with the caries management plan over the time. Progress will be measured by conducting a comparative analysis by distinguishing the CDTs that are utilized within this Domain and assessing whether the risk level associated with the child also affects the provider's ability to complete the CRA treatment plan and assessments. As CRA is not a covered benefit statewide, there are specific challenges imposed in this Domain as there is not a control county in which to compare. Rather, a study of the progress through all counties will be conducted. Stratifications consistent with the CMS 416 methodology will be utilized.
5. Utilization of emergency room visits for dental issues among the Domain 2 participating beneficiaries will decline. Utilization of emergency room visits will be measured across all of the pilot counties for Domain 2 and compared against counties similarly situated and in close geographic proximity to assess if the number of emergency room visits declines. Further analysis will also be performed to trend if counties in which there is a higher rate of completion of appropriate treatment for the management of childhood caries affects the ratio of restorative to preventive services as well as has a residual effect resulting in the decline of emergency room services. Comparative analysis Statewide will be conducted and as provided in Appendix 1, Evaluation Methodology Models.
6. Utilization and expenditures for dental related general anesthesia for target children will decline. Utilization of general anesthesia will be measured across all of the pilot counties for Domain 2 and compared against similarly situated and in close geographic proximity to assess if the number of general anesthesia

declines. Further analysis will also be performed to trend if counties in which there is a higher rate of completion of appropriate treatment for the management of childhood caries affects the ratio or restorative to preventive services and if there is a residual effect resulting in the decline of emergency room services. Comparative analysis Statewide will be conducted and as provided in Appendix 1, Evaluation Methodology Models.

7. Provider incentive payments are an effective method of promoting continuity of care for targeted children. Progress will be measured across all Domains by conducting a comparative analysis of the before and after percentage measures in a year by year comparison for continuity of care. This will entail the measurement of total number beneficiaries in comparison to the number of beneficiaries that continued to see the same provider on an annual basis. Utilization will also be measured by age stratifications consistent with the CMS 416 methodology to gauge the extent of success within this Domain. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted and as provided in Appendix 1, Evaluation Methodology Models.
8. Promising practices will be identified with the implementation of CRA and disease management and LDPPs. Comparative analysis for proximate counties prior to the demonstration with similar population and/or utilization that were not selected for participation will be conducted and as provided in Appendix 1, Evaluation Methodology Models.

Access will be evaluated using the following measures:

- Provider enrollment, beneficiary eligibility, encounter data, and claims data will be used to evaluate access to preventive services, continuity of care, emergency services, general anesthesia utilization, and provider enrollment for periods prior to the implementation of the demonstration pilots and subsequent to implementation of the pilots.
- Claims data will be analyzed to examine changes in access and whether the frequency of preventive services, CRA and treatment, and continuity of care have increased, remained the same, or decreased for the target populations. Claims data will be examined to determine changes in utilization of emergency room visits for dental services and utilization for dental related general anesthesia utilization to determine whether emergency room visits for dental services or utilization of dental related general anesthesia have declined, remained the same, or increased for the target populations.
- Medi-Cal beneficiary and dental provider surveys regarding access to care will be used to measure perceptions of access to care.

B. Quality Measures

Hypothesis:

1. Promising practices will be identified with the implementation of CRA and disease management and LDPPs. Progress will be measured by conducting a comparative analysis by distinguishing the CDTs that are utilized within this Domain and assessing whether the risk level associated with the child also affects the provider's ability to complete the CRA treatment plan and assessments, and assessing if the increased number of CRAs has a correlation to the improvement of care by decreasing new cavitation, pain, and operating room referrals within the targeted population.

Quality will be evaluated using the following measures:

- The team will analyze the information collected through data analysis, interviews, trending program costs, utilization, and document review.
- Qualitative research will be conducted where key stakeholders (providers, administrators, beneficiaries) will go through different levels of surveys and interviews across all four domains. Interviews will target evaluation questions focused on implementation processes, incentives, effectiveness of the programs/pilots, improvement opportunities, and sustainability.
- Surveys and interviews the evaluator plans to conduct include:
    - A web-based survey of a statewide sample of Medi-Cal dental providers that can support descriptive and impact analyses. The intent is a sample of 1,403 practices stratified by domain, with oversampling of Domain 2 and 3 practices. All providers would get questions relevant to Domain 1, with additional sections for questions relevant to Domains 2 and 3.
    - A computer-assisted telephone interview survey with a sample of Medi-Cal beneficiaries in Domain 2 and 3 counties to learn about their experiences with different aspects of the demonstration and their views on dental care. The intent is a sample size of 1,754 beneficiaries stratified by domain. We will compare beneficiaries served by Domain 2 opt-in providers versus others served by providers who do not opt in.
    - In-depth qualitative telephone interviews with (1) a sample of dental providers in Domain 2 and 3 counties about their experiences and perceptions, and (2) state officials, provider associations, and other stakeholders about contextual and other factors influencing the implementation and outcomes of the DTI. The work consists of approximately 60 telephone interviews for at least two rounds with the following types of informants (number of each in parentheses): MCOs (3), safety net clinics (3 clinics each in four Domain 2 and four Domain 3 counties, for a total of 24 clinics), and other providers (3 providers each in four Domain 2 and four Domain 3 counties1 for total of 24 providers) and state officials, provider associations, and other stakeholders (9).
- Benchmarks will be set initially and the quality measures will be trended periodically to assess the progress of the programs/pilots within each domain.
- Provider enrollment, beneficiary eligibility and claims data will be used to evaluate preventive services, continuity of care, emergency services, general

anesthesia, and provider enrollment for periods prior to the implementation of the demonstration project and subsequent to implementation of the pilots.
- Medi-Cal beneficiary and dental provider surveys will be used to measure perceptions of quality of care.
- Grievance reports and provider audits will be leveraged to track the type of concerns received by beneficiaries and providers.

C. Cost Measures

Hypotheses:

1. Utilization of emergency room visits for dental issues among the targeted children in Domain 2 will decline.
2. Utilization and expenditures for dental related general anesthesia utilization for target children in Domain 2 will decline.
3. The provider incentive payments for preventive services and continuity of care provide a more favorable cost benefit ratio than that of CRA. The cost benefit ratio is defined above

Costs will be evaluated using Medi-Cal claims data and the actual dollar amounts paid for dental services and DTI incentive payments for calendar time periods pre and post implementation on a quarterly basis. The following measures will be examined:

- Change in overall average costs for Medi-Cal children who receive preventive services, CRA and disease management, and/or continuity of care.
- Change in emergency room utilization for dental services among beneficiaries participating in Domain 2 to assess if there is a decrease in the cost of emergency room utilization based on increased utilization of preventive care services.
- Change in utilization and expenditures for dental related general anesthesia utilization among beneficiaries participating in Domain 2.
- Change in preventive services utilization and costs.
- Differences in costs among Medi-Cal children that received DTI services and beneficiaries that did not, analyzed to the extent possible by geographic location, delivery system, and type of service.

IV. Analysis Plan

A. Statistical Data Analysis

Administrative data and survey data will be collected and analyzed across the State and different Domains, pre-implementation and throughout the demonstration years to account for implementation periods and comparisons among participating and non-participating Medi-Cal dental providers. A variety of models may be used to analyze DTI statistical data. These analyses will be used to assist DHCS in answering the stated research questions.

For annual longitudinal quantitative data, a generalized linear model will be used to identify changes over time. These mixed effects models are similar to a multivariate regression model. Mixed effects regression models can account for the correlation seen between years within the same county. For example, one county may implement a Domain quicker than another county, which will influence the next year's measurement within that county. Generalized linear models are helpful in accounting for differences at a county level, such as multiple delivery systems while other counties may not have these. An analogous set of analyses can be conducted using a logistic mixed model to account for binary outcomes over time.

Where data is sufficient, a multiple baseline approach may be applied to account for different implementation periods and comparisons between two county types, for example, looking at data pre-implementation, partial implementation when some counties have implemented a Domain and some have not, and post-implementation, using a separate mixed effects model for each piece of the data.

Multivariate regression models using indicator variables for opt-in status (e.g. Domain 2) along with other possible confounding factors may be used to control for differences based on characteristics such as Medi-Cal enrollment, age, or race. It is also possible to test for interactions between confounding variables and opt-in status and when looking at binary outcomes, it is possible to account for differences using logistic regression.

Data may be insufficient for the analysis models described. In these cases, repeated measure methods may be used to compare baseline to any specific later observation or composite of later observations.

For surveys of beneficiaries or dental providers, statistical significance is a consideration since surveys will be conducted on sample sizes. The number of surveys may be adjusted up or down based on resource availability and the numbers of beneficiaries or providers participating in a Domain will be critical to the ability to detect an effective size in estimating the pre-and-post change of a continuous outcome.

B. Qualitative Analysis

Data collected will be analyzed separately as well as across the Domains, different groups, and over time to identify themes and patterns. Detailed information will provide an understanding of experiences, which will be used to supplement and expand on the quantitative data sets to answer the research questions. A majority of the evaluation resources will be devoted to quantitative research, although qualitative research will also be used to put quantitative results in context. The evaluator will conduct a web-based survey of a statewide sample of Medi-Cal dental providers that can support descriptive and impact analyses; a computer-assisted telephone interview survey with a sample of Medi-Cal beneficiaries in Domain 2 and 3 counties to learn about their experiences with different aspects of the demonstration and their views on dental care; an in-depth qualitative telephone interviews with (1) a sample of dental providers in Domain 2 and 3 counties about their experiences and perceptions, and (2) state

officials, provider associations, and other stakeholders about contextual and other factors influencing the implementation and outcomes of the DTI; and site visits focused on samples of the Domain 4 LDPP demonstrations.

DHCS will contract with the evaluator to provide a multivariate analysis that employs appropriate comparisons and integrates administrative, survey, and qualitative data to assess the impact of DTI interventions on provider participation, service use, expenditures, continuity of care, and related outcomes. Among the assortment of tools available to the evaluator are NVivo and Atlas both which are used for coding and analysis of qualitative data. A synthesis of quarterly reports and domain-specific monitoring and performance data used by DHCS in operating the demonstration program will also be presented in demonstrate qualitative findings and analysis.

The evaluation work will be inclusive of results from both qualitative and quantitative data sets, consider how they contribute to answering the research questions in the relevant Domains, and examine whether and where the results from the data sets converge, complement, expand one another, and/or perhaps contradict one another.

V. Evaluation Implementation

A. Evaluation Timeline

California shall submit the draft Evaluation Plan for the DTI on September 19, 2016. CMS shall provide comments on the draft design and the draft evaluation strategy within 60 days of receipt, and California shall submit a final design within 60 days of receipt of CMS' comments. The state must implement the evaluation design, and describe progress relating to the evaluation design in each of the quarterly and annual progress reports.

The draft Evaluation Plan will be posted on the DHCS DTI webpage for stakeholder review and comment upon submission to CMS. Stakeholders will also be able to submit comments and questions regarding the draft via the DTI email box. The final design will include a summary of stakeholder comments and questions and a description of any changes made to the final design based upon stakeholder input.

Consistent with 42 CFR 431.424(d), the state must submit to CMS an interim evaluation report in conjunction with its request to extend the demonstration, or any portion thereof. California must submit to CMS a draft of the evaluation final report by December 31, 2021.

B. Independent Evaluator

California has identified an independent evaluator and is negotiating a contract to perform the DTI evaluation. A data use agreement will be included in the contract to allow for the sharing of data with and access to data by the independent entity for purposes of conducing the DTI evaluation. California's selection has no conflict of interest.

References

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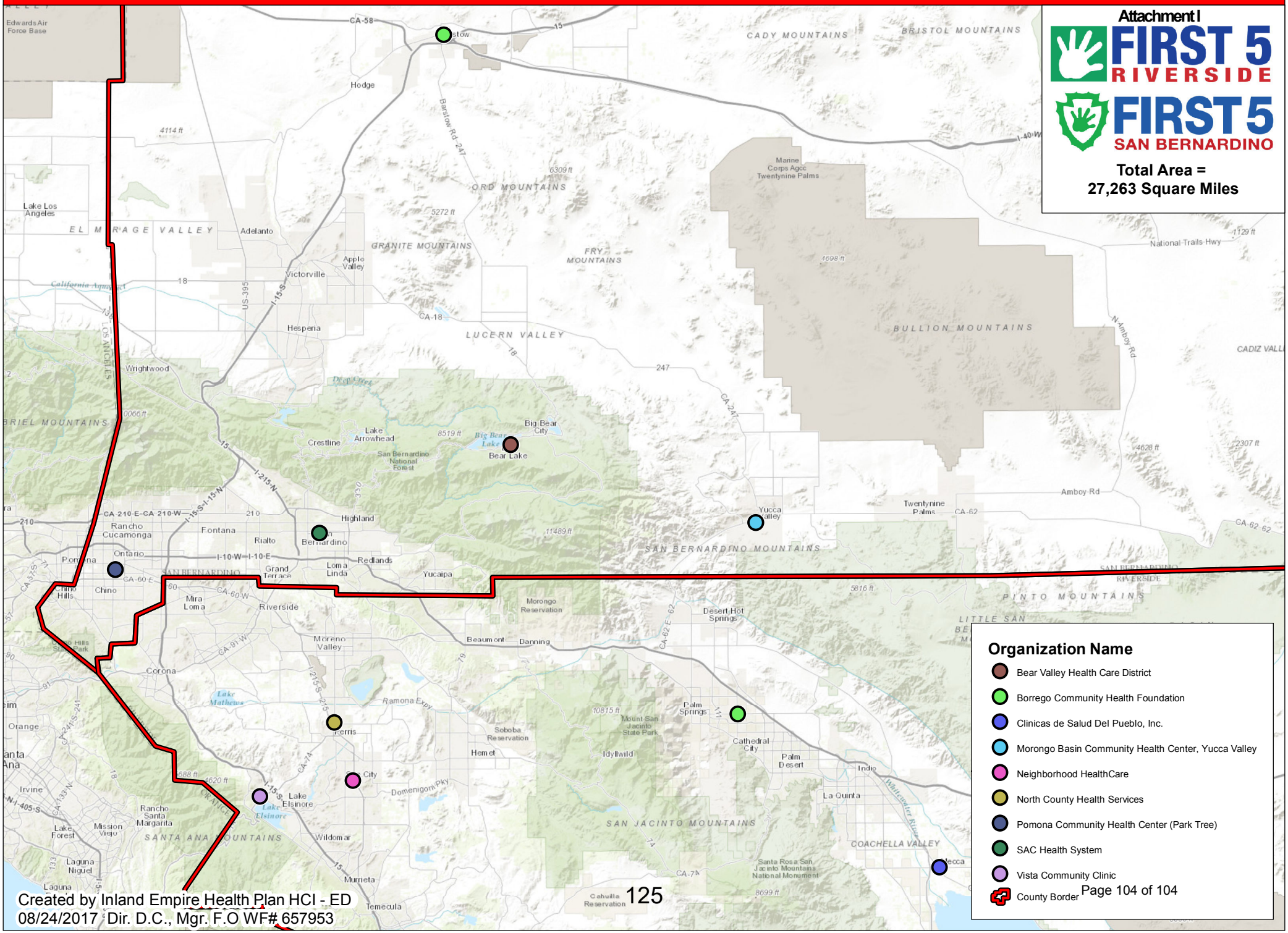
Community Health Center VDH Hubs - San Bernardino and Riverside Counties



RIVERSIDE COUNTY CHILDREN & FAMILIES COMMISSION

(FIRST 5 RIVERSIDE)

LOCAL DENTAL PILOT PROJECT APPLICATION

Contact:

Tammi Graham, Executive Director

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SECTION 1 – LDPP LEAD ENTITY AND PARTICIPATING ENTITY INFORMATION

APPLICANT DESCRIPTION

The Local Dental Pilot Project – Inland Empire (LDPP-IE) brings together resources from two of the largest counties in southern California to leverage strengths and achieve greater impact for the region. First 5 Riverside and First 5 San Bernardino formed a consortium of key stakeholders to develop a regional dental pilot project to integrate and coordinate innovative oral health interventions by creating an integrated system involving community health centers (CHCs), early care and education centers, schools, and home visitors.

The pilot aligns with all three (3) dental transformation initiative domains using a collective impact approach. The LDPP-IE involves a centralized infrastructure, dedicated staff, and a structured process that supports a common agenda, shared measurements, continuous communication, and mutually reinforcing activities among all participants. The pilot also aligns with several of the California Department of Public Health State Oral Health Plan strategies and goals that address the following: addressing determinants of oral health; promoting healthy habits and population-based interventions; aligning systems and programs to support community-clinical linkages; collaborating to expand infrastructure, capacity and payment systems; and developing and implementing communication strategies.

LDPP-IE builds from and aligns with Health Center and Public Health goals and initiatives currently being implemented in the region. Health centers are ideally situated to address the unique challenge of accessing oral health services. CHCs were created to bring comprehensive health services to underserved populations and to develop services in response to community needs. Health centers are often the main healthcare provider of services in rural and low-income neighborhoods and provide a myriad of primary medical care, behavioral health care, and dental services. The project serves children in settings where they are located: in early care and education centers, school districts, WIC centers, and at home through home visits. This approach will increase dental prevention, enhance caries risk assessment and disease management, and allow for continuity of care among children covered by Medi-Cal in the IE through two (2) innovative strategies – Virtual Dental Home (VDH) and Early Childhood Oral Health Assessment (ECOHA).

LEAD ENTITY DESCRIPTION

First 5 Riverside is the designated Lead Entity that will be responsible for coordinating the LDPP-IE and will be the single point of contact for DHCS and the Centers for Medicare and Medicaid Services (CMS) as required by STC 109.a. The First 5 Riverside and First 5 San Bernardino consortia supports the regional dental pilot project across the two counties. The LDPP-IE provides an unprecedented opportunity to leverage investments and assets in both counties to improve the oral health of children enrolled in Medi-Cal as well as to create systems change to ensure that State and local investments are sustainable.

Historically, First 5 Riverside and First 5 San Bernardino have funded oral health services for low-income children. In fact, since 2011, more than $18 million has been invested to meet the oral health needs for the youngest and most vulnerable children in the region. With Proposition 10 revenues consistently declining, First 5 San Bernardino and First 5 Riverside have established a strategic plan priority area, *Systems and Networks,* to provide leadership in the development of

support systems servicing children and families that result in sustainable and collective impact. The LDPP goals support systems improvements through innovative strategies.

PARTICIPATING ENTITY DESCRIPTION

Using a collective impact approach, the LDPP-IE will lead to systems change in the region creating an integrated oral health system of care resulting in improved health of Medi-Cal children served. The First 5 consortia are partnering with the UOP, TCP, and the COH to support the testing and implementation of the VDH and/or the newly developed ECOHA for non-dental providers through 10 CHCs, Riverside-San Bernardino County Indian Health, Inc., and committed supporting agencies. The participating entities will demonstrate the proposed interventions are achievable and successful in improving health outcomes for the target population.

1.1 LDPP LEAD ENTITY AND CONTACT PERSON

Lead Entity **Co-Lead Entity**	**Riverside County Children and Families Commission (First 5 Riverside)** **The Children and Families Commission for San Bernardino County (First 5 San Bernardino)**
Type of Entity	County Entity
Contact Person	Tammi Graham
Title	Executive Director, Riverside County Children and Families Commission
Telephone	951-715-4699
Email Address	TGraham@rccfc.org
Mailing Address	585 Technology Court, Riverside, CA 92507

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1.2 PARTICIPATING ENTITIES

Included in this application are 37 Letters of Commitment representing a diverse set of key local community partners, educational entities, Medi-Cal providers, and stakeholders indicating their agreement to participate in the LDPP-IE.

	Organization Name and Address	Description of Organization	Contact Name, Title, Telephone and Email	Role in LDPP
1	University of the Pacific (UOP) 155 5th Street San Francisco, CA 94103	University School of Dentistry	Paul Glassman, DDS (415) 929-6490 pglassman@pacific.edu	**Subcontractor** VDH & ECOHA Implementation, Training, Technical Assistance, Evaluation
2	Center for Oral Health (COH) 309 East Second St. Pomona, CA 91766	Non-Profit Organization	Conrado Barzaga, Executive Director (909) 469-8300 cbarzaga@tc4oh.org	**Subcontractor** Oral Health Action Coalition-IE Facilitator and Convener of LDPP-IE Partners for Collaboration
3	The Children's Partnership (TCP) 811 Wilshire Blvd. Ste.,1000 Los Angeles, CA 90017	Children's Policy, Research & Advocacy Organization	Mayra Alvarez, MPH, President (213) 341-1222 malvarez@childrenspartnerhip.org	**Subcontractor** Strategic partner-ECOHA Implementation
4	Social Interest Solutions (SIS) 81 N Freeway Blvd #210 Sacramento, CA 95834	Non-Profit Technology & Social Policy Organization	Robert Philips, President & CEO 916-563-4004 info@socialinterest.org	**Subcontractor** ECOHA Development, Implementation, Support & Hosting
5	Riverside-San Bernardino County Indian Health, Inc. (Indian Health) 11980 Mt. Vernon Ave Grand Terrace, CA 92313	Native American Health Care Organization Home Visitation	Jess Montoya, CEO (909) 864-1097 jmontoya@rsbcihi.org	**Vendor** Home Visitation, ECOHA
6	Bear Valley Community Health Care District 41870 Garstin Drive Big Bear Lake, CA 92315	Critical Access Hospital Health Care District	John Friel, CEO (909) 866-6501 John.friel@bvchd.com	**Subcontractor** Expand existing VDH to include Care Coordination and ECOHA
7	Borrego Community Health Foundation 955 Harbor Island Dr., Ste.,110 San Diego, CA 92101	Community Health Center	Bruce Hebets, CEO (619) 398-2405 bhebets@borregomedical.org	**Subcontractor** VDH-Clinic to Community Expansion, and ECOHA

	Organization Name and Address	Description of Organization	Contact Name, Title, Telephone and Email	Role in LDPP
8	Hi-Desert Memorial Health Care District (dba Morongo Basin Healthcare District) 6530 LaContenta Rd. Ste 100 Yucca Valley, CA 92284	Community Health Center	Jacqueline Combs, RN, MSN, CEO 760-820-9229 jcombs@mbhd.org	**Subcontractor** VDH-Clinic to Community Expansion, and ECOHA
9	Clinicas de Salud Del Pueblo Inc. 53-990 Enterprise Way, Suite 14 Coachella, CA 92236	Community Health Center	Yvonne Bell, CEO (760) 344-9951 yvonneb@cdsdp.org	**Subcontractor** VDH-Clinic to Community Expansion
10	Neighborhood Healthcare 425 N. Date Street Escondido, CA 92025	Community Health Center	Tracy Ream, CEO (760) 520-8372 NHCare@NHCare.org	**Subcontractor** VDH-Clinic to Community Expansion, and ECOHA
11	North County Health Services 150 Valpreda Road San Marcos, CA 92069	Community Health Center	Irma Cota, President/CEO (760) 736-8685 Irma.cota@nchs-health.org	**Subcontractor** VDH-Clinic to Community Expansion, and ECOHA
12	Pomona Community Health Center (dba ParkTree Community Health Center) 1450 E. Holt Avenue Pomona, CA 92767	Community Health Center	Carmen Muniz, COO (909) 630-7927 carmen.muniz@pomonachc.org	**Subcontractor** VDH-Clinic to Community Expansion
13	SAC Health System 1455 E. 3rd St. San Bernardino, CA 92408	Community Health Center	Gregory D. Mitchell - Supervising VDH Dentist (909) 382-7121 gdmitchell@llu.edu	**Subcontractor** VDH-Clinic to Community Expansion, and ECOHA
14	Vista Community Clinic 1000 Vale Terrance Vista, CA 92087	Community Health Center	Fernando Sanudo, CEO (760) 631-5000 ceo@vcc.clinic	**Subcontractor** VDH-Clinic to Community Expansion, and ECOHA
15	Coachella Valley Unified School District 87-225 Church Street, Thermal CA 92274	School District-VDH Community Site	Dr. Daryl Adams Superintendent (760)399-5137 daryl.adams@cvusd.us	**Supporting Agency** Clinicas De Salud Del Pueblo Inc. – VDH

	Organization Name and Address	Description of Organization	Contact Name, Title, Telephone and Email	Role in LDPP
16	Riverside University Health System-Medical Service Office (RUHS-MSO) 26250 Cactus Avenue Moreno Valley, CA 92555	Community Health Center	Daniel Fontoura, Executive Director, Care Clinics Chief Financial Officer (951) 486-4000 d.fontoura@ruhealth.org	**Subcontractor** ECOHA, oral health education, at RUHS Medical Center Pediatric Clinic. Oral Health-Primary Care Integration. Accept newly identified children in need of a dental home at Rubidoux Dental Clinic in Jurupa Valley
17	The Mom & Dad Project Bear Valley Community Healthcare District 41820 Garstin Drive Big Bear Lake, CA 92315	Parenting Education and Resource Center	Megan Meadors Program Director (909) 878-2326 megmeadors@hotmail.com	**Supporting Agency** Bear Valley Community Health Care District-VDH
18	Western University of Health Sciences 309 E. Second Street Pomona, CA 92766	Higher Education Institution	Steven W. Friedrichsen, DDS Professor and Dean (909) 706-3504 sfriedrichsen@westernu.edu	**Supporting Agency** Bear Valley Community Health Care District-VDH
19	Desert Sands Unified School District 47-950 Dune Palms Rd. La Quinta, CA 92253	School District- VDH Community Site	Ifthika Nissar, Principal (760) 771-8775 shine.nissar@desertsands.us	**Supporting Agency** Borrego Community Health Foundation – VDH
20	Hemet Unified School District 2085 W. Acacia Avenue Hemet, CA 92545	School District – VDH Community Site	Robin Fairfield, Ed. D, Principal (951) 765-5100 rfairfield@hemetusd.org	**Supporting Agency** Borrego Community Health Foundation – VDH
21	Jurupa Unified School District 4850 Pedley Road Jurupa Valley, CA 92509	School District – VDH Community Site	Jose Campos, Director of Parent Involvement and Community Outreach (951) 360-4100 josecampos@jusd.k12.ca.us	**Supporting Agency** Borrego Community Health Foundation – VDH
22	Lake Elsinore Unified School District 545 Chaney Street Lake Elsinore, CA 92530	School District – VDH Community Site	Doug Kimberly, Ed. D District Superintendent (951) 253-7000 doug.kimberly@leusd.k12.ca.us	**Supporting Agency** Vista Community Clinic – VDH

	Organization Name and Address	Description of Organization	Contact Name, Title, Telephone and Email	Role in LDPP
23	Riverside County Office of Education 3939 13th Street Riverside, CA 92501	Children's Services Unit Head Start; State Pre-School Program	Sharon Baskett, Assistant Superintendent (951) 826-6608 sbaskett@rcoe.us	**Supporting Agency** Early learning sites for VDH implementation And ECOHA
24	Riverside County Office of Education 3939 13th Street Riverside, CA 92501	County Office of Education Head Start and Early Head Start Administrator	Esmirna Valencia, Executive Director (951) 826-6617 evalencia@rcoe.us	**Supporting Agency** Early learning sites for VDH implementation and ECOHA
25	Palm Springs Unified School District 980 Tahquitz Canyon Way Palm Springs, CA 92262	School District – VDH Community Site	Dr. Michael Swize, Asst. Superintendent Educational Services (760) 416-6000 mswize@psusd.us	**Supporting Agency** Borrego Community Health Foundation – VDH
26	Romoland School District 25900 Leon Road Homeland, CA 92548	School District – VDH Community Site	Vanessa Rodriquez, Early Childhood Director (951) 926-9244 vrodriguez@romoland.net	**Supporting Agency** VDH Community Sites
27	San Bernardino Unified School Dist. 777 North F. Street San Bernardino, CA 92410	School District – VDH Community Site	Dale Marsden, Ed.D., Superintendent (909) 381-1240 Dale.marsden@sbcusd.com	**Supporting Agency** VDH Community Sites
28	Riverside Unified School District 7675 Magnolia Avenue Riverside, CA 92508	School District – VDH Community Site	Joseph Nieto Early Childhood Coordinator (951) 352-8290 jnieto@rusd.k12.ca.us	**Supporting Agency** Borrego Community Health Foundation – VDH Site
29	San Jacinto Unified School Dist. 2045 S. San Jacinto Ave. San Jacinto, CA 92583	School District – VDH Community Site	Elizabeth Zaragoza Director of Preschool (951) 929-7700 ezaragoza@sanjacinto.k12.ca.us	**Supporting Agency** Borrego Community Health Foundation – VDH Site
30	Child Care Resource Center 1111 E. Mill St., Ste. 100 San Bernardino, CA 92408	Resource Center- SB County Quality Start Coaches	Ellen Cervantes, Vice President and CEO (909) 384-8000 ecervantes@ccrcca.org	**Supporting Agency** Quality Start
31	Perris Elementary School District 222 S. A Street, Ste.,102 Perris, CA 92570	School District	Kara Couto, RN School Nurse (951) 940-4942 kara.couto@perris.k12.ca.us	**Supporting Agency** NCHS-Supporting site

	Organization Name and Address	Description of Organization	Contact Name, Title, Telephone and Email	Role in LDPP
32	California Baptist University 8432 Magnolia Avenue Riverside, CA 92504	California Baptist University	Robert G. LaChausse, PhD. CHES Department Chair & Associate Professor 951-689-5771 rlachausse@calbaptist.edu	**Supporting Agency**
33	California State University San Bernardino 5500 University Parkway San Bernardino, CA 92407	California State University	Dr. Barbara Sirotnik Director, Institute of Applied Research (909) 537-5729 BSirotni@csusb.edu	**Supporting Agency**
34	Riverside University Health System- Public Health 4065 County Circle Drive Riverside, CA 92503	Riverside County Public Health	Sarah Mack, MPH, Director (951) 358-7036 ssmack@rivcocha.org	**Supporting Agency** ECOHA at selected WIC sites by Community Health Workers (CHWs)
35	San Bernardino County Public Health 351 N. Mt. View Ave San Bernardino, CA 92415	San Bernardino County Public Health Department	Trudy Raymundo, Director (909) 387-9146 Trudy.raymundo@dph.sbcounty.gov	**Supporting Agency** ECOHA at selected WIC sites by CHWs
36	Unicare Community Health Center, Inc. 437 N. Euclid Avenue Ontario, CA 91762	Community Health Center	Avetik Machkalyan, CEO 909-988-2555 uchc@unicarechc.org	**Supporting Agency** Accept newly identified Medi-Cal enrolled and eligible children needing to establish a dental home.
37	Morongo Unified School District 5715 Utah Trail Twentynine Palms, CA 92277	School District-VDH Community Site	Tom Baumgarten Superintendent 760-367-9191 tom_baumgarten@morongo.k12.ca.us	**Supporting Agency** **Morongo Basin Healthcare District-VDH site**
38.	Palo Verde Unified School District 295 North First Street Blythe, CA 92225	School District	Dr. Charles Bush Superintendent 760-922-4164 charles.bush@pvusd.us	**Supporting Agency** **Clinicas de Salud del Pueblo**

1.3 LETTERS OF SUPPORT

Included in this application are seventeen (17) additional Letters of Support representing a diverse set of key local community partners, educational entities, Medi-Cal providers, and stakeholders indicating their agreement to participate in and/or support the LDPP-IE.

