SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Section 1: LDPP Lead Entity and Participating Entity Information

1.1 LDPP Lead Entity and Contact Person (STC 109.a)

Organization Name	San Francisco City and County Department of Public Health (SFDPH)
Type of Entity	☐ County ☐ County Entity[1] ☒ City and County ☐ Tribe ☐ Indian Health Program ☐ UC or CSU campus ☐ Consortium of counties serving a region consisting of more than one county
Contact Person	Steven Ambrose, DDS
Title	Director of Dental Services
Telephone	415-657-1742
Email Address	Steven.Ambrose@sfdph.org
Mailing Address	1525 Silver Avenue, San Francisco, CA 94134

1.2 Participating Entities

Organization Name and	Description of Organization	Contact Name, Title, Telephone and Email	Role in LDPP
San Francisco (SF) Children's Oral Health (COH) Implementation and Coordination Committee (ICC)	SF COH ICC is group of multi-disciplinary advocates of children's oral health that include local dentists, pediatricians, researchers, educators, community-based organization representatives	Margaret Fisher Oral Health Consultant San Francisco Department of Public Health 415-575-5719 Phone Margaret.Fisher@sfdph.org	• The SF LDPP represents 5 coordinated 'best practice' pilots within our larger countywide COH Strategic Plan to increase preventive utilization for Denti-Cal beneficiaries ages 0-5. • Subset of ICC members will act as an Advisory Committee to the LDPP and provide ongoing leadership, guidance and oversight to the pilot projects, including ensuring follow-through and accountability of all partners • The diverse membership of this group will help make decisions, regularly review data and provide input on the strategic approaches to each of the LDPP pilot projects and provide expertise to continue supporting data collection and evaluation of the successes and challenges of the programs proposed in SFDPH's DTI LDPP application.

San Francisco Community Clinic Consortium	A partnership of nonprofit health centers that provide primary care and dental care to San Francisco's most vulnerable populations	John Gressman
		President & CEO
		415-355-2220 Direct
		415-355-2277 Fax
		jgressman@sfccc.org
			• The San Francisco Community Clinic Consortium (SFCCC) is "a partnership of nonprofit health centers that provides leadership and fosters innovation to improve community health." SFCCC members are the leaders of each of the major Federally Qualified Health Centers (FQHCs) in San Francisco.
			• SFCCC will be a key partner in the process of engaging the local FQHC clinics for Pilots 1 & 5, especially those providing co-located dental and primary care services to the project's target population of Denti-Cal beneficiaries ages 0-5.
			• Actively encourage dental/ medical clinics to engage in innovative approaches aimed at increasing the utilization of preventative care services:
			  ○ Improving access to regular oral care
			  ○ Instituting fluoride varnish application in pediatric primary care settings
			  ○ Hosting ongoing training for our partner clinics and coordinating technical assistance opportunities

San Francisco Chinatown Task Force on Children's Oral Health	A group of community advocates who are committed to addressing the gaps in care and the health disparities in the Chinatown neighborhood. Group includes local clinicians, academics, educators, and community-based organization representatives	Yee-Bun B. Lui, MD Medical Director Chinatown Public Health Center SFDPH 415-364-7600 Phone 415-291-8794 Fax Yee-Bun.Lui@ucsf.edu Kent Woo, MSW Executive Director NICOS Chinese Health Coalition 415-788-6426 Phone 415-788-0966 Fax kentwoo@nicoschc.org	• Provide ongoing leadership and guidance to ensure that the pilot projects address the needs of the Chinatown community • Educate and mobilize the Chinatown community around children's oral health in order to promote healthful oral health practices
San Francisco Dental Society (SFDS)	Local component of the American Dental Association and the California Dental Association, representing 1100 plus members. Recognized resource for dental professionals in San Francisco. Mission to promote the oral health of the community.	Deborah Elam Executive Director 415-928-7337 Phone 415-928-5297 Fax exec@sfds.org	• SFDS members serve on all the plan implementation subcommittees • Advertise to and recruit SFDS members who are private practice Denti-Cal providers in SF to participate in the Pilot 1 SF Access Collaborative • Engage our membership in improving the oral health of vulnerable populations
San Francisco Unified School District (SFUSD)	Local school district	Mary Jue School District Nurse 415-242-2615 x3315 juem@sfusd.edu	• Continue screening and fluoride varnish (FV) application efforts in grades Pre-K, K, 5, 7, and 9 • Care coordination and navigation of services • Will hire a 1.0 health worker to act as a liaison between caregivers and dental offices, educating caregivers to increase dental appointment compliance, and disseminating dental provider office information to caregivers, and making and assisting caregivers in keeping students' dental appointments.

AFL Enterprises	Health Care Systems Consulting Organization	Colleen Lampron
		President - AFL Consulting
		2874 Yosemite St
		Denver, CO 80238
		Phone: (720) 838-7739
		colleenlampron@afl-enterprises.com
			• AFL Enterprises is a proposed quality improvement systems contractor for the Pilot 1: Access Collaborative.
			• Access Collaborative coordination, including training, meetings, and providing consultants who will:
			  ○ Plan, design, and launch the Access Collaborative
			  ○ Provider quality improvement and data collection support

University of California, San Francisco, School of Dentistry (UCSF)	Dental school, research and educational institution, long-term partner	Lisa Chung Associate Professor UCSF School of Dentistry 415-476-2532 Phone Lisa.Chung@ucsf.edu	• Provide dedicated staff for data collection, monitoring and reporting for the DTI LDPP efforts • Provide faculty time to provide training and technical assistance to dental practices in the Access Collaborative Pilot 1 and primary care clinicians Increasing intreprofessional Collaborative Practice Pilot 4.

1.3 Letters of Participation/Support

Attached please find letters of support from the following organizations:

1. University of California, San Francisco - UCSF School of Dentistry
2. University of California, San Francisco - Division of Pediatric Dentistry
3. AFL Enterprises
4. San Francisco Community Clinic Consortium
5. San Francisco Dental Society
6. San Francisco Unified School District
7. San Francisco Chinatown Task Force on Children's Oral Health (NICOS)
8. San Francisco Children's Oral Health (COH) Implementation and Coordination Committee (ICC)
9. San Francisco First Five Commission

1.4 Collaboration Plan

In order to implement the pilot projects outlined in this proposal, we have designed a collaboration plan that is clear and comprehensive, ensuring collaboration, integration, and communication between participating entities. This plan is based on the SF Children's Oral Health Strategic Plan structure (see http://assets.thehcn.net/content/sites/sanfrancisco/Final_document_Nov_2014_20141126111021.pdf), with a subset of members from the Implementation and Coordination Committee (ICC) of the SF Children's Oral Health (COH) initiative providing oversight, leadership, and direction to the effort overall as the SF LDPP Advisory Committee. This Advisory Committee will work closely with SFDPH (the LDPP Lead Entity), UCSF (the partner heading up data monitoring and reporting), and an LDPP Coordination Committee, which will meet monthly to ensure forward progress and achievement of benchmarks as required.

Integration and Participation. The ICC will engage champions from every area of this project that are already actively involved in COH efforts throughout SF; MOUs are active or pending with each participating entity, outlining clear expectations and work plans to guide their involvement. The SF LDPP Advisory Committee will meet quarterly to assess progress and give overall direction to each of the LDPP partners; at least once a year these meetings will be face-to-face to allow for the best integration and participation of members. With their oversight and advice, the real day-to-day work of the LDPP will be driven by the LDPP Coordination Committee, meeting monthly. The Coordination Committee will be comprised of:

- The SFDPH Project Coordinator, Dental Consultant, Data Manager, and Fiscal Analyst
- The UCSF lead for data collection, monitoring, and reporting
- A representative from AFL Enterprises, which will lead the Access Collaborative (Pilot 1)
- Three health workers who will manage Care Coordination (Pilot 2)
- A representative of the Health Promotion Messaging program (Pilot 3)
- The Technical Assistance Lead for the integration programs (Pilots 4, 5)

At each monthly LDPP Coordination Committee meeting a report-back will be provided on each pilot program, with an opportunity for the committee to discuss progress, provide troubleshooting support if needed, and look for opportunities to leverage resources or synchronize efforts. The group will also discuss information that will be included in a quarterly electronic newsletter that will update all SF LDPP partners (including all entities participating in any pilot program) on progress of the program overall.

Each of the 5 pilot projects described here – which will be described in greater detail in Section 3 of this proposal – were developed and prioritized by the SF COH collaborative; however, implementation of the pilots has not thus far been possible due to lack of funds. The LDPP provides a critical opportunity for us to realize this vision for improved children's oral health in San Francisco. This proposal also meets the aims of the Dental Transformation Initiative's Domains 1 and 3 by piloting strategies to increase the proportion of children ages 0-5 enrolled in the Medi-Cal program who receive preventive dental services in a given year and increasing continuity of care for these children.

The figure on the following page highlights the organization of the LDPP infrastructure, as well as the way it fits into the overall structure of the SF COH Strategic Plan.

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

San Francisco Children's Oral Health Strategic Plan

Implementation and Coordination Committee (Steering)

Pilot projects prioritized by the SF COH committees

1. Access Quality Improvement Collaborative
2. Care Coordination
3. Culturally Appropriate Messaging to Caregivers of Children Ages 0-5
4. Increase Inter-Professional Collaboratoin
5. Incentives to increase FQHC Dual-users

SF LDPP infrastructure to implement pilot programs

SFDPH (LDPP Lead Entity)
- Project Coordinator
- Data Manager
- Fiscal Analyst
- Dental Consultant
- Epidemiologist
- Health Workers

Subset of ICC members:

LDPP Advisory Committee

(strategic direction)

LDPP Coordination Committee
(meets monthly to coordinate progress)

SF LDPP implementing partners for each pilot

1. AFL & UCSF
   SFCCC & SFDS
   Individual dental practices
2. SFUSD
3. Community Task Forces
4. Individual Primary Care Practices
   UCSF
5. FQHC's

Decision-making

Since 2014 the San Francisco Children's Oral Health Strategic Plan's Implementation and Coordination Committee (ICC) has effectively provided ongoing leadership and coordination of cross sectional activities aimed at improving the status of children's oral health across San Francisco. The ICC is a diverse group of leaders from SFDPH, UCSF, local CBOs and community coalition leaders that has experienced very little turnover in members over the last 3 years. Based on the successes of this group, the DTI LDPP Advisory Committee will be formed to oversee the complex and interrelated pilot projects that will further turn the curve on the prevalence, and incidence of caries among Denti-Cal eligible children in San Francisco.

While the ultimate decision-making will remain the responsibility of the SFDPH as the Lead Entity, the DTI LDPP Advisory Committee will provide oversight and direction to any related activities based on the expertise of its diverse members and community input. UCSF partners, and AFL Enterprises staff will inform decisions related to data collection, monitoring, and reporting.

Similar to the multi-pronged approach of the Children's Oral Health Strategic Plan, each of the pilot projects will have a core team of leaders representing each implementing partner; this core team will make day-to-day decisions related to pilot implementation with the assistance of Oral Health (OH) Community Taskforces established to coordinate cross-cutting efforts focused on specific neighborhoods or communities within SF. All core teams will be expected to make decisions that are informed by data collection and ongoing evaluation practices, utilizing the ongoing quality improvement processes currently in place within the SF Department of Public Health, overseen by the Office of Equity and Quality Improvement within the Public Health Division. Currently the ongoing quality improvement efforts of the SFDPH utilize the following two models: Results Based Accountability and Plan-Do-Study-Act. Both models emphasize regular monitoring of data and results, and the regular adjustment of programs' efforts to ensure that the most impact is made on a community's health outcomes.

Although the Advisory Committee and Coordinating Committee will strive for consensus, when necessary, ultimate decision-making will be the responsibility of the LDPP Lead Entity, SFDPH. However, it is expected that there will be minimal instances where this authority as Lead Entity would need to be utilized. The organizational structure of the LDPP is one of two-way communication and collaboration. Most of the Participating Entities in the LDPP have years of history and experience working together. The SFDPH Fiscal Analyst will work with each organization with the understanding that contracts and agreements with clearly defined responsibilities and deliverables minimize the probability of disagreements.

Communication. For a group of projects like this to be successful, clear systems for communication between the Lead Entity and participating entities are critical. The SFDPH Project Coordinator will be ultimately responsible for oversight of communication throughout the LDPP. In this role, this person will identify a main point of contact at each participating entity who will liaise between the two groups. One of the strengths of our program is that there are existing relationships between individual staff and community organizations involved in the DTI LDPP – these existing networks and partnerships will be leveraged when possible to improve communication flow. In addition to these more informal routes, however, multiple formal lines of communication will be routinely used, including:

- Regular direct communication between the DTI Project Coordinator and the main points of contact at the participating entities as needed (via phone or email)
- Monthly Coordination Committee meetings, during which time:
    - The agenda will have a standing item for a report-back on progress in each project pilot

  - Clear work plans will be developed and implemented/reviewed on a regular basis
- Monthly Access Collaborative updates
- Quarterly LDPP Advisory Committee meetings, during which time any major changes to State guidance or local implementation will be communicated
- Quarterly electronic newsletter to all participants involved in the LDPP
- Annual community information sharing meetings where data are released, successes highlighted, and community input is sought to set the next year's priorities for each of the LDPP pilots.

Minimization of silos

In order to continue minimizing the effects of silos on the LDPP outcomes, the current SF COH systems will be utilized and improved upon. The DTI LDPP Participating Entities are committed to following steps to ensure that silos are minimized:

1. **Creating a unified vision of caries-free children in San Francisco and working together to achieve this common goal.** All participating entities are committed to addressing the health disparities in dental caries rates and access to dental care across San Francisco, and share the vision of zero new caries among the most vulnerable 0-5 year olds. The participating entities have already taken steps towards improving dental health outcomes, but will be able to expand their efforts to new and innovative projects proposed in this DTI LDPP proposal.

2. **Inter-Professional Collaboration:** The LDPP Participating Entities and the proposed Pilot projects utilize the collective impact of cross-systems and inter-professional collaborations between Public Health Department staff, university teams, dental providers, primary care providers, educators (preschool through university and professional schools), and actively engage community members through the proposed Community Task Forces (Pilot 3). Engagement and consensus of all involved parties will provide the LDPP with ability to have the biggest impact on oral health disparities as well as ensure that silos are minimized and cross-program integration occurs.

3. **Ongoing Data Measurement and Quality Improvement:** The regular Quality Improvement and data monitoring efforts built into each of the proposed pilot projects will ensure that as needed, a "course correction" can occur. The Results Based Accountability and Plan-Do-Study-Act models will be used to review and analyze the collective impact data collected.

The LDPP Lead Entity Core Team and Coordinator will ensure regular communications between all arms of the LDPP via the monthly LDPP Coordination Committee meeting. Key staff from all LDPP implementation partners in each of the five pilots will meet monthly to report data and updates and receive direction directly to and from the LDPP Project Coordinator. The Access Collaborative will produce a monthly update, and the UCSF Data Monitoring and Reporting Core will provide the SFDPH LDPP Lead Entity monthly reports, from all participating entities for quality improvement, and overall monitoring of the effectiveness of the comprehensive interprofessional efforts of the SF LDPP. This comprehensive monthly report will be a standing agenda item on the SF LDPP Coordinating Committee's monthly meetings, further eliminating "siloing" between the 5 pilots. This report will be disseminated to key staff from all five pilot projects monthly.

Our monthly Coordination Committee meetings are designed specifically to improve integration throughout the LDPP and to minimize siloing. Each pilot has multiple participants from varied stakeholder groups (e.g. childcare, education, pediatricians, dentists, community-based organizations, dental societies, universities, etc.), and some stakeholders will be part of multiple pilots. The Coordinating Committee will be a unifying force, however, with each pilot core team having a formal monthly check-in to share progress and note challenges; the Coordinating Committee will then be in a strong position to identify overlaps or synergies that could improve efficiency across groups. Community-specific efforts will be handled through existing and forming OH Community Taskforces, which are interdisciplinary and will serve to coordinate

various components of comprehensive efforts to improve COH in a particular neighborhood or community. Through the Taskforce model, community input will be regularly sought and integrated directly into the plans and implementation of the pilot projects. And finally, the San Francisco Health Commission and Board of Supervisors are already involved in the ongoing efforts, a high-level engagement that forces us to synthesize our efforts and share progress as a comprehensive package.

Resolution of issues. It is inevitable during collaborative work such as this that sometimes conflicts or other challenges will arise. We will attempt to head these issues off through ongoing, open communication – and utilizing communication strategies will always be our first strategy when issues must be resolved. However, when necessary the Coordinating Committee or Advisory Committee will remind participants of the importance of accountability and evidence-based approaches to the work. Experts (both within the DTI LDPP team and externally) may be brought in to assist with re-formulating strategies and priorities as needed, based on data or the latest implementation science. SFDPH leadership will make final decisions, if required, during disagreements, although we expect most issues to resolve before that point.