1.4 COLLABORATION PLAN

The LDPP-IE builds upon long-standing commitments to children's oral health and strengthens the capacity of community partners, both in funded and unfunded roles. LDPP-IE will implement innovative systems approaches to increase opportunities for children enrolled in Medi-Cal to have access to early preventive and risk-based care. By creating a system that promotes continuity of care, children will have an established dental home, thereby supporting the improvement of overall oral health in the community.

To accomplish the goals of the LDPP-IE, management, communication, and collaboration are paramount to its success. First 5 Riverside will staff a Program Director (Director) for the LDPP-IE for overall grant management and leadership for collaboration. Both First 5 Riverside and First 5 San Bernardino will designate analysts and fiscal support positions for the project, whose work will be coordinated by the Director. To communicate state pilot requirements and LDPP-IE requirements from the lead entity to participating entities, First 5 Riverside will establish contracts with each entity clearly outlining the agencies responsibilities including the requirement to attend LDPP-IE meetings and trainings, outline the scope of work and budget, and requirements for data collection and reporting, and budget. The Director will meet regularly with entities to reinforce LDPP-IE requirements and establish a micro-website and regular email updates to ensure effective communication.

In addition, the Director will collaborate with each of the funded entities and be available to non-funded supporting agencies to ensure that activities are coordinated among entities and with other efforts across the region to improve the oral health of Medi-Cal enrolled children. The Director and designated county analysts will ensure entities within service areas are communicating and coordinating LDPP-IE activities. For example, the Director or county analyst will serve as a conduit to facilitate a relationship between the entities that are implementing the ECOHA and the VDH hub clinic. This intentional relationship will support the goal to coordinate efforts to ensure entities implementing ECOHA are supporting children and families to the point of establishing a dental home at a community clinic.

To further support collaboration and communication and building from existing systems, the COH will participate in the LDPP-IE as a participating entity/subcontractor. The COH is the convener of the Oral Health Action Coalition - IE (OHAC-IE). Currently, First 5 San Bernardino provides funding to COH to mobilize and organize local resources to increase access to oral health care and to improve health outcomes for the residents in San Bernardino County. The vision for OHAC-IE is the eradication of oral disease among vulnerable populations in the IE. The mission of the OHAC-IE is to promote optimal oral health outcomes and advocate for a comprehensive health care delivery system using a health equity lens. OHAC-IE is composed of more than 30 organizations united by the common goal of improving the oral health of underserved residents in the IE. Members represent a diverse set of key local community partners including funders, hospitals, health plans, dental and dental hygiene schools, Denti-Cal providers, and other community stakeholders. As a participating entity, COH will establish a LDPP-IE Workgroup of the OHAC-IE. In collaboration with the Director, COH will pursue five key activities that will help ensure the collective impact of all organizations that participate in the collaborative. Activities include:

1. Supporting aligned activities, engaging extensively with community partners to preserve a common agenda, guiding all parties toward the same goals, minimizing silos, and support the LDPP-IE Program Director in facilitating conflict resolution when needed.

2. Establishing shared measurement practices to measure collective progress toward the desired outcomes and taking opportunities to leverage combined efforts to feed common goals.

3. Building public will by facilitating extensive, frequent, and regular communication platforms among community partners to ensure collaboration and collective impact.

4. Identifying and advancing public policy recommendations.

5. Mobilizing additional financial support, highlighting the work of the collaborative before potential funders.

The long-term expectation is that these activities will lead to desired system changes to ensure oral health equity in the IE. System changes, as envisioned by LDPP-IE and OHAC-IE, include improvements in four key dimensions that compose the system: 1) public policy, 2) financing, 3) community participation, and 4) the health care infrastructure. Successful system changes will lead to the desired outcomes of the LDPP-IE, which include:

1. Increase preventive services utilization for children;

2. Increase caries risk assessment and disease management; and

3. Increase continuity of care.

Moreover, key members of LDPP-IE such as TCP, COH, First 5 Riverside, First 5 San Bernardino, and University partners with strong relationships with state entities and decision makers, will share lessons learned, communicate policy barriers, and recommend solutions to the Department of Health Care Services, the Dental Director and the State Oral Health Advisory Committee. The LDPP-IE will share project information with other communities implementing LDPPs to identify and pursue solutions that will improve the operations of the LDPP in the IE and throughout the state.

One of aims of this LDPP-IE is to integrate oral health into all systems that support families with children enrolled in Medi-Cal and LDPP-IE intends to engage other state-level government and nongovernment entities, such as the California Home Visiting Program, California Department of Education, First 5 Commission, First 5 Association, California Head Start Association, California WIC Program, California Primary Care Association, and other entities to seek program changes and policy solutions to integrate oral health strategies, based on the lessons from the LDPP-IE and other LDPPs. Ultimately, the LDPP-IE will lead to systems change in the IE creating an integrated oral health system of care resulting in the improved health of children covered by Medi-Cal.

LDPP-IE APPLICATION

All components of the application are complete, the application is signed, and the two required attachments are included: 1. (Required) Letters of Participation Agreements and Support for all participating entities. 2. (Required) A funding diagram (Section 5.1 Diagram 3) illustrating how the requested funds would flow from DHCS to the Lead Entity and how the funds would be distributed among participating entities. Additionally, Attachment C Subcontractor Selection Justification provides a description of requested requirement exceptions.

Bonus Points: The LDPP-IE Application includes all priority elements to receive LDPP bonus points. Collaboration: One (1) participating Indian Health Program and one (1) CSU campus in the geographic areas where the pilot operates (maximum of 5 points). Community partners: More than two participating key community partners in the geographic areas where the pilot operates (maximum of 5 points). The regional approach has created the opportunity to engage with over 56 stakeholders in a collaborative partnership to deliver and evaluate a widespread innovative method of delivering services. Interventions: Innovative interventions (maximum of 5 points) The VDH and ECOHA strategies are innovative interventions that sync to provide a platform of comprehensive oral health services to Medi-Cal beneficiaries in the IE, spanning two counties. Through an intentional approach in expanding the current scope of practice in oral health through concerted efforts in elevated workforce capacity, this pilot program will address gaps within the current system. The utilization of technology through the VDH model as well as the mobile application by which the ECOHA is integrated through community settings, lends a robust and effective methodology in oral health practice.

SECTION 2 – GENERAL INFORMATION AND TARGET POPULATION

OVERVIEW OF LDPP APPROACH

The Local Dental Pilot Project (LDPP) proposed by First 5 Riverside and First 5 San Bernardino is a regional approach with the goal of combining resources in both counties to achieve sustainable oral health impact for the IE community. This proposal is a community-based driven project demonstrating innovative strategies that ensure children enrolled in Medi-Cal receive preventive services, risk assessments and care, resulting in increased continuity of care improving oral health outcomes.

The aim of the project is to incorporate oral health practices into all areas of health and social support systems, thereby building and expanding professional capacity of oral health providers. The implementation of the VDH will be enabled through providers and community sites participating in this project. Through these efforts, the VDH model will reach an increased proportion of the population with a system that emphasizes prevention and early intervention, improves the oral health of the population, and lowers the significant personal, social, and financial costs that result from neglected dental disease. To further extend the reach into high-risk communities, the project proposes to use the newly developed ECOHA for non-dental providers to screen for oral health risk and intentionally connect children to a dental home. Project activities will be coordinated through a formal collaborative process that will include rigorous data collection, monitoring, and evaluation.

State level evaluation will be conducted by DHCS. Funded partners will collect and report any data required by DHCS consistent with the performance metrics of the three domains of the respective strategies. First 5 San Bernardino will support the data collection and reporting efforts of the project.

NEEDS ASSESSMENT

A needs assessment was conducted using secondary sources of data from the Public Health Departments of Riverside and San Bernardino Counties, identifying areas of need and target populations relevant to this pilot project.

The IE, the region comprising both Riverside and San Bernardino counties, is one of the fastest growing regions in the United States. Between the 2000 and 2010 census, the IE population grew by nearly 30%; the current total population in the region is now 4,489,159 residents.[1] The vast geography spans 27,263.46 square miles.[2] [Attachment **A** is a visual representation of the 2 counties demonstrating the vast geographical reach]. Geographically, the IE is roughly equal to the states of New Hampshire, New Jersey, Connecticut, Delaware and Rhode Island combined.[3] The collective population of the two counties also exceeds the population of 25 states in the United States.[4]

[1] *"Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2015"*. *United States Census Bureau*, Population Division. March 2016. Retrieved 2016-04-25.
[2] U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates
[3] Riverside University Health System – Public Health 2016.
[4] Riverside University Health System – Public Health 2016.

The IE encompasses 52 incorporated cities and 58 school districts and is ethnically diverse; 48% is Hispanic/Latino, 35% white, 7% Black or African American, 6% Asian.[5] In the region, approximately 16% of the population over age five experience limitations in English proficiency.[6]

The vast inland region is home to more than 200,000 rural residents who are more likely to live in poverty than urban residents.[7] Many IE residents suffer from health conditions related to excesses of the urban environment such as overabundance of fast food, high levels of automobile pollution, inability to find safe spaces for children to play, and raised levels of stress. The IE's rural residents may find their health disrupted by an inability to access necessary services in a timely manner.

The geographical distribution of the population poses challenges for the planning and program location of resources to meet the urban and rural oral health needs of residents. These challenges are further exacerbated by poverty, which can create pockets of resource deficiency. The diversity of the IE is specifically important for this pilot project because young children of color face higher rates of dental decay and additional obstacles in obtaining oral health care. In addition, there are a limited number of providers that provide linguistically and culturally appropriate care.

COMMUTE TO WORK

Travel can also be an impediment to good health for those with jobs that require long distance commuting. The IE has some of the highest percentages of mega-commuters in the country. The average travel time for Riverside County is 32.1 minutes with 45% of the population driving more than 30 minutes to and from work and 17.4% of the working population with a commute of 1 hour or more. The average commute time for San Bernardino County is 33.3 minutes with 40% of the population driving more than 30 minutes to or from work and 18.4% of the working population with a commute of 1 hour or greater.[8]

Long commutes detract from one's capacity to schedule dental and medical appointments with the limited number of providers accepting new Medi-Cal patients. Similarly, low-income families experience hardship to take time off work, often without pay, for their child's appointment. Additionally, this detracts from families' ability to prepare healthful meals or to engage in physical activity contributing to increased risk of poor overall health and oral health that can lead to a poorer quality of life.

INCOME AND POVERTY

The median household income of Riverside County is $56,592, while San Bernardino County has a median household income of $54,100.[9] Both of which are lower than the median household income of $61,489 for the state of California. In the IE, 40.7% of individuals are living in households with income below 200% of the Federal Poverty Level (FPL) compared to 36.4% in California, (Riverside County, 39.2% and San Bernardino County, 42.3%).[10] Poverty contributes to poor health status because of the barriers created in accessing health services and other necessities. Of the estimated 1.2 million IE children ages 0-18, more than half (51.5%) live at or

[5] California Department of Finance, Demographic Research Unit, Report P-3, State and County Total Population 2010 through 2060 (as of July 1), December 15, 2014
[6] U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates
[7] U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates
[8] U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates [9]
U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates [10]
U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates

below 200% of the FPL (Riverside County, 49.6%, San Bernardino County, 53.6%)[11] and nearly 65% of IE children qualify for free/reduced price school lunches.[12]

ACCESS TO ORAL HEALTH CARE

Enrollment in Medi-Cal for children 0 through 5 years has been significantly higher in both counties, than most other counties in California. Riverside County has just over 65% of children 0 through 5 years of age, enrolled in Medi-Cal, and San Bernardino has approximately 67% of children 0 through 5 enrolled, compared to the State rate of 57%.[13]

The barriers to oral health care are evident in the low utilization rates in CHCs and community clinics (San Bernardino County's utilization rate was 0.8% and Riverside County was 3.0% in 2013), which is more common in rural, underserved areas. In the IE, 33.3% of children ages 0-5 in the IE have never been to a dentist.[14] Several systemic obstacles have led to a low oral health utilization rate. Both San Bernardino and Riverside County's service utilization rate for children receiving Medi-Cal was below that of the California rate and the national average utilization rate, 43.9% and 47.6%, respectively.[15] In San Bernardino County, the child beneficiary utilization rate was 40.3% and Riverside County was 40.6%. This suggests that almost 60% of the children covered by Medi-Cal did not receive dental care in 2013. Addressing the need for oral health care services in the IE would align with California's goal to increase services to Medi-Cal beneficiaries' ages 0 through 20 in a large and diverse portion of the state.

2.1 TARGET POPULATION

It is apparent that a significant need exists for innovative oral health interventions in the IE. Current traditionally supported programs to address oral health gaps appear to be limited in addressing ongoing needs. The aim of the LDPP-IE effort is to focus on preventive care to promote comprehensive oral health behaviors early in life through a strategic and intentional approach. The primary target population of LDPP-IE is children ages 0-5 enrolled in Medi-Cal and reached through LDPP-IE participating CHC entities at pilot sites in WIC, Home Visitation, schools, and Early Learning Centers.

The secondary target population is Medi-Cal eligible, school age children over six years of age. There is a significant cost to both counties and families when children miss school and parents miss work because of a dental problem. In 2003, 3,000 children (7.3%) in the IE, ages 6 to 18, missed work or school because of a dental problem.[16]

Through the VDH and ECOHA strategies, it is estimated that approximately 99,000 Medi-Cal beneficiaries will be served (15,800 through the VDH strategy and 83,325 children through the ECOHA strategy) and the majority expected to establish a dental home through this pilot project. Providing oral health services through the two interrelated strategies in the locations where

[11] U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates
[12] National Center for Education Statistics, NCES – Common Core of Data. 2013-2014
[13] Research and Analytic Studies Division. January 2016. Proportion of California Population Certified Eligible for Medi-Cal by County and Age Group – September 2015. Medi-Cal Statistical Brief. CA Department of Health Care Services
[14] California Health Interview Survey (CHIS) 2014
[15] This reflects the most recent utilization data available from 2013 from the California Department of Health Care Services Report, "Weaknesses in Its Medi-Cal Dental Program Limit Children's Access to Dental Care."
[16] California Health Interview Survey (CHIS) 2003

children go to school and where families receive social services will help break down barriers and address the oral health needs of the target population.

A comprehensive mapping of participating entities using geographical information systems (GIS) was undertaken as a strategy to identify target populations. This included sites that are categorized as: CHCs, Denti-Cal providers, community clinics with dental services, look-alike rural clinics, and school sites where mobile dental services are provided. Service areas have been identified as a pathway to implement the VDH in the areas of 29 Palms, Big Bear, Blythe, Barstow, Coachella Valley, Hemet, Jurupa Valley, Lake Elsinore, Mecca, Perris, Palm Desert, Palm Springs, Riverside, Ontario, San Bernardino, San Jacinto, Temecula, Thermal, Wildomar, and Yucca Valley. In addition, the ECOHA strategy includes reaching Medi-Cal enrolled children through home visitation efforts, early learning sites and schools, family resource centers, and Women Infant and Children (WIC) sites in Riverside and San Bernardino counties.

Through the establishment of program criteria, provider responsibilities and performance metrics, this LDPP-IE strategy will result in:

- increased preventive services utilization for children;
- provision of the ECOHA and care coordination; and
- increased continuity of care.

SECTION 3 – SERVICES, INTERVENTIONS, CARE COORDINATION AND DATA SHARING

3.1 SERVICES AND CARE COORDINATION

The LDPP-IE will test and implement two (2) innovative strategies (i.e., VDH and ECOHA. These prevention services are strengthened by care coordination to ensure children in the pilot communities of Riverside and San Bernardino counties are receiving continuous, risk-based preventive care.

The LDPP-IE aims to:

- Create an integrated, coordinated system of care, in collaboration with health centers and educational institutions, to reduce the burden of disease and improve the oral health of children enrolled in Medi-Cal;
- Support systems change that facilitates access to quality oral health services for Medi-Cal populations; and
- Create communities of optimal oral health for children enrolled in Medi-Cal including the use of technology supported care and risk-based interventions.

VIRTUAL DENTAL HOME STRATEGY

The VDH is a community-based oral health delivery system that provides risk-based preventive and early intervention therapeutic services in community settings such as schools and preschool sites where there is no dental care. It utilizes tele-health technology connecting a dentist in a community clinic to allied dental personnel which includes a hygienist providing education, triage, case management, preventive procedures, and Interim Therapeutic Restorations (ITR). When more complex dental treatment is needed, the VDH connects patients through care coordination efforts back to the community clinic. Research has shown that the VDH can keep two thirds of children healthy in community settings by providing education, triage, case management, preventive procedures, and ITR.[17]

Through the VDH, the hygienist or navigator will first meet with each family to explain the program to determine if their Medi-Cal enrolled child has an established dental home. Children in need of oral health services will have the opportunity to participate and consent will be obtained. The VDH team will routinely schedule return appointments for exams and follow-up visits at the community settings. When children need more extensive treatment, the navigator or community clinic care coordinator will assist the family in obtaining an appointment and accessing care at a LDPP-IE participating CHC or local Denti-Cal provider.

Preventive and restorative dental services will be provided through VDH in the community and through dental providers at participating entities when more complex dental treatment is needed

[17] Pacific Center for Special Care, University of the Pacific Arthur A. Dugoni School of Dentistry http://www.pacificspecialcare.org Improving the Oral Health of Vulnerable and Underserved Populations Using Geographically Distributed Telehealth-Connected Teams. June 2016

or when a new patient needs a dental home as a result of the ECOHA. CHC's in designated geographic areas will serve as the Denti-Cal provider network delivering dental services.

Health centers provide high quality preventive and primary health care to patients regardless of their ability to pay. Health center quality of care equals and often surpasses care that is provided by other primary care providers. Overall, health centers emphasize coordinated primary and preventive services or a "medical home" that promotes reductions in health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved populations.[18] VDH expands the reach of community clinics to connect more children and families to a medical home.

The LDPP-IE network of dental providers committed to deliver dental services in clinic (connected via ECOHA) or community settings (VDH tele-dentistry teams) include:

- Bear Valley Community Healthcare District, Inc. – San Bernardino County
- Borrego Community Health Foundation – Riverside County
- Borrego Community Health Foundation - San Bernardino County
- Clinicas de Salud Del Pueblo, Inc. – Riverside County
- Morongo Basin Healthcare District - San Bernardino County
- Neighborhood Healthcare – Riverside County
- North County Health Services – Riverside County
- ParkTree Community Health Center – San Bernardino County
- SAC Health System – San Bernardino County
- Vista Community Clinic – Riverside County

ECOHA STRATEGY

The ECOHA is a mobile application designed specifically for non-dental providers such as home visitors, CHWs, early learning providers, and social service providers that serve families with young children to identify risk level for dental disease. The goal of this strategy is to build new infrastructure between systems where Medi-Cal enrolled children routinely are, through a standardized oral health risk assessment. This strategy includes oral health caries risk assessment, education, and tracking to the point of service at a dental home, with a focus on connecting children to the clinics participating in the LDPP-IE. The mobile application includes functionality for parents to "check-in" at a participating dental provider for their child's dental visit and to access oral health education information.

At minimum, the ECOHA will be piloted in the following community settings that reach Medi-Cal eligible children in the geographic areas of the VDH communities and community clinics hubs:

Home Visitation: Indian Health administers the *Parents as Teachers* home visitation program to serve Native American families in San Bernardino and Riverside counties.

[18] Bureau of Primary Care http://bphc.hrsa.gov)

Quality Start: First 5 Riverside and First 5 San Bernardino are participating in California's Quality Rating and Improvement Systems (QRIS) program, initiating quality improvement supports to early learning sites throughout the region, known as Quality Start (QS). This is a statewide initiative supported through First 5 California and the California Department of Education. The primary focus of QS is improving the quality of early learning settings, with a target goal of 362 sites, through the connection of three key systems: 1) Early Learning and Development, 2) Child Health including oral health, and 3) Family Strengthening.

Women, Infants and Children (WIC): WIC sites providing pre and post-natal support to low income mothers located in communities implementing the VDH.

Primary Care Clinics: SAC Health System, Morongo Basin Healthcare District, and RUHS-MSO provide primary care services to Medi-Cal enrolled children.

Family Resource Centers: Family Resource Centers (FRC) function as a hub for community services designed to improve family life, particularly for overburdened or disadvantaged families and children. The FRC program focuses on seven core service types: parenting skills, self-sufficiency, community action, child abuse prevention services, information and referral services, education and literacy, and life skills.

CARE COORDINATION

Care Coordination is funded by the LDPP-IE at participating CHCs with VDH teams as a fundamental component of the LDPP-IE. The goal is to meet the needs of children enrolled in Medi-Cal and to provide care coordination to increase continuity of care in the most accessible setting. Care coordination efforts provided by other pilot projects, health plans and health systems will be assessed to prevent supplantation and avoid duplication of efforts. The target populations identified are Medi-Cal recipients.

A critical element of effective care coordination is making certain children establish a dental home [**Diagram 1 and 2** on the following 2 pages, outlines a flowchart depicting *"How To Establish a Dental Home"* under the LDPP-IE approach].

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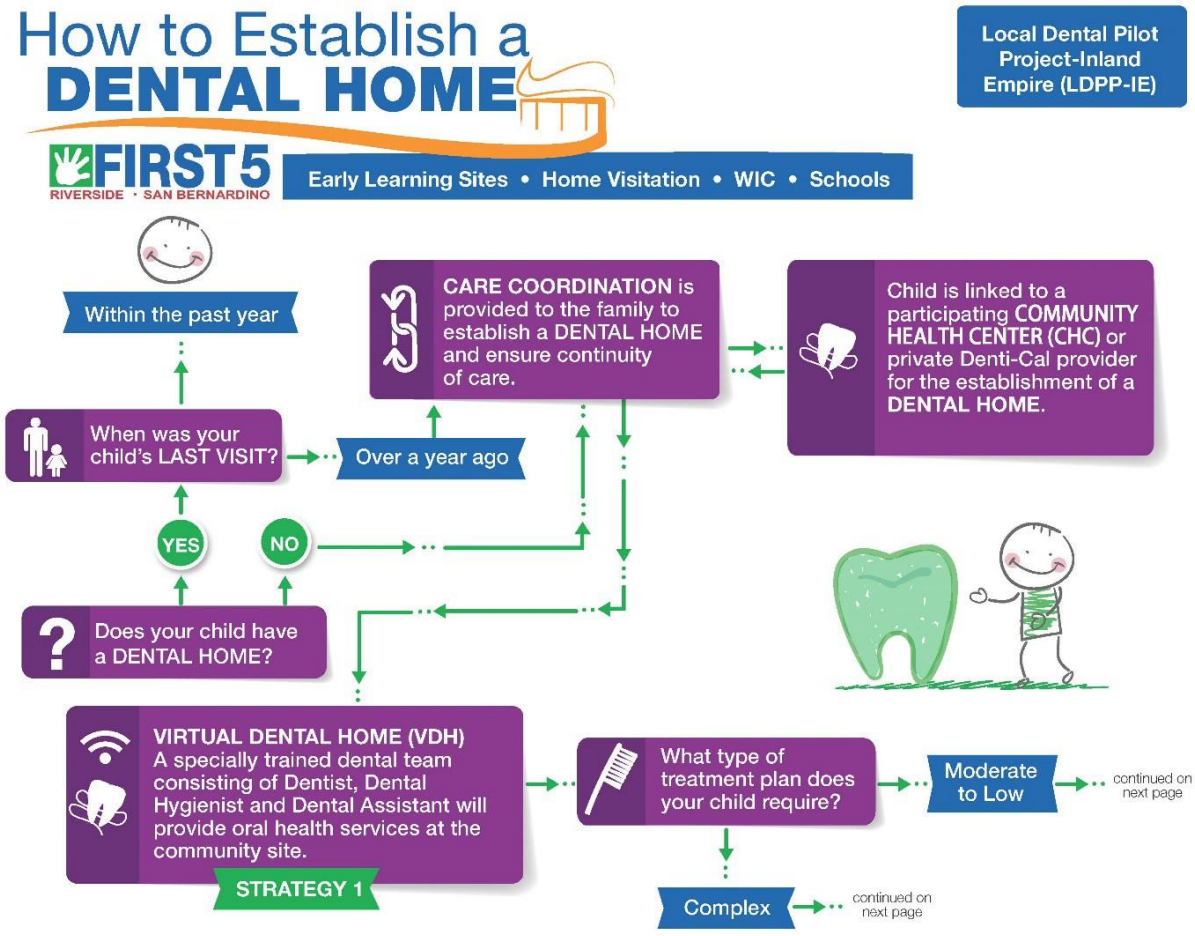
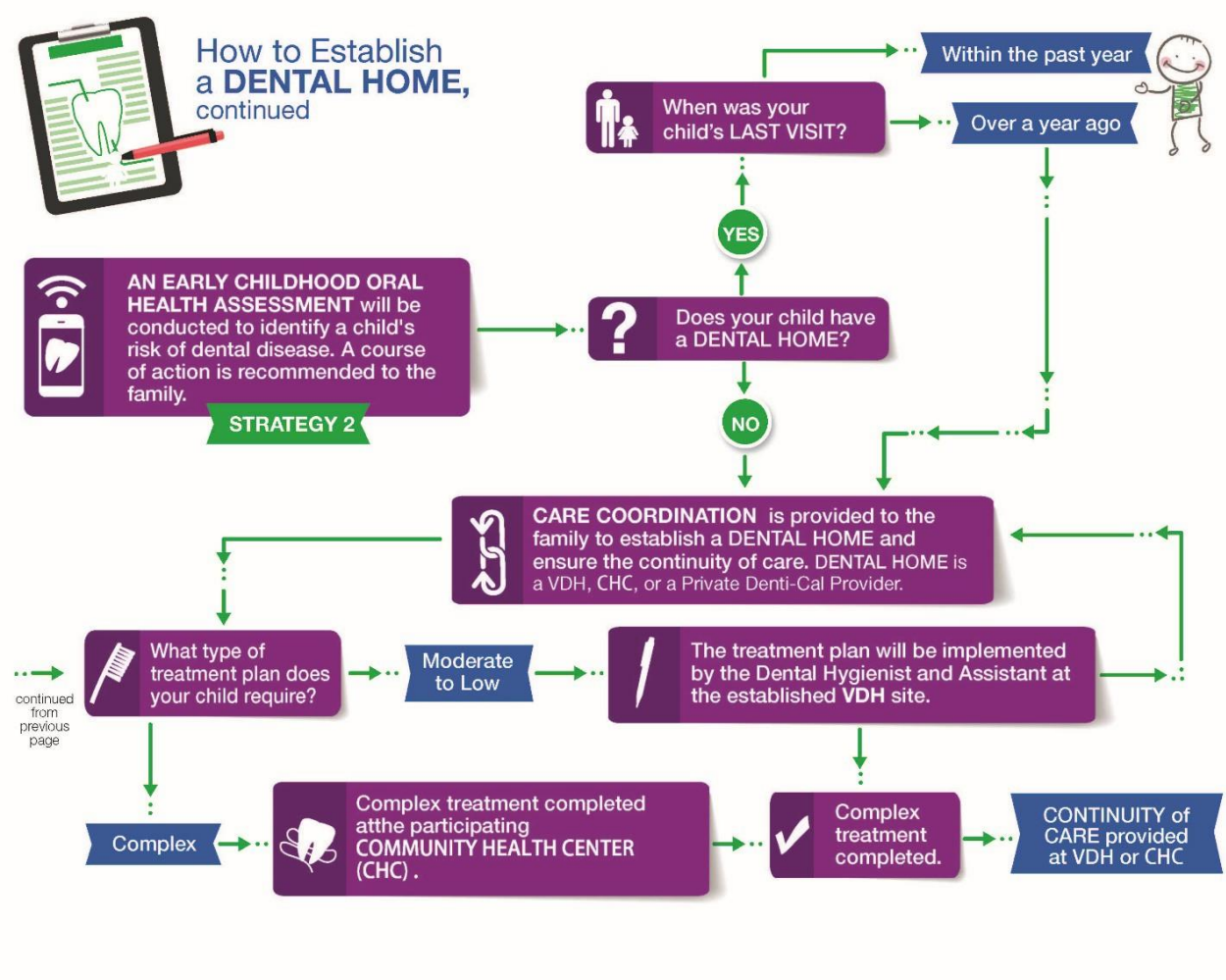
Diagram 1



SPACE INTENTIONALLY LEFT BLANK

Diagram 2



Riverside and San Bernardino county community clinics, health care systems, and social support systems that exist are robust and have a commitment to meeting the needs of the IE. LDPP-IE proposes to build on these strengths to integrate risk-based preventive oral health services and promote continuity of care in existing oral health, health, and social support systems in the community. The LDPP-IE design and implementation will increase preventive services utilization for children through the VDH or through the ECOHA and through intensive care coordination to increase disease management and improve continuity of care. Finally, as the collaboration plan suggests, the efforts of the LDPP will be coordinated with other non-LDPP activities to ensure leveraging of existing resources in Riverside and San Bernardino counties to improve the oral health of children enrolled in Medi-Cal.

Across systems, preventive services and care coordination will include:

- Submitting child's demographic information, Medi-Cal number, and for ECOHA, assessment data into the mobile application;

- Assistance to families with dental appointment scheduling;
- Provide individual education, administer ECOHA and screenings, provide oral health hygiene kits, and linkage to LDPP-IE dentists and community clinics;
- Communicate with families in a culturally appropriate manner;
- Track communication with families at regular intervals;
- Utilize motivational interview techniques to assist families who are ambivalent about obtaining dental care for their child;
- Provide comprehensive oral health promotion campaign to encourage staff engagement and build family participation;
- Provide care coordination through establishment of a dental home coupled with regular 6-month follow up with the family and dental provider to ensure continuity of care is sustained; and
- Identify children with Special Health Care needs and connect them with specialists as needed.

3.2 INNOVATIONS, INTERVENTIONS, AND STRATEGIES

According the California Department of Health Care Services DTI Domain 2 County Rankings, more than 324,460[19] children ages 0-6 are Medi-Cal eligible in the IE. The LDPP-IE aims to improve access to high-quality dental services for these children to achieve and maintain good oral health. The project will test and implement two community based strategies. The primary strategy is the implementation of the VDH through ten (10) CHCs to expand dental services in community settings. The second strategy is to create, test, and implement an ECOHA for non-dental providers to screen children for risk of oral health disease in community settings resulting in the establishment of dental homes. Both strategies are reinforced by care coordination and oral health education to ensure children in pilot communities in Riverside and San Bernardino counties are receiving continuous, risk-based preventive care. To execute these innovative strategies, First 5 Riverside will contract with UOP.

UOP has created best-practice models for improved access to dental care for anyone who faces challenges receiving oral health services through the traditional oral health care system. Specifically, UOP will be engaged in both strategies of the LDPP-IE. UOP will provide training, systems design, and technical assistance to instruct site implementation of the VDH. Secondly, UOP will work with a technology vendor, SIS to develop an electronic ECOHA and preventive services curriculum; provide training to home visitors and CHWs; and provide technical assistance related to implementation and data collection.

UOP

UOP will design and direct the integration of the VDH system through the following activities:

- Participate in meetings with implementing entities and OHAC-IE;
- Assist providers with specific protocol development for each site;

[19] Total Eligible are based on 11/12 months continuous eligibility with no more than a one-month gap.

- Train personnel, participating provider dental office/clinics and community sites;
- Provide technical assistance over the life of the demonstration;
- Assist in collection or analysis of qualitative and quantitative data; and
- Assist with report preparation and provide recommendations, when needed.

Planning, system design, and training topics include:

- Formation and use of advisory and steering committees.
- Planning for community awareness – building the system as it begins and grows.
- Selection of target populations for the system – investigation and understanding of their characteristics, locations, unique needs, and service systems.
- Selection or engagement of the oral health providers that will participate and investigation and understanding of their current training, capacity, and training needs for the VDH system.
- Assessment of current agreements in place between providers and other participants and community sites and the need for new agreements. Assistance with modifying existing agreements or developing new agreement for the VDH system.
- Assessment of current enrollment, program processes, and forms in use by providers and the need to modify or add new components and processes. Assistance with modifying existing enrollment and program processes and forms or developing new ones for the VDH system.
- Assessment of provider and community site staffing arrangements and assistance planning appropriate staffing organization and plans for the VDH system.
- Analysis of current provider electronic dental record (EDR) systems and assistance using, modifying, or incorporating new components needed for the VDH system.
- Assistance in developing operating protocols and documentation for use in community sites.

Specific training to various groups among providers and community sites on the following topics:

- The changing health care landscape, implications for the oral health system.
- Target populations and partner organizations, including culture, characteristics, and integrating oral health services.
- The use of tele-health in the delivery of oral health services in social, educational and general health systems including the use of tele-health in the delivery of oral health services including, use of cloud-based record system in distributed team environment, and function and communication of tele-health-connected teams.
- Legal considerations including Health Insurance Portability and Accountability Act 1996 (HIPAA), consent, scope of practice laws and regulations, tele-health billing regulations, and malpractice coverage.
- Operational protocols including arrangements with schools and other community sites, use and arrangement for space, roles and responsibilities of provider staff and school staff, scheduling, communications with administrators, staff, parents and other stakeholders, and infection control in community locations.
- EDR and Data management issues including using customized components of the EDR system including risk assessment and basic measures, tracking VDH outcomes using additional non-billing procedure codes, and using the EDR for communicating in tele-health connected team practice.

- Scientific basis for VDH procedures including scientific basis for examination and treatment planning using tele-health technology, risk adjusted prevention protocols, partial caries removal, and criteria and technique for placing Interim Therapeutic Restorations.
- Facilitating behavior change including factors that influence oral health, principles influencing behavior change, and motivational interviewing.
- Billing practice and strategies and other financial considerations.
- Training dental hygienists to place Interim Therapeutic Restorations.

For ECOHA, UOP will work with SIS to develop a mobile screening solution intended for non-dental providers to assess a child's risk for dental disease; building new infrastructure between community sites, schools, social service agencies, and dental providers. The assessment will be used to educate and inform parents/caregivers and promote interventions based on identified risk. UOP along with the vendor will create a supporting preventive services curriculum; train LDPP-IE participating home visitors and CHWs and provide technical assistance related to the application's implementation and data collection protocols. The mobile application will include functionality for providers and parents associated with an ECOHA that has been performed by a community health worker or home visitor. The end user "checks in" to a dental visit, the match is tracked to the point of service, and the visit confirmed for billing purposes. Medical information includes:

a. Dental appointment (date/time)
b. Check in (parent input) – arrived or completed
c. Patient Medi-cal/Denti-Cal #
d. Dentist Information – i.e., NPI # (national provider identifier – 10-digit identification number issued to health care providers by the Centers for Medicare and Medicaid Services (CMS).

UOP will play an instrumental role in the development and implementation of the ECOHA. UOP will develop and provide the curriculum and other content for ECOHA and collaborate with SIS and TCP to develop the pertinent protocols for the ECOHA. UOP will also train the providers that will use ECOHA. There will be two cohorts of users: 1) Indian Health home visitors; and 2) CHWs. Each year, UOP will host webinars for end users to provide updates on training and respond to questions users have about the assessment. These webinars will also serve to share best practices, identify problems with either the assessment itself or in the implementation, and identify solutions to address the problems. In addition, UOP will provide technical assistance to users, as needed; provide support to SIS in monitoring and updating the system. As new risk assessment practices become available and are appropriate for this program, updates will be made to the curriculum.

INNOVATIVE STRATEGY #1 – VDH

The VDH is the first of two main strategies under this LDPP. While each VDH site may vary to meet the needs of the specific community, all sites will follow the same protocol. Specifically, in the VDH, a supervising dentist directs a hygienist to provide care, within their scope of practice, at the community site. The navigator provides service coordination and completes community support activities. According to the report of the VDH Demonstration, the name of this system of

care indicates that it provides all the essential ingredients of a “Health Home,” which means it focuses on creating oral health, but does so using geographically distributed, tele-connected teams (2016).[20,21] The community-based team is equipped with portable imaging equipment and an internet-based dental record system. The hygienist collects electronic dental records such as X-rays, photographs, clinical findings, dental and medical histories, and uploads the information to a secure website where information is reviewed by the supervising dentist. The dentist reviews the patient's information and creates a dental treatment plan. The hygienist then carries out all aspects of the treatment plan that can be conducted in the community setting. The VDH creates the ideal situation for increasing the continuity of care among Medi-Cal children.

VDH services include health promotion and prevention education; preventive procedures such as application of fluoride varnish, dental sealants and within the scope of practice for dental hygienists – dental prophylaxis and periodontal scaling; placing ITR on carious teeth to stabilize patients and for the dentist to monitor to see if additional treatment is needed; and tracking and supporting family compliance with treatment recommendations for additional and follow-up dental services through the use of care coordination.

For complex procedures that require treatment outside the community setting, the VDH team links patients to the participating community clinic, including mobile dental clinics or a participating community-based Denti-Cal provider. When such visits occur, the patient arrives with a diagnosis and treatment plan already determined by the supervising dentist, preventive practices have been put in place and preventive procedures having been performed. The patient is much more likely to receive a successful first visit with the dentist as the patient's dental records and images have already been reviewed. Because most patient interactions and efforts to keep children healthy are performed by the hygienist in the community setting, this LDPP will demonstrate the creation of a true community-based dental home.

Implementation of the VDH system aims to enhance care delivery and oral health of children in IE communities as previously demonstrated by UOP. The project will reveal that incorporating a VDH system focused on children can allow the system to:

- Reach many more Denti-Cal beneficiaries than are currently being reached in the geographic areas where this demonstration will take place;
- Integrate oral health activities into the environment, activities, and processes of community sites where children are present;
- Apply proven prevention and early intervention procedures in community locations such as schools and pre-school programs;

[20]American Academy of Pediatrics. Role of the medical home in family-centered early intervention services. Council on Children With Disabilities. Pediatrics 2007:120(5);1153-1158.

[21]Pacific Center for Special Care, University of the Pacific Arthur A. Dugoni School of Dentistry http://www.pacificspecialcare.org Improving the Oral Health of Vulnerable and Underserved Populations Using Geographically Distributed Telehealth Connected Teams. June 2016.

- Establish a “continuous presence” system where the on-site dental team is present at the community site throughout the school year. This is known to increase awareness and focus on oral health which is critical to support adoption of health-producing daily mouth care and “tooth healthy” diets;
- Keep most children healthy on site in the schools and pre-school sites, and importantly verify through the tele-health system that they are healthy. This is possible because the dentist is involved through the tele-health system and can determine which children are healthy or can be made healthy through services provided by the dental hygienists on-site;
- Refer those children with advanced disease to dental offices/clinics for treatment of oral health problems, while maintaining on-going diagnostic and prevention services in the community;
- Improve the oral health of the children served in this demonstration, as measured by incidence of untreated dental caries, signs of pain and infection, and use of the hospital emergency department and operating room services for dental care; and
- Provide culturally and linguistically appropriate oral health services.

INNOVATIVE STRATEGY #2 – ECOHA TOOL

The LDPP-IE proposes to develop and demonstrate the use of a mobile-friendly caries risk assessment (i.e., a mobile application), called the ECOHA. This innovative tool is designed for use by early childhood home visitors (i.e., First 5 Riverside, and Indian Health home visitors), and CHWs. The goal is to empower a strategically located new workforce in addressing the oral health needs of young children.

During the design of the LDPP-IE, oral health stakeholders agreed that the proposed innovative strategies would not be successful unless preventive services and care coordination were embedded as emphasized activities. Both proposed strategies further the goals of the three dental domains: 1) increase preventive services utilization for children; 2) increase caries risk assessment and disease management; and 3) increase continuity of care.

The ECOHA, in English and Spanish, will guide the community provider through a set of questions. Based on the information provided, the child will be assigned one of the following risk categories and corresponding recommended activities.

- Low Risk: The family is following good preventive practices, understands how to prevent dental disease, has an established dental home, and no abnormalities were observed. Recommended activities include provision of oral health materials and counseling.

- Moderate Risk: The family is using some practices that could lead to dental disease, but after being provided with information the family seems to understand and is likely to follow good preventive practices and no abnormalities were observed. Recommended activities include referral to a dental hygienist for preventive care at a VDH site. If that is not possible, establish an appointment at a participating CHC Hub or a community Denti-Cal provider.

- High Risk: The family is using some practices that could lead to dental disease, and even

after being provided with information the family needs further education or help to understand and follow good preventive practices or some abnormalities were observed that warrant further evaluation from a dental professional. Recommended activities include making an appointment with a dental professional, an oral examination, preventive care and treatment.

GOALS OF THE EARLY CHILDHOOD ORAL HEALTH ASSESSMENT

- To provide risk-based assessment and tailored preventive care to children and families as early as possible in the child's life to help prevent poor oral health in the future;
- To ensure children enrolled in Medi-Cal through this strategy establish a dental home; and
- To integrate early preventive dental care within educational, social, or general health service programs that reach Medi-Cal-enrolled children, especially those most at risk of not receiving preventive care or having a dental home.

SUPPORTING ROLES AND RESPONSIBILITIES

COUNTIES

First 5 Riverside, as the county lead entity, and First 5 San Bernardino, as the co-lead entity are committed to ensure compliance with the agreement with DHCS and requirements of STC 109 (Local Dental Pilot Program). The First 5 Riverside LDPP-IE Program Director is responsible for overall project management. Both First 5 San Bernardino and First 5 Riverside are responsible for contract development, data collection and analysis, monitoring, communication, and collaboration. First 5 San Bernardino will lead the data collection coordination efforts in collaboration with subcontractors for the project to respond to DHCS evaluation requirements.

DENTAL PROVIDERS

Community Health Centers (CHC) employ the community dental team(s), including the supervising dentist, hygienist and navigator. The supervising dentist and hygienist are funded by the CHC with direct service revenue. The dentist reviews tele-health dental records and provides patient care through tele-dentistry technology, accepts new patients, and provides complex treatment services at the CHC when they aren't able to be provided in the community site because of the patient's advanced oral disease. The CHC also provides data on patients seen, and services provided as a part of this project. Oral health services are billed directly to Denti-Cal or billed to the State through the established PPS rate for reimbursable dental and case management services. Grant funded staff provide dental navigation, care coordination, and lead staff participate in the OHAC-IE, specifically, the LDPP-IE Work Group.

VDH is sustainable and achievable for CHCs since legislation enacted in 2014, Assembly Bill 1174, effective January 1, 2015, which enables health centers to bill for "store-and-forward" tele-dentistry services. This means that health centers can hire dental hygienists to collect records

and perform procedures within their scope in community sites. The health center can subsequently bill for the tele-health enabled team's community-based services. When a health center dental hygienist collects records and these are reviewed by a health center dentist, the health center will bill for an encounter, the same as if these procedures had taken place at the parent site. Additionally, if dentists direct the hygienist to perform additional procedures (i.e. sealants, interim therapeutic restorations) those visits will also be billed as encounters, the same as if these procedures had taken place at the parent site making this strategy sustainable and achievable.

PARTICIPATING HUBS & TEAMS

VDH Teams

A full-time VDH team will operate on average 4 days per week, 6 hours per day. A team consists of supervising dentist, hygienist, and navigator in support of 1,400 unique children over the 4 years (Table 1). Riverside and San Bernardino counties will establish 10 CHC Hub locations with 12 VDH teams (Table 4). The following table demonstrates the count of unique children each year of the project period:

Table 1. Unique Children Count – Project Period

Year 1	0 children	N/A
Year 2	800 children*	New children
Year 3	1,100 children*	400-500 new children + children from previous years
Year 4	1,400 children*	400-500 new children + children from previous years

***** Estimated numbers based on unique count of children (not cumulative); previous year children are receiving follow-up services, addressing continuity of care. Visit data will also be collected.

ECOHA Financing Models

ECOHA is an innovative approach to enable non-dental providers working directly with children 0 through 5 years of age and their families to administer an oral health risk assessment resulting in the establishment of a dental home. This project proposes to test two different financing models. First, through a grant funded community health worker strategy and second, through a professional service, pay-for-performance, agreement.

ECOHA Community Health Worker Strategy

The ECOHA community health worker strategy will consist of 2,400 assessments per year per 1.0 FTE community health worker. On average, assessments will be conducted 50 weeks per year, four days per week, four hours per day, completing 3 assessments an hour or 48 assessments per week.

Table 2. ECOHA Target Methodology

# ECOHA Per Hour	# ECOHA Hours Per Day	# Days Per Week	# Per Week	Annual Target
3	4	4	48	2400

ECOHA Pay for Performance (P4P) Strategy

To test the effectiveness of the ECOHA in determining risk, increasing preventative services, and establishing a dental home through home visitation, Indian Health's *Parents as Teachers* program. This program will test a pay-for-performance model (see Table 3. for P4P methodology) for each ECOHA completed ($10) with a subsequent completed dental encounter (additional $10).

Table 3. P4P ECOHA Strategy Methodology

# ECOHA	Incentive Per Assessments	Incentive Per Initial Dental Visit	Cost
525	$10	$10	$10,500

As noted below in Table 4, the LDPP-IE network of CHCs has committed to serve 15,800 unique children through VDH and complete 83,325 oral health assessments.

Table 4. Providers & Children Count

Community Health Center	Hub Location	Number of VDH Teams	Number of Unique Children	Number of Children through ECOHA
Bear Valley Health Care District	Big Bear	1	1,100	3,600
Borrego Community Health Foundation	Barstow	1 (a)	1,400	14,400
Borrego Community Health Foundation	Cathedral City	1 (b)	1,400	7,200
Morongo Basin Healthcare District	Yucca Valley	1	1,400	7,200
Clinicas de Salad Del Pueblo, Inc.	Mecca	1	700	
Neighborhood HealthCare	Menifee	1	1,400	7,200
North County Health Services	Perris	1	1,400	7,200
ParkTree Community Health Center	Ontario	1	1,400	
SAC Health System	San Bernardino	2	2,800	21,600
Vista Community Clinic	Lake Elsinore	2	2,800	7,200
CHC TOTAL	**10 Hubs**	**12 Teams**	**15,800**	
RUHS-MSO	Moreno Valley			7,200
Indian Health	Countywide			525
ECOHA TOTAL				**83,325**

[**Attachment A** – Map of Community Health Center Hub locations participating in this pilot]

COMMUNITY SERVICE LOCATIONS AND TARGET POPULATION FOR IMPLEMENTATION

The community sites, including rural and remote areas, have a high number of Medi-Cal enrolled children who are not receiving needed dental care primarily due to appointment barriers and lack of Denti-Cal providers able to address the socioeconomic barriers families face in getting care (Section 2.1, Target Population). Stakeholders identified the importance to have representation across both counties to satisfy unmet needs. The LDPP-IE team engaged local leaders and gained support for participation in the pilot project and targeted populations where lack of access to oral health services negatively impacts the health and well-being of residents.

The community service sites for this pilot project will be early care and learning sites, elementary schools, homes, WIC Centers, Family Resource Centers, or other community agencies serving Medi-Cal eligible children. Community agencies have agreed to provide space and access to LDPP-IE staff, execute required agreements and consents, and assist with arrangements for scheduling and integration of the system requirements and establish activities and processes.

More than 99,000 children ages 0 – 19 years of age will receive oral health preventive services throughout Riverside and San Bernardino counties in these identified community service locations. See Table 5. for locations and target population.

Table 5. Locations & Population Targets

CHCs	Community Service Locations	Target Population By Age
Bear Valley Health Care District	WIC, Bear Valley Unified School District, churches, Reach Out & Read providers, Community Based Organizations	Ages: 0-19
Borrego Community Health Foundation (Riverside County)	Riverside County WIC, Head Start, State Preschool, Quality Start Riverside County Sites, Community Based Organizations, Unified School Districts: Coachella Valley, Desert Sands, Hemet, Nuview, Riverside, Jurupa, Palm Springs, Romoland, and San Jacinto	Ages: 0-19
Borrego Community Health Foundation (San Bernardino County)	San Bernardino County WIC, Head Start, State Preschool, Quality Start San Bernardino County Sites, Community Based Organizations, Unified School Districts: Barstow and Helendale	Ages: 0-19
Morongo Basin Healthcare District	Unified School District: Morongo Unified School District-Primary Care Clinics, Head Start, San Bernardino County Quality Start sites	Ages: 0-18
Clinicas de Salad Del Pueblo, Inc.	Unified School Districts: Coachella Valley Palo Verde, Desert Mirage High School, Canyon Middle School, Head Start, Quality Start - Riverside County sites, Family Resource Center	Ages: 0-18
Neighborhood HealthCare	Menifee Health Center, Hemet Head Start, School Districts: Menifee, Romoland, Temecula, English Learner Advisory Academy, Quality Start sites - Riverside County sites	Ages: 0-18

North County Health Services	School Districts: Perris Elementary, Lake Elsinore, Val Verde, Quality Start Riverside County sites, Family Resource Center, Boys and Girls Club, local churches and non-profits	Ages: 0-5
ParkTree Community Health Center	School Districts, WIC, Head Start & State Preschool Quality Start Sites - San Bernardino County sites, local non-profits serving target population	Ages: 0-19
SAC Health System	San Bernardino Unified School District, Head Start, State Preschool, Elementary schools, SAC Health System, Primary and Pediatric Care clinics	Ages: 0-12
Vista Community Clinic	Lake Elsinore Unified School District, Boys and Girls Clubs, Head Start, State Preschool Program, Quality Start - Riverside County sites, non-profits	Ages: 0-19
RUHS-MSO	Riverside University Health System-Primary Care and Pediatric Clinic	Ages: 0-5
Riverside - San Bernardino County Indian Health Services	Tribal Home Visitation Program - Parents As Teachers	Ages: 0-5

ANTICIPATED OUTCOMES

ECOHA will be tested with providers who are located or work with families in the geographic locations of clinics that are implementing the VDH, except for children referred to Indian Health. This geographic designation ensures that children are able to complete recommended care at a VDH location or nearby clinic by a provider that already has a relationship to the project. Within the Tribal Family Program, home visitors are employed by Indian Health Services for establishment of a dental home.

By standardizing and simplifying ECOHA, community providers can easily assess and determine a child's risk for dental disease and have the tools needed to recommend and coordinate preventive treatment measures.

Key partners for this strategy include SIS, a non-profit organization, dedicated to improving access to quality health and social services through technology and policy solutions and with expertise in developing applications for health and social causes; the UOP; and TCP in collaboration with First 5 Riverside, First 5 San Bernardino, and the OHAC-IE. SIS will develop the application, store the data, conduct focus groups, and implement user testing.

As described in more detail below, TCP will coordinate the shaping of the ECOHA, and its implementation of the tool in its ability to assess children's risk for dental disease and provide guidance to providers on triaging the most appropriate oral health care for children. Additionally, TCP will work with all partners to identify and document lessons learned and best practices and share these outcomes with local stakeholders.

COMMUNITY SERVICE PARTNERS AND CAPACITY BUILDING FOR PARTICIPANTS

Community service partners will be early childhood home visitors, Quality Start sites, school

districts, FRCs, community based organizations, and WIC Sites, that are in the geographic regions of participating CHCs implementing the VDH. Oral health stakeholders in the IE agreed that the proposed innovative strategies would only be successful by focusing on preventive services and care coordination as critical community activities to ensure that children establish and maintain a dental home.

LDPP-IE funded care coordination will occur in CHC hubs. The Program Director will identify additional resources and be available to provide technical assistance to ensure the family is connected to a dental home that matches linguistic, cultural, geographic and other needs. Each CHC Hub and the identified provider network are committed to serve children who are screened by participating home visiting programs and CHWs. The CHW model ensures service access for children by connecting with families in the community to administer the ECOHA and coordinating care to the point of service at participating community clinics.

- **Quality Start**: As a systems approach, First 5 Riverside and First 5 San Bernardino will engage QS sites located geographically in each of the VDH pilot service areas. Memorandum of understanding (MOU) language in Riverside reflects their participation in this community-based preventive oral health program. Following the assessment completion, care coordination will link first to participating VDH sites then to CHCs.

- **Women, Infants and Children (WIC)**: This pilot project tests a new access point for dental services for underserved children and women enrolled in WIC. The LDPP-IE will increase awareness of the importance of oral health relative to overall health and well-being. The program will promote increased acceptance and adoption of evidence based, best practice early preventive interventions. The LDPP-IE will successfully link children assessed at WIC first to the community VDH sites then to CHCs.

- **Home Visiting**: Early childhood home visitation programs provide support to families with pregnant women and children birth through 5 years of age who are challenged by poverty, geographical isolation, and face language and literacy barriers. Services provided through home visits include a comprehensive clinical approach in providing case management services to very high risk families, reducing child maltreatment, improving parent-child interactions and children's social-emotional well-being, supporting the utilization of health care services, and school readiness activities.

- **Indian Health** employs eight (8) home visitors who will be trained to use the ECOHA to provide services to Native American families of children ages 0-4 years of age in both San Bernardino and Riverside counties implementing *Parents as Teachers* to approximately 163 families annually.

Strategic implementation will occur during the second year to test the ECOHA effectiveness to identify any anomalies and make improvements before making it more available throughout the counties. Additionally, implementation of the assessment requires connecting children to a dental home. In the third and fourth year of the LDPP-IE, the goal will be to expand provider use throughout the IE.

TECHNOLOGY

Home visitors and CHWs will be equipped with tablets or iPads©. First 5 Riverside and First 5 San Bernardino will purchase mobile devices for participating providers as needed.

QUALITY IMPROVEMENT: FOCUS GROUPS AND USER TESTING

As part of quality improvement, SIS will conduct focus groups and user testing for both user functions. During the first year of implementation, focus groups will be conducted with each cohort of Quality Start sites, WIC Sites, and early childhood home visitors to assess how the application is working to facilitate improved oral health among young children.

SIS will also conduct user testing by observing up to 20 providers while using the tool (or a prototype of the app) to assess usability. SIS will work with the LDPP-IE team to develop a script that allows as much natural observation as possible but also probe along the way about specific areas of interest. SIS will develop a report summarizing the results of the focus groups and user-testing, develop recommendations, and implement and track improvement.

COORDINATION EFFORTS & ACTIVITIES

TCP will coordinate the implementation of the ECOHA, including coordinating efforts among First 5 Riverside and First 5 San Bernardino, SIS, UOP, and COH. Additionally, TCP will coordinate the focus groups and user testing in the first year of implementation and other activities related to the assessment throughout the project period. TCP will be responsible for keeping OHAC-IE and First 5 Riverside and First 5 San Bernardino informed of all activities related to this element of the LDPP.

TCP will work with SIS and UOP to shape the tool, including its content and interface, to ensure it is appropriate for and addresses the specific circumstances of home visitors, early childhood education providers, and WIC providers. Additionally, TCP will work with SIS, UOP, and relevant entities in Riverside and San Bernardino counties, to create and coordinate trainings that will ensure that end users understand the assessment and its value in assessing risk and establishment of a dental home. These activities will support efforts to ensure the curriculum includes practice sessions and that training occurs at times and places most convenient for end users.

IDENTIFICATION AND SHARING LESSONS LEARNED

Because the ECOHA is such a unique activity that has not been previously demonstrated, additional attention is necessary to identify best practices and lessons learned that will ultimately be shared with local and state stakeholders. During project year three (3), TCP will develop a briefing document that outlines how the tool has been used, best practices, and lessons learned, along with policy and practical recommendations for statewide implementation.

As progress is made, in partnership with First 5 Riverside and First 5 San Bernardino, TCP will share lessons learned with DHCS and local audiences.

TIMELINE

YEAR 1 - (DECEMBER 2017)

- Development: Winter 2017

YEARS 2 – 4 (JANUARY 2018 – DECEMBER 2020)

- Implementation: Spring 2018
- Follow-up training: every three months
- Focus groups: early Spring 2018
- Development of initial results and recommendations based on focus groups and user testing: Spring 2018
- Implementation of recommendations based on focus groups and user testing: Summer 2018
- Technical support, training, data collection and analysis, tool and curriculum refinement, and coordination with state efforts: ongoing
- Sharing of best practices and lessons learned with state and local stakeholders
- Educational efforts and collaboration with Medi-Cal health plans to encourage adoption of the tool and promote medical-dental integration
- Development of briefing document, outlining best practices, lessons learned, and recommendations for statewide implementation.

GOALS

- To provide risk-based assessment and tailored preventive care to children and families within the first five years of the child's life to help prevent poor oral health in the future.
- To ensure children enrolled in Medi-Cal through this strategy are connected to a dental home.
- To maximize the workforce in Riverside and San Bernardino counties to improve the oral health of Medi-Cal enrolled young children by equipping WIC providers, child care providers, and early childhood home visitors with tools to provide preventive dental care to children. Additionally, ensuring all members of the dental team are coordinated in their efforts and supporting professional capacity building (i.e., education, skills, and expertise).
- To integrate early preventive dental care within educational, social, or general health service programs that reach Medi-Cal-enrolled children; especially those most at risk of not receiving preventive care or having a dental home.

As outlined in Section 4 (Progress Reports and Ongoing Monitoring) of this application, data will be collected continuously as services are provided and reported quarterly and annually to meet the requirements as outlined in the DTI STCs.

QUALITY IMPROVEMENT

Quality improvement will be a critical component of the LDPP-IE. This project provides the IE the opportunity to truly make a difference in the oral health of Medi-Cal enrolled children. Many stakeholders are invested in making sure that, by the end of this pilot, a sustainable system of oral health care exists for the most vulnerable children.

At the OHAC-IE meetings, a critical agenda item will focus on the review of data collected, feedback from the field, and observations from evaluation partners, First 5 Riverside, First 5 San Bernardino and other stakeholders. First 5 Data Analysts will be responsible for compiling both quantitative and qualitative data and analyzing the data in a manner that will be useful to the OHAC-IE so that the Coalition can observe and explore trends. Through this review, OHAC-IE will identify what is working well, where adjustments need to be made, and identify lessons learned. The OHAC-IE will make recommendations for next steps, and LDPP-IE participating entities will be responsible for implementation of the appropriate adjustments and Program Director will report back progress at OHAC-IE meetings.

From the initial stage of the Project, First 5 San Bernardino in partnership with evaluation partners will develop a system for documenting best practices and lessons learned, including a system for querying participating entities and subcontractors on a regular basis. The goal for this project is that LDPP-IE is implemented in a way that identifies best practices that can be replicated throughout Riverside and San Bernardino counties and ultimately throughout the State.

Critical to the process of identifying what is working, adjustments that need to be made and lessons learned is to ensure that success is measured against the desired outcomes. Therefore, First 5 Riverside and First 5 San Bernardino will ensure that quality improvement efforts are informed by evaluation data and practices to meet DHCS requirements to further the goals of all three dental domains.

CHWs will provide the following supports to the LDPP-IE: 1) Connect with families in the community; 2) administer the ECOHA; 3) coordinate referral to community clinics; and 4) follow up with families to ensure establishment of dental home.

First 5 Riverside and First 5 San Bernardino are committed to engaging in statewide dialogues to share best practices and lessons learned from the outcomes of the LDPP-IE, to learn from other LDPPs, and to assist with dissemination of best practices statewide.

3.3 ACCOUNTABILITY

First 5 Riverside, as the Lead Entity, in partnership with First 5 San Bernardino will ensure compliance with DHCS monitoring requirements, including the development of contract arrangements with participating entities and the overall management of the regional implementation. Through the contracting relationship, each participating VDH and ECOHA entity will have a scope of work (SOW) and budget, outlining contractual obligations, program

expectations, performance objectives, timely and accurate reporting, and budget requirements. The contractor will be responsible for reporting on the progress towards meeting their respective SOW on a quarterly basis or as negotiated. Contractors will also report out program data at least quarterly and annually for review by First 5 Riverside.

The LDPP-IE has broad-based provider and community support and collaboration amongst a variety of health programs that are aligned to the overall objectives of this two-fold oral health strategy. Accountability to meet project goals to increase preventive services utilization for children; increase caries risk assessment and disease management; and increase continuity of care will be accomplished through the collaborative efforts of funded partners and lead entities through formal contract monitoring, compliance, and quality improvement plans. Through the intentional identification of Medi-Cal enrolled children to access the benefits of this pilot project in high need areas and the matching of service providers in those respective areas, it is anticipated that significant integration of services and access to oral health services will be enhanced, delivering a heightened capacity for services and continuous quality improvement.

The LDPP-IE team will manage and coordinate various elements of the pilot:

Program Director: will oversee the overall implementation of the LDPP-IE, which incorporates collaboration with OHAC-IE and all participating entities.

Data Analysts: will compile, analyze and report on the data generated from the participating entities.

Analysts: will develop budgets, contracts and monitor contract compliance and performance requirements aligned with agreed contractual obligations.

Accounting Team: will monitor the LDPP-IE budget, process contract invoices, and provide recommendations on revised budgetary implications for program.