Learnings for potential future local efforts. The proposed projects under the DTI LDPP are a continuation of the efforts that have been unfolding in San Francisco as a result of the COH Strategic Plan. There is a strong history of San Francisco placing high value on children's oral health initiatives, as well as a track record of securing private funding to support COH efforts, including funding from the Hellman and Metta Foundations, which invest in Bay Area organizations looking to create positive change in their communities. In order to document our lessons learned for the benefit of future COH efforts in SF, we will continue to publish documents and manuals as we have done via the COH Strategic Plan (for example, the Federally Qualified Health Center (FQHC) Head Start Handbook). Additionally, we will present findings and lessons learned at local, regional, and national conferences to expand knowledge of partners doing similar work at various levels of government and community. Finally, we will maintain institutional memory and build upon knowledge gained through the LDPP by creating future partnerships, such as we have done with the OH Community Taskforces that now tackle neighborhood-specific issues and health inequities in SF. For example, our very successful Chinatown Taskforce is now serving as a model for new OH Community Taskforces currently forming in the Mission and Bayview neighborhoods in San Francisco.

Sustainability post-pilot. In San Francisco we are committed to implementing interventions that will be sustainable if they are shown to be effective. Therefore, we are putting infrastructure in place now that will allow us to continue effective programs in the absence of federal and state funding following the end of the pilots. First, we will carefully collect, summarize, and share data demonstrating the effectiveness of our pilot interventions, which can be used to secure additional funding to sustain projects. This strategy has been used to great success with the COH Strategic Plan (i.e. continued funding from the Hellman Foundation). Second, during the LDPP we will place a priority on developing and testing innovative provider incentive methods and other mechanisms to improve quality of programs and encourage improved patient utilization and outcomes. We will also work to thoroughly institutionalize evidence based interventions and established reimbursement mechanisms to dramatically improve sustainability at the state and/or local level. Finally, we know from experience that public education and empowerment – as we expect to see as a result of the LDPP – will shift social norms and expectations, driving legislator buy-in and improving our ability to receive local funding and support for programs that improve the oral health of children in San Francisco.

Section 2: General Information and Target Population

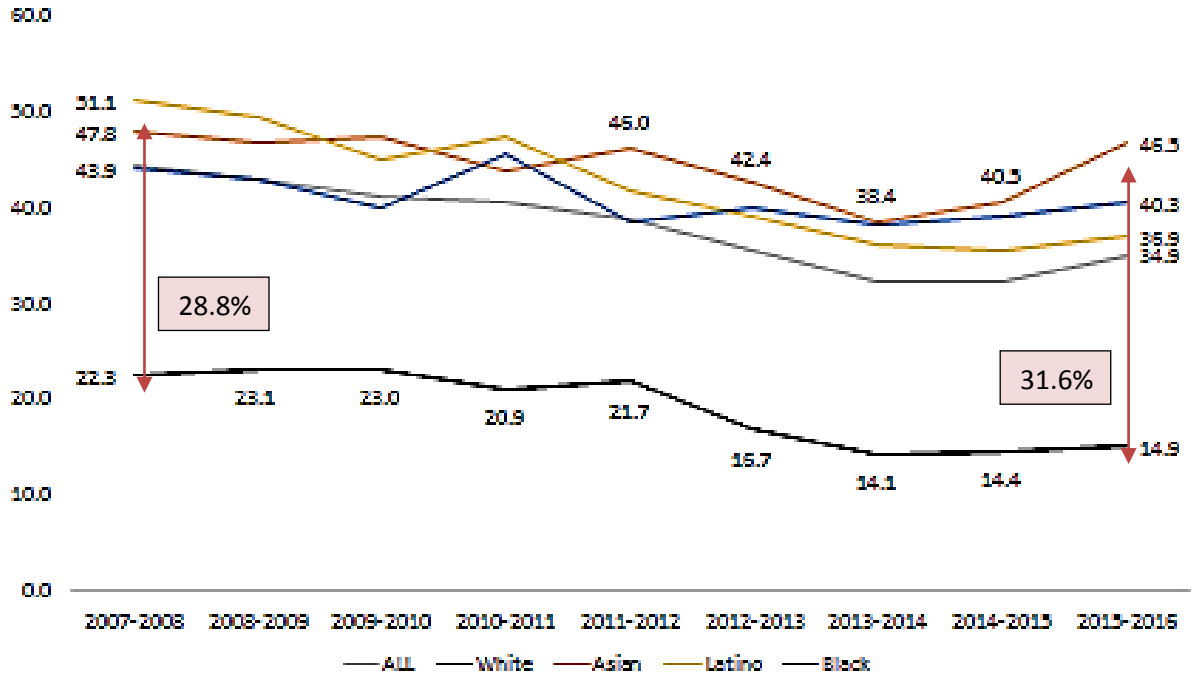
Though the DTI is focused on increasing utilization of preventive dental services among high-need populations, in San Francisco we are able to go one step beyond, using DTI resources to help us reach our goals of a reduction in dental caries among our children, through increased utilization. San Francisco is in

an excellent position to use LDPP funds to actually improve health outcomes in the areas it's needed most; our city is advanced in our efforts to improve children's oral health through a comprehensive strategic plan, extensive data collection, and a robust infrastructure that allows us to analyze data quickly and use findings to develop and improve programs. Our multidisciplinary teams of staff working on these issues – including, but not exclusively dentists – already have strong, functional relationships that will help us solidly execute the pilot programs described in detail in the next section. With the new addition of AFL Enterprises to coordinate our Access Collaborative (Pilot 1), we are well poised to engage with our OH Community Taskforces and improve children's oral health in the populations that have the greatest health inequities, as described below in section 2.1.

2.1 Target Population

Our target population is the approximately 14,300 low-income San Francisco children ages 0 through 5 years who are Denti-Cal beneficiaries. This population has been chosen through analysis of recent data from comprehensive screening of kindergarteners in the San Francisco Unified School District (SFUSD). Every year since 2001, forty to fifty licensed, volunteer dentists from the San Francisco Dental Society (SFDS) conduct dental screenings of kindergarten students throughout the entire SFUSD. The program annually gives the dentists a written training module detailing the clinical data to collect and the diagnostic criteria to use to ensure that screening is standardized. The oral health information collected for each child includes the number of primary and permanent teeth with untreated or treated decay and treatment need. Through this program, we have determined that the prevalence of untreated caries declined from 26% of kindergarteners in 2007 to 16% in 2015.[1] However, there is still much work to be done. Our analysis has shown that since 2014, both the untreated tooth decay rates and caries experience rates are now increasing again, from 32.1% in 2013 to 34.9% in 2015. Even more distressing, there are deep disparities in caries experience rates by race/ethnicity, with our children of color carrying the biggest burden of caries, by far (see Figure 1[2]). In fact, while the disparity in caries prevalance between white kindergarteners and non-white kindergarteners was 28.8% in 2007, in 2016 it has increased to 31.6%.

Figure 1. SFUSD kindergarteners' caries experience by ethnicity, 2007-2016



This recent increase in caries experience among kindergarteners – particularly those who are Asian, Latino, and Black and those who are from low-income families – is distressing. Our ability to rapidly identify this trend as a result of our current and comprehensive caries surveillance has led us to urgently begin work with community health providers to address these health disparities and begin reversing the trend. This data has been used by our SF COH collaborative to establish outcome measures and identify strategies, tactics, and pilot programs that we think will have an impact on caries prevalence in these populations; these are the exact pilots we propose to implement through the DTI LDPP.

Another reason we have selected this target population is that San Francisco has not yet met Healthy People (HP) 2020 goals for children's caries experience. The HP 2020 objective to reduce the proportion of children aged 3 to 5 years who experience dental caries in their primary teeth to 30% has not been met for San Francisco 5-6 year olds (kindergarteners). Figure 2 below shows that while dental caries rates are improving, we still have a ways to go to meet the HP 2020 goal:

Figure 2. San Francisco has not met HP 2020 goals for children's caries experience

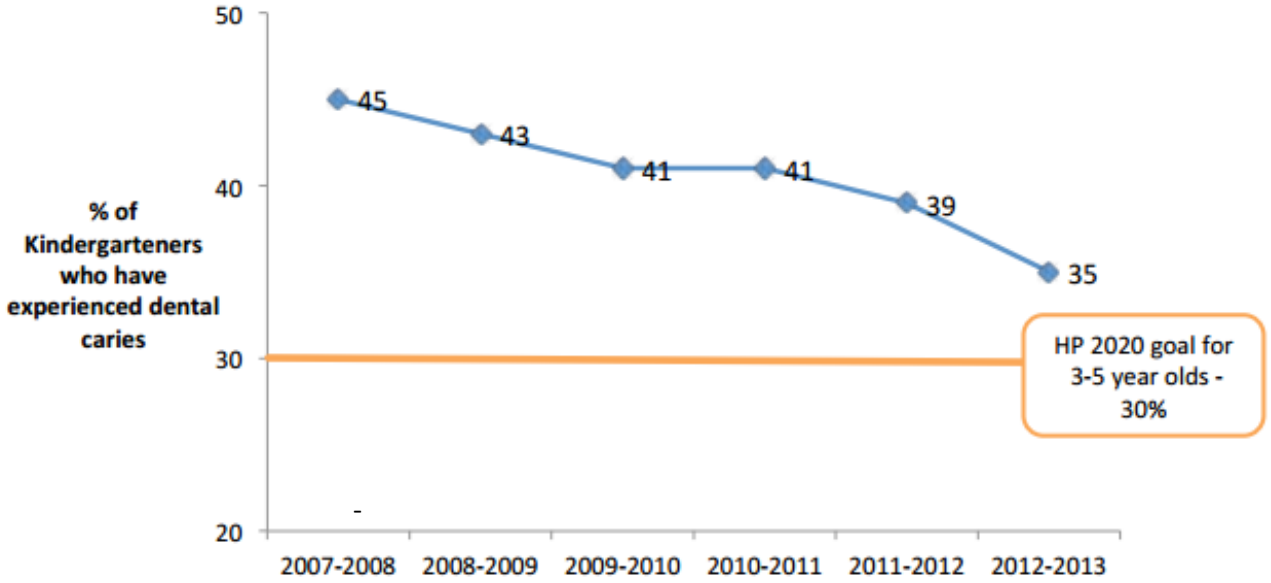
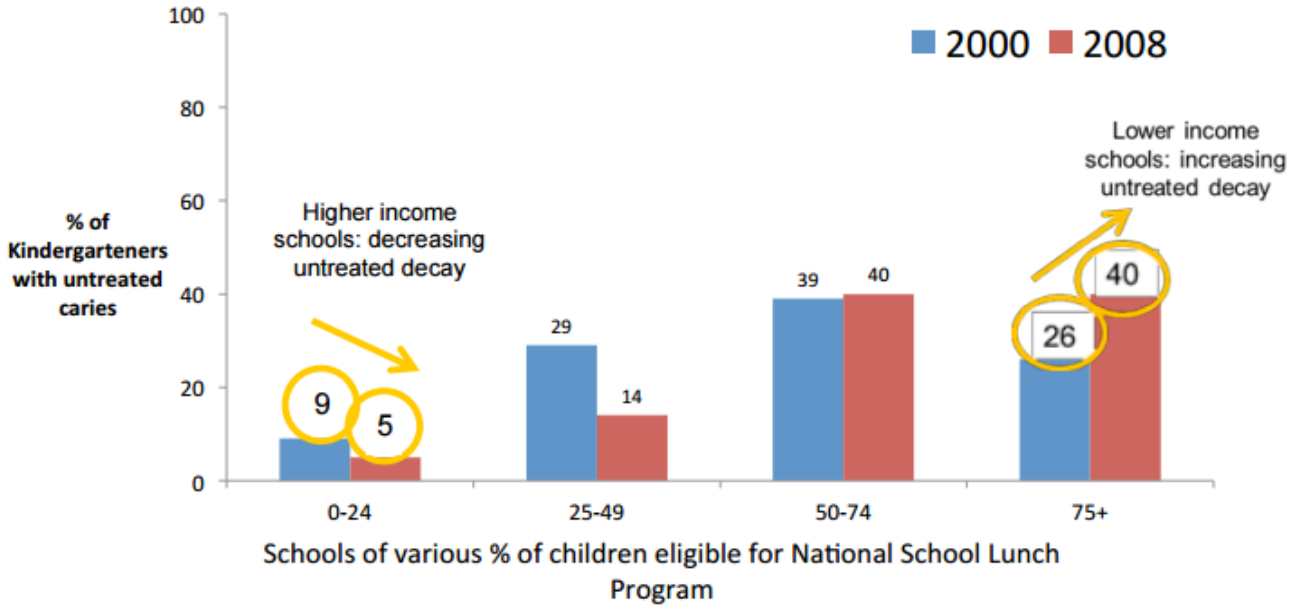
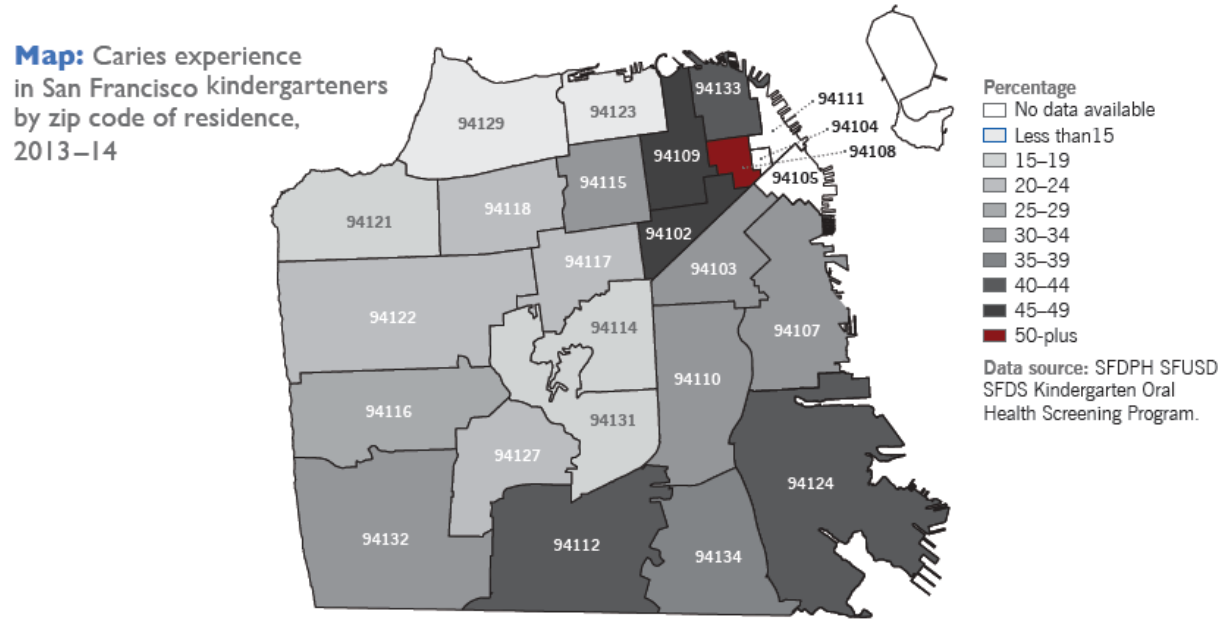


Figure 3. Low-income children in SF are 8 times more likely to have untreated caries



Finally, children who live in some geographic areas experience 2-3 times the rate of caries as children in other areas of the city, as can be seen below in Figure 4. For this reason, we have been working closely with OH Community Taskforces – and forming new ones – that focus on the specific dental needs of their own neighborhoods, and we will continue to do that through the LDPP.

Figure 4. Certain San Francisco neighborhoods have 2-3 times more children with caries



Beyond the data made available through the SFDS Kindergarten Screening program, a significant amount of data regarding children's oral health was gathered during the comprehensive Community Health Assessment (CHA) completed by the SFDPH in 2016. This CHA involved an "assessment of prior assessments" to learn about known, existing health needs and priorities in San Francisco. In March 2015, 21 health assessments that met pre-established inclusion criteria were reviewed and data extracted and synthesized into a comprehensive CHA report. This meta-analysis was supplemented with a community engagement process to identify current residents' health priorities in San Francisco, especially those of vulnerable populations, and those for which limited data had been obtained through earlier means. In total, 127 participants attended 11 meetings between July 1st and October 2nd, 2015. In summary, the CHA identified a series of major disparities for Black/African American (B/AA), Latino, and Asian/Pacific Islander (API) children, which have shaped the design of our LDPP target populations and programs (see below).

Key[1]: Performs badly, Likely performs badly, Performs equal to or better than the benchmark, Insufficient data/benchmark not available.

Overall	Datasheet	Variable	Disparities				
			B/AA	Latino	API	White	Place Disparity
	Children's Oral Health	Percentage of kindergarteners who have experienced caries					
		Percentage of kindergarteners who have untreated caries					
		Percentage of Denti-Cal eligible children ages 0–3 years who received dental care					

In order to address the serious need and ethnic and income-related health disparities demonstrated by the data presented above, this SF LDPP proposal focuses on our San Francisco population of 14,300 Denti-Cal beneficiaries age 0-5 years old. The goal of our LDPP application is to address these gaps in care by implementing a range of pilot projects developed by experts involved in the San Francisco Children's Oral Health Strategic Plan. These pilot projects aim to increase access to the provision of proven prevention services and health promotion messaging for low-income 0-5 year old Denti-Cal beneficiaries and their caregivers. A total of five different pilot projects will work together with a comprehensive evaluation strategy to reverse the distressing trends of increasing caries experience, untreated decay, and

racial/ethnic disparities in decay in our youngest San Franciscans by:

- **Pilot 1:** Implementing an "Access Collaborative" that will increase preventive dental care utilization through quality improvement support for dental practices that serve 0-5 year old Denti-Cal beneficiaries,
- **Pilot 2:** Improving care coordination through hiring 3 bilingual health workers (between them, speaking English, Spanish, and Cantonese) who will provide care coordination services specifically tailored to the needs of 0-5 year old Denti-Cal beneficiaries and their caregivers,
- **Pilot 3:** Developing targeted, culturally relevant health promotion messaging aimed at caregivers of Denti-Cal beneficiaries ages 0-5 to increase preventive care utilization,
- **Pilot 4:** Utilizing an Integration Technical Advisor (ITA) and primary care champions to increase interprofessional collaborative practice and increase primary care providers knowledge of dental referral resources in their practice area,
- **Pilot 5:** Incentivizing increased referrals between primary care and dental clinics in local Federally Qualified Health Centers (FQHCs).