Through these various linkages of responsibilities, First 5 Riverside and First 5 San Bernardino will ensure compliance with the DHCS agreement.

Quality improvement involves two primary activities:

- Measuring and assessing the performance of contractors through the collection and analysis of data; and
- Conducting quality improvement initiatives and acting where indicated, including the design of new services and/or improvement of existing services.

Modification and frequency of LDPP-IE activities require ongoing review for continuous improvement planning. Regular communication on how the quality improvement plan is implemented will be provided to all participating entities, contractors, and other partners.

COMPLIANCE

If a participating entity or contractor is unable to show progress towards meeting their scope of work, a corrective action plan will be created by the First 5 Analysts in accordance and agreement with the DHCS and requirements of STC 109 and Attachment JJ. If a portion of the pilot is adjusted or terminated that adversely affects children, a strategy will be created to ensure children access care, ensuring uninterrupted oral health services.

Progress reports and summarized data reports will be analyzed by the Data Analyst, who will compile and analyze reporting for the OHAC-IE review. As a part of the quality improvement, the OHAC-IE will recommend enhancements that need to be made or ways to refine strategies based on the data. First 5 will communicate any individual contractor implications to participating contractor entities in which they will have 1-3 months to implement the recommendations. the LDPP-IE Program Director, TCP, COH, and additional entities as identified to ensure the success of the project objectives.

With respect to accountability for the provision of timely and medically necessary care, an EDR will be utilized to capture client level data from screenings, referrals and treatment from the entities in the VDH and would then align with the care coordination approach outlined earlier. EDR and data management issues in addition to using customized components of the EDR system including risk assessment and basic measures, will also be a focus of compliance. Tracking VDH outcomes using additional non-billing procedure codes, and using the EDR for communicating in tele-health connected team practice will also be another aspect of ensuring accountability. Through care coordination, the targeted population will receive oral health services in a timely and medically necessary manner.

With regards to the implementation of the ECOHA, which will be utilized by many professionals, child level data for the assessment will be obtained and referred to the Data Analyst from the mobile application for continuity of service as identified through the assessment. Through the VDH care coordination pathway, the child will access appropriate dental care and ultimately establish a dental home.

PROGRAM MONITORING AND CONTRACT ADMINISTRATIVE REVIEW

LPDD-IE Analysts will review and inspect subcontractors through mandatory periodic administrative review for compliance with the terms of the contract. All books, financial records and program records including verification of target(s) and other documents relating to the performance of the contract must be open to inspection and examination by the First 5 staff or duly authorized representatives from state or federal government.

Upon completion of the program monitoring and administrative review, the subcontractors will be mailed a report summarizing the results of the review within forty-five (45) calendar days. The subcontractors may be required to respond to concerns or requests as specified in the report within thirty (30) calendar days of receipt.

Program data will be entered at least monthly and input will be completed to comply with DHCS requirements. Any changes that occur with program data input must be reported to First 5 staff and adjusted within the data management system before the end of the Quarter following the change.

Failure to comply with any conditions contained in the contract, First 5 may place the contractor in a probationary status, temporarily withhold payments until the deficiency is corrected, deny funds for all or part of the cost of activity not in compliance, and/or request repayment to First 5 if any disallowance is rendered. Written notification of non-compliance will be sent to the identified contact person and executive director within twenty (20) working days. First 5 may, by written notice, terminate the contract in whole or in part at any time due to default or breach of contract. First 5 may immediately terminate a contract, at the sole discretion of First 5 when the contractor has been found to be in violation of any county, state, or federal law and/or regulation related to the health and safety of clients. Contract may also be immediately terminated at the sole discretion of First 5 if the contractor fails to provide for the health and safety of clients served under this Contract where the health and safety of clients are placed at risk by contractor. Funding is contingent upon funding from California Department of Health Care Services. Termination may occur if no funds or insufficient funds are available for payments. After the Contract is terminated under these provisions, First 5 shall have no obligation to make further payments. Termination shall be effective immediately upon written notification of the decrease or elimination of funds.

The contractor may terminate this Contract in whole or in part upon thirty (30) calendar-days written notice to the First 5.

DATA MANAGEMENT

Subcontractors will agree to participate in a comprehensive, countywide, internet-based evaluation and management process as defined by First 5 and California Department of Health Care Services. Participation shall include, but is not limited to, monthly input of program and financial data, submission of quarterly and annual Program Progress Reports, utilization of First 5 developed reporting systems and Administrative Review formats and required training to familiarize and implement the results-based accountability framework.

3.4 DATA SHARING

INFRASTRUCTURE TO SUPPORT DATA SHARING

Through contractual arrangements there will be provisions that require participating entities to submit timely data to First 5 Riverside, First 5 San Bernardino, evaluation partners, and DHCS. Data sharing will be coordinated by the Data Analyst who will utilize existing data collection platforms from the VDH and ECOHA located on mobile devices and/or EDR systems. The Data Analyst will work with subcontractors to provide necessary support for the subcontractors

implementing the VDH and ECOHA and to extract and submit the appropriate data from their various data systems. Quarterly and annual reports will be created and distributed to all participating entities and partners by the Data Analysts.

For CHC subcontractors implementing the VDH, data including X-rays, charts of dental findings, and dental and medical histories, will be entered into existing agency EDR systems for review by the dentist. Required data elements will be exported/ extracted from those records to create a flat file of structured data (e.g. XML import). Additional administrative/identification elements will need to be added to the CHC's export data file to facilitate the import. For the ECOHA, the data collected through the mobile devices would be hosted by SIS, who will comply with the reporting requirements and provide data to be uploaded into Persimmony by the Data Analysts. Additionally, the Program Director and Data Analysts will work to ensure that all contractors understand the data to be gathered and how to maintain the integrity of the data between reporting periods. The Data Analysts will establish a data "point person" at each of the organizations implementing the VDH, work with SIS, and UOP to assist in establishing a system of data collection and reporting.

The Program Director, Data Analyst, the participating entity staff leading data collection at implementing sites, SIS staff, and staff from UOP will design a schedule and plan the implementation of the data collection for the VDH and ECOHA, as well as data sharing mechanisms, ongoing data collection, and reporting. Best practices and lessons learned on utilization of oral health data to inform future program design, how to share data across systems, and how to integrate oral health data into existing data systems will be included in the information shared locally and statewide.

The Data Analysts will be responsible for collecting the data from each participating entity, uploading data into the First 5 Riverside and First 5 San Bernardino data systems, analyzing the data, and compiling reports to be reviewed by First 5 Riverside, First 5 San Bernardino, and the OHAC-IE.

Utilizing the database systems used by First 5 Riverside and First 5 San Bernardino will allow oral health data to be further contextualized and integrated into existing data systems.

Riverside: First 5 Riverside currently utilizes two (2) database systems:

(1) Persimmony is a web-based data and evaluation system to store data collected for current funded partners such as home visitation programs. This includes an array of demographic data, service utilization activities, and participant outcomes.

(2) iPinwheel is a browser-based web application with a centralized database that tracks, measures, stores, and reports the data needed to implement a successful Tiered Quality Rating and Improvement System (TQRIS) to help improve the quality of early childhood education programs. The early learning sites participating in Quality Start Riverside County, will be utilizing the iPinwheel database to track core level child data as well as classroom and site quality improvement data.

San Bernardino: First 5 San Bernardino utilizes one data system, Persimmony, which is the same system utilized by First 5 Riverside for funded partners.

Through these databases, the systematic collection of information, activities, stakeholder information and program outcomes is more seamless and integrated. This also allows heightened opportunities to leverage resources, such as compilation and analysis of data through specific identified teams.

DATA ELEMENTS TO BE SHARED

The data points that will be shared with DHCS, participating entities and contractors are:

Aggregate Level:

First 5 San Bernardino will collate data from the VDH participating sites. With respect to the ECOHA, data is compiled into the mobile application which will be uploaded to Persimmony and analyzed for broader level analysis. If the entity completing the assessment is not funded for care coordination, then the expectation is that linkage to care will be completed by LDPP-IE Community Health Worker.

Other data elements that may be shared, but not be limited to:

- Procedures performed at VDH and CHC sites
- Re-call and follow-up visits scheduled and kept.
- Education sessions provided at the community site
- Number of participants at education sessions
- Number of unique children who received preventive dental services through VDH
- Number of unique children who received risk assessments, care coordination and treatment at a dental home
- Number of unique children who received continuity of care as long as they were participants of the community

Ultimately, the intent of data sharing is to provide an integrated pathway of the various oral health services, into a cohesive and seamless system for children enrolled in Medi-Cal in the IE to connect them with a dental home, increase the amount of preventive dental services they receive, and increase the number of children who receive continuity of care.

DATA PROTECTION

The LDPP-IE will adhere to the Health Care Insurance Portability and Accountability Act (1996) (HIPPA) pertaining to client health care records and management obligations as outlined in the DHCS LDPP Application, Exhibit A.

CARE COORDINATION

Care Coordination, ensures that the linkage and consultation between providers enables a streamlined process for children and families to access oral health services. Data sharing strategies and established protocols will provide a structured platform for information sharing. As outlined in Section 3.1 of the DHCS application, outlining across systems, preventive services and care coordination will include:

- Enter child's information into ECOHA including child's Medi-Cal BIC number
- Assist families with dental appointment scheduling
- Provide individual education, complete ECOHA and screenings, provide oral health kits, apply varnish to teeth, and linkage to LDPP-IE dentists and community clinics
- Communicate with families in a culturally appropriate manner
- Track communication with families at regular intervals
- Utilize motivation interview techniques to assist families who are ambivalent about obtaining dental care for their child
- Provide comprehensive oral health promotion campaign to encourage staff engagement and build family participation
- Provide care coordination through establishment of a dental home including coordination of transportation assistance;
- Identify children with Special Health Care needs and connect them with Specialists as needed.

These elements lend a robust opportunity to increase care coordination across project participating entities.

CHALLENGES AND STRATEGIES

Data sharing can pose some challenges such as concerns regarding confidentiality, use of varying technological tools, having different expectations or understanding of project objectives. This can all lead to the reluctance to share data. The Program Director, Data Analyst, CHCs, UOP, the participating entity staff leading data collection at implementing sites, SIS staff, and staff from First 5's will work together to address and develop strategies as challenges arise.

Through a shared data portal, utilizing the same database system (Persimmony) will increase the likelihood of shared understanding of the data elements and objectives of the program. In addition, by having the database systems integrate into one database to then house the data will provide the opportunity to standardize how information is collected and analyzed. In addition to data sharing practices, the intent will be to develop agreements to ensure stakeholders and participating sites adopt shared practices thereby, improving collaboration, resulting in enhanced workflow opportunities within the LDPP-IE.

As data is collated, this will be shared with participating entities, DCHS and evaluators as outlined above, ensuring ongoing data collection, and reporting. As the pilot is implemented and data is collected, timelines and necessary infrastructure to allow continued data sharing will be reviewed and adjusted accordingly. Best practices and lessons learned on utilization of oral health data to

inform future program design, how to share data across systems, and how to integrate oral health data into existing data systems will be included in the information shared with DHCS and locally.

DATA GOVERNANCE

Data governance is necessary to ensure data quality across the LDPP-IE pilot. A plan will be developed for a data governance and submitted to DHCS for approval to incorporate working groups and IT support to ensure data integrity is maintained. The OHAC-IE will have an evaluation committee established that will oversee and review data structures. The LDPP-IE will comply with the data security precautions listed in Attachment A, the Business Associate Data Security Requirements, of the DHCS LDPP Application.

SECTION 4 – PROGRESS REPORTS AND ONGOING MONITORING

4.1 LDPP MONITORING

The primary goal of the LDPP-IE is to improve the oral health of Medi-Cal enrolled children in the IE by focusing on early intervention to drive delivery system reform. More specifically, this pilot aims to:

1. increase the use of preventive dental services;
2. prevent and treat more early childhood caries; and
3. increase continuity of care for children through implementation of the VDH and through the creation and implementation of the ECOHA.

Performance metrics for this pilot are delineated in the DTI STC and reference below for Domains 1, 2 and 3. Process metrics and outcomes measures have been identified for each strategy of LDPP-IE pilot.

The LDPP-IE has established performance measures across all three DTI domains.

Domain 1 - Increase utilization of preventive services in the IE by at least ten percentage points over the project period for Medi-Cal beneficiaries ages one through 19;

Domain 2 - Assess and manage caries risk and emphasize preventive services, in lieu of more invasive and costly procedures, for Medi-Cal children age six and under in the IE; and

Domain 3 - Increase continuity of care for Medi-Cal beneficiaries ages 19 and under in the IE for two, three, and four year continuous periods.

INNOVATIVE STRATEGY #1 - VDH: PERFORMANCE MEASURES

By 2020, an additional 15,800 unduplicated children ages 0 through 19 enrolled in Medi-Cal will receive Medi-Cal covered preventive dental services through the VDH strategy (10% increase over 2014-2015 baseline receiving preventive services). The annual target benchmark for VDH is outlined in Table 6.

Table 6. Annual Target Benchmark for VDH

Unduplicated Children Served through VDH				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Total Years 1-4**
0	8,950	12,350	15,800	15,800*

* Estimated numbers based on unique count of children per year; subsequent years, children are receiving follow-up services, addressing continuity of care.

By the end of the second year of LDPP-IE VDH, 10 dentists will provide oral health services through tele-dentistry.

The goals of the VDH pilot project will be to demonstrate that incorporating a VDH system focused on children can allow the system to:

- Reach many more Denti-Cal beneficiaries than are currently being reached in the geographical areas where this pilot project will take place;

- Integrate oral health activities into the environment, events, and processes of community sites where children are located;
- Apply proven prevention and early intervention procedures in community locations such as schools and preschool programs;
- Establish a "continuous presence" system where the on-site dental team is present at the community site throughout the school year. This is known to increase awareness and focus on oral health which is critical to support adoption of health-producing daily mouth care and "tooth healthy" diets;
- Keep most children healthy in the schools and preschool sites, and importantly verify through the telehealth system that they are healthy. This is possible because the dentist is involved through the telehealth system and can determine which children are healthy, or can be made healthy, through services provided by the dental hygienists on-site;
- Treat children with advanced disease in the CHC/dental offices, while maintaining on-going diagnostic and prevention services in the community; and
- Improve the oral health of the children served in this demonstration as measured by incidence of untreated dental caries, signs of pain and infection, and use of the hospital emergency department and operating room services for dental care.

For VDH specific patient data, each community health center will use their existing EDR system and billing systems to collect VDH required data elements. UOP will collaborate with providers and design additional project and health measures to determine project outcomes. Data, as outlined in Table 8 and Table 9, will be collected continuously as services are provided. Participating entities will report required data to First 5s monthly. First 5 Riverside will report and submit timely and complete data to DHCS in a format specified by the State and as defined in the agree with the State.

Care Coordination

Care coordination is a primary function of the VDH strategy to increase continuity of care over the project period. To support successful outreach and care coordination, CHCs and implementation partners will provide extensive training and mentoring to care coordinators, with the objective that:

1. **100% of care coordinators will demonstrate proficiency in their main duties** including:

   - Conducting dental assessment interviews
   - Oral health education using motivation interviewing
   - Collecting and correctly entering data into the CHC electronic health record or Persimmony
   - Provide care coordination to increase continuity of care

2. **100% of care coordinators will demonstrate significant increases in knowledge, confidence, and skills** in the following areas:

   - Children's oral health, prevention, and identifying urgency of dental care
   - Best practice of motivational interviewing and its implication in oral health education

OVERSIGHT, MONITORING, AND REPORTING – VDH STRATEGY

Through pilot innovations, dental providers will be uniquely positioned to increase the delivery of preventative oral health care to children enrolled in Medi-Cal while maintaining preventive oral health services children in the community through the VDH strategy. Participating VDH providers, who are all CHCs, will continue to follow claiming and billing guidelines of the Medi-Cal Dental Program.

INNOVATIVE STRATEGY #2 - ECOHA: PERFORMANCE MEASURES

By 2020, 83,325 ECOHAs will be conducted with children age 0 through age 5 enrolled in Medi-Cal through the ECOHA strategy. The annual target benchmark for ECOHA is listed in Table 7.

Table 7. Target Benchmark for ECOHA by Year and Total

ECOHAs Target				
Year 1	**Year 2**	**Year 3**	**Year 4**	**Total**
0	27,775	27,775	27,775	83,325

By the end of the second year of the LDPP-IE, 12 CHWs will conduct ECOHAs in community locations throughout Riverside and San Bernardino counties through the mobile application.

LDPP-IE will use four systems to track performance metrics for ECOHA, which are Department of Health Care Services (DHCS) data, community health center (CHC) data, ECOHA Mobile Application data, and Persimmony data.

Data from the ECOHA will be imported from the ECOHA mobile application to the Persimmony data systems at First 5 San Bernardino and First 5 Riverside, depending on the service location of the child. As outlined in Section 4 of this application, data will be collected continuously as assessments are conducted and reported at least quarterly.

Annually, the number of children assessed who also receive preventive services through an initial dental exam and return for a second or third exam will be corroborated with Medi-Cal claims and encounter data from the DHCS warehouse or community health center.

To achieve the target metric of 83,325 ECOHAs completed within 3 years and the percentage of assessments resulting in a dental visit and establishment of a dental home, implementation of an integrated evaluation approach will include:

- CHWs and care coordinators as health center staff;
- home visitors;
- mobile application data for child assessment;
- dental visit “check-in”;
- parent education mobile application utilization; and
- CHC encounter data or DHCS data.

The goals of the ECOHA pilot project will be to demonstrate that incorporating such an approach in locations where children are located, can allow the system to:

- Provide risk-based assessment and tailored preventive care to children and families within the first five years of the child’s life to help prevent poor oral health in the future;

- Maximize workforce in Riverside and San Bernardino counties to improve the oral health of Medi-Cal enrolled young children by equipping child care providers, CHWs and early childhood home visitors with tools to provide preventive dental care to children;
- Integrate early preventive dental care within educational, social, or general health service programs that reach Medi-Cal enrolled children; especially those most at risk of not receiving preventive care or having a dental home;
- Increase the rate of children's utilization of preventive services to improve the oral health of children in Medi-Cal in the IE (IE);
- Improve oral health of children enrolled in Medi-Cal by connecting them with a dental home; and
- Improve the oral health of children enrolled in Medi-Cal in the IE by increasing the number of children who increase continuity of care.

To support successful completion of ECOHAs, UOP, TCP, and SIS will provide extensive training and mentoring to CHWs, with the objective that:

1. 100% of CHWs and home visitors will demonstrate proficiency in their main duties including:
   - Conducting ECOHAs
   - Oral health education using motivation interviewing
   - Collecting and correctly entering data into the ECOHA
   - Provide basic care coordination to establish the initial dental visit.

2. 100% of CHWs and Home Visitors will demonstrate significant increases in knowledge, confidence, and skills in the following areas:
   - Children's Oral Health, prevention, and identifying urgency of dental care
   - Best practice of Motivational interviewing, and its implication in oral health education

For the ECOHA approach, as the statewide performance measures are reassessed throughout the pilot project period and are further developed, then the pilot project will align with these requirements. UOP will collaborate with providers and design a series of project and health measures to determine project outcomes. In addition, there will be opportunities to identify other measures that are unique to ECOHA for local consideration. See Table 9 for an outline of data fields, short term measures, process measures and outcome measures.

Data will be collected continuously as services are provided and reported monthly to First 5 and reported to DHCS quarterly and annually as required.

OVERSIGHT, MONITORING, AND REPORTING

First 5 Riverside, Program Director has primary responsibility for oversight of the pilot project. The projects contract analysts will conduct routine monitoring of the progress made by each participating entity. Project progress, successes, and needs for technical assistance will be formalized in the contract Monitoring and Administrative Review report. Scope of Work activities and target accomplishments are documented and comments and course corrections noted during a collaborative process with the goal to keep the project on track for success. Official findings of non-compliance are addressed formally, in writing with the subcontractor for corrective action. If poor performance continues, the subcontractor will be terminated from the pilot.

First 5 Riverside will submit reports to DHCS as required, including detailed description of how the LDPP-IE has operationalized with respect to specific strategies, target populations,

performance metrics and goals achieved. A descriptive assessment of the impact of the strategies and an analysis of the program challenges generated through the proposed implementation and any adjustments that have been made will be reported to DHCS quarterly and annually in a format specified by the State. The Program Director and COH will report project progress to the LDPP-IE Workgroup for review and input at each OHAC-IE meeting.

PLAN FOR COLLECTING AND DOCUMENTING METRICS

Data collection and documentation of metrics are key components of the VDH and ECOHA strategies to drive systems change in the IE. THE LDPP-IE uses a collaborative approach that allows for accountability and validation processes as well as identifying opportunities for efficiencies and identification of project improvements. Participation in the State's program evaluation activities includes providing data to measure success of key activities of the work plan throughout the duration of the project. The First 5 Data Analysts will be responsible to compile both quantitative and qualitative data for reporting to DHCS and analyzing the data into reports for OHAC-IE meetings.

UOP will direct data collection efforts and provide analysis of qualitative and quantitative data for the VDH strategy. The UOP team will assist with the preparation of reports and recommendations. For VDH specific patient data, each community health center will use the existing EDR system to collect VDH required data elements. Staff from UOP will support the analysis of the current EDR systems and provide additional assistance using, modifying, or incorporating new components needed for the VDH implementation, data collection and reporting. VDH data will be exported as a flat file of structured data (e.g., XML import) and entered in the Persimmony database for analysis by the First 5 San Bernardino data analyst for reporting to DHCS.

TCP will direct data collection efforts for the ECOHA Strategy. Participating providers implementing the ECOHA will use a mobile device to collect demographic and assessment data. The data collected through the mobile application, managed by SIS. The application should store data in a secure manner. The data security will be HIPAA compliant, which means there are access controls and only people who are authorized to see the data can see it.

LDPP-IE partnering entities are responsible for data collection, and reporting, as well as data sharing mechanisms, ongoing data collection, and reporting. Best practices and lessons learned on utilization of oral health data to inform future program design, how to share data across systems, and how to integrate oral health data into existing data systems will be included in the information shared locally and statewide. This will inform evaluation efforts across the State as well as provide dialogue for local implications of the LDPP-IE. The overall project evaluation will incorporate these elements as part of a comprehensive systems analysis.

QUALITY IMPROVEMENT PLAN

Quality improvement activities will be designed for both LDPP-IE strategies to improve oral health care for Medi-Cal enrolled children in the IE. The LDPP-IE providers providing direct services for this pilot are CHCs with established QI requirements and established oral health performance measures to provide preventive services. CHC participating entities are invested in making sure that, by the end of this pilot, a sustainable system of oral health care exists for the most vulnerable children.

The quality improvement plan will be structured to include the following:

- The use of data and measurable outcomes to determine progress toward target benchmarks;
- A data-driven approach for monitoring and analysis to determine whether the strategies are achieving the desired outcomes;
- A continuous process that is adaptive to change and that fits within the framework of quality assurance and quality improvement activities.

To provide leadership and data governance, The COH will establish a LDPP-IE Workgroup of the OHAC-IE. QI activities will focus on the review of data collected, feedback from the field, and observations from LDPP-IE participating entities. The data analysts will be responsible for compiling both quantitative and qualitative data and analyzing the data in a manner that will be useful to the OHAC-IE so that the Coalition can observe and explore trends. Through this review, the LDPP-IE workgroup of the OHAC-IE will identify what is working well, where adjustments need to be made, and identify lessons learned. The LDPP-IE Workgroup will make recommendations for next steps, and LDPP-IE participating entities will be responsible for implementation of the appropriate adjustments and will report back progress at OHAC-IE meetings.

Technical assistance will be provided to participating CHCs by UOP, TCP, SIS, and the COH. Additionally, the First 5 data analysts will provide training on data collection requirements to home visitors, care coordinators, and CHWs.

First 5 Riverside, First 5 San Bernardino, UOP, TCP, SIS, and the COH are committed to engaging in statewide dialogue to share best practices and lessons learned from the outcomes of the LDPP-IE, to learn from other LDPPs, and to assist with dissemination of best practices statewide.

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4.2 DATA ANALYSIS AND REPORTING

PLAN FOR DATA COLLECTION, ANALYSIS AND REPORTING:

Systemic data collection and analysis for both innovative strategies will be used to measure whether the VDH and the ECOHA is improving the oral health of children served in the pilot project. Data collected through EDR, and collected through the ECOHA mobile application, as well as qualitative date collected through focus groups and surveys will inform the overall outcomes of this regional pilot.

STRATEGY 1 - VDH: Participating Health Centers and the associated VDH team will utilize the existing EDR to examine and collect dental information, including X-rays, photographs, charts of dental findings, and dental and medical histories. Individual patient information will be sent through a secure tele-health system to a dentist who establishes a diagnosis and creates a dental treatment plan. The required LDPP-IE data elements will be exported from the EDR's through a flat file of the structured data (e.g., an XML import). Program data will be submitted to First 5 Riverside monthly. Additionally, LDPP-IE participating entities will be required to submit quarterly program reports.

STRATEGY 2 - ECOHA: The assessment and corresponding field of information will be loaded onto a mobile device such as a smart phone or tablet and community providers will be guided through a series of questions relating to the child's oral health, eating practices and lifestyle aspects. In addition, the parent portal of the application will allow confirmation of the child's dental visit and any oral health education parents receive through this electronic portal. This combined information will assess the child's risk level for oral health intervention (low, moderate, or high) and with recommended actions. Data will be transferred to a back-end system and stored for further analysis. Export to Persimmony using .csv will allow transfer of data for further analysis, aggregating the data with reported care coordination, treatment and continuity of care linked to the outcomes for that child. Through the utilization of the Medi-Cal Benefits Identification Card (BIC) Number, cross tabulation of clients receiving care coordination through CHCs will be monitored and reported. The Data Analysts will analyze ECOHA data provided by SIS each month and report the data on a quarterly and annual basis to the state.

Data from both the VDH and the ECOHA will be uploaded into Persimmony for data analysis and reporting. The Data Analysts will compile reports to be reviewed by implementation partners and participating entities, ensuring extensive engagement of LDPP-IE partners. In addition, data will be provided to the lead evaluation team for further analysis based on the agreed upon methodology for the evaluation over the four-year period.

Data related through a payment strategy to incentivize providers will also be analyzed to determine utilization and outcomes. As a method to test the effectiveness of the ECOHA in determining risk and establishing a dental home, LDPP-IE will provide the Indian Health Home Visitation program a pay-for-performance incentive for each ECOHA completed ($10) resulting in a completed dental encounter (additional $10).

Through this coordinated collaborative process, consolidation of the intended outcomes of this pilot program will be completed as a pathway to determine the projects impact on the incidence of untreated dental caries, signs of pain and infection, and use of the hospital emergency department for dental care in Riverside and San Bernardino counties.

DATA THAT WILL DEMONSTRATE INTENDED IMPACT

VDH STRATEGY: To measure progress on the performance metrics across all three DTI domains through the VDH strategy, Table 8 identifies the measures that will be used to determine impact, data fields and measures.

Table 8. VDH Data Collection

Data for VDH	Data Source	Frequency of Measurement Collection and Reporting
Number of children enrolled in Medi-Cal who receive preventive services in community-based VDH sites	Participating site data collated across all sites	Monthly collection and quarterly/annual reporting
Number of children enrolled in Medi-Cal who receive risk assessments and treatment plans through VDH team	Participating site data collated across all sites	Monthly collection and quarterly/annual reporting
Number of children enrolled in Medi-Cal who receive care coordination (including motivational interviewing, education, connection to community resources)	Participating site data collated across all sites	Monthly collection and quarterly/annual reporting
Number of children who are connected to a dental home	Participating site data collated across all sites	Monthly collection and quarterly/annual reporting
Number of children participating in the VDH who complete the care designated in their treatment plans	Participating site data collated across all sites	Monthly collection and quarterly/annual reporting
Number of community providers who have basic knowledge about oral health and integrate oral health education and awareness into their day-to-day activities	Participating site data collated across all sites through pre/post testing	Monthly collection and quarterly/annual reporting
Number of parents/caregivers who received oral health education at the community site	Participating site data collated across all sites through pre/post testing	Monthly collection and quarterly/annual reporting
Common Data Fields	**Process Measures**	**Qualitative Measures (surveys and focus groups)**
• Number of unduplicated children • Demographics, including race/ethnicity and primary language spoken of child and family members, as appropriate • Procedures performed with an emphasis on preventive procedures • Risk assessments and subsequent interventions • Decisions made by dentists (virtual) about the need for children to be evaluated and/or treated in-person by a dentist • Recall and follow-up visits needed and kept • Costs and revenue attributable to this system	• Number of children who will receive preventive dental services in community sites • Number of children who will receive oral health assessments and treatment plans • Number of children who will receive continuous care in the community site	• Opinions of participant providers and site personnel • Satisfaction of children and parents

ECOHA STRATEGY: To measure progress on the performance metrics across DTI domains through the ECOHA strategy, Table 9 identifies the measures that will be used to determine impact, data fields and measures.

Table 9. ECOHA Data Collection

Data to Collect for the ECOHA	Data Source	Frequency of Measurement Collection and Reporting
Number of children enrolled in Medi-Cal who receive ECOHAs through designated community locations	Participating site data collated across all sites utilizing the mobile application functionality	Monthly collection and quarterly/annual reporting
Number of children enrolled in Medi-Cal who will receive care coordination	Through participating site that has care coordination utilizing the mobile application functionality	Monthly collection and quarterly/annual reporting
Number of children involved in the program who receive a recommended follow-up service as determined by the ECOHA	Participating site data collated across all sites utilizing the mobile application functionality where updated	Monthly collection and quarterly/annual reporting
Number of children enrolled in Medi-Cal who received a treatment plan from a dentist following the oral health assessment	Participating site data collated across all sites utilizing the mobile application functionality	Monthly collection and quarterly/annual reporting
Number of children who are connected to a dental home	Participating site data collated across all sites utilizing the mobile application functionality	Monthly collection and quarterly/annual reporting
Common Data Fields	**Process Measures**	**Short Term Measures**
• Agency and provider information • Date of assessment • Demographics, race/ethnicity and primary language spoken of child and family members, • Medi-Cal Benefits Identification Card (BIC) Number • If the child has a usual source of oral health care • Age the child first visited a dental provider • Last time the child saw a dental provider • Answers to family-reported information about the child's oral health and oral health behaviors • Risk level • Care coordination activities • Dental Visit "Check-In" at provider office • Follow-up activities conducted by family	• Number of Medi-Cal enrolled children who receive early childhood oral health risk assessments at designated community sites. • Number of Medi-Cal enrolled children who "check-in" for a dental visit • Number of children who receive recommended services as determined by the early childhood oral health risk assessment • Number of children who receive treatment plans and care coordination • Number of children who established a dental home	• Number of Medi-Cal enrolled children who received early childhood oral health risk assessments, treatment plans, and care coordination through home visitation programs, Quality Start programs, WIC, Primary care clinics and Family Resource Centers • Number of children who received recommended services as determined by the OHAC • Number of children who established a dental home

Data will be collected continuously as services are provided and reported monthly to First 5's and reported to DHCS quarterly and annually as required.

ANALYSIS FOR SUSTAINABILITY PLANNING

An important achievement of the VDH system is that sustainability is intrinsic. Since the VDH examination is completed in community settings, limited referral and care navigation resources can be directed towards focusing on individuals requiring more complex care and follow up, thereby providing continuity of care. An analysis of the economic viability of the preventive care model completed by UOP has demonstrated that such a model produces savings. The VDH model has been shown to have better economic sustainability through similar pilot programs in California. As the oral health system is moving towards outcome based payments, it is imperative that outcomes data demonstrates how early detection and intervention strategies can benefit not only the recipients of oral health services, but also the service system that provides a fiscal platform by which services are provided.

The ECOHA mobile application will be created in conjunction with First 5 Riverside, TCP, UOP and SIS. SIS over the course of its history, has successfully delivered and continues to support online, innovative technology solutions. The assessment will leverage technology and influence policy with the goal of connecting children with needed oral health services. Creating a mobile application that streamlines and simplifies the oral health screening process will increase the usability and accessibility of the device for non-oral health professionals. In addition, this will create effective and efficient methods to assess young children in locations where they are already receiving community based services.

The collection of data, analysis and reporting, allows for comprehensive evaluation of the intended strategies. Ongoing review and monitoring will support the continuous improvement efforts by each participating entity. At a greater level, COH will provide oversight of the continuous improvement efforts and ensure effective practices retain the goal of viable planning.

The overall approach with the analysis of these interfacing strategies will deliver a platform for sustainability planning and guide policy formation in the oral health field by shifting the scope of practice from individual clinic practice to a comprehensive service system by enhancing workforce capacity and engagement in patient coordinated care.

SECTION 5 – FINANCING

5.1 FINANCING STRUCTURE

As noted in Diagram 3 below, Riverside County Children & Families Commission (aka First 5 Riverside) is the designated Lead Entity that will be the single point of contact for DHCS and the Centers for Medicare and Medicaid Services (CMS) as required by STC 109.a. The LDPP-IE proposes funding a collective impact model including both First 5 Commissions, UOP, COH, TCP, SIS, ten (10) Health Centers/Health Systems, and Indian Health.

As the fiscal agent, First 5 Riverside will distribute funds through contracts directly with subcontractors. Each subcontractor will have an approved annual budget. In accordance with county and state requirements and regulations, reimbursement for allowable and reasonable actual expenses will be processed in arrears after receipt and approval of invoice and supporting documentation. Expenses will be recorded and supporting documentation uploaded into the First 5 Persimmony database monthly for oversight and monitoring of payments. Additionally, LPDD-IE analysts will conduct mandatory periodic administrative reviews for compliance with the terms of the contracts. All books, financial records and program records, including verification of target(s) and other documents relating to the performance of the contract, must be open to inspection and examination by the Commission staff or duly authorized representatives from the state or federal government.

Due to rounding, numbers presented throughout this section and its attachments may not add up precisely to the totals provided and percentages may not precisely reflect the absolute figures. There is no impact to the final calculation overall.

SELECTION OF SUBCONTRACTORS - JUSTIFICATION

Due to the expedited application process, development of an RFP and the time associated with the formal selection process was not feasible prior to the application deadline. Additionally, the demonstration period begins shortly after the award notification thereby impacting timely execution of the proposed strategies to conduct a formal RFP. Therefore, selection of the subcontractors without a formal bid process was determined based on the following factors: 1) known leaders in the industry and reputable firms; and 2) each have the internal capacity to meet short deadlines associated with the demonstration period. Below is a summary justification for each subcontractor detailing capacity to meet the needs of this project.

UOP – The Pacific Center for Special Care at the UOP School of Dentistry has developed and tested an innovative and customizable oral health delivery system called the VDH system of care. The success of the demonstration of the VDH system resulted in legislation being passed in 2014 that has now created a regulatory environment where this system can be expanded and local programs can be established that will become self-sustaining using program revenue. Dr. Paul Glassman, creator of the system, is the only certified dentist to provide training of the VDH system and is a known leader in tele-dentistry, as well as implementing oral health systems and tools for use by non-dental professionals. As such, the LDPP-IE has elected to subcontract with Dr. Glassman and the Pacific Center for Special Care at the UOP School of Dentistry for both strategies 1) VDH and 2) ECOHA. UOP will also play an instrumental role in the development, implementation, and evaluation of the ECOHA.

TCP – California–based national children's advocacy organization committed to improving the lives of underserved children where they live, learn, and play with breakthrough solutions at the

intersection of research, policy, and community engagement. Since 1993, TCP has been a leading voice for children and a critical resource for communities across California and the nation, working every day to champion policies that provide all children with the resources and opportunities they need to thrive. TCP is a reputable leader with an established track record of policy work in oral health and home visitation programs and therefore has been selected to assist with the implementation of the ECOHA.

SIS has a long and successful track record of helping national, state, county, and individual program stakeholders to effectively leverage technology solutions to automate and improve screening, eligibility, and enrollment processes. They are a known leader in their specialty and have the internal capacity to meet the short timeline to create the downloadable electronic assessment (i.e. mobile application – ECOHA) for use with this program through tablets and smart phones.

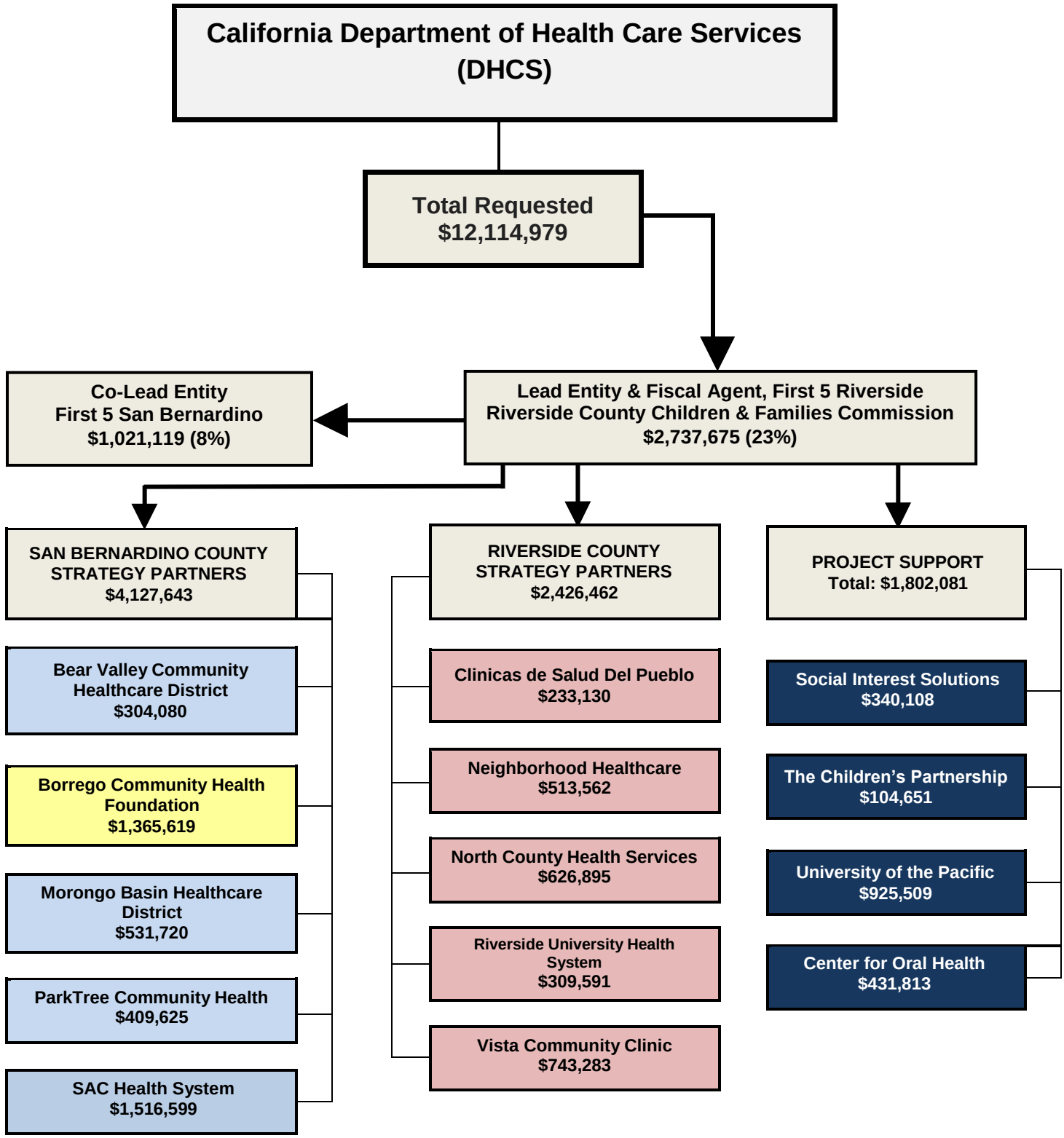
COH to further support collaboration and communication, building from existing systems, the COH is the convener of the OHAC-IE, composed of more than 30 organizations united by the common goal of improving the oral health of underserved residents in the IE. COH will establish a LDPP-IE Workgroup that will pursue key activities to assist with collective impact efforts across the partner entities.

Partner Agencies The remaining subcontractors include the partner agencies (CHCs) that submitted a letter of commitment to implement the VDH and/or ECOHA. First 5 Riverside, as the lead entity and fiscal agent, will maintain oversight of 15 subcontracts. However, within the regional and co-lead framework, the day-to-day oversight of subcontracts will be monitored and controlled based on county point of service (see Diagram 3, Section 5.1).

First 5 Riverside will maintain oversight and control over the following subcontracts $9,377,304:

1. First 5 San Bernardino (co-lead) $1,021,119
2. Clinicas de Salud Del Pueblo – $233,130
3. Morongo Basin Healthcare District – $531,720
4. Neighborhood Health Care – $513,562
5. North County Health Services – $626,895
6. Riverside University Health System, Medical Services Office – $309,591
7. SIS – $340,108
8. TCP – $104,651
9. UOP– $925,509
10. Vista Community Care – $743,283
11. Bear Valley Community Health District - $304,080
12. Borrego Community Health Foundation - $1,365,619
13. COH - $431,813
14. ParkTree Community Health - $409,625
15. SAC Health Center - $1,516,599

Diagram 3. Financial Flow



PARTNER AGENCIES – STRATEGY COSTS = $8,356,182 (69%)

Riverside – 2,426,461 (20%)	San Bernardino – 2,762,024 (23%)	Both Counties – 1,365,619 (11%)	Project Support – 1,802,081 (15%)

5.2 FUNDING REQUEST

As depicted in Table 10 the total requested support across all demonstration years is $12,114,979. Approximately 65%% ($7,924,374) of the total budget is allocated to the development and implementation of both strategies (VDH & ECOHA). Budget details for each partner entity is captured in the proceeding budget pages.

Table 10. LDPP-IE Budget

	F5 Riverside	F5 San Bernardino	Project Development	Implementation Center/Hubs	Total
Salaries	1,035,793	563,454	1,045,236	4,038,441	6,682,924
Fringe Benefits	452,746	287,813	307,785	1,229,994	2,278,338
Operating	237,003	57,162	79,357	350,400	723,922
Equipment	495,000				495,000
Travel	98		174,225	127,582	301,905
Other	309,876				309,876
Indirect	207,159	112,690	195,478	807,687	1,323,014
Total	**2,737,675**	**1,021,119**	**1,802,081**	**6,554,104**	**12,114,979**

*Other expenditure line under Project Development includes $299,376 for stipends. These costs are part of the First 5 Riverside budget.

LDPP-IE PROJECT BUDGET

The allocation of funds for administrative and operating costs for the entire projection period is $2,737,675 (23%), which supports the management and oversight of 15 subcontracts including co-lead First 5 San Bernardino, centers/hubs and project development – $9,366,304 (77%).

Table 11. LDPP-IE Budget (Detailing Lead and Subcontractor Budgets)

Costs	Year 1	Year 2	Year 3	Year 4	Total
Salaries	37,499	316,335	333,591	348,368	1,035,793
Fringe Benefits	16,391	138,270	145,813	152,272	452,746
Operating	13,500	74,501	74,501	74,501	237,003
Equipment		495,000			495,000
Subcontractors	188,607	3,270,608	2,976,611	2,941,478	9,377,304
Travel	98				98
Other Costs		138,068	117,908	53,900	309,876
Indirect	7,500	63,267	66,718	69,674	207,159
Total	**263,595**	**4,496,049**	**3,715,142**	**3,640,193**	**12,114,979**

YEARS 1 – 4 BUDGET JUSTIFICATION

Details of each funding element for Years 1 – 4 are listed below, excluding any covered services reimbursable by Medi-Cal Dental or other federal funding resource.

PERSONNEL YRS 1 – 4 - The core administrative positions within the lead and co-lead entities will be tasked with various program oversight, working closely with subcontractors to ensure that program objectives and milestones are met within each demonstration year. Program Director (LDPP-IE) will reside at First 5 Riverside and will provide complete oversight of the LDPP-IE program. Both First 5 Riverside and First 5 San Bernardino will fund analysts and fiscal support to manage the programmatic and fiscal aspects of the contracts between the partnering agencies. First 5 San Bernardino will fund a Data Analyst and Supervisor, Data and Community Engagement to manage the data component of the contract. Through these various linkages of responsibilities, First 5 Riverside will ensure compliance with its agreement with DHCS. Positions listed below are budgeted in each project year and detailed budget amounts are referenced in Table 11.

Program Director (LDPP-IE) – This position is the single point of contact with DHCS and will be tasked with complete oversight of the LDPP-IE – organizing, developing, administering, monitoring and evaluating the program. A key function is to coordinate and collaborate with partner entities and subcontractors to ensure objectives and milestones are met within the demonstration year.

Analyst – Each First 5 analyst will be tasked with budget development, contract negotiation, compliance, and monitoring to ensure performance requirements are aligned with agreed upon contractual obligations.

Data Analyst - will be tasked as the liaison between partner agencies to compile, analyze and report on the data generated from the participating entities.

Fiscal Support – Each First 5 will be tasked providing fiscal support to process contract invoices and provide recommendations on revised budgetary implications for program implementation. However, majority of the fiscal support will be accomplished at the lead entity.

Supervisor, Data and Community Engagement – will be responsible for the supervision of the Data Analyst and will oversee and review all data collected under this project.

FRINGE BENEFITS YRS 1 – 4 – The fringe benefit rate was calculated based on the allowable DHCS fringe benefit expenses. The lead entity and co-lead entity established fringe benefits rate are 43.71% and 51.08%, respectively.

OPERATING YRS 1 – 4 – Operating costs include the following expenses: communication/mobile devices (i.e., cell phones, internet access plan, desk phone, internet, voicemail, email and fax), educational materials/dental hygiene kits (i.e. brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters), office supplies (i.e., desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments), County services, rent expense and computers. As noted below in Table 12, funds each year have been set aside for dental hygiene kits that will be distributed as incentives for completion of the ECOHA and/or completion of the dental visit.

Table 12. Dental Hygiene Kits Calculation

DENTAL HYGIENE KITS	Year 1	Year 2	Year 3	Year 4	Total
Number of kits to be purchased	0	33,431	33,431	33,431	100,293
Estimated Kit Cost	N/A	$2.18	$2.18	$2.18	$2.18
Budget- Kits	N/A	$72,821	$72,821	$72,821	$218,463

EQUIPMENT YRS 1 – 4 – N/A

SUBCONTRACTOR YRS 1 – 4 – Details are listed below for subcontractor costs.

TRAVEL YR 1 - 4 – Travel costs were calculated based on the California Department of Human Resources (CalHR) reimbursement rates, which mirror those of the Internal Revenue Service (IRS) published mileage reimbursement rates. There could be subsequent changes to the IRS rates within the demonstration years. The travel costs include private mileage to community site, trainings & meetings related to the DTI initiative. Table 15 provides the overall cost per project year. Subsequent subcontractor budgets provide additional details for mileage amounts.

OTHER COSTS YRS 1 - 4 – Stipends will be paid to project agencies based on the total number of training hours and technical assistance per year. Each year the stipend amount decreases based on the level and type of training necessary. The bulk of the training costs are captured in the initial year. The training will be for each VDH field team consisting of a dentist, hygienist, and navigator. Stipend payments will be monitored for each agency.

Table 13. Training Stipend

	Year 1	Year 2	Year 3	Year 4	Total
Stipends	$0	$134,568	$114,408	$50,400	$299,376

Pay for Performance Incentives – This line item will support the implementation of the ECOHA through home visitation employed with Indian Health. Estimated number of assessments for the project period is 525 at $20 for a total of $10,500.

Table 14. Indian Health Pay-for-Performance Methodology

Pay for Performance	Payment Amount	**YR 1** # Completed	**YR 2** # Completed	**YR 3** # Completed	**YR 4** # Completed	TOTAL
		0	175	175	175	525
Assessment Completed	$10.00	$0.00	$1,750	$1,750	$1,750	$5,250
Dental Visit Completed	$10.00	$0.00	$1,750	$1,750	$1,750	$5,250
		$0.00	$3,500	$3,500	$3,500	$10,500

INDIRECT YRS 1 – 4 – Indirect costs were calculated on the total salary only at the maximum allowable 20% rate, excluding fringe benefits.

SUBCONTRACTORS

The table below illustrates the total requested for subcontractors across all demonstration years is $9,377,304.

Table 15. Subcontractor Budgets

Costs	Year 1	Year 2	Year 3	Year 4	Total
Salaries	90,353	1,991,096	1,792,997	1,772,685	5,647,131
Fringe Benefits	29,652	637,908	581,745	576,287	1,825,592
Operating	13,382	158,179	160,179	155,179	486,919
Equipment		-			-
Subcontractors		-			-
Travel	39,750	94,967	83,695	83,395	301,807
Other Costs					-
Indirect	15,470	388,458	357,995	353,932	1,115,855
Total	**188,607**	**3,270,608**	**2,976,611**	**2,941,478**	**9,377,304**

YRS 1 – 4 SUBCONTRACTOR BUDGET JUSTIFICATION

Details of each funding element for Years 1 – 4 are listed above, excluding any covered services reimbursable by Medi-Cal Dental or other federal funding resource. Position details are standardized across all agencies within each strategy, including administrative support. Table 15 provides the project year budget amounts for all subcontractors.

PERSONNEL ONLY YRS 1 – 4

There are 12 VDH teams within the following Health Centers/Health Systems:

1. Bear Valley Community Healthcare District (San Bernardino County) – 1 team
2. Borrego Community Health Foundation (Riverside County) – 1 team
3. Borrego Community Health Foundation (San Bernardino County) – 1 team
4. Clinicas de Salud Del Pueblo (Riverside County) – 1 team
5. Morongo Basin Healthcare District (San Bernardino County) – 1 team
6. Neighborhood Health Care (Riverside County) – 1 team
7. North County Health Services (Riverside County) – 1 team
8. ParkTree Community Health Center (San Bernardino County) – 1 team
9. SAC Health System (San Bernardino County) – 2 teams
10. Vista Community Clinic (Riverside County) – 2 teams

VDH (Strategy 1) VDH teams consist of a designated project lead, dentist, hygienist, care coordinator and navigator. VDH field team include the dentist, hygienist and navigator. Direct services from dentist and hygienist are billed directly to Medi-Cal Dental.

> Project Lead – Salary for a portion of this position across all participating VDH teams is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance

at OHAC-IE meetings. The project lead is budgeted at .10 FTE for each FTE navigator and care coordinator across all participating VDH teams.

Care Coordinator – This position is a key component for the VDH and ECOHA strategies to reach the target population. This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted at .5 FTE for each VDH team across all participating VDH teams.

Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to: oral health education, providing program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted at 1.0 FTE for each team across all participating VDH teams.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted at .10 FTE for each participating VDH and ECOHA entity.

There are 12 ECOHA CHWs within the following Health Centers/Health Systems:

1. Bear Valley Community Health Care District (San Bernardino County) – 1 CHW
2. Borrego Community Health Foundation (Riverside County) – 2 CHWs
3. Borrego Community Health Foundation (San Bernardino County) -1 CHW
4. Morongo Basin Healthcare District (San Bernardino County) – 1 CHW
5. Neighborhood Healthcare (Riverside County) – 1 CHW
6. North County Health Services (Riverside County) – 1 CHW
7. Riverside University Health System – Medical Service Office (Riverside County) – 1 CHW
8. SAC Health System (San Bernardino County) – 3 CHWs
9. Vista Community Clinic (Riverside County) – 1 CHW

ECOHA (Strategy 2) Positions budgeted within the ECOHA will implement the use of the assessment within various community settings and provide the linkage between families in need of dental services to dental homes. The ECOHA strategy will consist of 2,400 assessments per year per 1.0 FTE community health worker. The assessments will be conducted 50 weeks per year, four days per week, four hours per day completing a total three per hour or 48 per week.

Project Lead – Salary for a portion of this position across all participating ECOHA teams is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted at .10 FTE for each FTE community health worker across all participating ECOHA teams.

Community Health Worker – This is a key component for the ECOHA strategy to reach the target population. This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain

recommended dental care for their child. Most importantly, this position will link Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted at 1.0 FTE for each team across all participating ECOHA teams.

UNIVERSITY OF THE PACIFIC

Project Director- This position will direct and coordinate the VDH project.

Director of Operations – This position will oversee communications and implementation with providers and sites.

Program Manager – This position will schedule and track deliverables, reporting, training and monitoring activities.

Program Content Expert – This position will provide expert consultation on scientific, dental practice, and operational workflow integration.

Contracts Manager – This position will be responsible for contracts, expenses, reporting systems.

Assistant Project Manager – This position will be responsible for technical training and assistance on data systems and equipment.

SIS

Vice President, Policy – This position will assist in user testing, as part of the creation and implementation of ECOHA along with the UOP and SIS to ensure that the tool reaches 83,325 children in the IE. The director will review, edit summary report and lead discussion.

Senior Policy Manager – This position will provide primary oversight of user testing for ECOHA. There will be on premise user testing as part of quality improvement. SIS will conduct user testing including script preparation, two days on location with two people performing eight to 10, one-hour one-one-one sessions.

Policy Analyst – This position will be part of on premise user testing working with Senior Policy Manager.

Business Analyst/Project Support – This position will provide requirements for the ECOHA project. There are additional hours for making program modifications for client to improve the system based on feedback. In addition to the development of the application, there is an ongoing maintenance, support, and hosting of the application, which project support will provide.

Senior Project Manager – This position will provide project oversight for the ECOHA project. In addition, there are additional hours for making program modifications for client

to improve the system based on feedback. In addition to the development of the application, there is an ongoing maintenance, support, and hosting of the application, which project support will provide.

IT Help Desk Support – This position will be responsible for providing help desk support for the app.

Cloud Based IT Support – This position will be responsible for providing Cloud Based support for the app.

Project Manager – This position will assist in the implementation and post-implementation support of a web-based application, work closely with Sr. Project Manager, internal clients to organize and coordinate project activities.

Architect – Creator of architectural framework of system and application design.

Customer Interaction – Liaison between SIS and participating entities regarding functional elements of the ECOHA App and requested modification through the user interface.

Application/Mobile Developers (Temp Employees) - Responsibilities include: Understanding interactive application development, ability to translate technical requirements into real user solutions (Spanish and English), experience and knowledge regarding iOS and Android.

TCP

President – This position will supervise overall direction of TCP's role in the LDPP-IE for an average of an hour per week and promote lessons learned with state and national stakeholders.

Senior Director, Policy & Programs – This position will support the associate director in the creation and implementation of the ECOHA for an average of three hours per week to help to reach 83,325 children in the IE.

Associate Director, Strategy & Policy - This position will assist in the creation and implementation of ECOHA along with the UOP and SIS to ensure that the tool reaches 83,325 children in the IE. The president will participate in local and state stakeholder meetings on the ECOHA and overall LDPP-IE project to inform the State Oral Health Plan. Average of seven hours/week.

Senior Policy Associate – This position will supervise associate director for an average of an hour per week and provide overall guidance for the ECOHA to reach 83,325 children in the IE, as a part of TCP's organizational work on improving access to health care for children.

Communications Program Support – This position will include the LDPP-IE in social media and email blasts to raise awareness of the project among state and national stakeholders, engage the media and identify opportunities for earned media, and format the creation of the brief in Year 3 for an average of 1.5 hours per week.

THE COH

Executive Director – This position will provide strategic oversight to the LDPP-IE Work Group and assist the senior program manager in her role as coordinator and convener of the LDPP-IE Work Group. The executive director will help identify and advance public policy recommendations; mobilize additional financial support, and highlight the work of the LDPP-IE.

Senior Program Manager – This position will oversee the coordination of all activities related to LDPP-IE workgroup. The senior program manager will coordinate meetings, convene stakeholders, align activities, engage extensively with community partners to keep a common agenda, and keep all parties moving toward the same goals, minimizing silos, and facilitating conflict resolution when needed; building public will by facilitating extensive, frequent, and regular communication among community partners to ensure collaboration and collective impact.

Director of Public Policy Research – This position will be responsible for helping establish shared measurement practices to measure collective progress toward the desired outcomes and taking opportunities to leverage each other's efforts to feed common goals.

Program Assistant – This position will assist the senior program manager by coordinating meetings and providing material support to her role in facilitating extensive, frequent, and regular communication among community partners to ensure collaboration and collective impact.

FRINGE BENEFITS YRS 1 – 4 – The fringe benefit rate was calculated based on the allowable DHCS fringe benefit expenses. Each subcontractor established fringe benefits rate is indicated below. The same rate has been calculated for each subsequent project year.

Table 16. Fringe Benefit Rate

Bear Valley Community Healthcare District, Inc. – 35%
Borrego Community Health Foundation – 25%
Clinicas de Salud Del Pueblo, Inc. – 30%
Morongo Basin Healthcare District- 24%
Neighborhood Healthcare – 20.76%
North County Health Services – 24%
ParkTree Community Health Center (formerly Pomona Community Health Center) – 20%
Riverside University Health System – Medical Service Organization - 45%
SAC Health System – 51.08%
SIS – 22%
SIS-31% Temp Help
The COH – 30%
TCP – 27%
University of Pacific – 31.2%
Vista Community Clinic – 19.39%

OPERATING YRS 1 – 4 – Operating costs include the following expenses: communication/mobile devices (i.e., cell phones, internet access plan, desk phone, internet, voicemail, email and fax), educational materials/dental hygiene kits (i.e. brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters), office supplies (i.e., desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments), printing, training/meeting expenses and outreach & marketing. See Table 18 for project year details.

EQUIPMENT YRS 1 – 4 – Equipment costs will be incurred in the second year of the project period for Strategy 1 – VDH. There are 12 VDH teams across the partner entities necessitating 11* VDH kits (11 x $45,000). Each VDH kit includes the equipment and associated components as listed below in Table 17. VDH equipment Costs are included in the Riverside County budget.
*please note; Bear Valley Community Health Care District has existing VDH equipment; purchase of equipment not required for this site.

Table 17. VDH Equipment Details

Equipment	Vendor	Price $
Nomad Pro 2 X-ray incl. Carrying Case	Henry Schein	$8,000
with Total Care Plan 1st Year		
Digital X-ray Sensor - size 0	Carestream	$6,900
plus Care Plan - 5 YR ADV Plan	Carestream	$1,600
Total Equipment		$16,500
Supplies	Vendor	Price $
Digital X-ray Sensor - size 1	XDR	$4,650
Digital X-ray Sensor - size 2	XDR	$3,700
Intra-oral camera	XDR	$4,000
Laptop - Dell	Dell	$1,600
Portable Light	Henry Schein	$1,400
Portable chair	Henry Schein	$330
Extra oral camera - Pentax - WG30	Lester Dine, Inc	$600
Curing Light	Henry Schein	$550
Amalgamator - Touchpad	Henry Schein	$380
Clinial instruments	Henry Schein	$1,000
Lead Apron		
Adult		$270
Child		$270
Mifi hotspot		$45
Aseptico Delivery unit	Aseptico	$4,580
Aseptico Fiber Opics	Aseptico	$430
Cavitron	Henry Schein	$180
Hand pieces	Henry Schein	$2,000
Instruments	Henry Schein	$2,515
Total Supplies		$28,500
Overall Total		**$45,000**

TRAVEL YRS 1 – 4 – Travel costs were calculated based on the California Department of Human Resources (CalHR) reimbursement rates, which mirror those of the Internal Revenue Service's (IRS) published mileage reimbursement rates. There could be subsequent changes to the IRS rates within the demonstration years. The travel costs include private mileage to community site, trainings & meetings related to the DTI initiative.

OTHER COSTS YRS 1 – 4 - Other costs include curriculum development; ECOHA development & maintenance; focus groups & stakeholder engagement; technical assistance, systems support & updates; and trainings/webinars.

INDIRECT YRS 1 – 4 – Indirect costs were calculated on the total salary only at the maximum allowable 20% rate, excluding fringe benefits.

5.3 BUDGET

The total requested budget amount for LDPP-IE is $12,114,979. Table 18 links budget amounts to expected impact(s) that will be achieved in the project period. Specifically, under Domain 4, approximately $3,758,794 (31%) of the overall budget is allocated to Governance for infrastructure and overall support, which includes budget allocations for First 5 Riverside, First 5 San Bernardino and costs for equipment and training stipends.

Table 18. Finance Strategy Impact

Domain 4 - LDDP	Finance Strategy Impact	Total	Percent
Required Governance	Lead & Co-Lead *	3,758,794	31%
Project Support	Coalition/Convener	431,813	4%
Project Support	Training, Technicial Assistance & Development	1,370,268	11%
Strategy Implementation	Partner Agencies	6,554,104	54%
	Total Project Period	12,114,979	

** Includes costs for equipment & training stipends*

PROJECT SUPPORT

Project Support for program development, training, and technical assistance costs for both strategies is approximately $1,370,268 (11%) of the total budget. Collective efforts between UOP, SIS and TCP will develop the application/assessment tools and curriculum for the VDH and ECOHA strategies. For project support through the established coalition, the COH will serve as the convener of project partners, while supporting aligned activities and preserving a common agenda at a cost of $431,813 (4%) of the total budget.

STRATEGY IMPLEMENTATION

Strategy implementation costs of approximately $6,554,106 (54%) includes personnel and operational costs for partner agencies that have committed to implementation of one or both pilot strategies.