Each one of the five pilot projects has a specific role in achieving the goal of improving the dental health for Denti-Cal beneficiaries ages 0-5 in San Francisco by increasing the use of preventive dental services. Pilot 1 will train participating dental offices in quality improvement methods to create systems that will create capacity to increase number of clients served and the amount of preventive services provided, as well as educate dental providers about evidence-based preventive interventions. Pilot 2 will utilize HWs trained in motivational interviewing and in culturally appropriate messaging, developed by Pilot 3, to address caregiver barriers and case manage Denti-Cal beneficiaries into dental care. Pilot 3 will develop targeted, culturally relevant health promotion messaging aimed at caregivers of Denti-Cal beneficiaries ages 0-5 to increase utilization of preventive dental care based on information derived from caregivers themselves. Pilot 4 will utilize peers to educate and train primary care providers who have much more frequent contact with the target population of children ages 0-5 to increase interprofessional collaborative practice, increase knowledge of dental referral resources, and increase knowlegde of culturally appropriate messaging, developed by Pilot 3, to addresses caregiver barriers to increase utilization of preventive dental care. Pilot 5 will increase interprofessional collaborative practice by incentivizing FQHCs with co-located primary care and dental services to develop and implement systems change to increase the percentage of dual users receiving preventive dental care.

By increasing the education about oral health and referrals to dental care for San Franciscans aged 0-5 who are most likely to have poor dental health outcomes according to our CHA, we expect to see increases in the utilization of preventive dental services, and a reduction in health inequities and improvement in overall oral health for our most vulnerable children. Our LDPP proposal is also designed to improve the quality of care that these residents receive once they access services, through an increase in services delivered in multiple languages, improved integration of oral health into primary care, and implementation of new quality improvement strategies in dental practices that serve our target population.

Having caries in the primary teeth is a risk factor for having caries in the permanent teeth and a lifetime of dental disease. To reduce this disease burden in the community at large, caries experience in the primary teeth must be reduced. Data from SF Kindergarten school screenings show 35% of Kindergarteners (5 & 6 year olds) have experienced caries, overwhelmingly in the primary teeth. Numerous studies have shown that children with preventive dental visits have less caries than children without preventive dental visits. Therefore, in order to reduce caries experience in the 0-5 population, prior to Kindergarten, the five pilot projects in this proposed project work together to increase the use of preventive dental services by the target population, Denti-Cal beneficiaries ages 0-5.

This comprehensive set of programs is ambitious, but completely achievable given the groundwork already laid through our SF COH Strategic Planning efforts. The table below highlights the scope of each pilot, and the cap on service provision where applicable.

Table 1. Scope of Pilots and Cap on Service Provision

Pilot	Scope	Cap
1: Access Collaborative	Limited to patients aged 0-5 who are Denti-Cal beneficiaries in each participating dental practice	N/A within participating practices
2: Care Coordination	Children referred to SFDPH for care coordination who are not currently utilizing preventive dental services. Ninety-five percent of San Francisco Medi-Cal beneficiaries are enrolled in Medi-Cal Managed Care plans and the remaining five percent are enrolled in fee-for-Service Medi-Cal. Using existing data we estimate that 62% of the 13,586 SF Denti-Cal beneficiaries ages 0-5 in Medi-Cal Managed Care plans (8,423 children) did not have a yearly dental visit. This includes children in the SFUSD preschool program and kindergarteners with caries.	The three health workers will be able to carry a total caseload of 450 total cases/month. This will allow us to contact up to approximately 4,500 children per year with this pilot
3: Health Promotion Messaging	The three health workers and Integration Technical Advisor will receive Health Promotion Messaging training. In turn, the three health workers will serve the caregivers of children described in Pilot 2 and the Integration Team Lead will serve primary care providers described in Pilot 4	For the three health workers the same caps as Pilot 2. For the Integration Technical Advisor N/A within participating practices
4: Increase Interprofessional Collaborative Practice	Limited to current patients aged 0-5 who are Denti-Cal beneficiaries in each participating primary care practice	N/A within participating practices
5: Incentivizing FQHC dual-users	Limited to current patients aged 0-5 who are Denti-Cal beneficiaries in each participating FQHC	N/A within participating practices

The following table provides estimates of the number of the 14,300 Denti-cal beneficiaries aged 0-5 that will be served by each pilot during each year of the DTI. Children may be served by multiple pilots in multiple years.

Table 2. LDPP Impact

Pilot	Year 1 2017	Year 2 2018	Year 3 2019	Year 4 2020	Total
1: Access Collaborative	0	720	2,160	2,160	5,040
2: Care Coordination (dental appt attended)	700	2,310	2,541	2,795	8,346

3: Health Promotion Messaging	0	210	441	695	1,346
4: Increase Interprofessional Collaborative Practice	469	1,547	1,702	1,873	5,591
5: Incentivizing FQHC dual-users	0	140	460	530	1,130
Total	1,169	4,927	7,304	8,053	

Our target population of Denti-Cal beneficiaries ages 0-5 will be identified and recruited through extensive outreach efforts both within the SFUSD preschool programs and elementary school Kindergartens, by primary care offices serving Medi-Cal Managed Care plan beneficiaries (SFHP and Anthem Blue Cross) , and within both private dental and primary care practices and FQHCs that serve Denti-Cal beneficiaries. More information about the details of outreach and identification of the target population is available in Section 3, in the description of each pilot program.

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

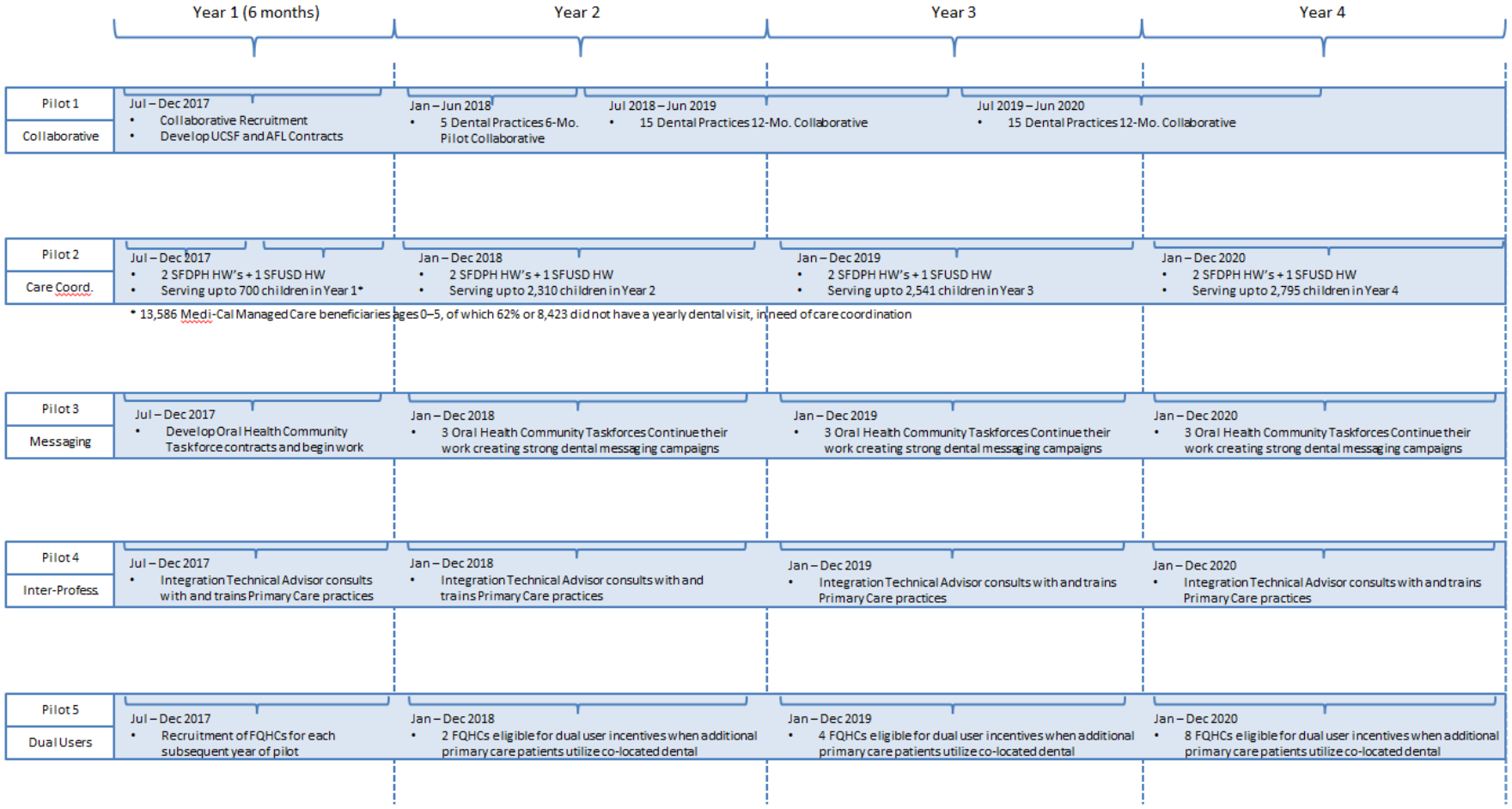
3.1 Services and Care Coordination

The five proposed pilot project activities align with, complement, and build upon our citywide collaborative work under the SF COH Strategic Plan, to both maximize the effort of our community partners and demonstrate the efficacy of our proposal's activities. As the Lead Agency for the LDPP, the SFDPH will provide overall coordination for each of the pilot projects.

The following page offers a 4-year timeline for the LDPP, with details of activities for each of the pilot projects throughout each year of the grant.

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

DTI SF Timeline



Pilot 1: Access Collaborative

The first pilot project aimed at increasing access to Denti-Cal preventive services for 0-5 year old Denti-Cal beneficiaries in San Francisco is the development of an Access Collaborative to improve quality of services within dental practices that serve large proportions of Denti-Cal beneficiaries. This pilot will utilize the Breakthrough Series Collaborative methodology[3] to teach dental practices in San Francisco how to implement efficient practice systems and provide preventive services to Denti-Cal beneficiaries in a sustainable manner. A key tenet of the Breakthrough Series Collaborative methodology is that while training is necessary, it is not sufficient to create lasting systems change. The Access Collaborative will provide dental practices with opportunities to learn and also *practice* the skills they need to integrate continuous quality improvement into their ongoing and daily work.

The Access Collaborative will leverage longtime existing partnerships between the San Francisco Community Clinic Consortium (SFCCC), which represents four Federally Qualified Health Centers (FQHCs) in San Francisco that provide dental services directly or through contracting; the San Francisco Health Network (SFHN), a series of 4 safety net health centers that include dental services for children run by the SFDPH; and the San Francisco Dental Society (SFDS), the local county society representing organized dentistry, primarily dentists in private practice. It will be coordinated by a subcontracting agency specializing in this type of work: AFL Enterprises. If funded, the LDPP will incentivize these partners to recruit safety net and private dental practices to participate in the Access Collaborative during the three years in which the pilot project will be conducted, through providing stipends to providers to cover a portion of practice revenues lost during attendance at the collaborative Learning Sessions that are critical to the project. Beginning with 5 pilot practices in the first half of year 2, LDPP efforts will spread to an additional 15 practices July of year 2 and again in July of year 3. By the end of the LDPP a large proportion of dental practices currently serving Denti-Cal beneficiaries in San Francisco will have participated in the Access Collaborative, if not other pilot projects.

Pilot 2: Care Coordination

Although there will be aspects of care coordination that run through most of the pilot projects, care coordination will primarily be implemented through this second pilot. This pilot involves the hiring of bilingual health workers (between them covering English, Spanish, and Cantonese) to provide coordination of care for 0-5 year old Denti-Cal beneficiaries and their caregivers, with the goal of increasing access to preventive dental care for this target population. In addition to typical care coordination activities, these health workers will also provide appointment compliance education and health promotion messaging.

Currently, approximately only 5% (715) of the approximately 14,300 Medi-Cal beneficiaries ages 0-5 in the City & County of San Francisco, those children with FFS Medi-Cal, are being care coordinated into dental care. Therefore Pilot 2 will begin to provide care coordination to the remaining 95% (13,586) of Medi-Cal beneficiaries ages 0-5, those with Medi-Cal managed care, who are not currently being care coordinated into dental care.

<u>Site A: SFUSD.</u> One 1.0 FTE bilingual health worker and a 0.1 FTE nurse coordinator will be located at the SFUSD and will coordinate access to dental care for all children with Denti-Cal benefits screened in SFUSD preschools, as well as dental referrals of Denti-Cal beneficiaries with untreated decay from the annual kindergarten screenings. The health worker must be placed in the school district offices because SFUSD policies limit contact for health related issues with parents/guardians to school district employees.

During the 2015-2016 school year, 1,600 children were enrolled in SFUSD pre-schools, of which approximately 50%, or 800 SFUSD preschool children, were Denti-Cal beneficiaries. Of the 376 preschool children screened, in 2015, 36% had caries experience and 30% had untreated tooth decay. During the 2015-2016 school year, 4,034 kindergarteners enrolled in the SFUSD were screened, of which 16%, or 645 children, had untreated tooth decay. Previous analyses of kindergarten screening data show a correlation

between low-income status and untreated decay; therefore, we project that a higher percentage of kindergarteners with untreated tooth decay are Denti-Cal beneficiaries than the general SFUSD population (50%). Assuming that 75% of kindergarteners with untreated decay are Denti-Cal beneficiaries, this means 484 kindergarten children will need care coordination into dental care. Therefore, the approximate number of children eligible for care coordination is 800 preschoolers and 484 kindergarteners, for a total of 1,284 children. With a caseload capacity of about 150 children/month over nine school months (1,350 children total), our SFUSD health worker should be able to contact all Denti-Cal beneficiaries in the SFUSD pre-schools and Kindergarteners with dental caries for care coordination into dental care in each year of the pilot project.

Site B: SFDPH. There will be two 1.0 FTE bilingual health workers located in the SFDPH offices, working to coordinate access to dental care for the rest of the Medi-Cal managed care plan beneficiaries ages 0-5 who are not currently being care coordinated into dental care. The SFDPH health workers will receive referrals from primary care providers, dental offices, community based organizations including First Five grantees, and other entitles. The SFDPH health workers will also be available to provide specialist care coordination between general practitioners and pediatric dentist and oral surgery specialists from SFDPH clinics and other providers as needed. The two health workers are anticipated to contact approximately 3,150 cases a year for care coordination. The SFDPH health workers will prioritize care coordination for children ages 1 to 3 and then children ages 4 and 5.

Training and support. Health Workers will be trained in skills needed to perform the essential duties of the project. Training will include how to enter data and manage the care coordination database as the HW move their clients from initial contact through successful completion of necessary dental care including preventive procedures. HWs will receive initial and then yearly training in motivational interviewing skills. Motivational interviewing is a counseling approach to engage clients, elicit change talk, and evoke motivation to make positive changes. As such it is well suited to engaging caregivers of children ages 0-5 to make and attend preventive dental care visits. HWs will also receive education on caregiver attitudes and beliefs that act as barriers to accessing preventive dental care for children ages 0-5 and training in culturally relevant messaging developed through Pilot 3 to address these barriers. The health workers will need a range of support skills, in order to most effectively coordinate care in a way that will increase access to preventive dental care for Denti-Cal beneficiaries age 0-5. Health workers will be trained on motivational interviewing techniques and health promotion content, in addition to ensuring familiarity with dental resources, policies, and procedures that will impact care for their patients. With these motivational interviewing skills, the health workers will work to understand individual barriers to appointment compliance and work with caregivers to mitigate issues; their health promotion skills will be useful when they determine that caregiver attitudes toward dental care for their children (i.e. that young children have no need to see a dentist) might influence appointment compliance. Many dental offices in San Francisco have noted that appointment compliance is a disincentive to participation in the Denti-Cal program for their patients, so this is an area upon which we plan to place considerable focus within our care coordination project.

Data-sharing. To avoid duplication of care coordination efforts between the health workers in Pilot 2, the process for establishing a data-sharing MOU between SFUSD and SFDPH has already been initiated. Both agencies' health workers will be in regular communication with each other and will follow the same protocol for both client intake, and documenting client contacts and referral outcomes. Because the health workers will be placed in two different agencies, two separate secure databases must be maintained. However, the data-sharing MOU will allow the health workers to contact each other and share whether specific clients are already in their client portfolio. Since the health workers placed at SFDPH will build a larger client base than the health worker placed at SFUSD, it is expected that the SFUSD health worker will more frequently contact the SFDPH health workers to determine if a child is already having care

coordinated by the SFDPH. One example of this would be following kindergarten and preschool dental screenings, when the SFDPH coordinator will send a list of children needing dental follow up to the SFUSD health worker. The SFUSD health worker will then reply to the SFDPH health workers with the list of children for whom she is already coordinating care. The SFDPH health workers can then check in the SFDPH database to see if the child has already been successfully contacted, and communicate the status of those children back to the SFUSD school health worker in order to eliminate duplication of case management services.