Both strategies engage families in the establishment of a dental home for Medi-Cal eligible children in the IE and provides oral health education and care coordination. Estimated number of children reached throughout the project period: VDH (12 teams) = 15,800 and ECOHA (12

CHWs) = 83,325 (see Table 4, Section 3.2).

Incentives included in the ECOHA implementation (costs captured in F5 Riverside budget, see Table 11) aim to test a pay-for-performance model to increase oral health risk assessment and increase dental home establishment for this vulnerable population and ultimately reduce costly ER visits. The pay-for-performance model will be piloted through Indian Health based on estimated numbers listed in Table 14. As a vendor, Indian Health will be paid for assessments completed and confirmation that the dental appointment was completed.

The LDPP-IE budget excludes costs for services reimbursable by Medi-Cal Dental or other federal funding resources.

Name of Contractor: First 5 Riverside

Exhibit B - Attachment 1

(Year 1) [Retain if multiple budgets are present]
(11/15/17 through 12/31/17) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	*Annual Cost	
Senior Accountant	1.0	$5,346	40%	$ 3,207	
Accounting Technician	1.0	$4,213	100%	$ 6,320	
Accounting Technician	1.0	$4,213	100%	$ 6,320	
Grants & Contracts Analyst	1.0	$6,316	20%	$ 1,895	
Grants & Contracts Analyst	1.0	$6,660	20%	$ 1,998	
Grants & Contracts Analyst	1.0	$6,841	60%	$ 6,157	
Program Director	1.0	$7,735	100%	$ 11,602	
			Total Salary	**$ 37,499**	
		Fringe Benefits	**43.71%**	$ 16,391	
				Total Personnel	**$ 53,890**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$ 1,400	
Computers	$ 6,100	
Contracting/Database Management System and Monitoring	$ 6,000	
	Total Operating Expenses	**$ 13,500**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$ -	
	Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage (183 miles @ .535/mile)	$ 98	
	Total Travel	**$ 98**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

First 5 San Bernardino

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 21,923	$ 7,593	$ -	$ -	$ -	$ -	$ 2,902	**$ 32,418**

University of the Pacific

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 51,932	$ -	$ -	$ 38,000	$ -	$ -	$ 7,916	**$ 97,848**

Center for Oral Health

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 10,236	$ 5,000	$ -	$ -	$ -	$ -	$ 1,575	**$ 16,811**

Social Interest Solutions

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 33,030	$ 410	$ -	$ 1,750	$ -	$ -	$ 2,623	**$ 37,813**

The Children's Partnership

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 2,884	$ 379	$ -	$ -	$ -	$ -	$ 454	**$ 3,717**

Exhibit B - Attachment 1

(Year 1) [Retain if multiple budgets are present]
(11/15/17 through 12/31/17) [Retain if multiple budgets are present]

Bear Valley

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Borrego Community Health Foundation

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Clinicas de Salud

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Morongo Basin Health District

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Neighborhood Health Center

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

North County Health Systems

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

ParkTree Community Health Center (Pomona)

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Riverside University Health System - Medical Service Office

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

SAC Health System

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Vista

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Total Subcontracts $ 188,607

Other Costs [Itemize each expense]

None	$ -

Total Other Costs $ -

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) 20%

Indirect Costs $ 7,500

Annual Budget Total $ 263,595

FIRST 5 RIVERSIDE · SAN BERNARDINO

Name of Contractor: First 5 Riverside

Exhibit B - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Senior Accountant	1.0	$5,63	40%	$ 27,062
Accounting Technician	1.0	$4,441	100%	$ 53,286
Accounting Technician	1.0	$4,441	100%	$ 53,286
Grants & Contracts Analyst	1.0	$6,66	20%	$ 15,983
Grants & Contracts Analyst	1.0	$7,02	20%	$ 16,862
Grants & Contracts Analyst	1.0	$7,21	60%	$ 51,959
Program Director	1.0	$8,15	100%	$ 97,897
			Total Salary	**$ 316,335**
		Fringe Benefits	**43.71%**	$ 138,270
				Total Personnel **$ 454,605**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	1,680
Educational Materials / Dental Hygiene Kits	$	72,821
	Total Operating Expenses	**$ 74,501**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

Nomad Pro 2 X-ray incl. Carrying Case & 1-year Total Care Plan (11 Sets x $8000/set);Digital X-ray Sensor - size 0 w /5 year ADV Plan (11 Sets x $8500/set); Dental Supplies & Minor Equipment (11 sets x $28,500/set)	$	495,000
	Total Equipment Expenses	**$ 495,000**

Travel (At CalHR reimbursement rates)

None	$	-
	Total Travel	**$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

First 5 San Bernardinc

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 269,651	$ 16,523	$ -	$ -	$ -	$ -	$ 35,696	**$ 321,870**

University of the Pacific

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 299,065	$ -	$ -	$ 46,000	$ -	$ -	$ 45,589	**$ 390,654**

Center for Oral Health

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 126,498	$ 2,500	$ -	$ 1,500	$ -	$ -	$ 19,461	**$ 149,959**

Social Interest Solutions

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 152,994	$ 18,986	$ -	$ 1,750	$ -	$ -	$ 14,601	**$ 188,331**

The Children's Partnership

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 24,651	$ 1,370	$ -	$ 2,075	$ -	$ -	$ 3,882	**$ 31,978**

Exhibit B - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(01/01/18 through 12/31/18) [Retain if multiple budgets are present]

Bear Valley

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 80,965	$ 7,200	$ -	$ 1,400	$ -	$ -	$ 11,995	**$ 101,560**

Borrego Community Health Foundation

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 374,989	$ 14,400	$ -	$ 7,234	$ -	$ -	$ 59,998	**$ 456,621**

Clinicas de Salud

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 51,922	$ 7,200	$ -	$ 10,800	$ -	$ -	$ 7,988	**$ 77,910**

Morongo Basin Health District

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 135,487	$ 14,100	$ -	$ 6,000	$ -	$ -	$ 21,853	**$ 177,440**

Neighborhood Health Center

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 133,996	$ 14,100	$ -	$ 1,200	$ -	$ -	$ 22,192	**$ 171,488**

North County Health Systems

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 162,806	$ 14,100	$ -	$ 6,000	$ -	$ -	$ 26,259	**$ 209,165**

ParkTree Community Health Center (Pomona)

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 104,092	$ 12,300	$ -	$ 3,000	$ -	$ -	$ 17,349	**$ 136,741**

Riverside University Health System - Medical Service Office

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 84,361	$ 7,200	$ -	$ -	$ -	$ -	$ 11,636	**$ 103,197**

SAC Health System

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 431,510	$ 14,100	$ -	$ 3,000	$ -	$ -	$ 57,123	**$ 505,733**

Vista

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 196,017	$ 14,100	$ -	$ 5,008	$ -	$ -	$ 32,836	**$ 247,961**

Total Subcontracts **$ 3,270,608**

Other Costs [Itemize each expense]

Stipends	$ 134,568	
Pay for Performance Incentives	$ 3,500	
	Total Other Costs	**$ 138,068**

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) 20%

Indirect Costs **$ 63,267**

Annual Budget Total **$ 4,496,049**

Name of Contractor: First 5 Riverside

Exhibit B - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(01/01/19 through 12/31/19) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Senior Accountant	1.0	$5,948	40%	$ 28,548
Accounting Technician	1.0	$4,681	100%	$ 56,174
Accounting Technician	1.0	$4,686	100%	$ 56,174
Grants & Contracts Analyst	1.0	$7,025	20%	$ 16,863
Grants & Contracts Analyst	1.0	$7,408	20%	$ 17,789
Grants & Contracts Analyst	1.0	$7,609	60%	$ 54,813
Program Director	1.0	$8,602	100%	$ 103,230
			Total Salary	**$ 333,591**
		Fringe Benefits	**43.71%**	$ 145,813
				Total Personnel **$ 479,404**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	1,680
Educational Materials / Dental Hygiene Kits	$	72,821
	Total Operating Expenses	**$ 74,501**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-
	Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

None	$	-
	Total Travel	**$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

First 5 San Bernardino

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 276,392	$ 16,523	$ -	$ -	$ -	$ -	$ 36,589	**$ 329,504**

University of the Pacific

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 174,611	$ -	$ -	$ 38,000	$ -	$ -	$ 26,618	**$ 239,229**

Center for Oral Health

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 109,741	$ 2,500	$ -	$ 1,500	$ -	$ -	$ 16,883	**$ 130,624**

Social Interest Solutions

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 33,202	$ 18,986	$ -	$ -	$ -	$ -	$ 4,794	**$ 56,982**

The Children's Partnership

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 24,651	$ 6,370	$ -	$ 2,075	$ -	$ -	$ 3,882	**$ 36,978**

Exhibit B - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(01/01/19 through 12/31/19) [Retain if multiple budgets are present]

Bear Valley

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 80,965	$ 6,900	$ -	$ 1,400	$ -	$ -	$ 11,995	**$ 101,260**

Borrego Community Health Foundation

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 374,989	$ 13,800	$ -	$ 5,712	$ -	$ -	$ 59,998	**$ 454,499**

Clinicas de Salud

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 51,922	$ 6,900	$ -	$ 10,800	$ -	$ -	$ 7,988	**$ 77,610**

Morongo Basin Health District

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 135,487	$ 13,800	$ -	$ 6,000	$ -	$ -	$ 21,853	**$ 177,140**

Neighborhood Health Center

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 133,995	$ 13,800	$ -	$ 1,200	$ -	$ -	$ 22,192	**$ 171,187**

North County Health Systems

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 162,806	$ 13,800	$ -	$ 6,000	$ -	$ -	$ 26,259	**$ 208,865**

ParkTree Community Health Center (Pomona)

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 104,093	$ 12,000	$ -	$ 3,000	$ -	$ -	$ 17,349	**$ 136,442**

Riverside University Health System - Medical Service Office

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 84,361	$ 7,200	$ -	$ -	$ -	$ -	$ 11,636	**$ 103,197**

SAC Health System

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 431,510	$ 13,800	$ -	$ 3,000	$ -	$ -	$ 57,123	**$ 505,433**

Vista

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 196,017	$ 13,800	$ -	$ 5,008	$ -	$ -	$ 32,836	**$ 247,661**

Total Subcontracts $ 2,976,611

Other Costs [Itemize each expense]

Stipends	$	114,408
Pay for Performance Incentives	$	3,500
	Total Other Costs	**$ 117,908**

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) 20% **Indirect Costs $ 66,718**

Annual Budget Total $ 3,715,142

Name of Contractor: First 5 Riverside

Exhibit B - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(01/01/20 through 12/31/20) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost	
Senior Accountant	1.0	$6,271	40%	$	30,117	
Accounting Technician	1.0	$4,942	100%	$	59,260	
Accounting Technician	1.0	$4,942	100%	$	59,260	
Grants & Contracts Analyst	1.0	$7,409	20%	$	17,789	
Grants & Contracts Analyst	1.0	$7,812	20%	$	18,271	
Grants & Contracts Analyst	1.0	$8,024	60%	$	54,813	
Program Director	1.0	$9,072	100%	$	108,858	
			Total Salary	**$**	**348,368**	
		Fringe Benefits	**43.71%**	$	152,272	
					Total Personnel	**$ 500,640**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	1,680	
Educational Materials / Dental Hygiene Kits	$	72,821	
		Total Operating Expenses	**$ 74,501**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

None	$	-	
		Total Travel	**$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

First 5 San Bernardino

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 283,301	$ 16,523	$ -	$ -	$ -	$ -	$ 37,503	**$ 337,327**

University of the Pacific

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 138,643	$ -	$ -	$ 38,000	$ -	$ -	$ 21,135	**$ 197,778**

Center for Oral Health

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 113,030	$ 2,500	$ -	$ 1,500	$ -	$ -	$ 17,389	**$ 134,419**

Social Interest Solutions

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 33,202	$ 18,986	$ -	$ -	$ -	$ -	$ 4,794	**$ 56,982**

The Children's Partnership

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 24,651	$ 1,370	$ -	$ 2,075	$ -	$ -	$ 3,882	**$ 31,978**

Exhibit B - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(01/01/20 through 12/31/20) [Retain if multiple budgets are present]

Bear Valley

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 80,965	$ 6,900	$ -	$ 1,400	$ -	$ -	$ 11,995	**$ 101,260**

Borrego Community Health Foundation

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 374,989	$ 13,800	$ -	$ 5,712	$ -	$ -	$ 59,998	**$ 454,499**

Clinicas de Salud

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 51,922	$ 6,900	$ -	$ 10,800	$ -	$ -	$ 7,988	**$ 77,610**

Morongo Basin Health District

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 135,487	$ 13,800	$ -	$ 6,000	$ -	$ -	$ 21,853	**$ 177,140**

Neighborhood Health Center

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 133,995	$ 13,800	$ -	$ 900	$ -	$ -	$ 22,192	**$ 170,887**

North County Health Systems

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 162,806	$ 13,800	$ -	$ 6,000	$ -	$ -	$ 26,259	**$ 208,865**

ParkTree Community Health Center (Pomona)

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 104,093	$ 12,000	$ -	$ 3,000	$ -	$ -	$ 17,349	**$ 136,442**

Riverside University Health System - Medical Service Office

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 84,361	$ 7,200	$ -	$ -	$ -	$ -	$ 11,636	**$ 103,197**

SAC Health System

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 431,510	$ 13,800	$ -	$ 3,000	$ -	$ -	$ 57,123	**$ 505,433**

Vista

Personnel	Operating Expenses	Equipment	Travel	Sub-Contracts	Other Costs	Indirect Costs	Total Costs
$ 196,017	$ 13,800	$ -	$ 5,008	$ -	$ -	$ 32,836	**$ 247,661**

Total Subcontracts **$ 2,941,478**

Other Costs [Itemize each expense]

Stipends	$ 50,400
Pay for Performance Incentives	$ 3,500
Total Other Costs	**$ 53,900**

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) 20%

Indirect Costs **$ 69,674**

Annual Budget Total **$ 3,640,193**

EXHIBIT B – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 1 - 11/15/17 through 12/31/17
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

Senior Accountant - This position will be responsible for fiscal oversight of the contract between the state and the lead entity, between the lead entity and the subcontractors, and supervision of the Accounting Technicians. Year one has been allocated at 4 months. The position has been allocated at 40% effort to this program for the term of the contract. (.40 FTE)

Accounting Technicians - This position will be responsible for processing contract invoices received from subcontractors, and tracking stipend payments. Year one has been allocated at 4 months. The position has been allocated at 100% effort to this program for the term of the contract. (2 FTEs)

Contract and Grants Analyst - This position will be tasked with budget development, contract negotiation, compliance, and monitoring to ensure performance requirements are aligned with agreed upon contractual obligations. Year one has been allocated at 4 months. The position has been allocated at 100% effort to this program for the term of the contract. There have been three (3) staff designated to this role totaling a combined FTE of one (1).

LDPP-IE Program Director - This position is the single point of contact with DHCS and will be tasked with complete oversight of the LDPP-IE - organizing, developing, administering, monitoring and evaluating the program. A key function is to coordinate and collaborate with partner entities and subcontractors to ensure objectives and milestones are met within the demonstration year. Year one has been allocated at 4 months. The position has been allocated at 100% effort to this program for the term of the contract. (1 FTE)

OPERATIONAL EXPENSES

Communication / Mobile Devices – Year 1 purchase 2 cell phones (or one cell phone and one data card), plus monthly service cost. Years 2-4 monthly service cost.

Computers – Year 1 purchase two desktop computers and two laptop/tablets. Cost includes IT set-up and maintenance, software licensing.

Educational Materials / Dental Hygiene Kits – brochures, flyers, floss, toothpaste samples, storybooks, fact sheets and posters.

Contract Data Management System – System for tracking contract status, contract compliance, and fiscal expenses.

EQUIPMENT

Equipment costs will be incurred in the first year of the project period for Virtual Dental Homes. Equipment will be purchased for the following agencies:

Borrego Community Health Foundation: Two (2) VDH Units (1 = Riverside, 1 = San Bernardino)
Clinicas de Salud Del Pueblo: One (1) VDH Unit
Morongo Basin Healthcare District: One (1) VDH Unit
Neighborhood Healthcare: One (1) VDH Unit
North County Health Services: One (1) VDH Unit
ParkTree (Pomona): One (1) VDH Unit
SAC Health System: Two (2) VDH Units (two teams)
Vista Community Clinic: Two (2) VDH Units (two teams)
Total VDH Units: 11

Each VDH kit includes the equipment and associated components as listed below:

Equipment	Vendor	Price $
Nomad Pro 2 X-ray incl. Carrying Case	Henry Schein	$8,000
with Total Care Plan 1st Year		
Digital X-ray Sensor - size 0	Carestream	$6,900
plus Care Plan - 5 YR ADV Plan	Carestream	$1,600
Total Equipment		$16,500
Supplies	Vendor	Price $
Digital X-ray Sensor - size 1	XDR	$4,650
Digital X-ray Sensor - size 2	XDR	$3,700
Intra-oral camera	XDR	$4,000
Laptop - Dell	Dell	$1,600
Portable Light	Henry Schein	$1,400
Portable chair	Henry Schein	$330
Extra oral camera - Pentax - WG30	Lester Dine, Inc	$600
Curing Light	Henry Schein	$550
Amalgamator - Touchpad	Henry Schein	$380
Clinial instruments	Henry Schein	$1,000
Lead Apron		
Adult		$270
Child		$270
Mifi hotspot		$45
Aseptico Delivery unit	Aseptico	$4,580
Aseptico Fiber Opics	Aseptico	$430
Cavitron	Henry Schein	$180
Hand pieces	Henry Schein	$2,000
Instruments	Henry Schein	$2,515
Total Supplies		$28,500
Overall Total		**$45,000**

TRAVEL

Mileage costs are the only travel costs allocated to this line item and are calculated at the prevailing CalHR rate. Mileage will be incurred due to traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

See individual subcontractor budgets for detail.

There are 12 VDH teams within the following Health Centers/Health Systems:

1. Bear Valley Community Healthcare District (San Bernardino County) – 1 team
2. Borrego Community Health Foundation (Riverside County) – 1 team
3. Borrego Community Health Foundation (San Bernardino County) 1 team
4. Clinicas De Salud Del Pueblo (Riverside County) – 1 team
5. Morongo Basin Healthcare District (San Bernardino County) – 1 team
6. Neighborhood Health Care (Riverside County) – 1 team
7. North County Health Services (Riverside County) – 1 team
8. ParkTree Community Health Center (San Bernardino County) – 1 team
9. SAC Health System (San Bernardino County) – 2 teams
10. Vista Community Clinic (Riverside County) – 2 teams

There are 12 participating ECOHA CHWs within the following Health Centers/Health Systems:

1. Bear Valley Community Health Care District (San Bernardino County) – 1 CHW
2. Borrego Community Health Foundation (Riverside County) – 2 CHWs
3. Borrego Community Health Foundation (San Bernardino County) – 1 CHW
4. Morongo Basin Healthcare District (San Bernardino County) – 1 CHW
5. Neighborhood Healthcare (Riverside County) – 1 CHW
6. North County Health Services (Riverside County) – 1 CHW
7. Riverside University Health System – Medical Service Office (Riverside County) – 1 CHW
8. SAC Health System (San Bernardino County) – 3 CHWs
9. Vista Community Clinic (Riverside County) – 1 CHW

OTHER COSTS

Stipends – Stipends will be paid to project agencies based on the total number of training hours and technical assistance per year. Each year the stipend amount decreases based on the level and type of training necessary. The bulk of the training costs are captured in the initial implementation year. The training will be for each VDH field team consisting of a dentist, hygienist, and navigator. Stipend payments will be monitored for each agency. Year one stipend expenses will be zero, year two, $134,568, year three, $114,408, year four, $50,400 for a combined total of $299,376.

Pay for Performance Incentives – This line item will support the implementation of the ECOHA through home visitation employed with Riverside-San Bernardino County Indian Health, Inc. Estimated number of assessments for the project period is 525 at $20 for a total of $10,500.

Pay for Performance	Payment Amount	YR 1 # Completed	YR 2 # Completed	YR 3 # Completed	YR 4 # Completed	TOTAL
		0	175	175	175	525
Assessment Completed	$10.00	$0.00	$1,750	$1,750	$1,750	$5,250
Dental Visit Completed	$10.00	$0.00	$1,750	$1,750	$1,750	$5,250
		$0.00	$3,500	$3,500	$3,500	$10,500

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits, operational costs, equipment, travel, subcontracts, and other costs.

Exhibit B.1 - Attachment 1

(Year 1) [Retain if multiple budgets are present]
(**12/01/17** through **12/31/17**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
Contract Analyst	1.0	$6,165.47 X 1	100%	$	6,165		
Accountant	1.0	$4,655.73 X 1	20%	$	931		
Supervisor, Data and Community Engagement	1.0	$6,243.47 X 1	20%	$	1,249		
Data Analyst	1.0	$6,165.47 X 1	100%	$	6,165		
			Total Salary	**$**	**14,511**		
		Fringe Benefits	**51.08%**	$	7,412		
					Total Personnel	**$**	**21,923**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	129		
County Services	$	303		
Office Supplies	$	401		
Rent Expense	$	760		
Data Management System and Monitoring	$	6,000		
		Total Operating Expenses	**$**	**7,593**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

None	$	-		
		Total Travel	**$**	**-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Total Subcontracts	**$**	**-**

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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	**$**	**2,902**

Annual Budget Total	**$**	**32,418**

Exhibit B.1 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
Contract Analyst	1.0	$6,319.60 X 12	100%	$	75,835		
Accountant	1.0	$4,772.13 X 12	20%	$	11,453		
Supervisor, Data and Community Engagement	1.0	$6,399.55 X 12	20%	$	15,359		
Data Analyst	1.0	$6,319.60 X 12	100%	$	75,835		
			Total Salary	**$**	**178,482**		
		Fringe Benefits	**51.08%**	$	91,169		
					Total Personnel	**$**	**269,651**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	774	
County Services	$	1,820	
Office Supplies	$	4,809	
Rent Expense	$	9,120	
Data Management System and Monitoring	$	-	
		Total Operating Expenses	**$ 16,523**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

None	$	-	
		Total Travel	**$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Total Subcontracts **$ -**

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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) **20%** **Indirect Costs** **$ 35,696**

Annual Budget Total **$ 321,870**

Exhibit B.1 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
Contract Analyst	1.0	$6,477.59 X 12	100%	$	77,731		
Accountant	1.0	$4,891.43 X 12	20%	$	11,739		
Supervisor, Data and Community Engagement	1.0	$6,559.54 X 12	20%	$	15,743		
Data Analyst	1.0	$6,477.59 X 12	100%	$	77,731		
			Total Salary	**$**	**182,944**		
		Fringe Benefits	**51.08%**	$	93,448		
					Total Personnel	**$**	**276,392**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	774		
County Services	$	1,820		
Office Supplies	$	4,809		
Rent Expense	$	9,120		
Data Management System and Monitoring				
		Total Operating Expenses	**$**	**16,523**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

None	$	-		
		Total Travel	**$**	**-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None			
	Total Subcontracts	**$**	**-**

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)

20%		**Indirect Costs**	**$**	**36,589**
		Annual Budget Total	**$**	**329,504**

Exhibit B.1 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
Contract Analyst	1.0	$6,639.53 X 12	100%	$	79,674		
Accountant	1.0	$5,013.72 X 12	20%	$	12,033		
Supervisor, Data and Community Engagement	1.0	$6,723.53 X 12	20%	$	16,136		
Data Analyst	1.0	$6,639.53 X 12	100%	$	79,674		
			Total Salary	**$**	**187,517**		
		Fringe Benefits	**51.08%**	$	95,784		
					Total Personnel	**$**	**283,301**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	774	
County Services	$	1,820	
Office Supplies	$	4,809	
Rent Expense	$	9,120	
Data Management System and Monitoring	$	-	
		Total Operating Expenses	**$** **16,523**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$** **-**

Travel (At CalHR reimbursement rates)

None	$	-	
		Total Travel	**$** **-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Total Subcontracts **$** **-**

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$** **-**

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) **20%** **Indirect Costs** **$** **37,503**

Annual Budget Total **$** **337,327**

EXHIBIT B.1 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION-
Year 1 - 12/01/17 through 12/31/17
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

Accountant - This position will be responsible for fiscal oversight of the contract between First 5 San Bernardino and First 5 Riverside. Year one has been allocated at one month and is at 20% effort to this program for the term of the contract.

Contract Analyst - This position will be tasked with budget development, contract negotiation, compliance, and monitoring to ensure performance requirements are aligned with agreed upon contractual obligations. One FTE has been allocated to this position. Year one has been allocated at one month, and is at 100% effort to this program for the term of the contract.

Data Analyst - This position will be tasked as the co-lead liaison between partner agencies to compile, analyze and report on the data generated from the participating entities. One FTE has been allocated to this position. Year one has been allocated at one month, and is at 100% effort to this program for the term of the contract.

Supervisor, Data and Community Engagement – This position will be responsible for the supervision of the Contract and Data Analysts. Year one has been allocated at one month, and is at 20% effort for the term of the contract.

OPERATING EXPENSES

Communication / Mobile Devices – This budget line will pay for Webinar/Conference call costs and the portion of the phone system allocated to staff under this program.

County Services – This line will pay for a portion of the MOU with the County of San Bernardino for payroll processing, IT services, human resources, and legal services.

Office Supplies – Exclusively for use by the staff associated with this program and include generic office supplies such as pens, paper, staples, paperclips, paper.

Contract Data Management System – Cost related to the establishment of a separate stand-alone module within current electronic data management system (Persimmony) for the LDPP-IE program to monitor contract compliance, and for subcontractors to report fiscal expenses.

EQUIPMENT

None

TRAVEL

None

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, and other costs.

Exhibit B.2 - Attachment 1

(Year 1) [Retain if multiple budgets are present]
(12/**01/17** through **12/31/17**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost
Project Director (VDH)	1.00	$23,357	11%	$	2,655
Director of Operations (VDH)	1.00	$9,083	29%	$	2,655
Program Manager (VDH)	1.00	$8,886	100%	$	8,886
Assistant Project Manager (VDH)	1.00	$8,175	32%	$	2,655
Contracts Manager (VDH)	1.00	$8,175	16%	$	1,328
Program Content Expert (VDH)	1.00	$12,908	31%	$	3,982
Project Director (ECOHA)	1.00	$23,357	9%	$	2,102
Director of Operations (ECOHA)	1.00	$9,083	19%	$	1,697
Program Manager (ECOHA)	1.00	$8,886	60%	$	5,296
Assistant Project Manager (ECOHA)	1.00	$8,175	21%	$	1,717
Contracts Manager (ECOHA)	1.00	$8,175	24%	$	1,962
Program Content Expert (ECOHA)	1.00	$12,908	36%	$	4,647
			Total Salary	**$**	**39,582**
		Fringe Benefits	**31.20%**	$	12,350
				Total Personnel	**$ 51,932**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses $ -

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None $ -

Total Equipment Expenses $ -

Travel (At CalHR reimbursement rates)

Mileage $ 38,000

Total Travel $ 38,000

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs $ -

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) **20%** **Indirect Costs $ 7,916**

Annual Budget Total $ 97,848

Exhibit B.2 - Attachment 1

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost
Project Director (VDH)	1.00	$23,357	7%	$	19,620
Director of Operations (VDH)	1.00	$9,083	18%	$	19,620
Program Manager (VDH)	1.00	$8,886	92%	$	98,100
Assistant Project Manager (VDH)	1.00	$8,175	20%	$	19,620
Contracts Manager (VDH)	1.00	$8,175	10%	$	9,810
Program Content Expert (VDH)	1.00	$12,908	19%	$	29,430
Project Director (ECOHA)	1.00	$23,357	3%	$	8,409
Director of Operations (ECOHA)	1.00	$9,083	3%	$	3,270
Program Manager (ECOHA)	1.00	$8,886	3%	$	3,338
Assistant Project Manager (ECOHA)	1.00	$8,175	3%	$	2,943
Contracts Manager (ECOHA)	1.00	$8,175	3%	$	2,943
Program Content Expert (ECOHA)	1.00	$12,908	7%	$	10,843
			Total Salary	**$**	**227,946**
		Fringe Benefits	**31.20%**	$	71,119
				Total Personnel	**$ 299,065**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses **$ -**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None $ -

Total Equipment Expenses **$ -**

Travel (At CalHR reimbursement rates)

Mileage $ 46,000

Total Travel **$ 46,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs **$ -**

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) **20%** **Indirect Costs** **$ 45,589**

Annual Budget Total **$ 390,654**

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Exhibit B.2 - Attachment 1

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost
Project Director (VDH)	1.00	$23,357	4%	$	11,211
Director of Operations (VDH)	1.00	$9,083	9%	$	9,810
Program Manager (VDH)	1.00	$8,886	47%	$	50,116
Assistant Project Manager (VDH)	1.00	$8,175	10%	$	9,810
Contracts Manager (VDH)	1.00	$8,175	5%	$	4,905
Program Content Expert (VDH)	1.00	$12,908	10%	$	15,490
Project Director (ECOHA)	1.00	$23,357	3%	$	8,409
Director of Operations (ECOHA)	1.00	$9,083	3%	$	3,270
Program Manager (ECOHA)	1.00	$8,886	3%	$	3,338
Assistant Project Manager (ECOHA)	1.00	$8,175	3%	$	2,943
Contracts Manager (ECOHA)	1.00	$8,175	3%	$	2,943
Program Content Expert (ECOHA)	1.00	$12,908	7%	$	10,843
			Total Salary	**$**	**133,088**
		Fringe Benefits	**31.20%**	$	41,523
				Total Personnel	**$ 174,611**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None	$	-	
		Total Operating Expenses	**$ -**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage	$	38,000	
		Total Travel	**$ 38,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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) **20%** **Indirect Costs** **$ 26,618**

Annual Budget Total **$ 239,229**

Exhibit B.2 - Attachment 1

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost
Project Director (VDH)	1.00	$23,357	3%	$	8,409
Director of Operations (VDH)	1.00	$9,083	7%	$	7,630
Program Manager (VDH)	1.00	$8,886	34%	$	36,254
Assistant Project Manager (VDH)	1.00	$8,175	7%	$	6,867
Contracts Manager (VDH)	1.00	$8,175	4%	$	3,924
Program Content Expert (VDH)	1.00	$12,908	7%	$	10,843
Project Director (ECOHA)	1.00	$23,357	3%	$	8,409
Director of Operations (ECOHA)	1.00	$9,083	3%	$	3,270
Program Manager (ECOHA)	1.00	$8,886	3%	$	3,338
Assistant Project Manager (ECOHA)	1.00	$8,175	3%	$	2,943
Contracts Manager (ECOHA)	1.00	$8,175	3%	$	2,943
Program Content Expert (ECOHA)	1.00	$12,908	7%	$	10,843
			Total Salary		**$105,673**
		Fringe Benefits	**31.20%**	$	32,970
				Total Personnel	**$ 138,643**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses **$ -**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None $ -

Total Equipment Expenses **$ -**

Travel (At CalHR reimbursement rates)

Mileage $ 38,000

Total Travel **$ 38,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs **$ -**

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) **20%** **Indirect Costs** **$ 21,135**

Annual Budget Total **$ 197,778**

EXHIBIT B.2 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 1 - 12/01/17 through 12/31/17
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

Project Director - Will direct and coordinate the VDH and ECOHA projects. (FTE: Yr 1 - .20, Yr 2 - .10, Yr 3 - .07, Yr 4 - .06)

Director of Operations – Will oversee communications and implementation of the VDH and ECOHA with providers and at sites. (FTE: Yr 1 - .48, Yr 2 - .21, Yr 3 - .12, Yr 4 - .10)

Program Manager – Will schedule and track deliverables, fulfill reporting requirements, provide training and monitor activities on the VDH and ECOHA projects. (FTE: Yr 1 – 1.6 [2 staff], Yr 2 - .95, Yr 3 - .50, Yr 4 - .37)

Assistant Project Manager – Will be responsible for convening focus groups, stakeholder engagement, technical training onsite or via webinars, provide assistance on data systems and equipment for the VDH and ECOHA projects. (FTE: Yr 1 - .53, Yr 2 - .23, Yr 3 - .13, Yr 4 - .10)

Contracts Manager – Will be responsible for contracts, expenses, reporting systems. (FTE: Yr 1 - .40, Yr 2 - .13, Yr 3 - .08, Yr 4 - .07)

Program Content Expert – Will provide expert consultation on scientific, dental practice, operational workflow integration, curriculum development intended to facilitate behavior change including factors that influence oral health, risk adjusted prevention protocols criteria and techniques for placing Interim Therapeutic Restorations (VDH). (FTE: Yr 1 - .67, Yr 2 - .26, Yr 3 - .17, Yr 4 - .14)

OPERATING EXPENSES

None

EQUIPMENT

None

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites, travel for trainings, and attendance at the OHAC-IE, focus groups, stakeholder engagement, and various other meetings. May include airfare, meals and hotel expense.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Exhibit B.3 - Attachment 1

(Year 1) [Retain if multiple budgets are present]
(**12/01/17** through **12/31/17**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE%		Annual Cost		
Program Assoc (Communications)	1.00	$3,605	50%	$	1,803		
Director Policy Research	1.00	$6,438	25%	$	1,610		
Executive Director	1.00	$12,417	10%	$	1,242		
Senior Program Manager - OHAC-IE	1.00	$6,438	50%	$	3,219		
			Total Salary	**$**	**7,874**		
		Fringe Benefits	**30%**	$	2,362		
					Total Personnel	**$**	**10,236**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Software	$	5,000	
		Total Operating Expenses	**$** **5,000**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$** **-**

Travel (At CalHR reimbursement rates)

Mileage			
		Total Travel	**$** **-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$** **-**

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)	**20%**	**Indirect Costs**	**$**	**1,575**
		Annual Budget Total	**$**	**16,811**

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Subcontractor: Center for Oral Health

Exhibit B.3 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Program Assoc (Communications)	1.00	$3,713	50%	$	22,279		
Director Policy Research	1.00	$6,631	25%	$	19,893		
Executive Director	1.00	$12,790	10%	$	15,347		
Senior Program Manager - OHAC-IE	1.00	$6,631	50%	$	39,787		
			Total Salary	**$**	**97,306**		
		Fringe Benefits	**30%**	$	29,192		
					Total Personnel	**$**	**126,498**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	2,500	
		Total Operating Expenses	**$ 2,500**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage	$	1,500	
		Total Travel	**$ 1,500**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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)	**20%**	**Indirect Costs**	**$**	**19,461**
		Annual Budget Total	**$**	**149,959**

Exhibit B.3 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Program Assoc (Communications)	1.00	$3,824	50%	$	22,946		
Director Policy Research	1.00	$6,830	25%	$	20,490		
Senior Program Manager - OHAC-IE	1.00	$6,830	50%	$	40,980		
			Total Salary	**$**	**84,416**		
		Fringe Benefits	**30%**	$	25,325		
					Total Personnel	**$**	**109,741**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	2,500		
		Total Operating Expenses	**$**	**2,500**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	1,500		
		Total Travel	**$**	**1,500**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**16,883**
		Annual Budget Total	**$**	**130,624**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Exhibit B.3 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Program Assoc (Communications)	1.00	$3,939	50%	$	23,632		
Director Policy Research	1.00	$7,035	25%	$	21,105		
Senior Program Manager - OHAC-IE	1.00	$7,035	50%	$	42,209		
			Total Salary	**$**	**86,946**		
		Fringe Benefits	**30%**	$	26,084		
					Total Personnel	**$**	**113,030**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	2,500	
		Total Operating Expenses	**$ 2,500**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage	$	1,500	
		Total Travel	**$ 1,500**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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)	**20%**	**Indirect Costs**	**$ 17,389**
		Annual Budget Total	**$ 134,419**

EXHIBIT B.3 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 1 - 12/01/17 through 12/31/17
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

Executive Director – This position will provide strategic oversight to the LDPP-IE Work Group and assist the senior program manager in her role as coordinator and convener of the LDPP-IE Work Group. The executive director will help identify and advance public policy recommendations; mobilize additional financial support, and highlight the work of the LDPP-IE.

Senior Program Manager – This position will oversee the coordination of all activities related to LDPP-IE workgroup. The senior program manager will coordinate meetings, convene stakeholders, align activities, engage extensively with community partners to keep a common agenda, and keep all parties moving toward the same goals, minimizing silos, and facilitating conflict resolution when needed; building public will by facilitating extensive, frequent, and regular communication among community partners to ensure collaboration and collective impact.

Director of Public Policy Research – This position will be responsible for helping establish shared measurement practices to measure collective progress toward the desired outcomes and taking opportunities to leverage each other's efforts to feed common goals.

Program Assistant – This position will assist the senior program manager by coordinating meetings and providing material support to her role in facilitating extensive, frequent, and regular communication among community partners to ensure collaboration and collective impact.

OPERATING EXPENSES

Communication / Mobile Devices – cell phone and monthly service costs for webinars/WebEx.

Software - The Coalition will acquire a collaborative project management software (Asana, BaseCamp or similar) for up to $5,000 to ensure communications amongst members of the Coalition.

EQUIPMENT

None

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

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Exhibit B.4 - Attachment 1

(Year 1) [Retain if multiple budgets are present]
(12/01/17 through 12/31/17) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost		
Policy Analyst	1.00	$5,875	5%	$ 294		
Business Analyst / Project Support	1.00	$7,341	4%	$ 294		
Senior Policy Manager	1.00	$26,130	2%	$ 523		
Senior Project Manager	1.00	$12,118	3%	$ 364		
Vice President, Policy	1.00	$21,313	3%	$ 639		
Cloud Based IT Support	1.00	$8,970	17%	$ 1,525		
Help Desk IT	1.00	$10,500	5%	$ 473		
Project Manager	1.00	$5,018	39%	$ 1,957		
Architect	1.00	$11,250	10%	$ 1,125		
Customer Interaction	1.00	$12,083	49%	$ 5,921		
		Total Salary (Employees)		**$ 13,115**		
		Fringe Benefits (Employees)	**22%**	$ 2,885		
				Total Personnel	**$**	**16,000**
Appl/Mobile Developer - Temp Empl	1.00	$13,000	50%	$ 6,500		
Appl/Mobile Developer - Temp Empl	1.00	$13,000	50%	$ 6,500		
		Total Salary (Temp Employees)		**$ 13,000**		
		Fringe Benefits (Temp Employees)	**31%**	$ 4,030		
				Total Temp Personnel	**$**	**17,030**
				Grand Total	**$**	**33,030**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Printing	$ 410		
Total Operating Expenses		**$**	**410**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$ -		
Total Equipment Expenses		**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$ 1,750		
Total Travel		**$**	**1,750**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None **-**

Other Costs [Itemize each expense]

None	$ -		
Total Other Costs		**$**	**-**

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) - **DOES NOT INCLUDE TEMP EMPLOYEES IN CALCULATION** **20%** **Indirect Costs** **$ 2,623**

Annual Budget Total **$ 37,813**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Exhibit B.4 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Policy Analyst	1.00	$5,875	7%	$	5,112		
Business Analyst / Project Support	1.00	$7,341	1%	$	881		
Senior Policy Manager	1.00	$26,130	1%	$	1,567		
Senior Project Manager	1.00	$12,118	3%	$	3,998		
Vice President, Policy	1.00	$21,313	2%	$	4,477		
Cloud Based IT Support	1.00	$8,970	21%	$	22,874		
Help Desk IT	1.00	$10,500	6%	$	7,087		
Project Manager	1.00	$5,018	10%	$	5,871		
Architect	1.00	$11,250	3%	$	3,375		
Customer Interaction	1.00	$12,083	12%	$	17,762		
		Total Salary (Employees)		**$**	**73,004**		
		Fringe Benefits (Employees)	**22%**	$	16,061		
					Total Personnel	**$**	**89,065**
Appl/Mobile Developer - Temp Empl	1.00	$13,000	16%	$	24,401		
Appl/Mobile Developer - Temp Empl	1.00	$13,000	16%	$	24,401		
		Total Salary (Temp Employees)		**$**	**48,801**		
		Fringe Benefits (Temp Employees)	**31%**	$	15,128		
					Total Temp Personnel	**$**	**63,929**
					Grand Total	**$**	**152,994**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Printing	$	410		
Hosting for ECOHA (FedRAMP and Twilio messaging)	$	18,576		
		Total Operating Expenses	**$**	**18,986**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	1,750		
		Total Travel	**$**	**1,750**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None **-**

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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) - **DOES NOT INCLUDE TEMP EMPLOYEES IN CALCULATION** **20%** **Indirect Costs** **$** **14,601**

Annual Budget Total **$** **188,331**

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Exhibit B.4 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost		
Cloud Based IT Support	1.00	$8,970	17%	$ 18,299		
Help Desk IT	1.00	$10,500	4.5%	$ 5,670		
		Total Salary (Employees)		**$ 23,969**		
		Fringe Benefits (Employees)	**22%**	$ 5,273		
				Total Personnel	**$**	**29,242**
Appl/Mobile Developer - Temp Empl	1.00	$13,000	1%	$ 1,512		
Appl/Mobile Developer - Temp Empl	1.00	$13,000	1%	$ 1,511		
		Total Salary (Temp Employees)		**$ 3,023**		
		Fringe Benefits (Temp Employees)	**31%**	$ 937		
				Total Temp Personnel	**$**	**3,960**
				Grand Total	**$**	**33,202**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Printing	$ 410		
Hosting for ECOHA (FedRAMP and Twilio messaging)	$ 18,576		
Total Operating Expenses		**$**	**18,986**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$ -		
Total Equipment Expenses		**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$ -		
Total Travel		**$**	**-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None **-**

Other Costs [Itemize each expense]

None	$ -		
Total Other Costs		**$**	**-**

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) - **DOES NOT INCLUDE TEMP EMPLOYEES IN CALCULATION**

20%	**Indirect Costs**	**$**	**4,794**
	Annual Budget Total	**$**	**56,982**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Exhibit B.4 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost		
Cloud Based IT Support	1.00	$8,970	17%	$ 18,299		
Help Desk IT	1.00	$10,500	4.5%	$ 5,670		
			Total Salary (Employees)	**$ 23,969**		
			Fringe Benefits (Employees) 22%	$ 5,273		
				Total Personnel	**$**	**29,242**
Appl/Mobile Developer - Temp Empl	1.00	$13,000	1%	$ 1,512		
Appl/Mobile Developer - Temp Empl	1.00	$13,000	1%	$ 1,511		
			Total Salary (Temp Employees)	**$ 3,023**		
			Fringe Benefits (Temp Employees) 31%	$ 937		
				Total Temp Personnel	**$**	**3,960**
				Grand Total	**$**	**33,202**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Printing	$ 410		
Hosting for ECOHA (FedRAMP and Twilio messaging)	$ 18,576		
Total Operating Expenses		**$**	**18,986**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$ -		
Total Equipment Expenses		**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$ -		
Total Travel		**$**	**-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None **-**

Other Costs [Itemize each expense]

None	$ -		
Total Other Costs		**$**	**-**

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) - **DOES NOT INCLUDE TEMP EMPLOYEES IN CALCULATION**	**20%**	**Indirect Costs**	**$**	**4,794**
		Annual Budget Total	**$**	**56,982**

EXHIBIT B.4 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 1 - 12/01/17 through 12/31/17
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

Vice President, Policy – This position will assist in user testing, as part of the creation and implementation of ECOHA along with the UOP and SIS (SIS) to ensure that the tool reaches 97,260 children in the IE. The director will review, edit summary report and lead discussion.

Senior Policy Manager – This position will provide primary oversight of user testing for ECOHA. There will be on premise user testing as part of quality improvement. SIS will conduct user testing including script preparation, two days on location with two people performing eight to 10, one-hour one-one-one sessions.

Policy Analyst – This position will be part of on premise user testing working with Senior Policy Manager.

Business Analyst/Project Support – This position will provide requirements for the ECOHA project. There are additional hours for making program modifications for client to improve the system based on feedback. In addition to the development of the application, there is an ongoing maintenance, support, and hosting of the application, which project support will provide.

Senior Project Manager – This position will provide project oversight for the ECOHA project. In addition, there are additional hours for making program modifications for client to improve the system based on feedback. In addition to the development of the application, there is an ongoing maintenance, support, and hosting of the application, which project support will provide.

IT Help Desk Support – This position will be responsible for providing help desk support for the app.

Cloud Based IT Support – This position will be responsible for providing Cloud Based support for the app.

Project Manager – This position will assist in the implementation and post-implementation support of a web-based application, work closely with Sr. Project Manager, internal clients to organize and coordinate project activities.

Architect – Creator of architectural framework of system and application design.

Customer Interaction – Liaison between SIS and participating entities regarding functional elements of the ECOHA App and requested modification through the user interface.

Application/Mobile Developers (Temp Employees) - Responsibilities include: Understanding interactive application development, ability to translate technical requirements into real user solutions (Spanish and English), experience and knowledge regarding iOS and Android.

OPERATING EXPENSES

ECOHA Maintenance/Hosting Costs – SIS will host the app using Microsoft Azure FedRAMP to comply with required security compliance.

EQUIPMENT

None

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings. Travel may include airfare and hotel.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding temporary employee salaries, fringe benefits (perm and temp), operational costs, equipment, travel, subcontracts, and other costs. Please note, this does not include indirect calculation on the temporary employees.

Subcontractor: The Children's Partnership

Exhibit B.5 - Attachment 1

(Year 1) [Retain if multiple budgets are present]
(**12/01/17** through **12/31/17**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Program Support	1.00	$3,925	7%	$	275		
Senior Policy Associate	1.00	$4,800	7%	$	336		
Communications	1.00	$6,125	4%	$	245		
Associate Director, Strategy & Policy	1.00	$5,675	17%	$	965		
President	1.00	$14,150	2%	$	283		
Senior Director, Policy & Program	1.00	$8,325	2%	$	167		
			Total Salary	**$**	**2,271**		
		Fringe Benefits	**27%**	$	613		
					Total Personnel	**$**	**2,884**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communications / Mobile Devices	$	110		
Office Supplies	$	154		
Outreach / Marketing	$	115		
		Total Operating Expenses	**$**	**379**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage				
		Total Travel	**$**	**-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**454**
		Annual Budget Total	**$**	**3,717**

Subcontractor: The Children's Partnership

Exhibit B.5 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
Program Support	1.00	$3,925	3%	$	1,413		
Senior Policy Associate	1.00	$4,800	5%	$	2,880		
Communications	1.00	$6,125	3%	$	2,205		
Associate Director, Strategy & Policy	1.00	$5,675	15%	$	10,215		
President	1.00	$14,150	1%	$	1,698		
Senior Director, Policy & Program	1.00	$8,325	1%	$	999		
			Total Salary	**$**	**19,410**		
		Fringe Benefits	**27%**	$	5,241		
					Total Personnel	**$**	**24,651**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communications / Mobile Devices	$	475		
Office Supplies	$	445		
Outreach / Marketing	$	450		
		Total Operating Expenses	**$**	**1,370**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	2,075		
		Total Travel	**$**	**2,075**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	20%	**Indirect Costs**	**$**	**3,882**
		Annual Budget Total	**$**	**31,978**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Exhibit B.5 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost	
Program Support	1.00	$3,925	3%	$ 1,413	
Senior Policy Associate	1.00	$4,800	5%	$ 2,880	
Communications	1.00	$6,125	3%	$ 2,205	
Associate Director, Strategy & Policy	1.00	$5,675	15%	$ 10,215	
President	1.00	$14,150	1%	$ 1,698	
Senior Director, Policy & Program	1.00	$8,325	1%	$ 999	
			Total Salary	**$ 19,410**	
		Fringe Benefits	**27%**	$ 5,241	
				Total Personnel	**$ 24,651**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communications / Mobile Devices	$ 475	
Office Supplies	$ 445	
Outreach / Marketing	450	
Printing (Issue Brief)	$ 5,000	
	Total Operating Expenses	**$ 6,370**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$ -	
	Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage	$ 2,075	
	Total Travel	**$ 2,075**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$ -	
	Total Other Costs	**$ -**

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)	**20%**	**Indirect Costs**	**$**	**3,882**
		Annual Budget Total	**$**	**36,978**

Subcontractor: The Children's Partnership

Exhibit B.5 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(01/01/20 through 12/31/20) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost
Program Support	1.00	$3,925	3%	$	1,413
Senior Policy Associate	1.00	$4,800	5%	$	2,880
Communications	1.00	$6,125	3%	$	2,205
Associate Director, Strategy & Policy	1.00	$5,675	15%	$	10,215
President	1.00	$14,150	1%	$	1,698
Senior Director, Policy & Program	1.00	$8,325	1%	$	999
			Total Salary	**$**	**19,410**
		Fringe Benefits	**27%**	$	5,241
				Total Personnel	**$ 24,651**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communications / Mobile Devices	$	475	
Office Supplies	$	445	
Outreach / Marketing		450	
		Total Operating Expenses	**$ 1,370**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage	$	2,075	
		Total Travel	**$ 2,075**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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)	**20%**	**Indirect Costs**	**$ 3,882**
		Annual Budget Total	**$ 31,978**

EXHIBIT B.5 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 1 - 12/01/17 through 12/31/17
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

President – This position will supervise overall direction of TCP's role in the LDPP-IE for an average of an hour per week and promote lessons learned with state and national stakeholders.

Senior Director, Policy & Programs – This position will support the associate director in the creation and implementation of the ECOHA for an average of three hours per week to help to reach 97,260 children in the IE.

Associate Director, Strategy & Policy - This position will assist in the creation and implementation of ECOHA along with the UOP and SIS to ensure that the tool reaches 97,260 children in the IE. The president will participate in local and state stakeholder meetings on the ECOHA and overall LDPP-IE project to inform the State Oral Health Plan. Average of seven hours/week.

Senior Policy Associate – This position will supervise associate director for an average of an hour per week and provide overall guidance for the ECOHA to reach 97,260 children in the IE, as a part of TCP's organizational work on improving access to health care for children.

Communications Program Support – This position will include the LDPP-IE in social media and email blasts to raise awareness of the project among state and national stakeholders, engage the media and identify opportunities for earned media, and format the creation of the brief in Year 3 for an average of 1.5 hours per week.

OPERATING EXPENSES

Communication / Mobile Devices – cell phone, internet access plan, desk phone, internet, voicemail, email, expenses for conference calls and webinars, and fax.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

Printing – materials for outreach activities.

Outreach & Marketing – cost to establish and maintain social media presence.

EQUIPMENT

None

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings. Flight and meal costs for one trip per year to Sacramento (Associate Director).

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Sub-Contractor: Bear Valley Community Health care District

Exhibit B.6 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
None				
			Total Salary	**$ -**
			Fringe Benefits **35.00%**	$ -
				Total Personnel **$ -**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses **$ -**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None $ -

Total Equipment Expenses **$ -**

Travel (At CalHR reimbursement rates)

None

Total Travel **$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs $ -

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) **20%** **Indirect Costs** **$ -**

Annual Budget Total **$ -**

Exhibit B.6 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (Clinic	1.00	$3,780 - $4,199	50%	$	25,194		
VDH - Project Lead / Manager	1.00	$7,263 - $8,069	5%	$	4,841		
ECOHA - Comm Health Worker	1.00	$3,127 - $3,474	50%	$	20,848		
ECOHA - Project Lead	1.00	$7,263 - $8,069	5%	$	4,841		
Data Reporting / IT Position	1.00	$6,375 - $7,083	5%	$	4,250		
			Total Salary	**$**	**59,974**		
		Fringe Benefits	**35.00%**	$	20,991		
					Total Personnel	**$**	**80,965**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone)	$	2,700		
Educational Materials / Dental Hygiene Kits	$	2,400		
Office Supplies	$	2,100		
		Total Operating Expenses	**$**	**7,200**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	1,400		
		Total Travel	**$**	**1,400**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	$	-

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)	**20%**	**Indirect Costs**	**$**	**11,995**
		Annual Budget Total	**$**	**101,560**

Exhibit B.6 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (Clinic	1.00	$3,780 - $4,199	50%	$	25,194		
VDH - Project Lead / Manager	1.00	$7,263 - $8,069	5%	$	4,841		
ECOHA - Comm Health Worker	1.00	$3,127 - $3,474	50%	$	20,848		
ECOHA - Project Lead	1.00	$7,263 - $8,069	5%	$	4,841		
Data Reporting / IT Position	1.00	$6,375 - $7,083	5%	$	4,250		
			Total Salary	**$**	**59,974**		
		Fringe Benefits	**35.00%**	$	20,991		
					Total Personnel	**$**	**80,965**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	2,400		
Educational Materials / Dental Hygiene Kits	$	2,400		
Office Supplies	$	2,100		
		Total Operating Expenses	**$**	**6,900**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	1,400		
		Total Travel	**$**	**1,400**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	$	-

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)	**20%**	**Indirect Costs**	**$**	**11,995**
		Annual Budget Total	**$**	**101,260**

Sub-Contractor: Bear Valley Community Health care District

Exhibit B.6 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (Clinic	1.00	$3,780 - $4,199	50%	$	25,194		
VDH - Project Lead / Manager	1.00	$7,263 - $8,069	5%	$	4,841		
ECOHA - Comm Health Worker	1.00	$3,127 - $3,474	50%	$	20,848		
ECOHA - Project Lead	1.00	$7,263 - $8,069	5%	$	4,841		
Data Reporting / IT Position	1.00	$6,375 - $7,083	5%	$	4,250		
			Total Salary	**$**	**59,974**		
		Fringe Benefits	**35.00%**	$	20,991		
					Total Personnel	**$**	**80,965**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	2,400		
Educational Materials / Dental Hygiene Kits	$	2,400		
Office Supplies	$	2,100		
		Total Operating Expenses	**$**	**6,900**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	1,400		
		Total Travel	**$**	**1,400**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	$	-

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)	**20%**	**Indirect Costs**	**$**	**11,995**
		Annual Budget Total	**$**	**101,260**

EXHIBIT B.6 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at .50 FTE for years 2-4.

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .05 FTE for years 2-4.

ECOHA - Community Health Worker – This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will also be responsible for linking Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted annually at .50 FTE for years 2-4.

ECOHA - Project Lead – This position is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted annually at .05 FTE for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .05 FTE for years 2-4.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

EQUIPMENT

None

TRAVEL

Mileage costs are the only travel costs allocated to this line item and are calculated at the prevailing CalHR rate. Mileage will be incurred due to traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, and other costs.

Subcontractor: Borrego Community Health Foundation

Exhibit B.7 - Attachment 1

(Year 1) [Retain if multiple budgets are present]
[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost
None				
			Total Salary	$ -
		Fringe Benefits	25%	$ -
				Total Personnel $ -

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses $ -

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

Total Equipment Expenses $ -

Travel (At CalHR reimbursement rates)

None

Total Travel $ -

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs $ -

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)

20% Indirect Costs - Riv Co $ -

20% Indirect Costs - SB Co $ -

Annual Budget Total $ -

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Borrego Community Health Foundation

Exhibit B.7 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost
VDH - Care Coordinator (clinic) - Riv Co	1.00	$3,500	50%	$	21,000
VDH - Care Coordinator (clinic) - SB Co	1.00	$3,500	50%	$	21,000
VDH - Navigator (field) - Riv Co	1.00	$3,750	100%	$	45,000
VDH - Navigator (field) - SB Co	1.00	$3,750	100%	$	45,000
VDH - Project Lead / Manager - Riv Co	1.00	$7,916	10%	$	9,499
VDH - Project Lead / Manager - SB Co	1.00	$7,916	10%	$	9,499
ECOHA - Comm Health Worker - Riv Co	1.00	$3,111	100%	$	37,332
ECOHA - Comm Health Worker - SB Co	1.00	$3,111	100%	$	37,332
ECOHA - Comm Health Worker - SB Co	1.00	$3,111	100%	$	37,332
ECOHA - Project Lead - Riv Co	1.00	$7,916	10%	$	9,499
ECOHA - Project Lead - SB Co	1.00	$7,916	20%	$	18,998
Data Reporting / IT Position - Riv Co	1.00	$7,084	5%	$	4,250
Data Reporting / IT Position - SB Co	1.00	$7,084	5%	$	4,250
		Total Salary		**$**	**299,991**
		Fringe Benefits	**25%**	$	74,998
				Total Personnel	**$ 374,989**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone) - Riv Co	$	2,700	
Communication / Mobile Devices (includes one-time purchase of cell phone) - SB Co	$	2,700	
Educational Materials / Dental Hygiene Kits - Riv Co	$	2,400	
Educational Materials / Dental Hygiene Kits - SB Co	$	2,400	
Office Supplies - Riv Co	$	2,100	
Office Supplies - SB Co	$	2,100	
		Total Operating Expenses	**$ 14,400**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage - Riv Co	$	2,414	
Mileage - SB Co	$	4,820	
		Total Travel	**$ 7,234**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None

		Total Other Costs	**$ -**
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)	20%	**Indirect Costs - Riv Co**	**$ 25,316**
	20%	**Indirect Costs - SB Co**	**$ 34,682**
		Annual Budget Total	**$ 456,621**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Borrego Community Health Foundation

Exhibit B.7 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
VDH - Care Coordinator (clinic) - Riv Co	1.00	$3,500	50%	$	21,000		
VDH - Care Coordinator (clinic) - SB Co	1.00	$3,500	50%	$	21,000		
VDH - Navigator (field) - Riv Co	1.00	$3,750	100%	$	45,000		
VDH - Navigator (field) - SB Co	1.00	$3,750	100%	$	45,000		
VDH - Project Lead / Manager - Riv Co	1.00	$7,916	10%	$	9,499		
VDH - Project Lead / Manager - SB Co	1.00	$7,916	10%	$	9,499		
ECOHA - Comm Health Worker - Riv Co	1.00	$3,111	100%	$	37,332		
ECOHA - Comm Health Worker - SB Co	1.00	$3,111	100%	$	37,332		
ECOHA - Comm Health Worker - SB Co	1.00	$3,111	100%	$	37,332		
ECOHA - Project Lead - Riv Co	1.00	$7,916	10%	$	9,499		
ECOHA - Project Lead - SB Co	1.00	$7,916	20%	$	18,998		
Data Reporting / IT Position - Riv Co	1.00	$7,084	5%	$	4,250		
Data Reporting / IT Position - SB Co	1.00	$7,084	5%	$	4,250		
			Total Salary	**$**	**299,991**		
		Fringe Benefits	**25%**	$	74,998		
					Total Personnel	**$**	**374,989**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices - Riv Co	$	2,400		
Communication / Mobile Devices - SB Co	$	2,400		
Educational Materials / Dental Hygiene Kits - Riv Co	$	2,400		
Educational Materials / Dental Hygiene Kits - SB Co	$	2,400		
Office Supplies - Riv Co	$	2,100		
Office Supplies - SB Co	$	2,100		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage - Riv Co	$	2,285		
Mileage - SB Co	$	3,427		
		Total Travel	**$**	**5,712**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)

20%	**Indirect Costs - Riv Co**	**$**	**25,316**
20%	**Indirect Costs - SB Co**	**$**	**34,682**
	Annual Budget Total	**$**	**454,499**

FIRST 5 RIVERSIDE • SAN BERNARDINO

Subcontractor: Borrego Community Health Foundation

Exhibit B.7 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(01/01/20 through 12/31/20) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost
VDH - Care Coordinator (clinic) - Riv Co	1.00	$3,500	50%	$	21,000
VDH - Care Coordinator (clinic) - SB Co	1.00	$3,500	50%	$	21,000
VDH - Navigator (field) - Riv Co	1.00	$3,750	100%	$	45,000
VDH - Navigator (field) - SB Co	1.00	$3,750	100%	$	45,000
VDH - Project Lead / Manager - Riv Co	1.00	$7,916	10%	$	9,499
VDH - Project Lead / Manager - SB Co	1.00	$7,916	10%	$	9,499
ECOHA - Comm Health Worker - Riv Co	1.00	$3,111	100%	$	37,332
ECOHA - Comm Health Worker - SB Co	1.00	$3,111	100%	$	37,332
ECOHA - Comm Health Worker - SB Co	1.00	$3,111	100%	$	37,332
ECOHA - Project Lead - Riv Co	1.00	$7,916	10%	$	9,499
ECOHA - Project Lead - SB Co	1.00	$7,916	20%	$	18,998
Data Reporting / IT Position - Riv Co	1.00	$7,084	5%	$	4,250
Data Reporting / IT Position - SB Co	1.00	$7,084	5%	$	4,250
			Total Salary	**$**	**299,991**
		Fringe Benefits	**25%**	$	74,998
				Total Personnel	**$ 374,989**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices - Riv Co	$	2,400	
Communication / Mobile Devices - SB Co	$	2,400	
Educational Materials / Dental Hygiene Kits - Riv Co	$	2,400	
Educational Materials / Dental Hygiene Kits - SB Co	$	2,400	
Office Supplies - Riv Co	$	2,100	
Office Supplies - SB Co	$	2,100	
		Total Operating Expenses	**$ 13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage - Riv Co	$	2,285	
Mileage - SB Co	$	3,427	
		Total Travel	**$ 5,712**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be suppl ied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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)

20%	**Indirect Costs - Riv Co**	**$ 25,316**
20%	**Indirect Costs - SB Co**	**$ 34,682**
	Annual Budget Total	**$ 454,499**

EXHIBIT B.7 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .20 FTE (allocation .10 FTE for Riverside County, .10 FTE for San Bernardino County) for years 2-4.