There are two other agencies in San Francisco that are currently conducting care coordination into dental care for children 0-5 including Denti-Cal beneficiaries. These are the local Head Start programs and the SFDPH Child Health and Disability Program (CHDP), which conducts care coordination for the approximately 500 children on Fee-for-Service Medi-Cal. When the LDPP health workers contact the parents/guardians of referred clients, one of the intake protocol questions will be to ask if other agencies are assisting the family to access dental care, to further reduce duplication of effort.

A database for care coordination will be developed based on an existing case management system used by the CHDP, and will be located on secure servers at both SFUSD and SFDPH. A care coordination protocol will be developed, including criteria for identifying ownership of a case, guidance on which health worker is responsible for children served by both entities, and procedures for conducting and documenting client intake, client contacts and referral outcomes.

Coordination between LDPP Lead and Care Coordinators: The data from both SFUSD and SFDPH Care Coordination databases will be submitted to the LDPP Project Coordinator and Data Manager both weekly and also in a Quarterly Report of numbers of children referred; contacts made and appointments kept, from both SFUSD and SFDPH LDPP Care Coordinators. This quarterly data report will be analyzed and discussed with both SF LDPP lead staff and Care Coordinators to investigate what were the most effective methods to reaching parents and linking to dental services, and to record and adapt these most effective strategies.

Pilot 3: Health Promotion Messaging

One of the ways we plan to increase utilization of Denti-Cal preventive services for 0-5 year olds is through promoting the importance of oral health for young children and by developing messaging to increase appointment compliance. To this end, we will use LDPP funding to develop culturally appropriate messaging in collaboration with local OH Community Taskforces. The three local OH Community Taskforces based in the Chinatown (Asian), Mission (Latino) and Bayview/HP (African-American) communities will be charged with developing culturally appropriate messages that promote children's oral health and address appointment compliance in a culturally sensitive manner. This messaging will be another component of the training that the health worker care coordinators (hired as part of Pilot 2) will receive, and will enhance and complement their motivational interviewing skills to encourage appointment compliance and promote oral health for young children. This messaging training will also be provided to the Integration Technical Advisor (Pilot 4) who can then share this information with primary care offices as part of the efforts to increase interprofessional collaboration.

The Taskforces have formed in response to the concern community leaders have related to disparities in oral health status present in the children in their communities; they represent three distinct communities that are suffering significant oral health disparities. As an example, the Chinatown Children's Oral Health Taskforce has developed the message *"Rethink your Asian (boba) Drink",* to highlight that boba drinks, popular in the Chinatown community, contain large amounts of added sugar.

Introduction to Pilots 4-5

In 2011 the Institute of Medicine recommended increasing the oral health competency of primary care providers as one strategy for increasing access to early preventive oral health services for vulnerable and underserved populations including interprofessional collaborative practice.[4] In 2014 the Health Resources and Services Administration (HRSA) announced the Integration of Oral Health into Primary Care Practice (IOHPCP) initiative for safety-net primary care providers. Building on that initiative, Pilots 4 and 5 focus on increasing interprofessional collaborative practice and integration between dental and primary care practices serving our target population. The clinical competencies under the Domain of Interprofessional Collaborative Practice include exchanging meaningful information among health care providers to identify and implement appropriate, high quality care for patients, based on comprehensive evaluations and options available within the local health delivery and referral system, and facilitating patient navigation in the oral health care delivery system through collaboration and communication with oral health care providers, and provide appropriate referrals, as stated in the HRSA integration of Oral Health and Primary Care Practice initiative.

The Medi-Cal/Denti-Cal provider network. San Francisco had 92 Denti-Cal service offices in 2015 according to California DHS data. Regular surveys by the local county CHDP office identify fewer providers, however, and indicate the Denti-Cal provider network is composed of 2 local dental schools, approximately 50 private dental offices, 4 FQHCs represented in the SFCCC, and 4 safety net community dental clinics serving children within the SFHN FQHCs. While there are 50 private practices that offer Denti-Cal services to children in SF, only 22 of these accept children less than 3 years of age. Thirty-two percent of San Francisco children age 0-5 insured through Denti-Cal are served through these private practices,[5] and we therefore felt it critically important to include private practices in our DTI intervention strategies. It is important to keep in mind that wait time at these practices and clinics can range from 1 – 2 months for a first visit.

The table below highlights the number of children served per year ages 0-5 who are Medi-Cal beneficiaries at each of the listed San Francisco primary care access points.

Table 3. San Francisco Primary Access Points for Children's Dental Services

Health Center	Focus Population: San Francisco Primary Care Medi Cal	Estimated # of Medi Cal children 0 5 served per year*
Native American Health Center (NAHC)	Serves primarily Native American and Hispanics- 1 main dental clinic that provides school based dental services to elementary and preschool sites	240
Northeast Medical Services (NEMS)	Serves primarily Chinese American and other Asian ethnic groups in SF - 6 primary care clinic locations – 2 dental clinics	2,794 (2,411 with co-located dental)
South of Market Health Center	Serves a smaller number of mixed ethnicities in two locations in the neighborhood south of Market Street – 2 primary care clinics and 1 dental clinic	260
Mission Neighborhood Health Center (MNHC)	Serves primarily Hispanic children. MNHC does not currently have a dental clinic, but is currently contracting with a co-located private Denti-Cal office to provide Denti-Cal services to their patients. - 2 primary care clinics and contracts with one private dental clinic	800
San Francisco Health Network (SFHN)	A network of safety net public health medical clinics, including four that also provided co-located children's dental services: Southeast Health	4,400 (675 with co-

* based on the average 2.5 visits per year, per https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. With a recommended 15 well child visits (in the six years when children are between ages 0-5), we estimate an average of 2.5 well child Medi-Cal visits per year.

	Center, Silver Ave Health Center, Chinatown Public Health Center, and Potrero Hill Health Center. SFGH sites do not have dental clinics.	located dental)
Private Clinics Serving Medi Cal Patients	Kaiser, UCSF, St. Luke's, St. Anthony's and other Private MDs – 22 medical clinics and private MD offices spread across SF – 0 dental clinics	5,092
	TOTAL	**13,586**

*These numbers were supplied by the San Francisco Health Plan which serves 95% of SF Medi-Cal child beneficiaries in San Francisco.

The UCSF Pediatric Dentistry Clinic, the University of the Pacific Pediatric Dental Clinic, NAHC Dental Clinic, and Children's Choice Dental Clinic are the only four clinics in San Francisco that have board certified pediatric dentists serving children insured through Medi-Cal who need hospital-based dental services. UCSF offers both conscious sedation treatment and hospital dental treatment for the entire northern California region, providing care to children as far away as Merced. There is currently a 4-6 month wait for hospital dental services through UCSF. NAHC and University of the Pacific also provide limited hospital dental treatment through California Pacific Medical Center (CPMC) hospital system. When possible, these providers will also be included in the Access Collaborative to improve quality of dental care for our target population.

Pilots 4 and 5 would each leverage the existing partnerships of the entities above, the San Francisco Health Plan, the Medi-Cal Managed Care plan for 95% of Medi-Cal beneficiaries ages 0-5 in San Francisco and the SF COH Strategic Plan integration workgroup. The San Francisco Community Clinic Consortium (SFCCC) will recruit community-based practices to participate in the projects to increase the number of FQHC dual primary care-dental users (Pilot 5). The San Francisco Health Plan will help recruit private medical practices for training to Increase Interprofessional Collaborative Practice (Pilot 4). The SF COH Strategic Plan integration workgroup will support Pilot 4 with primary care champions, along with the guidance of the Integration Technical Advisor from UCSF, as the workgroup already contains several physician champions working in both safety net and private practice settings with expertise in oral health clinical competency training .

Pilot 4: Increase Interprofessional Collaborative Practice

Pilot 4 will utilize a 0.15 FTE (0.175 FTE in year 1) Integration Technical Advisor and a series of local primary care champions to teach the oral health competencies for Interprofessional Collaborative Practice including how to exchange meaningful information among health care providers to identify and implement appropriate, high quality care for patients, based on comprehensive evaluations and options available within the local health delivery and referral system, and how to facilitate patient navigation in the oral health care delivery system through collaboration and communication with oral health care providers, and provide appropriate referrals. The ITA will be an MD with expertise in Electronic Medical Records (EMR) systems, who has local working knowledge of implementing clinic workflows that incorporate Interprofessional Collaborative Practice in a variety of medical settings, and experience providing technical assistance to clinical providers. The work of the ITA will be supported by primary care champions (in-kind) who are currently members of the SF COH Strategic Plan integration workgroup. The primary care champions will then train providers and support staff on how to approach caregivers with culturally relevant messaging, developed in Pilot 3, that address barriers to successful referral of Medi-Cal beneficiaries ages 0-5 for preventive dental services and will train offices in methods for identifying Denti-Cal providers near their offices. During pilot implementation, the ITA will support the local primary care champions and the clinics directly, and will troubleshoot workflow and reporting issues that might arise when needed and the ITA will attend the monthly LDPP Coordination Committee meetings for the

length of the LDPP.

Pilot 5: Incentivizing FQHC Dual-Users

The fifth and final pilot project will incentivize increased referrals between the primary care and dental clinics in local FQHCs to increase the proportion of dual primary care-dental users. Currently there are nine FQHC clinics in San Francisco with co-located primary care and dental clinics that serve large proportions of San Francisco's Medi-Cal beneficiaries. This project will incentivize clinic sites to increase the proportion of Medi-Cal beneficiaries age 0-5 with both a primary care and a dental visit in the same 12-month period. The FQHCs initiated in years 2 and 3 will continue into year 4, and the incentives will apply to 0 FQHCs in year 1, 2 FQHC in year 2, 4 FQHCs in year 3, and 8 FQHCs in year 4.

How the pilot projects work together to address the goals of the DTI. The SF LDPP addresses each of the following stated goals of the DTI through our five pilot projects, including:

1) Improve access to dental care,
2) Increase the use of preventive dental services for children,
3) Prevent and treat more early childhood caries,
4) Increase continuity of care for children, and
5) Utilize performance measures to drive delivery system reform.

Each one of the five pilot projects has a specific role in achieving the goal of improving the dental health for Denti-Cal beneficiaries ages 0-5 in San Francisco by increasing the use of preventive dental services. Pilot 1 will train participating dental offices in quality improvement methods to create systems that will create capacity to increase number of clients served and the amount of preventive services provided, as well as educate dental providers about evidence-based preventive interventions. Pilot 2 will utilize Health Workers (HWs) trained in motivational interviewing and in culturally appropriate messaging, developed by Pilot 3, to addresses caregiver barriers and case manage Denti-Cal beneficiaries (referred through interprofessional collaboration of Medi-Cal primary care providers, SFUSD nurses, and other agencies) into dental care. Pilot 3 will develop targeted, culturally relevant health promotion messaging aimed at caregivers of Denti-Cal beneficiaries ages 0-5 to increase utilization of preventive dental care based on information derived from caregivers themselves. Pilot 4 will utilize peers to educate and train primary care providers who have much more frequent contact with the target population of children ages 0-5 to increase interprofessional collaborative practice and knowledge of dental referral resources to increase utilization of preventive dental care. Pilot 5 will increase interprofessional collaborative practice by incentivizing FQHCs with co-located primary care and dental services to develop and implement systems change to increase the percentage of dual user receiving preventive dental care.

We will improve access to dental care and increase the use of preventive dental services for children primarily through three of our projects: three bilingual health worker care coordinators assigned to SFUSD and SFDPH (Pilot 2), an incentive program to increase referrals for dental care from primary care providers (Pilot 5) and an increase in dental health messaging for caregivers of Denti-Cal beneficiaries age 0-5 (Pilot 3) addressing barriers to accessing preventive dental care.

We will prevent and treat more early childhood caries through the Access Collaborative (Pilot 1), which will train dental practices in the most current evidence based techniques to prevent early childhood caries, and use quality improvement tools to develop of practice systems to increase capacity to provide more preventive care.

Finally, we will utilize performance measures to drive delivery system reform in numerous projects; the Access Collaborative (Pilot 1) will use a set of performance measures to drive change in participating practices. The FQHC dual primary care-dental users (Pilot 5) will also use performance measures to drive

change in participating practices. More information about specific performance metrics for each of the pilots is available in section 3.2.

3.2 Innovations, Interventions, and Strategies

Pilot 1: Access Collaborative

Quality improvement skills taught through the methodology utilized by the Access Collaborative (as described in Section 3.1) will be leveraged by participating dental practices to optimize the incentives they can receive for increased provision of preventive services to Denti-Cal beneficiaries under the DTI. As a result of this project, the practices will be able to increase the current scope of Denti-Cal preventive services provided to their patients aged 0-20 and benefit from the increased incentives provided under Domain 1.

Participants in the Access Collaborative will be recruited through the SFCCC for FQHCs, SFHN for safety-net dental practices, and through the San Francisco Dental Society for private dental practices. A mix of San Francisco's safety net dental clinics and private dental practices serving Denti-Cal beneficiaries aged 0-5 will be targeted each year of the DTI grant. Beginning with 5 pilot practices in year 2, and spreading to an additional 15 practices each in years 2 and 3, the Access Collaborative will train dentists and support staff on the Model for Improvement and other quality improvement tools will allow practices to develop systems to sustainably provide these preventive services to Denti-Cal beneficiaries.

AFL Enterprises is the proposed contractor to implement the Access Collaborative. The Breakthrough Series Collaborative framework consists of 3 two-day Learning Sessions where participants receive training from UCSF and other contracted faculty in clinical preventive practices such as infant oral health care, sealants and motivational interviewing. Additionally, practices will learn the Model for Improvement and other quality improvement tools that will allow them to develop systems to sustainably provide these preventive services to Denti-Cal beneficiaries 0-5. Participating practices will receive scholarships to offset a portion of lost practice revenues for dental practices participating in the Access Collaborative Learning Sessions. The San Francisco Community Clinic Consortium has shared that loss of practice revenues when attending non-mandatory trainings, is one key reason that administrators of its member clinics are reluctant to approve sending providers to external trainings. The data collection system implemented for practices to collect collaborative measure data will provide feedback to test further systems changes.

Quality Improvement. The entire Access Collaborative is a quality improvement activity. As such, practices will use Quality Improvement tools, such as PDSA (Plan, Do, Study, Act) cycles, to conduct small tests to develop the systems that will allow improvement on the collaborative measures. AFL Enterprises and collaborative staff will evaluate monthly the data that practices submit on the collaborative measure set as well as the practice's PDSA logs, to identify areas for improvement and suggest future PDSA tests. Furthermore, the core team of staff working on the Access Collaborative pilot implementation will work with the UCSF Data Monitoring and Reporting Core to develop a set of collaborative measures that drive change. The practices will report the measures monthly to UCSF. These measures will also be used as process measures for the LDPP and for monitoring and compliance.

Pilot 2: Care Coordination

As described previously, the second project under the Access strategy will involve hiring three bilingual health worker positions to provide care coordination for low-income 0-5 year old Denti-Cal beneficiaries within SFUSD as well as for children referred by primary care providers, dental offices, and community-based organizations including First Five grantees.

A key aspect of the care coordination will be encouragement of appointment compliance and follow-up after non-compliance to assess and address barriers. The health workers will receive training in motivational interviewing in order to use that approach when working with caregiver clients on non-compliance issues. Additionally, the health workers will receive training on culturally appropriate oral health messaging with content informed and developed in conjunction with the three local OH Community Taskforces. The taskforces are based in the Chinatown (Asian), Mission (Latino) and Bayview/HP (African-American) communities. These trainings will assist the health workers in understanding cultural beliefs and attitudes that may affect perception of preventive dental care, the importance of baby teeth, and other aspects of accessing dental care, as they work with caregivers to make and attend dental appointments.

Quality Improvement. Health workers will engage in regular, periodic quality improvement activities. Quarterly, in conjunction with their immediate supervisors, the health workers will identify an area of their work they feel needs improvement, and develop and run PDSA cycles and assess results. As described in section 3.1, a database for care coordination will be developed based on an existing CHDP case management system and will be located on secure servers at SFUSD and SFDPH. The database will include fields such as referral source, intake date, contact date, appointments made, appointment confirmed and referral outcomes. Data including referral outcomes will be sent to the UCSF Monitoring and Reporting Core on a monthly basis.

Pilot 3: Health Promotion Messaging

As described in section 3.1, in this pilot three local OH Community Taskforces will work to develop and disseminate culturally appropriate communications promoting the importance of oral health for young children as well as the importance of appointment compliance to the HWs and ITA. This messaging will be complementary to the motivational interviewing skills the health worker care coordinators will receive to encourage appointment compliance with caregivers and promote oral health for young children.

Quality Improvement. The SFDPH Project Coordinator will monitor the messaging developed by the OH Community Taskforces and if the agreed-upon quantity or quality of messaging is inadequate the SFDPH Project Coordinator will work with the 3 OH Community Taskforces to improve deliverables. If messaging is not impacting appointment compliance metrics for the health workers, the OH Community Taskforces will be directed to review and revise message content. In a separate project, the SF COH Collaborative is currently working with UC Berkeley and the COH Chinatown Community Task Force to develop a standardized caregiver survey protocol, which will be tested and used to improve the efficacy of children's oral health messaging for caregivers. The results of this survey will be utilized by the OH Community Taskforces to inform development and revision of messaging during the LDPP.

Pilots 4: Increasing Interprofessional Collaborative Practice

While the Institute of Medicine has recommended increasing the oral health competency of primary care providers as one strategy for increasing access to early preventive oral health services for vulnerable and underserved populations including interprofessional collaborative practice, these innovative strategies have not been widely adopted.[6] Pilot 4 focuses on increasing interprofessional collaborative practice between dental and primary care practices serving the target population of Medi-Cal beneficiaries ages 0-5. Primary care practices receiving traning under this project will learn the clinical competencies to be able to exchange meaningful information between health care providers to identify and implement appropriate, high quality care for patients, based on the options available within the local health delivery and referral system, and training on how to facilitate patient navigation in the oral health care delivery system through collaboration and communication with oral health care providers, and provide appropriate referrals. Practices will learn how to identify Denti-Cal providers in their communities.

Primary care practices will generate referrals of children 0-5 to the SFDPH health workers performing care coordination. Primary care providers and support staff will receive training on how to approach caregivers with culturally relevant messaging, developed in Pilot 3, that address barriers to successful referral of Medi-Cal beneficiaries ages 0-5 for preventive dental services to increase the probability of completed dental referrals.

Quality Improvement. To support the practices participating in acquiring the oral health competencies necessary to increase interprofessional collaborative practice and to provide support for implementing the most efficient clinical systems for referral, local primary care champions will be providing in-kind training and technical assistance to the participating practices as needed. If during random chart review, referral data integrity is unverifiable or does not increase from baseline, the relevant practice will be contacted and appropriate staff will be surveyed for "root causes" (e.g. miscommunication between medical staff and health workers, staff turnover, or lack of knowledge) and either retrained, technically supported, and/or flagged for more frequent monthly monitoring.

Pilot 5: Incentivize FQHC Dual-Users

Pilot 5 will incentivize increased referral between the primary care and dental clinics in local FQHCs to increase the proportion of dual primary care-dental users. This project will incentivize clinic sites to increase the proportion of Medi-Cal beneficiaries age 0-5 with both a primary care and a dental visit in the same 12-month period. Since all departments in FQHCs share the same registration and billing systems, it will be possible to compute on a yearly basis the number of unduplicated users age 0-5 who are Medi-Cal beneficiaries that had both a primary care and a dental visit in the same year. This is why this pilot is limited to FQHCs.

Quality Improvement. To support the practices local primary care champions under the guidance of the Integration Technical Advisor will be providing training and technical assistance to the participating practices as needed. If during random chart review, dual-user data integrity is unverifiable or incentivized interventions do not increase from baseline, the relevant practice will be contacted and appropriate staff will be surveyed for "root causes" (e.g. miscommunication between medical staff and dental clinic, staff turnover, or lack of knowledge) and either retrained, technically supported, and/or flagged for more frequent monthly monitoring.

Data Collection, Monitoring, and Reporting

A team led by the University of California San Francisco (UCSF) School of Dentistry, in collaboration with the SFDPH, will support all data collection, monitoring, and reporting activities throughout the LDPP. Funding through this grant will support UCSF to be the centralized repository for LDPP data and support UCSF faculty in compiling data relevant to DTI performance metrics, generating reports, and collaborating with SFDPH to inform implementation of quality improvement plans.

LDPP funding will support an epidemiologist based at SFDPH to conduct more in-depth and timely monitoring of SFUSD pre-school and kindergarten screening data to inform LDPP priorities. The SFDPH epidemiologist will also monitor the final outcome measures of reduction in caries prevalence and caries disparities as measured in the annual K dental screening. The Access Collaborative will generate its own set of process measures, as the collaborative methodology specifically includes the use of measures to drive change. Therefore, participating practices in the Access Collaborative will also be reporting on specific metrics related to improvement in delivering preventive interventions.

The major data collection and monitoring partners will be UCSF, SFDPH, SFUSD and AFL Enterprises, the

proposed contractor implementing the Access Collaborative. If funded, UCSF will commit faculty and staff FTE to the LDPP data collection and monitoring activities. SFDPH will commit to hiring an epidemiologist dedicated to oral health data. The SFUSD will continue its current MOU with SFDPH to allow collection and analysis of pre-school and kindergarten screening data. Finally, the contractor managing the Access Collaborative will be required to submit measure data to the data collection and monitoring team.

UCSF will securely house, clean, and monitor the data and produce regular reports that will be disseminated to the LDPP coordinating committee and the Advisory Committee. UCSF faculty will collaborate with the SFDPH to develop and implement quantitative performance metrics for LDPP projects that are consistent with the performance metrics of the three DTI domains (Table 3). For example, reports will feature the number and percent of eligible dentists participating in the Access Collaborative, and the number of children within those practices who return for an annual periodic oral examination.

The epidemiologist based at SFDPH will be responsible for more in-depth and timely monitoring of SFUSD pre-school and kindergarten screening data to inform LDPP priorities. S/he will monitor the final outcome measures of caries prevalence and caries disparities as measured in the annual K dental screening. The SF DTI Advisory Committee will review reports quarterly. Input from this group, as well as SF DTI Dental Consultant and UCSF Data Team, will advise the SFDPH to adjust reports appropriately.

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Performance Metrics

The table below outlines the stated goals, anticipated outcomes, data that will be used to measure whether each of the five pilot projects are having the intended impact, and the frequency of performance metric measurements throughout this program.

Table 4. PEFORMANCE METRICS									
Pilot	Goals	Outcomes	Performance Metric	Annual Target Benchmarks				Frequency	Data Source
				Yr 1	Yr 2	Yr 3	Yr 4		
1: Access Collaborative	• Teach dental practices QI • Increase number of evidence-based preventive procedures performed • Increase number of children receiving preventive services	• Practices participate in Access Collaborative • Practices sustainably provide evidence-based preventive procedures	Number of dental practices that participate in Access Collaborative (total)	-	5	20	35	Weekly calls during period of Access Collaborative recruitment	• Learning Session attendance sheets
			Number of participating dental practices with attendance at all Learning Sessions (yearly)	-	5	15	15	After each learning session	• Learning Session attendance sheets • PDSA logs
		• Increase number of evidence-based preventive procedures performed	*Participating dental practices measure set:* • % children 0-5 receiving preventive service	-	90%	90%	90%	Monthly	• Collaborative measure set
		• Increase number of children receiving preventive services	• % increase in children receiving preventive service from baseline	-	10%	10%	10%	Monthly	• Collaborative measure set

2: Care Coordination	• Increase access to dental care for Denti-cal beneficiaries 0-5	• Children are care coordinated into dental care	• Applicability of MI training	-	4.25 out of 5	4.25 out of 5	4.25 out of 5	Yearly at minimum	• Post-training evaluation survey
			Care coordination database client metrics: • # clients referred to case management	4500	4500	4500	4500	Monthly	• Care coordination database
			• # clients contacted	1133	3400	3400	3400	Monthly	• Care coordination database
			• # clients appointed	933	3080	3176	3288	Monthly	• Care coordination database
			• # clients attending dental visit	700	2310	2541	2795	Monthly	• Care coordination database
3: Health Promotion Messaging	• Develop culturally appropriate COH promotion messages including appointment compliance • Health workers & ITA trained in culturally appropriate COH promotion messages including appointment compliance	• Content is developed • HW receive training on health promotion messaging	Training evaluations for COH Taskforce on culturally appropriate messaging	8.5 out of 10	8.5 out of 10	8.5 out of 10	8.5 out of 10	Yearly at minimum	• Training evaluations
4: Increase Interprofessional Collaborative Practice	• Primary care practices refer clients to dental care	• Primary care practices receive training on Interprofessional Collaboration & referring	Training evaluations on Interprofessional Collaboration	4 out of 5	4 out of 5	4 out of 5	4 out of 5	After each training session	• Training evaluations

		clients							
5: Incentivizing FQHC Dual Users	• Increase collaboration and infrastructure between PC-dental in FQHC	• Increase proportion of dual PC-dental users 0-5 in FQHC	Percentage increase in FQHC Dual primary care-dental users from baseline year	-	10%	20%	30%	Quarterly	• EHR /registration data from FQHCs
Overall DTI LDPP Outcomes (from SF COH Strategic Plan)	• Improve dental health for Denti-Cal beneficiaries ages 0-5 in San Francisco	• Increase the use of preventive dental services	Number Denti-Cal beneficiaries receiving preventive intervention (DTI Domain 1)	*Awaiting Denti-Cal figures (State-based benchmarks still TBA)*				Yearly	• California Department of Health Services
			Percentage of children on Denti-Cal ages 0-5 who receive a dental service during the past year (from 48% in 2012)	48%	50%	54%	58%	Yearly	• California Department of Health Services
		• Decrease early childhood caries experience in Kindergarteners	Percentage of kindergarteners with untreated tooth decay (from 16% in 2015)	16%	13%	11%	8%	Yearly	• K Screening data
			Percentage of kindergarteners with caries experience (from 34.9% in 2015)	34.9%	33%	31%	30%	Yearly	• K Screening data
			Gap in caries experience between white and non-white kindergarteners (from 23% in 2015)	31.6%	29.6%	27%	24%	Yearly	• K Screening data

The goals, outcomes and performance metrics for analyzing the success of the pilot project are consistent with and build upon the performance metrics of the three DTI domains, and are not wholly redundant of the approaches taken in the three domains. The proposed projects are not redundant of Domain 1, and the quality improvement skills learned in the Access Collaborative should assist individual practices to improve their performance in receiving Domain 1 incentives.

3.3 Accountability

The SF LDPP will have two separate Monitoring Divisions for ensuring accountability. First, the SFDPH Contract Office Monitoring Division will monitor all city contracted vendors and internal MOUs. This includes direct contracts with AFL Enterprises and UCSF. Second, the SFDPH LDPP coordination group, composed of the LDPP program coordinator, LDPP data manager, fiscal analyst and dental consultant, will lead compliance monitoring for subcontractors and work with direct supervisors to monitors activities of SFDPH employees; this will specifically include periodic auditing by the dental consultant. The following table describes the monitoring plan including frequency of monitoring.

Table 5. MONITORING MATRIX

Pilot	Vendor/ Activity monitored	Direct Contract	SFDPH Employee	Who Monitors	Frequency	For what?
1: Access Collaborative	AFL Enterprises/ Collaborative	X		SFDPH Contract Office Monitoring Division	Annual	Meeting collaborative timeline & deliverables
	SFCCC & SFDS/ Collaborative recruitment incentives			AFL Enterprises and SFDPH Fiscal Analyst	Quarterly	Meeting recruitment timeline & deliverables
	Collaborative dental practices/ Scholarships			AFL Enterprises and SFDPH Fiscal Analyst	Quarterly	Attendance at collaborative Learning Sessions
2: Care Coordination	Health Worker SFDPH/Care Coordination		X	SF LDPP Program Coordinator & immediate supervisor	Monthly	Supervision and SOW, Deliverables Direct DPH employees: performance reviews
	Health Worker & Nurse manager SFUSD/Care Coordination	X		SFDPH Contract Office Monitoring Division	Annual	Supervision and SOW and Deliverables
3: Health Promotion Messaging	COH Taskforces / Culturally appropriate messaging, tools	X		SFDPH Contract Office Monitoring Division	Annual	Meeting promotion deliverables
4: Increase Interprofessional Collaborative Practice	SF COH Strategic Plan integration workgroup/ PC office Trainings/ Integration Technical Advisor	X		SF LDPP Program Coordinator & SFDPH Contract Office Monitoring Division	As trainings occur & Annual	Primary care office attendee lists, evaluations Meeting deliverables
5: Incentivizing FQHC Dual Users	FQHC/Dual primary care-dental user	X		SFDPH Contract Office	Annual	Random sample EDR/EMR or chart review to verify that

	incentives			Monitoring Division for external FQHC & SFDPH Program Coordinator for SFDPH FQHCs		both primary care and dental user. Verify data integrity.
Data Collection, Monitoring and Reporting	SFDPH Epidemiologist/ Analysis & Reporting		X	SF LDPP Program Coordinator & immediate supervisor	Annual	Supervision and SOW, Deliverables Direct DPH employees: performance reviews
	UCSF Data Monitoring & Reporting Core	X		SFDPH Contract Office Monitoring Division	Annual	Meeting data monitoring and reporting timeline & deliverables
Project Coordination	LDPP program coordinator LDPP data manager LDPP fiscal analyst Dental Consultant		X	Supervisor of each employee, SFDPH Dental Director and LDPP Advisory Committee	Annual	Supervision and SOW, Deliverables Direct DPH employees: performance reviews

Quality Improvement. Using performance measures and data from UCSF for each of pilot programs, SFDPH and AFL Enterprises staff will identify areas that need improvement on a monthly or quarterly basis (whether timing is monthly or quarterly will be a function of the nature of the pilot programs and performance metrics). The UCSF Data Monitoring and Reporting Core will compile monthly performance reports for each of the pilot programs. The LDPP Lead Entity (SFDPH) will review the monthly reports to identify underperforming sites. Benchmarks for adequate progress will be based on established baseline performance (measured during recruitment and enrollment) and agreed-upon improvement goals. Benchmarks will be revisited and updated as needed, no less than annually, to maintain relevance throughout implementation of the LDPP pilots programs.

Aggregate de-identified performance reports will be shared with program components for use in developing quality improvement strategies. For example, dental practices enrolled in the Access Collaborative will receive a monthly aggregate report showing the combined performance of the Collaborative, as well as an individual report demonstrating metrics for only for their particular practice.

Table 6 details the quality improvement plan, including how data will be used to adjust and modify pilot project activities when deficiencies are identified.

Table 6.	**QUALITY IMPROVEMENT**		
Activity	**Data source**	**How data will be used to adjust and modify pilot project activities**	**Frequency**
1: Access Collaborative	Learning Session evaluations	Subsequent learning sessions will incorporate and document needed refinements according to feedback from both instructors and dental practices.	After each Learning Session
	Quantitative data: Numbers	SFCCC & SFDS will report referral efforts; number of	30 days after

	of clinics/offices/staff that both commit to attending training, attend 80% of trainings and subsequently implement skills; keep to timeline.	emails, letters and newsletters used to recruit; AFL Enterprises will report numbers applying; asking applicants what medium they responded to. Coordinator will collect this information and share recommendations w/ SFCCC & SFDS to alter approach.	start of each Access Collaborative
	Qualitative data from participating practices and quantitative scholarship data.	Using attendance from Learning Sessions data, and qualitative self-reporting from dental practices.	After each Learning Session
2: Care Coordination	Numbers and % of children within SFDPH who have kept appointments	If found during monthly performance review that Care Coordination deliverables are not being met, health worker will be surveyed to target root cause of inadequate deliverables with PDSA action to improve, and reviewed at 2 weeks, intervals.	Monthly
	Numbers and % of children within SFUSD who have kept dental appointments	If found during monthly performance review that Care Coordination deliverables are not being met, health worker will be surveyed to target root cause of inadequate deliverables with PDSA action to improve, and reviewed at 2 weeks, intervals.	Monthly
3: Health Promotion Messaging	Evaluation of cultural relevancy trainings for health workers provided by COH Taskforces. Number of no-shows from health worker care coordination database	Subsequent trainings will incorporate and document needed refinements according to feedback from health workers. If no-show numbers and/or percentages do not improve yearly, will review training materials to determine whether health workers are appropriately addressing appointment compliance with caregivers.	Quarterly & annually
4: Increase Interprofessional Collaborative Practice	Evaluation data from training participants	Primary care office attendee lists, evaluations will be reviewed after each training, in addition an office check-in by trainer at one month and at 3 months, following initial training. If staff requests more training or one on one skills building, staff will be retrained.	After each training; 1-mo. Follow-up; 3-mo. Follow-up
5: Incentivizing FQHC Dual Users	Quantitative data from FQHCs	If chart review data integrity is unverifiable and/or incentivized increases from baseline are not being met, practice will be contacted, surveyed for "root causes" and either retrained, technically supported, and flagged for monthly monitoring.	Yearly
Data Collection, Monitoring, and Reporting	Completion of written and graphical reports on SFUSD pre-school and K screening data focusing on caries prevalence and caries disparities.	SF LDPP Advisory Committee will review reports before dissemination. Input from this group as well as SF LDPP Dental Consultant, and Integration Technical Advisor will inform revisions.	Yearly at minimum and more often if needed.
	Written and graphical report on the utilization data for both dental and medical preventive services received by 0-5, for all incentivized interventions.	SFDPH Epidemiology team and SF LDPP Advisory Committee will review reports quarterly. Input from this group as well as SF LDPP Dental Consultant will inform revisions.	Quarterly
Project Coordination	SFDPH Project Coordination staff: SOW assignment /project completion data spreadsheet, review, based on completed targeted dates and tasks.	If during SOW supervision by DPH supervisor, completed deliverables have not been met, a performance plan will be developed to trouble shoot areas needing improvement, and staff progress will be reviewed monthly following performance plan initiation.	Quarterly

Detailed methods to ensure compliance with STC 109 and agreement with DHCS. The SF LDPP will be monitored and reported to DHCS both quarterly and annually, as per our attestation agreement and via the monitoring system demonstrated in Monitoring Matrix Table (Table 5) above. As the lead entity, SFDPH

will be responsible for ensuring compliance with the STC 109 requirements of the grant and will be reviewing the reports from UCSF Monitoring and Reporting Core, and SFDPH Epidemiology Team to evaluate each of the outcomes on a monthly basis. We will report up-to-date results on a quarterly basis to the SF LDPP Advisory Committee to ensure achievement of the performance metrics and benchmarks listed in the Performance Monitoring Table (Table 8, in Section 4.1).