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at 1.0 FTE (allocation .50 FTE for Riverside County, .50 FTE for San Bernardino County) for years 2-4.

VDH - Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to: oral health education, providing program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted annually at 2.0 FTEs (allocation 1.0 FTE for Riverside County, 1.0 FTE for San Bernardino County) for years 2-4.

ECOHA - Project Lead – This position is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted annually at .30 FTE (allocation .10 FTE for Riverside County, .20 FTE for San Bernardino County) for years 2-4.

ECOHA - Community Health Worker – This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will also be responsible for linking Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted annually at 3.0 FTEs (allocation 1.0 FTE for Riverside County, 2.0 FTE for San Bernardino County) for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE (allocation .05 FTE for Riverside County, .05 FTE for San Bernardino County) for each participating VDH and ECOHA entity.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, floss, toothpaste samples, storybooks, fact sheets and posters. Riverside County and San Bernardino County expenses have been budgeted separately.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments. Riverside County and San Bernardino County expenses have been budgeted separately.

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings. Riverside County and San Bernardino County expenses have been budgeted separately.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, and other costs. Riverside County and San Bernardino County indirect rates have been calculated separately.

Subcontractor: Clinicas de Salud Del Pueblo

Exhibit B.8 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
None				
			Total Salary	**$ -**
			Fringe Benefits **30%**	$ -
				Total Personnel **$ -**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses **$ -**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

Total Equipment Expenses

Travel (At CalHR reimbursement rates)

None

Total Travel **$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$ -	
	Total Other Costs	**$ -**

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) **20%** **Indirect Costs** **$ -**

Annual Budget Total **$ -**

Subcontractor: Clinicas de Salud Del Pueblo

Exhibit B.8 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1	$2,205 - $2,450	50%	$	14,700		
VDH - Navigator (field)	1	$2,205 - $2,450	50%	$	14,700		
VDH - Project Lead / Manager	1	$3,060 - $3,400	5%	$	2,040		
Data Reporting / IT Position	1	$6,375 - $7,983	10%	$	8,500		
			Total Salary	**$**	**39,940**		
		Fringe Benefits	**30%**	$	11,982		
					Total Personnel	**$**	**51,922**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone)	$	2,700		
Educational Materials / Dental Hygiene Kits	$	2,400		
Office Supplies	$	2,100		
		Total Operating Expenses	**$**	**7,200**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	10,800		
		Total Travel	**$**	**10,800**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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) **20%**

Indirect Costs	**$**	**7,988**
Annual Budget Total	**$**	**77,910**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Clinicas de Salud Del Pueblo

Exhibit B.8 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1	$2,205 - $2,450	50%	$	14,700		
VDH - Navigator (field)	1	$2,205 - $2,450	50%	$	14,700		
VDH - Project Lead / Manager	1	$3,060 - $3,400	5%	$	2,040		
Data Reporting / IT Position	1	$6,375 - $7,983	10%	$	8,500		
			Total Salary	**$**	**39,940**		
		Fringe Benefits	**30%**	$	11,982		
					Total Personnel	**$**	**51,922**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	2,400		
Educational Materials / Dental Hygiene Kits	$	2,400		
Office Supplies	$	2,100		
		Total Operating Expenses	**$**	**6,900**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

	Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	10,800		
		Total Travel	**$**	**10,800**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be suppl ied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**7,988**
		Annual Budget Total	**$**	**77,610**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Clinicas de Salud Del Pueblo

Exhibit B.8 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1	$2,205 - $2,450	50%	$	14,700		
VDH - Navigator (field)	1	$2,205 - $2,450	50%	$	14,700		
VDH - Project Lead / Manager	1	$3,060 - $3,400	5%	$	2,040		
Data Reporting / IT Position	1	$6,375 - $7,983	10%	$	8,500		
			Total Salary	**$**	**39,940**		
		Fringe Benefits	**30%**	$	11,982		
					Total Personnel	**$**	**51,922**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	2,400		
Educational Materials / Dental Hygiene Kits	$	2,400		
Office Supplies	$	2,100		
		Total Operating Expenses	**$**	**6,900**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	10,800		
		Total Travel	**$**	**10,800**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**7,988**
		Annual Budget Total	**$**	**77,610**

EXHIBIT B.8 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .05 FTE for years 2-4.

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at .50 FTE for years 2-4.

VDH - Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to providing: oral health education, program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted annually at .50 FTE for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE for each participating VDH and ECOHA entity for years 2-4.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Subcontractor: Morongo Basin HD

Exhibit B.9 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
None				
			Total Salary	**$ -**
			Fringe Benefits **24%**	$ -
				Total Personnel $ -

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses $ -

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

Total Equipment Expenses $ -

Travel (At CalHR reimbursement rates)

None

Total Travel $ -

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None

Total Other Costs $ -

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) **20%** **Indirect Costs $ -**

Annual Budget Total $ -

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Morongo Basin HD

Exhibit B.9 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost
VDH - Care Coordinator (clinic)	1.00	$2,916 X 12	50%	$	17,500
VDH - Navigator (field)	1.00	$2,916 X 12	100%	$	35,000
VDH - Project Lead / Manager	1.00	$4,167 X 12	10%	$	5,000
ECOHA - Comm Health Worker	1.00	$3,120 X 12	100%	$	37,440
ECOHA - Project Lead	1.00	$4,853 X 12	10%	$	5,824
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500
		Total Salary		**$**	**109,264**
		Fringe Benefits	**24%**	$	26,223
				Total Personnel	**$ 135,487**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone)	$	5,100	
Educational Materials / Dental Hygiene Kits	$	4,800	
Office Supplies	$	4,200	
		Total Operating Expenses	**$ 14,100**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage	$	6,000	
		Total Travel	**$ 6,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None

		Total Other Costs	**$ -**
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)	**20%**	**Indirect Costs**	**$ 21,853**
		Annual Budget Total	**$ 177,440**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Exhibit B.9 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,916 X 12	50%	$	17,500		
VDH - Navigator (field)	1.00	$2,916 X 12	100%	$	35,000		
VDH - Project Lead / Manager	1.00	$4,167 X 12	10%	$	5,000		
ECOHA - Comm Health Worker	1.00	$3,120 X 12	100%	$	37,440		
ECOHA - Project Lead	1.00	$4,853 X 12	10%	$	5,824		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**109,264**		
		Fringe Benefits	**24%**	$	26,223		
					Total Personnel	**$**	**135,487**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	6,000		
		Total Travel	**$**	**6,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None

		Total Other Costs	**$**	**-**
Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)	**20%**	**Indirect Costs**	**$**	**21,853**
		Annual Budget Total	**$**	**177,140**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Morongo Basin HD

Exhibit B.9 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,916 X 12	50%	$	17,500		
VDH - Navigator (field)	1.00	$2,916 X 12	100%	$	35,000		
VDH - Project Lead / Manager	1.00	$4,167 X 12	10%	$	5,000		
ECOHA - Comm Health Worker	1.00	$3,120 X 12	100%	$	37,440		
ECOHA - Project Lead	1.00	$4,853 X 12	10%	$	5,824		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**109,264**		
		Fringe Benefits	**24%**	$	26,223		
					Total Personnel	**$**	**135,487**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	6,000		
		Total Travel	**$**	**6,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None

		Total Other Costs	**$**	**-**
Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)	**20%**	**Indirect Costs**	**$**	**21,853**
		Annual Budget Total	**$**	**177,140**

EXHIBIT B.9 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .10 FTE for years 2-4.

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at .50 FTE for years 2-4.

VDH - Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to providing: oral health education, program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted annually at 1.0 FTE for years 2-4.

ECOHA - Project Lead – This position is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted annually at .10 FTE for years 2-4.

ECOHA - Community Health Worker – This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will also be responsible for linking Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted annually at 1.0 FTE for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE for each participating VDH and ECOHA entity.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Subcontractor: Neighborhood Health Care

Exhibit B.10 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
None				
			Total Salary	**$ -**
			Fringe Benefits **20.76%**	$ -
				Total Personnel **$ -**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses **$ -**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

Total Equipment Expenses

Travel (At CalHR reimbursement rates)

None

Total Travel

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs **$ -**

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) **20%** **Indirect Costs** **$ -**

Annual Budget Total **$ -**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Neighborhood Health Care

Exhibit B.10 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,882 X 12	50%	$	17,292		
VDH - Navigator (field)	1.00	$2,882 X 12	100%	$	34,584		
VDH - Project Lead / Manager	1.00	$6,667 X 12	10%	$	8,000		
ECOHA - Comm Health Worker	1.00	$2,882 X 12	100%	$	34,584		
ECOHA - Project Lead	1.00	$6,667 X 12	10%	$	8,000		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**110,961**		
		Fringe Benefits	**20.76%**	$	23,035		
					Total Personnel	**$**	**133,996**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone)	$	5,100		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**14,100**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	1,200		
		Total Travel	**$**	**1,200**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense] **0**

None	$	-		
		Total Other Costs	**$**	**-**

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) **20%** **Indirect Costs** **$** **22,192**

Annual Budget Total **$** **171,488**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Neighborhood Health Care

Exhibit B.10 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,882 X 12	50%	$	17,292		
VDH - Navigator (field)	1.00	$2,882 X 12	100%	$	34,584		
VDH - Project Lead / Manager	1.00	$6,667 X 12	10%	$	8,000		
ECOHA - Comm Health Worker	1.00	$2,882 X 12	100%	$	34,584		
ECOHA - Project Lead	1.00	$6,667 X 12	10%	$	8,000		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**110,960**		
		Fringe Benefits	**20.76%**	$	23,035		
					Total Personnel	**$**	**133,995**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	1,200		
		Total Travel	**$**	**1,200**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be suppl ied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense] **0**

None

	Total Other Costs	**$**	**-**

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) **20%**

Indirect Costs	**$**	**22,192**
Annual Budget Total	**$**	**171,187**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Neighborhood Health Care

Exhibit B.10 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,882 X 12	50%	$	17,292		
VDH - Navigator (field)	1.00	$2,882 X 12	100%	$	34,584		
VDH - Project Lead / Manager	1.00	$6,667 X 12	10%	$	8,000		
ECOHA - Comm Health Worker	1.00	$2,882 X 12	100%	$	34,584		
ECOHA - Project Lead	1.00	$6,667 X 12	10%	$	8,000		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**110,960**		
		Fringe Benefits	**20.76%**	$	23,035		
					Total Personnel	**$**	**133,995**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	900		
		Total Travel	**$**	**900**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None

		Total Other Costs	**$**	**-**
Indirect Costs (the lower of 20% of Total Personnel Salary excluding Fringe Benefits or indirect costs computed based on the organization's approved federal indirect cost rate or methodology)	**20%**	**Indirect Costs**	**$**	**22,192**
		Annual Budget Total	**$**	**170,887**

EXHIBIT B.10 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .10 FTE for years 2-4.

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at .50 FTE for years 2-4.

VDH - Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to providing: oral health education, program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted annually at 1.0 FTE for years 2-4.

ECOHA - Project Lead – This position is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted annually at .10 FTE for years 2-4.

ECOHA - Community Health Worker – This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will also be responsible for linking Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted annually at 1.0 FTE for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE for each participating VDH and ECOHA entity.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Subcontractor: North County Health Systems

Exhibit B.11 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
None				
			Total Salary	**$ -**
			Fringe Benefits **24%**	$ -
				Total Personnel **$ -**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses **$ -**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

Total Equipment Expenses **$ -**

Travel (At CalHR reimbursement rates)

None

Total Travel

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs **$ -**

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) **20%** **Indirect Costs** **$ -**

Annual Budget Total **$ -**

Subcontractor: North County Health Systems

Exhibit B.11 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$3,870 X 12	50%	$	23,220		
VDH - Navigator (field)	1.00	$3,870 X 12	100%	$	46,440		
VDH - Project Lead / Manager	1.00	$6,973 X 12	10%	$	8,368		
ECOHA - Comm Health Worker	1.00	$3,034 X 12	100%	$	36,399		
ECOHA - Project Lead	1.00	$6,973 X 12	10%	$	8,368		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**131,295**		
		Fringe Benefits	**24%**	$	31,511		
					Total Personnel	**$**	**162,806**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone)	$	5,100		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**14,100**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	6,000		
		Total Travel	**$**	**6,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**26,259**
		Annual Budget Total	**$**	**209,165**

Subcontractor: North County Health Systems

Exhibit B.11 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(01/01/19 through 12/31/19) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$3,870 X 12	50%	$	23,220		
VDH - Navigator (field)	1.00	$3,870 X 12	100%	$	46,440		
VDH - Project Lead / Manager	1.00	$6,973 X 12	10%	$	8,368		
ECOHA - Comm Health Worker	1.00	$3,034 X 12	100%	$	36,399		
ECOHA - Project Lead	1.00	$6,973 X 12	10%	$	8,368		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**131,295**		
		Fringe Benefits	**24%**	$	31,511		
					Total Personnel	**$**	**162,806**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	6,000		
		Total Travel	**$**	**6,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	20%	**Indirect Costs**	**$**	**26,259**
		Annual Budget Total	**$**	**208,865**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: North County Health Systems

Exhibit B.11 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$3,870 X 12	50%	$	23,220		
VDH - Navigator (field)	1.00	$3,870 X 12	100%	$	46,440		
VDH - Project Lead / Manager	1.00	$6,973 X 12	10%	$	8,368		
ECOHA - Comm Health Worker	1.00	$3,034 X 12	100%	$	36,399		
ECOHA - Project Lead	1.00	$6,973 X 12	10%	$	8,368		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**131,295**		
		Fringe Benefits	**24%**	$	31,511		
					Total Personnel	**$**	**162,806**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800	
Educational Materials / Dental Hygiene Kits	$	4,800	
Office Supplies	$	4,200	
		Total Operating Expenses	**$ 13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage	$	6,000	
		Total Travel	**$ 6,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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)	**20%**	**Indirect Costs**	**$ 26,259**
		Annual Budget Total	**$ 208,865**

EXHIBIT B.11 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .10 FTE for years 2-4.

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at .50 FTE for years 2-4.

VDH - Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to providing: oral health education, program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted annually at 1.0 FTE for years 2-4.

ECOHA - Project Lead – This position is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted annually at .10 FTE for years 2-4.

ECOHA - Community Health Worker – This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will also be responsible for linking Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted annually at 1.0 FTE for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE for each participating VDH and ECOHA entity.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Exhibit B.12 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
None				
			Total Salary	**$ -**
			Fringe Benefits **20%**	$ -
				Total Personnel **$ -**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses **$ -**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

Total Equipment Expenses **$ -**

Travel (At CalHR reimbursement rates)

None

Total Travel **$ -**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$ -	
	Total Other Costs	**$ -**

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)	**20%**	**Indirect Costs**	**$ -**
		Annual Budget Total	**$ -**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: ParkTree Community Health Center

Exhibit B.12 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$3,333 X 12	50%	$	19,998		
VDH - Navigator (field)	1.00	$3,333 X 12	100%	$	39,995		
VDH - Project Lead / Manager	1.00	$15,208 X 12	10%	$	18,250		
Data Reporting / IT Position	1.00	$7,083 X 12	10%	$	8,500		
			Total Salary	**$**	**86,743**		
		Fringe Benefits	**20%**	$	17,349		
					Total Personnel	**$**	**104,092**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone)	$	5,100		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	2,400		
		Total Operating Expenses	**$**	**12,300**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	3,000		
		Total Travel	**$**	**3,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**17,349**
		Annual Budget Total	**$**	**136,741**

Subcontractor: ParkTree Community Health Center

Exhibit B.12 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(01/01/19 through 12/31/19) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost
VDH - Care Coordinator (clinic)	1.00	$3,333 X 12	50%	$	19,998
VDH - Navigator (field)	1.00	$3,333 X 12	100%	$	39,996
VDH - Project Lead / Manager	1.00	$15,208 X 12	10%	$	18,250
Data Reporting / IT Position	1.00	$7,083 X 12	10%	$	8,500
			Total Salary	**$**	**86,744**
		Fringe Benefits	**20%**	$	17,349
				Total Personnel	**$ 104,093**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800	
Educational Materials / Dental Hygiene Kits	$	4,800	
Office Supplies	$	2,400	
		Total Operating Expenses	**$ 12,000**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$ -**

Travel (At CalHR reimbursement rates)

Mileage	$	3,000	
		Total Travel	**$ 3,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be suppl ied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$ -**

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) 20% **Indirect Costs $ 17,349**

Annual Budget Total $ 136,442

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: ParkTree Community Health Center

Exhibit B.12 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$3,333 X 12	50%	$	19,998		
VDH - Navigator (field)	1.00	$3,333 X 12	100%	$	39,996		
VDH - Project Lead / Manager	1.00	$15,208 X 12	10%	$	18,250		
Data Reporting / IT Position	1.00	$7,083 X 12	10%	$	8,500		
			Total Salary	**$**	**86,744**		
		Fringe Benefits	**20%**	$	17,349		
					Total Personnel	**$**	**104,093**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	2,400		
		Total Operating Expenses	**$**	**12,000**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	3,000		
		Total Travel	**$**	**3,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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) **20%** **Indirect Costs** **$** **17,349**

Annual Budget Total **$** **136,442**

EXHIBIT B.12 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .10 FTE for years 2-4.

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at .50 FTE for years 2-4.

VDH - Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to providing: oral health education, program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted annually at 1.0 FTE for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE for each participating VDH and ECOHA entity.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Subcontractor: Riverside University Health System

Exhibit B.13 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost
None				
			Total Salary	**$ -**
		Fringe Benefits	**45%**	$ -
				Total Personnel $ -

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses $ -

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None $ -

Total Equipment Expenses $ -

Travel (At CalHR reimbursement rates)

None $ -

Total Travel $ -

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs $ -

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) **20%** **Indirect Costs $ -**

Annual Budget Total $ -

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Riverside University Health System

Exhibit B.13 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
ECOHA - Comm Health Worker	1.00	$3,640 X 12	100%	$	43,680		
ECOHA - Project Lead	1.00	$5,000 X 12	10%	$	6,000		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**58,180**		
		Fringe Benefits	**45%**	$	26,181		
					Total Personnel	**$**	**84,361**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	-		
Educational Materials / Dental Hygiene Kits	$	7,200		
		Total Operating Expenses	**$**	**7,200**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

None	$	-		
		Total Travel	**$**	**-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**11,636**
		Annual Budget Total	**$**	**103,197**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Riverside University Health System

Exhibit B.13 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
ECOHA - Comm Health Worker	1.00	$3,640 X 12	100%	$	43,680		
ECOHA - Project Lead	1.00	$5,000 X 12	10%	$	6,000		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**58,180**		
		Fringe Benefits	**45%**	$	26,181		
					Total Personnel	**$**	**84,361**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	-		
Educational Materials / Dental Hygiene Kits	$	7,200		
		Total Operating Expenses	**$**	**7,200**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

None	$	-		
		Total Travel	**$**	**-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**11,636**
		Annual Budget Total	**$**	**103,197**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Riverside University Health System

Exhibit B.13 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
ECOHA - Comm Health Worker	1.00	$3,640 X 12	100%	$	43,680		
ECOHA - Project Lead	1.00	$5,000 X 12	10%	$	6,000		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**58,180**		
		Fringe Benefits	**45%**	$	26,181		
					Total Personnel	**$**	**84,361**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	-	
Educational Materials / Dental Hygiene Kits	$	7,200	
		Total Operating Expenses	**$** **7,200**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-	
		Total Equipment Expenses	**$** **-**

Travel (At CalHR reimbursement rates)

None	$	-	
		Total Travel	**$** **-**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-	
		Total Other Costs	**$** **-**

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)

20%		**Indirect Costs**	**$** **11,636**
		Annual Budget Total	**$** **103,197**

EXHIBIT B.13 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

ECOHA - Project Lead – This position is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted annually at .10 FTE for years 2-4.

ECOHA - Community Health Worker – This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will also be responsible for linking Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted annually at 1.0 FTE for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE for each participating VDH and ECOHA entity.

OPERATING EXPENSES

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

EQUIPMENT

None

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Exhibit B.14 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %	Annual Cost
None				
			Total Salary	**$ -**
			Fringe Benefits **51.08%**	$ -
				Total Personnel $ -

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses $ -

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

Total Equipment Expenses $ -

Travel (At CalHR reimbursement rates)

None

Total Travel $ -

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs $ -

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) **20%** **Indirect Costs $ -**

Annual Budget Total $ -

Exhibit B.14 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Navigator (field)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Navigator (field)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Project Lead / Manager	1.00	$14,167 X 12	20%	$	34,000		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Project Lead	1.00	$5,417 X 12	30%	$	19,500		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**285,617**		
		Fringe Benefits	**51.08%**	$	145,893		
					Total Personnel	**$**	**431,510**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone)	$	5,100		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**14,100**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	3,000		
		Total Travel	**$**	**3,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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) **20%** **Indirect Costs** **$** **57,123**

Annual Budget Total **$** **505,733**

FIRST 5 RIVERSIDE · SAN BERNARDINO

Exhibit B.14 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Navigator (field)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Navigator (field)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Project Lead / Manager	1.00	$14,167 X 12	20%	$	34,000		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Project Lead	1.00	$5,417 X 12	30%	$	19,500		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**285,617**		
		Fringe Benefits	**51.08%**	$	145,893		
					Total Personnel	**$**	**431,510**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	3,000		
		Total Travel	**$**	**3,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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) **20%** **Indirect Costs** **$** **57,123**

Annual Budget Total **$** **505,433**

Exhibit B.14 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Navigator (field)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Navigator (field)	1.00	$2,917 X 12	100%	$	35,000		
VDH - Project Lead / Manager	1.00	$14,167 X 12	20%	$	34,000		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Comm Health Worker	1.00	$3,292 X 12	100%	$	39,539		
ECOHA - Project Lead	1.00	$5,417 X 12	30%	$	19,500		
Data Reporting / IT Position	1.00	$7,084 X 12	10%	$	8,500		
			Total Salary	**$**	**285,617**		
		Fringe Benefits	**51.08%**	$	145,893		
					Total Personnel	**$**	**431,510**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	3,000		
		Total Travel	**$**	**3,000**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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) **20%** **Indirect Costs** **$** **57,123**

Annual Budget Total **$** **505,433**

EXHIBIT B.14 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .20 FTE for years 2-4.

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at 1.0 FTE for years 2-4.

VDH - Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to providing: oral health education, program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted annually at 2.0 FTEs for years 2-4.

ECOHA - Project Lead – This position is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted annually at .30 FTE for years 2-4.

ECOHA - Community Health Worker – This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will also be responsible for linking Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted annually at 3.0 FTEs for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE for each participating VDH and ECOHA entity.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.

Exhibit B.15 - Attachment 1

(Year 1) [Retain if multiple budgets are present]

[Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %	Annual Cost
None				
			Total Salary	**$ -**
			Fringe Benefits	**19.39%** $ -
				Total Personnel

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

None

Total Operating Expenses $ -

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None

Total Equipment Expenses $ -

Travel (At CalHR reimbursement rates)

None

Total Travel $ -

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None $ -

Total Other Costs $ -

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) **20%** **Indirect Costs $ -**

Annual Budget Total $ -

Subcontractor: Vista Community Clinic

Exhibit B.15 - Attachment 2

(Year 2) [Retain if multiple budgets are present]
(**01/01/18** through **12/31/18**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,457 - $2,730	100%	$	32,760		
VDH - Navigator (field)	1.00	$2,700 - $3,000	100%	$	36,000		
VDH - Navigator (field)	1.00	$2,700 - $3,000	100%	$	36,000		
VDH - Project Lead / Manager	1.00	$4,650 - $5,167	20%	$	12,401		
ECOHA - Comm Health Worker	1.00	$2,424 - $2,694	100%	$	32,321		
ECOHA - Project Lead	1.00	$4,650 - $5,167	10%	$	6,200		
Data Reporting / IT Position	1.00	$6,785 - $7,084	10%	$	8,500		
			Total Salary	**$**	**164,182**		
		Fringe Benefits	**19.39%**	$	31,835		
					Total Personnel	**$**	**196,017**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices (includes one-time purchase of cell phone)	$	5,100		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**14,100**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	5,008		
		Total Travel	**$**	**5,008**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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) **20%**

	Indirect Costs	**$**	**32,836**
	Annual Budget Total	**$**	**247,961**

Exhibit B.15 - Attachment 3

(Year 3) [Retain if multiple budgets are present]
(**01/01/19** through **12/31/19**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,457 - $2,730	100%	$	32,760		
VDH - Navigator (field)	1.00	$2,700 - $3,000	100%	$	36,000		
VDH - Navigator (field)	1.00	$2,700 - $3,000	100%	$	36,000		
VDH - Project Lead / Manager	1.00	$4,650 - $5,167	20%	$	12,401		
ECOHA - Comm Health Worker	1.00	$2,424 - $2,694	100%	$	32,321		
ECOHA - Project Lead	1.00	$4,650 - $5,167	10%	$	6,200		
Data Reporting / IT Position	1.00	$6,785 - $7,084	10%	$	8,500		
			Total Salary	**$**	**164,182**		
		Fringe Benefits	**19.39%**	$	31,835		
					Total Personnel	**$**	**196,017**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	5,008		
		Total Travel	**$**	**5,008**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each sub contractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be suppl ied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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) **20%**

Indirect Costs	**$**	**32,836**	
Annual Budget Total	**$**	**247,661**	

FIRST 5 RIVERSIDE · SAN BERNARDINO

Subcontractor: Vista Community Clinic

Exhibit B.15 - Attachment 4

(Year 4) [Retain if multiple budgets are present]
(**01/01/20** through **12/31/20**) [Retain if multiple budgets are present]

Personnel [Itemize all expenses]

Position and Title	# of Staff	Monthly Salary Range	FTE %		Annual Cost		
VDH - Care Coordinator (clinic)	1.00	$2,457 - $2,730	100%	$	32,760		
VDH - Navigator (field)	1.00	$2,700 - $3,000	100%	$	36,000		
VDH - Navigator (field)	1.00	$2,700 - $3,000	100%	$	36,000		
VDH - Project Lead / Manager	1.00	$4,650 - $5,167	20%	$	12,401		
ECOHA - Comm Health Worker	1.00	$2,424 - $2,694	100%	$	32,321		
ECOHA - Project Lead	1.00	$4,650 - $5,167	10%	$	6,200		
Data Reporting / IT Position	1.00	$6,785 - $7,084	10%	$	8,500		
			Total Salary	**$**	**164,182**		
		Fringe Benefits	**19.39%**	$	31,835		
					Total Personnel	**$**	**196,017**

Operating Expenses [Itemize all expenses including minor equipment with a Unit cost under $5,000]

Communication / Mobile Devices	$	4,800		
Educational Materials / Dental Hygiene Kits	$	4,800		
Office Supplies	$	4,200		
		Total Operating Expenses	**$**	**13,800**

Equipment [Itemize equipment expenses i.e., items with a Unit cost of $5,000 or more]

None	$	-		
		Total Equipment Expenses	**$**	**-**

Travel (At CalHR reimbursement rates)

Mileage	$	5,008		
		Total Travel	**$**	**5,008**

Subcontracts [Itemize all subcontracts. A subcontractor budget should be included for all subcontractors and must be included for each subcontractor whose total costs under a contract will equal $50,000 or more. If a subcontractor budget is required and cannot be supplied, an explanation must accompany the STD 215. DGS can require additional budget detail for any and all subcontractors and other line items]

None

Other Costs [Itemize each expense]

None	$	-		
		Total Other Costs	**$**	**-**

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)	**20%**	**Indirect Costs**	**$**	**32,836**
		Annual Budget Total	**$**	**247,661**

EXHIBIT B.15 – Attachment 5
BUDGET NARRATIVE AND JUSTIFICATION
Year 2 - 01/01/18 through 12/31/18
Year 3 - 01/01/19 through 12/31/19
Year 4 - 01/01/20 through 12/31/20

PERSONNEL

VDH - Project Lead – This position is responsible for the overall program implementation and will be the primary liaison between the VDH team and service providers. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports and attendance at OHAC-IE meetings. The project lead is budgeted annually at .20 FTE for years 2-4.

VDH - Care Coordinator – This position resides at the health center and will coordinate care across systems, including provider sites. Care coordination may include addressing appointment compliance barriers; coordination of oral health services across multiple providers, provider types, specialties, health care settings, health care organizations, and payment systems; motivational interviewing; and/or education to improve oral health literacy. The care coordinator is budgeted annually at 1.0 FTE for years 2-4.

VDH - Navigator – This position is a key component for the VDH strategy to reach the target population. The navigator will guide and support families' access to VDH services including but not limited to providing: oral health education, program information, conducting intake interviews, obtaining consent, appointment scheduling, arranging and following up on referrals. The navigator is budgeted annually at 2.0 FTEs for years 2-4.

ECOHA - Project Lead – This position is responsible for the overall program implementation and in WIC sites and will be the primary liaison with health center providers, First 5 and OHAC-IE. The project lead will provide supervision for the community health worker. The project lead is tasked with tracking program objectives and outcomes, as well as completing required program reports. The project lead is budgeted annually at .10 FTE for years 2-4.

ECOHA - Community Health Worker – This position will coordinate care across provider sites and communicate with the family at regular intervals to ensure they are able to obtain recommended dental care for their child. This position will also be responsible for linking Medi-Cal children to community-based dental services including newly established VDH hubs across the County. The community health worker is tasked with .50 of time for direct patient care to administer the ECOHA assessment and .50 of time for administrative patient follow-up to include appointment scheduling and/or coordination, traveling to the sites, data collection, application download and education to improve oral health literacy. The community health worker is budgeted annually at 1.0 FTE for years 2-4.

IT Support - Minimal support is required for data collection support through internal IT staff. The IT support is budgeted annually at .10 FTE for each participating VDH and ECOHA entity.

OPERATING EXPENSES

Communication / Mobile Devices – For purchase of a cell phone ($300 in year 2), to be used by Community Health Worker. This line item also includes monthly service costs of $100 ($1,200 annually) for cellphone and internet access plan. Remaining dollars will be used for desk phone, internet, voicemail, email, and fax.

Educational Materials / Dental Hygiene Kits – brochures, flyers, toothbrushes, floss, toothpaste samples, storybooks, fact sheets and posters.

Office Supplies – desk supplies, forms, paper, pens, pencils, toner cartridges and writing instruments.

TRAVEL

Mileage costs are allocated at the prevailing CalHR rate and will be used for the traveling between sites and attendance at the OHAC-IE meetings.

SUBCONTRACTS

None

OTHER COSTS

None

INDIRECT COSTS

Indirect costs are based on 20% of the total personnel salary costs, excluding fringe benefits or operational costs, equipment, travel, subcontracts, and other costs.