The San Francisco Department of Public Health is either participating in currently or has an application under review for three other Medi-Cal Waiver programs: PRIME, Whole Person Care, and Global Payments Program that will comply with STC 109. This Denti-Cal LDPP DTI program is designed to be and will be administered in compliance with STC 109 requirements (a) through (f).

Ensuring timely, medically necessary care for the target population. The hiring of the three bilingual health worker positions through the LDPP (Pilot 2) is a key strategy to ensure that the target population of Denti-Cal beneficiaries 0-5 receives timely, medically necessary dental care. Multiple barriers hamper early access to dental care. These include difficulty with the English language and low literacy levels, making it difficult to navigate the dental care delivery system to access care. Other barriers are related to the dental care delivery system. Prior research has described barriers identified by caregivers of Medicaid-insured children during use of dental services, including excessive wait times, demeaning interactions with front office staff, and negative interactions with dentists, especially for families of certain racial and ethnic backgrounds.[7]

Barriers to accessing preventive dental care can also be individual, social or cultural; for example, perceived need, health literacy level, and fear. Culturally influenced factors that affect dental care utilization include behaviors, beliefs, attitudes and values, such as about the importance of primary teeth, value of preventive dental care of primary teeth, concern for oral health and dental knowledge.[8] For example, belonging to a group in which preventive oral health is not the norm or belonging to a population in which a condition such as tooth decay is endemic and may not be defined as illness are ways in which cultural issues can affect oral care.

Health workers will be prepared to address these barriers to accessing dental care, through training in motivational interviewing and cultural competency through technical assistance from the three local OH Community Taskforces. The health workers' bilingual skills will assist caregivers who have English language and literacy barriers to navigate the dental care delivery system, by contacting dental offices and making dental appointments. While making appointments, health workers will engage caregivers to assess barriers to accessing preventive dental care such as lack of perceived need, low oral health literacy level, caregiver fear of dental treatment for their children, and other previous negative dental office interactions. Using motivational interviewing techniques, beliefs, attitudes and values about the importance of primary teeth and the perceived value of preventive dental care of primary teeth will be elicited. Caregivers will be asked about provider language preference, and if requested, every effort will be made to attempt to achieve language congruency between caregivers and dental practices. Health workers will also make efforts to accommodate caregiver time of day and date of the week preferences for appointment making.

Another strategy to ensure that the target population receives timely, medically necessary dental care is to assure caregivers bring children to their dental appointments. Health workers will review with caregivers the importance of dental appointment compliance, and work with caregivers of children with frequent non-attendance, using motivation techniques to effect behavioral change in a culturally sensitive manner.

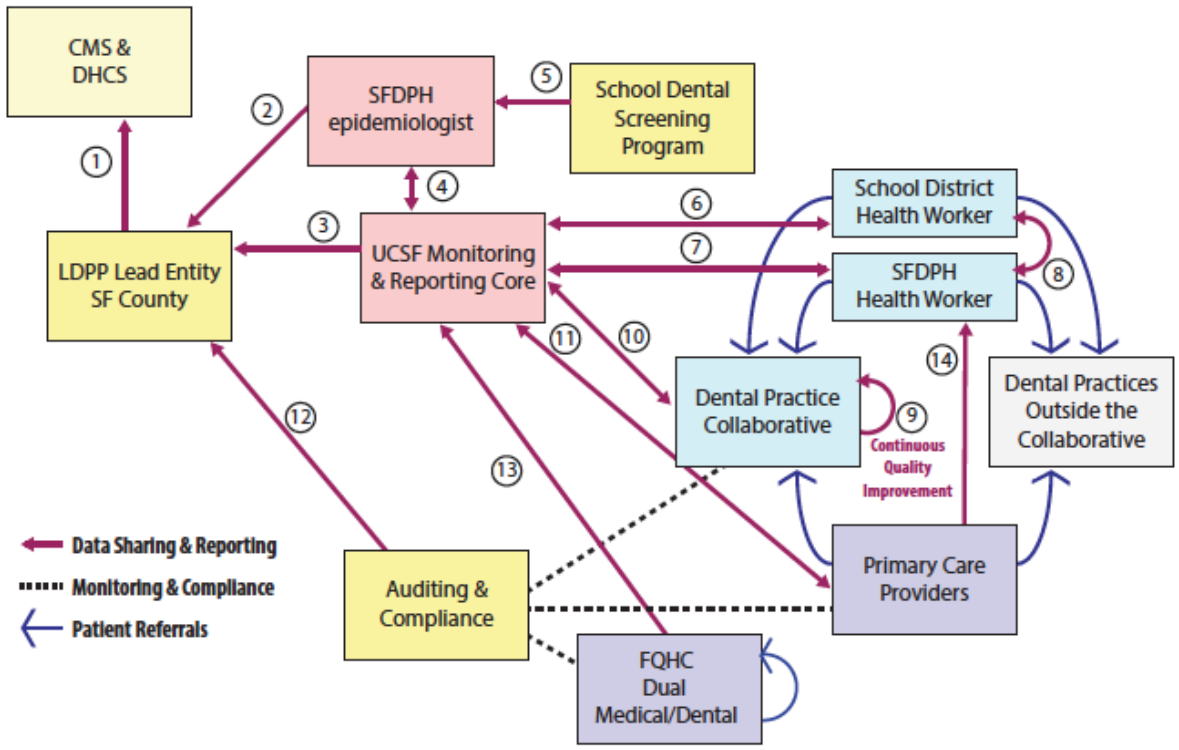
Finally, we will help ensure timely care for our target population through regular data review. SFDPH LDPP coordination staff, in collaboration with AFL Enterprises, will track wait times for routine and emergency appointments at the practices participating in the Access Collaborative (Pilot 1). Collaborative measures can be designed to drive practice changes that will create access to preventive care within a desired time frame, for example, within 30 days. For the rest of San Francisco's Denti-Cal provider network, the health worker care coordinators will report monthly on wait times, including for specialty pediatric dentistry care.

3.4 Data Sharing

Throughout the LDPP, all pilot projects will submit process data to the UCSF Monitoring and Reporting Core and to the SFDPH data manager at standard intervals. UCSF will complete data cleaning, aggregation, and produce regular reports that will go back to the SFDPH LDPP coordination team and the Advisory Committee. The UCSF Monitoring and Reporting Core will meet internally on a weekly basis to review operational and logistical tasks and to assess data quality for completeness and accuracy. The UCSF data monitoring team and SFDPH epidemiologist will then meet with representatives of the LDPP Lead Entity (SFDPH) on a monthly basis to review progress reports for each of the participating entities, and will hold as-needed meetings with those individual entities to ensure high performance and quality service delivery.

The figure below illustrates the flow of data among various participating entities in the LDPP. The red arrows demonstrate flow of data and reporting and are numbered.

Figure 5. Flow of San Francisco LDPP DTI Data



1. SF LDPP Lead Entity will report data from all 5 pilots to DHCS, on a quarterly and annual basis
2. SFDPH Epidemiology team will report data to LDPP Lead Entity
3. UCSF Monitoring and Reporting (M&R) Core will provide SF LDPP Lead Entity monthly reports, from all participating entities for quality improvement
4. SFDPH Epidemiology team will share SFUSD preschool & K screening data with UCSF M&R Core
5. SFUSD preschool & K screening data will be shared by SFDPH Dental Services with SFDPH Epidemiologist

6. SFUSD health worker will securely upload de-identified client referral records to the UCSF M&R Core
7. De-identified client referral data will be shared between SFDPH Health Workers and UCSF M&R Core
8. The SFUSD health worker and SFDPH health workers will share a secure database of client referrals to maximize collaboration and avoid duplication of effort. We are currently working with SFUSD to develop an MOU for data sharing, which will be executed by the time the project starts
9. Data will be shared within the Access Collaborative for quality improvement in participating dental practices
10. Aggregate de-identified performance data will be shared with participants in the Access Collaborative for quality improvement purposes
11. Primary Care data (Number of providers trained, etc.) sent to UCSF M&R Core
12. SF GOV Auditing records & SFDPH Business Office of Contract Compliance reports provided to SFDPH program contact (LDPP Lead Entity) for monitoring
13. FQHC data (Number and percentage) of dual Medical/Dental user sent to UCSF M&R Core
14. Client referral data securely sent from Primary Care providers to SFDPH Health Workers

More detail about the specific data that will be shared between the various participating entities is detailed in the table below. In setting up all DTI contracts and agreements, we will incorporate the required HIPAA language and DTI appendices.

Table 7.	**DATA SHARING**		
Pilot	**Activity**	**Data shared with UCSF M&R Core and SFDPH data manager**	**Intra project data sharing**
1: Access Collaborative	AFL Enterprises / Access Collaborative	Learning session attendance sheets / Learning Session evaluations / Access Collaborative measure set	Learning Session evaluations PDSA logs Access Collaborative measure set
	Recruitment incentives	Numbers of clinics/practices outreached Numbers of clinics/practices that commit	Between SFCCC/ SFDS and AFL Enterprises: Numbers of clinics/practices outreached Numbers of clinics/practices that commit
	Dental practice scholarships	AFL Enterprises reports to SFDPH data manager when Collaborative dental practice scholarships are paid	
2: Care Coordination	Health Workers SFDPH/Health Worker & Nurse manager SFUSD Care Coordination	Care coordination database / PHI	Between health workers (HW) at SFUSD & SFDPH (requires data sharing MPU), between HW and dental practices, between HW and caregivers. At SFUSD from pre-school & K screeners, school nurses to HW. At SFDPH from PCP offices, dental offices, caregiver self-referral: Names Denti-Cal beneficiaries 0-5/PHI
3: Health Promotion Messaging	COH Taskforces / Culturally appropriate messaging, tools	Evaluation of culturally appropriate health promotion messaging trainings for health workers.	Within COH Taskforces and between the three Task Forces: Evaluation of culturally appropriate health promotion messaging trainings for health workers.

4: Increase Interprofessional Collaborative Practice	Primary Care Champion trainings and Integration Technical Advisor assistance	Training session attendance sheets Training Session evaluations	Within SF COH Strategic Plan integration workgroup: Training Session evaluations
5: Incentivizing FQHC Dual Users	Dual-user incentives	Quantitative data from participating practices	Between SFDPH data manager and SF COH Strategic Plan integration workgroup
Data Collection, Monitoring, and Reporting	SFDPH Epidemiologist/ Analysis and Reporting	Pre-school & K screening data for LDPP outcomes measures. Publications reviewed by UCSF Monitoring and Reporting Core and SFDPH Project team	
	UCSF Monitoring and Reporting Core & SFDPH LDPP team	Will share LDPP data from all five pilot projects	

Evolution of data sharing. Data sharing is intended to expand throughout the length of the pilot, with additional dental and primary care practices being added in each year to pilots 1, 4 and 5. The monthly Coordination Committee will pay special attention to continuously improving data sharing plans and supporting data sharing among participating entities.

Relevance for Care Coordination. Continuous data monitoring and the frequent reporting schedule enable responsiveness to unanticipated challenges or potentially underperforming project components. The Lead and participating entities will be better positioned to achieve quality assurance/quality improvement goals for care coordination based on the availability of timely data. Reports will be tailored to specific needs and objectives of individual participating entities to maximize relevance and facilitate translation into actionable care coordination improvement plans.

Sustainable infrastructure for data sharing. The Access Collaborative will teach participating practices how to develop system infrastructure to collect and report on monthly measures to drive systems changes in the practices. For the SFUSD, the LDPP will fund the creation of a permanent care coordination health database, which can be utilized in the future to track care coordination for SFUSD enrollees. The project will also result in the development and implementation of a structured MOU between SFUSD and SFDPH to share PPI data for care coordination now and in the future. We have already seen positive step towards the creation of sustainable relationships that will lead to data sharing and other collaborations. In the process of planning and developing our LDPP proposal, we have reached out and established stronger relationships with two local entities, the SFCCC and the SFHP. These meetings have resulted in establishment of a regular meeting schedule and better communication that can only benefit the children we serve, as we plan for new ways to share data and plan collaborative projects. The LDPP has also allowed SFDPH to continue to strengthen its existing MOU/data sharing relationship with UCSF with regards to the kindergarten screening program data.

Data Governance. The Lead Entity, UCSF Monitoring and Reporting Core, SFDPH Epidemiologist, and other stakeholders will develop a formal plan for data governance at the onset of the LDPP. Broadly, the Lead Entity will maintain ownership of all collected data and takes ultimate responsibility for the integrity and security of the data. The UCSF Monitoring and Reporting Core will be responsibility for routine monitoring of the data for completeness, accuracy, and consistency, and will report any irregularities to the Lead

Entity in a timely manner. Each participating entity will be responsible for the security of the data that pass through their control. For example, the UCSF Monitoring and Reporting Core will store collected data as encrypted files on the secure UCSF campus network. UCSF Information Technology Services provides computing support services and security and software updates through the campus-wide high-speed network infrastructure. Cloud-based data sharing and storage technology allow personnel to manage data in a secure environment, minimizing the need to maintain confidential patient/client information on personal computers. Data will only by accessible to authorized personnel with defined roles in data collection, cleaning, monitoring, or generation of reports.

Anticipated data sharing challenges. In data sharing efforts it is critical to protect protected health information (PHI) at all stages and ensure that all participants fully understand how to store and protect PHI data on their own systems when producing aggregate data to share. We will develop a handout to share with all participating dental and medical practices at the beginning of each new interaction that may involve data sharing to minimize this risk. Lack of IT capacity is the other significant challenge in data sharing, and we are attempting to overcome that barrier through incentivizing data collection, and structuring payments around the achievement of preventative quality improvement targets.

Section 4: Progress Reports and Ongoing Monitoring

4.1 LDPP Monitoring

Monitoring data to assess the performance of pilot projects will be drawn from multiple sources, as described in previous sections. The LDPP Lead Entity will review progress reports compiled by the UCSF Analysis and Reporting Core and compare to specified benchmarks for acceptable performance on a routine basis.

The table below provides details about the performance metrics that will be used to assess progress for each pilot project, annual target benchmarks to be hit, process to provide technical assistance if needed, and corrective action to be imposed if required. **Data about performance measures and monitoring for each participating LDPP entity has already been provided in the table in Section 3.3.**

Table 8. PERFORMANCE MONITORING

Pilot	Performance Metrics	Annual Target Benchmarks				Process to provide technical assistance if poor performance is identified or to make subsequent adjustments	Frequency	Corrective action, termination
		Yr 1	Yr 2	Yr 3	Yr 4			
1: Access Collaborative	Total number of dental practices that participate in Access Collaborative	-	5	20	35	SFDPH LDPP staff work with SFCCC & SFDS to provide TA to determine barriers to participation by dental practices	Weekly calls during period of Access Collaborative recruitment	30-day clause to terminate SFCCC & SFDS agreement
	Number of participating dental practices with attendance at all Learning Sessions yearly	-	5	15	15	SFDPH LDPP staff and AFL Enterprises convey attendance expectations to practices before they commit; work with practices to ensure attendance	After each learning session	Practices that do not attend all Sessions may be terminated from the Access Collaborative
	Participating dental practices measure set:	-	90%	90%	90%	Practices not showing improvement in collaborative metrics over	Monthly	Although QI does not assign blame, practices that do

Pilot	Performance Metrics	Annual Target Benchmarks				Process to provide technical assistance if poor performance is identified or to make subsequent adjustments	Frequency	Corrective action, termination
		Yr 1	Yr 2	Yr 3	Yr 4			
	% children 0-5 receiving preventive service					time will receive technical assistance including coaching and site visits from Access Collaborative faculty and coaches		not show adequate improvement may mutually agree to separate from the LDPP
	% increase in children 0-5 receiving preventive service from baseline	-	10%	10%	10%			
2: Care Coordination	Motivational interviewing training evaluation	Average score: -	4.25 out of 5	4.25 out of 5	4.25 out of 5	SFDPH LDPP staff will work with MI trainers if training receives low evaluations scores to improve content and presentation	As needed after trainings	Trainers may be replaced if performance does not improve
	Care coordination database client metrics: • # clients referred to case management	4500	4500	4500	4500	SFDPH and SFUSD have protocols for developing improvement plans for employees that are not meeting job expectations, with subsequent reassessment and cycles of corrective action	Monthly assessment of data reports	Employees may be terminated for non-performance if all appropriate personnel policies are followed
	• # clients contacted	1133	3400	3400	3400			
	• # clients appointed	933	3080	3176	3288			
	• # clients attending dental visit	700	2310	2541	2795			
3: Health Promotion Messaging	Training evaluations for COH Taskforce re culturally appropriate messaging	Average score: 8.5 out of 10	8.5 out of 10	8.5 out of 10	8.5 out of 10	SFDPH LDPP staff will work with COH task forces if training receives low evaluations scores to improve content and presentation.	Monthly LDPP calls	30-day clause to terminate OH task force agreement
4: Increase Interprofessional Collaborative Practice	Training evaluations by primary care offices after support by primary care champions	Average score: 4 out of 5	4 out of 5	4 out of 5	4 out of 5	SFDPH LDPP staff will work with Integration workgroup members and Integration Technical Advisor if training receives low evaluations scores to improve content and presentation	As needed after trainings	Trainers may be replaced if performance does not improve
5: Incentivizing FQHC Dual Users	Percentage increase in FQHC Dual primary care-dental users from baseline year	-	10%	20%	30%	Practices not showing improvement in yearly percentage increase will receive technical assistance on best practice strategies from LDPP staff supported by online resources from national orgs	Quarterly check in with practices Yearly metrics review	Practices not showing yearly improvement in percentage increase may be terminated from the LDPP
Overall DTI LDPP Outcomes (from SF COH Strategic Plan)	Number Denti-Cal beneficiaries receiving preventive intervention (DTI Domain 1)	*Awaiting Denti-Cal figures (State-based benchmarks still TBA)*				Assuming yearly DTI Domain 1 data is available from DHCS, if there is lack of progress in meeting the annual target benchmarks SFDPH LDPP staff and the	Yearly	N/A

Pilot	Performance Metrics	Annual Target Benchmarks				Process to provide technical assistance if poor performance is identified or to make subsequent adjustments	Frequency	Corrective action, termination
		Yr 1	Yr 2	Yr 3	Yr 4			
						LDPP Advisory Committee will reassess the pilot activities and in collaboration with the State may consider alternative pilots		
	Percentage of kindergarteners with untreated tooth decay (from 16% in 2015)	16%	13%	11%	8%	Since this LDPP Outcome is based on the SF COH Strategic Plan, lack of progress in meeting the annual target benchmarks SFDPH LDPP staff and the SF COH Strategic Plan ICC will reassess the activities of the LDPP and may consider modifying or revising projects	Yearly	N/A
	Percentage of kindergarteners with caries experience (from 34.9% in 2015)	34.9%	33%	31%	30%	Since this LDPP Outcome is based on the SF COH Strategic Plan, lack of progress in meeting the annual target benchmarks SFDPH LDPP staff and the SF COH Strategic Plan ICC will study the broad environment and reassess the activities of the LDPP and may consider modifying or revising projects	Yearly	N/A
	Gap in caries experience between white and non-white kindergarteners (from 31.6 in 2015)	31.6%	29.6%	27%	24%	Since this LDPP Outcome is based on the SF COH Strategic Plan, lack of progress in meeting the annual target benchmarks SFDPH LDPP staff and the SF COH Strategic Plan ICC will study the broad environment and reassess the activities of the LDPP and may consider modifying or revising projects	Yearly	N/A

Pilot	Performance Metrics	Annual Target Benchmarks				Process to provide technical assistance if poor performance is identified or to make subsequent adjustments	Frequency	Corrective action, termination
		Yr 1	Yr 2	Yr 3	Yr 4			
	Percentage of children on Denti-Cal ages 0-5 who receive a dental service during the past year (from 48% in 2012)	48%	50%	54%	58%	Since this LDPP Outcome is based on the SF COH Strategic Plan, lack of progress in meeting the annual target benchmarks SFDPH LDPP staff and the SF COH Strategic Plan ICC will study the broad environment and reassess the activities of the LDPP and may consider modifying or revising projects	Yearly	NA

4.2 Data Analysis and Reporting

Data Collection Plans and Timeline. Data collection and analysis will commence simultaneously with the implementation of the pilot projects and occur across the multiple components of the SF LDPP. Collected data will be used for calculating progress toward LDPP target outcomes (for example, as compiled in quarterly and annual reports) and for continuous quality improvement (for example, via passing aggregate reports back to care coordinators and dental providers to inform potential modifications to program strategies and tactics, as needed, in response to accumulated evidence).

Specific timelines for data collection will be tailored for each LDPP project, with data reporting frequencies reported in Table 8. For example, the Access Collaborative (Pilot 1) will recruit 5 practices in Year 2, beginning a period of continuing data collection and monitoring. Performance measures will be compiled and analyzed for monthly reports. A more intensive period of data analysis will precede the preparation of detailed reports annually.

Data security. All data management, analysis, and storage will take place on encrypted computers and password-protected files. To the greatest extent possible, analysis will be completed using de-identified datasets that have been stripped of names, encounter dates, Medi-Cal beneficiary numbers, chart numbers, birth dates, addresses, or any other potentially identifiable information. Communication between SF LDPP entities will occur over secure email only. For data analysis that occurs at the UCSF School of Dentistry, UCSF Information Technology Services provides computing support services and security and software updates through the campus-wide high-speed network infrastructure. Cloud-based secure data-sharing and storage technology will minimize the need to maintain confidential information on personal computers. All proposed members of the UCSF Monitoring and Reporting Core have completed required data security and HIPAA trainings, and are required to complete training updates during the course of the LDPP.

Details of data collection plans for each of the pilots are below.

Pilot 1: Access Collaborative

Child encounter information: Dental practices in the Access Collaborative will be provided with password-protected, standardized electronic data-entry files to record relevant encounter data for the LDPP target population (Denti-Cal beneficiaries ages 0-5). Data of interest include provision of the following services:

patient oral evaluation (baseline or return visit), prophy, fluoride varnish application, nutritional counseling.

On a monthly basis, the dental practices will pass de-identified data to the Data Monitoring and Reporting Core (the SFDPH Epidemiologist and staff within the UCSF School of Dentistry), already stripped of HIPAA-protected information. For example, to protect identifiable patient information, date of birth will be converted to age (in years) at time of encounter, encounter date will be shifted by a random value within 0-5 days, and medical record number will be converted to a unique, random identifier following a repeatable algorithm unknown to the Monitoring and Reporting Core.

Participating dental provider information: Upon enrolling in the Access Collaborative, dental practices will be required to participate in Learning Sessions. Pre- and post- training questionnaires will be used to assess providers' knowledge, attitudes, and perceptions in relation to preventive dental care for young children. Questionnaire information will also be used to assess the perceived quality and effectiveness of the Learning Sessions, based on participant feedback.

Additional process measures: In addition, the Access Collaborative will generate its own set of process measures for assessment and monitoring. This approach will follow standard, best-practice collaborative methodology, which emphasizes developing and using measurements to drive change in participating practices. Thus, in partnership with AFL Enterprises, the Access Collaborative will measure and report on specific metrics deemed to be most related to quality improvement in delivering preventive interventions.

Pilot 2: Care Coordination

Health worker training: The health worker training will be assessed via pre- and post-training questionnaires, covering knowledge related to pre-defined learning objectives. Questionnaires will also measure health worker self-efficacy and beliefs. The post-training assessment will be repeated after 6-months to assess knowledge retention.

Client data: Case managers working in the SFUSD and the SFDPH will enter client data at each encounter using a standardized, secure electronic database. For each age 0-5 client with whom a health worker comes in contact, entered data will include whether, where, and when a dental appointment was successfully scheduled. Then, health workers will follow-up with each client family and dental practice, recording whether appointments were kept and dental preventive services provided, or the reasons for missing a scheduled appointment or not receiving services. Monthly reports will be generated from the care coordination database and passed to the Data Monitoring and Reporting Core to generate progress reports. Progress reports will be shared with the SF LDPP lead and the case managers for monitoring and quality improvement.

Pilot 3: Health Promotion Messaging

Messaging and cultural relevancy training: The health worker training will be assessed via pre- and post-training questionnaires, covering knowledge related to pre-defined learning objectives. Questionnaires will also measure health worker self-efficacy and beliefs. The post-training assessment will be repeated after 6 months to assess knowledge retention.

Pilot 4: Increase Interprofessional Collaborative Practice

The primary care provider and support staff training to increase competency in Interprofessional Collaborative Practice will be assessed via pre- and post-training questionnaires, covering knowledge related to pre-defined learning objectives. Questionnaires will also measure primary care provider and support staff self-efficacy and beliefs. The post-training assessment will be repeated after 6-months to assess knowledge retention.

Pilot 5: Incentivizing FQHC Dual-Users

Patient visit data: For the local FQHC facilities with co-located primary care and dental clinics, we will track the number of Medi-Cal beneficiaries age 0-5 with both a primary care and dental visit in the same 12-month period. The Integration Technical Advisor and physician champions in the SF COH Strategic Plan integration workgroup have the expertise in configuring EMRs for documentation of oral health services. Participating FQHCs will submit quarterly aggregate reports to the Data Monitoring and Reporting Core to follow the percentage of dual primary care-dental care utilizing children at each site.

Countywide SF COH Strategic Plan Outcomes

Kindergarten screening: Decayed, Missing, Filled Teeth (DMFT) data will be obtained from the annual Kindergarten Dental Screening Program, conducted by the SFDPH in collaboration with the SFUSD and the San Francisco Dental Society. A list of all public elementary schools is obtained from the SFUSD School Health Programs Office. Each school is contacted by telephone and offered dental screening services for their kindergarten students. A written notice is also issued to each school via the district newsletter. Of the schools that agree to participate (typically 100% of elementary schools in the district), a passive consent form is sent home with the child. Participants are screened by licensed volunteer dentists from the SFDS, with SFDPH staff, at each school site, each school year. The screenings are performed using disposable gloves, tongue blades, and penlights following ASTDD Basic Screening Survey methodology.[9] An evaluation form of the findings, addressed to the parent/guardian, is completed and given to the child, along with a list of dental resources and a contact person at the SFDPH. Additionally, the schools receive a list of those children experiencing dental problems and needing treatment. Data is recorded and entered into a secure Microsoft Access database, through which data is available for the SFDPH and UCSF to use as part of the LDPP monitoring and reporting.

DHCS Data: Finally, the SF LDPP will request San Francisco County-specific Medi-Cal Dental utilization data from the California Department of Health Care Services. These data will be essential for tracking overall impact of the innovative pilot programs in improving DTI Domain 1 (number of Denti-Cal beneficiaries receiving preventive services) from pre-DTI baseline levels.

Together, the countywide metrics will serve as the broadest measure of the impact of the proposed SF LDPP strategies.

The table on the following page details the data that will be collected and used to measure whether the project is having the intended impact, along with the frequency of measurement and reporting.

Table 9. DATA COLLECTION

Pilot	Data to be collected	Purpose	Frequency	Source
1: Access Collaborative	• Participation of 2 FQHC dental clinic sites in Collaborative pilot 1. • Participation of 3 private/dental school practices in Collaborative pilot 1 • Participation of 3 FQHC dental clinic site each year in Collaboratives 2 &3 • Participation of 12 private/dental school practices per year for Collaboratives 2 &3	Confirm participation of dental practice teams, validate Scholarship payments	Quarterly	Collaborative Learning Session and Action Period call attendance rolls

	# children 0-5 seen and # of preventive services performed *(all data de-identified)*	Determine increases in number of children seen and preventive procedures for the target population	Monthly	Collaborative measure set
2: Care Coordination	MI training pre/post evaluation; documentation of MI question(s) asked.	QI and program planning	initial and follow-up training	Health Worker evaluations
	• # clients referred to case management • # clients contacted • # clients appointed • # clients attending dental exam visit *(all data de-identified)*	Data Analysis for QI and program planning	Monthly, quarterly, and annually	SFUSD and SFDPH shared care coordination database
3: Health Promotion Messaging	• Pre/post scores and evaluation from health worker training; documentation of health promotion and appt compliance addressed with caregivers	Assess the impact of messaging on no-show rates	Quarterly	SFDPH Program Coordinator data from COH Taskforces
4: Increase Interprofessional Collaborative Practice	• Evaluation of training and technical support by primary care offices	Assess need for TA and whether needs are met	Monthly	Integration Technical Advisor, Trainers Evaluations by PC offices
5: Incentivizing FQHC Dual Users	• Participation of 2, 4 and 8 FQHC each year from 2018-2020 respectively • % children 0-5 with PC & dental visit in the same year from baseline	Incentivize increased % of 0-5 with PC & dental visit in the same year	Quarterly	FQHCs
Data Collection, Analysis, and Reporting	Case Management Data; K Caries Screening Data	Data monitoring, analysis and reporting	Biannual/ yearly	Reports from SFDPH
	Quarterly project data, final evaluation	Data monitoring, analysis and reporting	Quarterly	Reporting according to agreed performance measures
Project Coordination	• Date deliverables completed by program manager • Date deliverables completed by program coordinator • Date deliverables completed by dental consultant	Assess whether SOW activities are successfully completed by due dates	Quarterly	SF DTI LDPP supervisor; SF LDPP Advisory Committee

Data analysis. For all outcomes of interest, quarterly and annual reports will include descriptive summary statistics (e.g. means, proportions, and total counts). Temporal trends will be assessed for each main outcome metric of interest to estimate progress relative to target benchmarks. Linear tests for trend will be assessed using generalized linear regression models with a continuous term for project year. Monthly trends will be analyzed quarterly, if sufficient sample size is available. Analytics will be provided to optimize

relevance for monitoring activities, implementing quality improvement plans and will occur at appropriate frequencies to measure whether pilot projects are having the intended impact. All quantitative analyses will be completed using statistical software (Stata 14.1 and R 3.3.1).

Data analysis will occur continuously throughout the project to allow for timely feedback to the Coordinating Committee and core staff of each pilot program so that adaptations can be made as necessary in response to emerging data.

Secondary analyses and sensitivity checks. All main quantitative analyses will be reported at the aggregate (county) level. In addition, subgroup analyses will be conducted by gender, race/ethnicity, practice type (FQHC vs. private), and geographic location (neighborhood level of granularity dependent on sufficient sample size in each subgroup to maintain confidentiality of practices and patients).

Primary outcomes will be reported as marginal proportions, means, and other population-wide summary statistics. In addition, we will assess the robustness of the primary findings to alternative methodological approaches, such as clustered analysis to account for intra-practice or intra-neighborhood correlation (generalized estimating equations), multiple imputation for missing data or outcomes lost-to-follow-up (multiple imputation by chained-equations, formula method), removal of outlier observations (e.g. exclude best- or least-performing sites), and multivariable regression adjustment for practice characteristics (e.g., size, type, geographic location, or years of operation) or patient/family characteristics (e.g., age, race/ethnicity).

Careful attention will be taken to interpret any observed changes in the context of economic or demographic shifts that may occur over the analysis period: for example, population growth, in-migration/out-migration, total school enrollment, county and regional unemployment metrics, cost of living, total dental workforce capacity, or changes in local, regional, or national policy that could potentially impact defined SF LDPP outcomes. Furthermore, observed countywide trends will be compared to oral health surveillance metrics reported for the regional, state, and national levels. While outside data sources (e.g. national surveillance) are likely to differ from the SF LDPP in both measures and the composition of the analytic population, such data sources offering additional context for interpreting the magnitude and external consistency of any locally observed changes in key SF LDPP outcomes.

Sustainability planning. Best-practices and lessons learned will be compiled and widely disseminated through platforms including academic publications and presentations at local, region, and, if appropriate, national meetings. To facilitate potential implementation of successful strategies and tactics in other jurisdictions, we will compile free, accessible content for dental providers, public health departments, policy makers, and other stakeholders to expand the potential impact of the SF LDPP beyond the initial funding period.

Surveillance data initially revealed and defined a serious oral health problem affecting children 0-5 in the City and County of San Francisco. That data was the catalyst for the development, in a community participatory process, of a set of strategies to address that problem. Data produced by the LDPP will show whether or not the combination of programmatic strategies will be able to successfully address the oral health problem and improve the oral health of children 0-5 in San Francisco. That will make the best case for sustainability of these strategies.

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[7] Mofidi M, Rozier RG, King RS. Problems with Access to Dental Care for Medicaid-Insured Children: What Caregivers Think. *American Journal of Public Health*. 2002 Jan; 92(1): 53-58.

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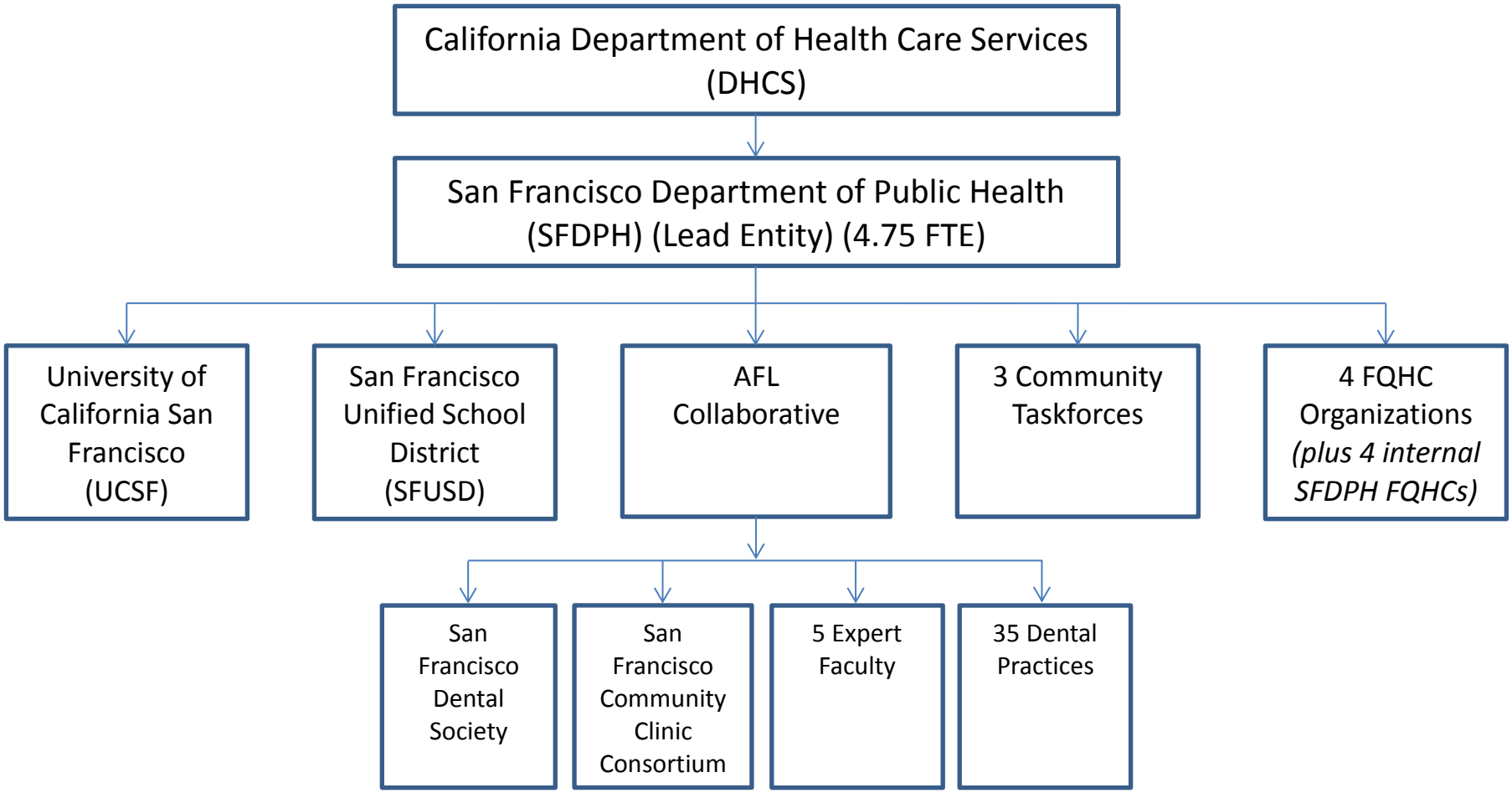
5.1 Financing Structure

DTI SF Funding Diagram



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5.2 Funding Request

Exhibit B Attachment I – Year 1
SFDPH Lead Entity Budget
Year 1
07/01/17 through 12/31/17

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Project Coordinator (all pilots)	1	$ 7,484	100 %	$ 44,902
Data Manager (all pilots)	1	$ 7,696	75 %	$ 34,631
Fiscal Analyst (all pilots)	1	$ 9,273	25 %	$ 13,910
Epidemiologist (all pilots)	1	$ 9,366	50 %	$ 28,099
Dental Consultant (all pilots)	1	$ 14,968	25 %	$ 22,452
Health Workers (Pilot 2)	2	$ 4,593	100 %	$ 55,113
			Total Salary	$ 199,107
			Fringe Benefits (35%)	$ 69,687
			Total Personnel	$ 268,794

Operating Expenses

SFDPH FQHC #1 Incentives for Dual Users	$ 0
SFDPH FQHC #2 Incentives for Dual Users	$ 0
SFDPH FQHC #3 Incentives for Dual Users	$ 0
SFDPH FQHC #4 Incentives for Dual Users	$ 0
Total Operating Expenses	$ 0

Equipment

Total Equipment Expenses $ 0

Travel **Total Travel** $ 0

Subcontracts

UCSF (Monitoring, Reporting, and Technical Assistance)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 130,048	$ 968	$ 200	$ 0	$ 0	$ 18,848	$ 150,064

SFUSD (Pilot 2 Care Coordination)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 54,776	$ 0	$ 0	$ 0	$ 0	$ 0	$ 54,776

AFL (Pilot 1 Collaborative)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 30,600	$ 5,000	$ 0	$ 21,000	$ 5,000	$ 0	$ 61,600

Community Taskforce 1 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 2 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 3 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community FQHC Organization #1 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

Community FQHC Organization #2 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

Community FQHC Organization #3 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

Community FQHC Organization #4 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

	Total Subcontracts	$ 296,440
Other Costs		
	Total Other Costs	$ 0
Indirect Costs (20%)	**Indirect Costs**	$ 39,821
	Annual Budget Total	**$** 605,055

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Exhibit B Attachment I – Year 1 Budget Justification

SFDPH Lead Entity Budget
Year 1: 07/01/17 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

Position Title	Activities to be Accomplished	Name	Annual Salary*	FTE %	Annual Cost – Year 1 6 month
Project Coordinator	Manage the LDPP DTI program budget, deliverables, and quarterly and annual DHCS reporting	To be hired	89,804	100 %	44,902
Data Manager	Support data collection, analysis, and presentation to include in DHCS reporting and coordinate with UCSF Monitoring and Reporting activities	To be hired	92,350	75 %	34,631
Fiscal Analyst	Manage contract development for subcontracts and monitor subcontract invoicing	Beth Neary, PhD	111,280	25 %	13,910
Epidemiologist	Research and conduct population health assessment of children ages 0-5 in San Francisco, as well as develop methodology to track dental health disparities annually moving forward	To be hired	112,396	50 %	28,099
Dental Consultant	Provide direction to the Access Collaborative and serve as an expert on SFDPH staff on all aspects of implementing the DTI LDPP program	Irene Hilton, DDS MPH	179,619	25 %	22,452
Health Workers (2)	Care coordinate and manage children's dental referrals, connect children to dental appointments, and check in on follow through of these referrals	To be hired	55,113	(2) 100 %	55,113
				Total Salary	$ 199,107
				Fringe Benefits (35%)	$ 69,687
				Total Personnel	$ 268,794

Operating Expenses

SFDPH FQHC #1 Incentives for Dual Users	$ 0	($ 31,320 in Years 2, 3, and 4)
SFDPH FQHC #2 Incentives for Dual Users	$ 0	($ 21,150 in Years 3 and 4)
SFDPH FQHC #3 Incentives for Dual Users	$ 0	($ 6,120 in Year 4)
SFDPH FQHC #4 Incentives for Dual Users	$ 0	($ 2,160 in Year 4)

Total Operating Expenses $ 0

Equipment

Total Equipment Expenses $ 0

Travel **Total Travel** $ 0

Subcontracts (Year 1 amounts included below, Year 2-4 amounts specified in included subcontractor budgets)

UCSF (Monitoring, Reporting, and Technical Assistance)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 130,048	$ 968	$ 200	$ 0	$ 0	$ 18,848	$ 150,064

SFUSD (Pilot 2 Care Coordination)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 54,776	$ 0	$ 0	$ 0	$ 0	$ 0	$ 54,776

AFL (Pilot 1 Collaborative)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 30,600	$ 5,000	$ 0	$ 21,000	$ 5,000	$ 0	$ 61,600

Community Taskforce 1 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 2 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 3 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community FQHC Organization #1 – Contractor TBD (Pilot 5 Dual User Incentives)**

Total Costs
$ 0

Community FQHC Organization #2 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

Community FQHC Organization #3 – Contractor TBD (Pilot 5 Dual User Incentives)

	Total Costs
	$ 0

Community FQHC Organization #4 – Contractor TBD (Pilot 5 Dual User Incentives)

	Total Costs
	$ 0

	Total Subcontracts	$ 296,440
Other Costs		
	Total Other Costs	$ 0
Indirect Costs (20%)	**Indirect Costs**	$ 39,821
	Annual Budget Total	**$** 605,055

* SFDPH salaries increase by 3% (COLA) or 8% (3% COLA plus 5% step increase as applicable) in Years 2-4 budgets
**Community FQHC incentives will be arranged through subcontracts and the allocation of incentive funding for Community FQHCs is described in Appendix XII

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Exhibit B Attachment I – Year 2
SFDPH Lead Entity Budget
Year 2
01/01/18 through 12/31/18

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Project Coordinator (all pilots)	1	$ 8,082	100 %	$ 96,988
Data Manager (all pilots)	1	$ 8,312	75 %	$ 74,804
Fiscal Analyst (all pilots)	1	$ 9,552	25 %	$ 28,655
Epidemiologist (all pilots)	1	$ 9,647	50 %	$ 57,884
Dental Consultant (all pilots)	1	$ 15,417	25 %	$ 46,252
Health Workers (Pilot 2)	2	$ 4,960	100 %	$ 119,044
		Total Salary		$ 423,627
		Fringe Benefits (35%)		$ 148,269
			Total Personnel	$ 571,896

Operating Expenses

SFDPH FQHC #1 Incentives for Dual Users	$ 31,320
SFDPH FQHC #2 Incentives for Dual Users	$ 0
SFDPH FQHC #3 Incentives for Dual Users	$ 0
SFDPH FQHC #4 Incentives for Dual Users	$ 0
Total Operating Expenses	$ 31,320

Equipment

Total Equipment Expenses $ 0

Travel

Total Travel $ 0

Subcontracts

UCSF (Monitoring, Reporting, and Technical Assistance)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 165,523	$ 994	$ 200	$ 0	$ 0	$ 23,989	$ 190,706

SFUSD (Pilot 2 Care Coordination)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 109,552	$ 0	$ 0	$ 0	$ 0	$ 0	$ 109,552

AFL (Pilot 1 Collaborative)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 192,780	$ 67,500	$48,000	$ 126,000	$ 82,500	$ 0	$ 516,780

Community Taskforce 1 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 2 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 3 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community FQHC Organization #1 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 72,000

Community FQHC Organization #2 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

Community FQHC Organization #3 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

Community FQHC Organization #4 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

	Total Subcontracts	$ 919,038
Other Costs		
	Total Other Costs	$ 0
Indirect Costs (20%)	**Indirect Costs**	$ 84,725
	Annual Budget Total	**$** 1,606,979

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Exhibit B Attachment I – Year 3
SFDPH Lead Entity Budget
Year 3
01/01/19 through 12/31/19

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Project Coordinator (all pilots)	1	$ 8,729	100 %	$ 104,747
Data Manager (all pilots)	1	$ 8,561	75 %	$ 77,048
Fiscal Analyst (all pilots)	1	$ 9,838	25 %	$ 29,514
Epidemiologist (all pilots)	1	$ 9,937	50 %	$ 59,620
Dental Consultant (all pilots)	1	$ 15,880	25 %	$ 47,639
Health Workers (Pilot 2)	2	$ 5,357	100 %	$ 128,568
		Total Salary		$ 447,136
		Fringe Benefits (35%)		$ 156,498
			Total Personnel	$ 603,634

Operating Expenses

SFDPH FQHC #1 Incentives for Dual Users	$ 31,320
SFDPH FQHC #2 Incentives for Dual Users	$ 21,150
SFDPH FQHC #3 Incentives for Dual Users	$ 0
SFDPH FQHC #4 Incentives for Dual Users	$ 0
Total Operating Expenses	$ 52,470

Equipment

Total Equipment Expenses	$ 0

Travel

Total Travel	$ 0

Subcontracts

UCSF (Monitoring, Reporting, and Technical Assistance)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 170,488	$ 977	$ 200	$ 0	$ 0	$ 24,708	$ 196,373

SFUSD (Pilot 2 Care Coordination)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 109,552	$ 0	$ 0	$ 0	$ 0	$ 0	$ 109,552

AFL (Pilot 1 Collaborative)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 202,419	$ 60,000	$36,000	$ 126,000	$ 97,500	$ 0	$ 521,919

Community Taskforce 1 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 2 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 3 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community FQHC Organization #1 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 72,000

Community FQHC Organization #2 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 216,990

Community FQHC Organization #3 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

Community FQHC Organization #4 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 0

	Total Subcontracts	$ 1,146,834
Other Costs		
	Total Other Costs	$ 0
Indirect Costs (20%)	**Indirect Costs**	$ 89,427
	Annual Budget Total	**$** 1,892,365

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Exhibit B Attachment I – Year 4
SFDPH Lead Entity Budget
Year 4
01/01/20 through 12/31/20

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Project Coordinator (all pilots)	1	$ 8,991	100 %	$ 107,890
Data Manager (all pilots)	1	$ 8,818	75 %	$ 79,359
Fiscal Analyst (all pilots)	1	$ 10,133	25 %	$ 30,400
Epidemiologist (all pilots)	1	$ 10,235	50 %	$ 61,409
Dental Consultant (all pilots)	1	$ 16,356	25 %	$ 49,069
Health Workers (Pilot 2)	2	$ 5,786	100 %	$ 138,853
			Total Salary	$ 466,980
			Fringe Benefits (35%)	$ 163,443
				Total Personnel $ 630,423

Operating Expenses

SFDPH FQHC #1 Incentives for Dual Users	$ 31,320
SFDPH FQHC #2 Incentives for Dual Users	$ 21,150
SFDPH FQHC #3 Incentives for Dual Users	$ 6,120
SFDPH FQHC #4 Incentives for Dual Users	$ 2,160
Total Operating Expenses	$ 60,750

Equipment

Total Equipment Expenses $ 0

Travel **Total Travel** $ 0

Subcontracts

UCSF (Monitoring, Reporting, and Technical Assistance)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 175,603	$ 920	$ 200	$ 0	$ 0	$ 25,450	$ 202,173

SFUSD (Pilot 2 Care Coordination)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 109,552	$ 0	$ 0	$ 0	$ 0	$ 0	$ 109,552

AFL (Pilot 1 Collaborative)

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 106,270	$ 32,500	$24,000	$ 63,000	$ 45,000	$ 0	$ 270,770

Community Taskforce 1 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 2 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community Taskforce 3 – Contractor TBD (Pilot 3 Culturally Appropriate Messaging)

Total Costs
$ 10,000

Community FQHC Organization #1 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 72,000

Community FQHC Organization #2 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 216,990

Community FQHC Organization #3 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 23,400

Community FQHC Organization #4 – Contractor TBD (Pilot 5 Dual User Incentives)

Total Costs
$ 21,600

	Total Subcontracts	$ 946,485
Other Costs		
	Total Other Costs	$ 0
Indirect Costs (20%)	**Indirect Costs**	$ 93,396
	Annual Budget Total	**$** 1,731,054

SF HEALTH NETWORK
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Exhibit B Attachment II – Year 1
UCSF Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost – Year 1 6 month
Monitoring & Reporting Core Director	1	$ 10,200	35 %	$ 21,420
Monitoring and Reporting Core Co-Director	1	$ 9,318	17.5 %	$ 9,784
Dental Training and Technical Assistance Lead	1	$ 17,000	17.5 %	$ 17,850
Monitoring & Reporting Analyst	1	$ 6,102	35 %	$ 12,814
Monitoring & Reporting Project Director	1	$ 6,498	43.8 %	$ 17,057
Integration Technical Advisor	1	$ 14,583	17.5 %	$ 15,313
		Total Salary		$ 94,238
		Fringe Benefits (38%)		$ 35,810
			Total Personnel	$ 130,048

Operating Expenses

Office Supplies and Printing	$ 300		
Data Network Recharge	$ 668		
		Total Operating Expenses	$ 968

Equipment

	Total Equipment Expenses	$ 0

Travel

Mileage Reimbursement $200		
	Total Travel	$ 200

Subcontracts

Total Subcontracts	$ 0

Other Costs

Total Other Costs	$ 0

Indirect Costs (25%)	**Indirect Costs**	$ 18,848
	Annual Budget Total	**$** 150,064

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment II – Year 1 Budget Justification

UCSF Subcontractor Budget

Year 1: 07/01/17 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

Position Title	Activities to be Accomplished	Name	Annual Salary *	FTE % **	Annual Cost – Year 1 6 month
Monitoring & Reporting Core Director	Epidemiologist who will direct the UCSF Monitoring & Reporting Core, including leading the design of data collection and monitoring systems, analysis plans, and preparation of reports	Benjamin Chaffee, DDS MPH PhD	122,400	35 %	21,420
Monitoring & Reporting Core Co-Director	Board certified public health dentist who will contribute to the design of performance metrics, data collection strategies, analysis plans, and reports	Lisa Chung, DDS MPH	92,350	17.5 %	9,784
Dental Training and Technical Assistance	Faculty dentist who will lead the skills-based training program for dentists participating in the Access Collaborative	Ray Stewart, DMD MS	204,000	17.5 %	17,850
Monitoring & Reporting Analyst	Lead contact for data submissions and flow into the monitoring and reporting core, and will assist the Project Director in weekly operations	Elizabeth Couch, RDH MS	73,224	35 %	12,814
Monitoring & Reporting Project Director	Project director who will coordinate the weekly operations, logistics, and communication of the monitoring and reporting activities	Joanna Hill	77,976	43.8 %	17,057

Integration Technical Advisor	MD with joint specialties in Pediatrics and Preventative and Restorative Dental Sciences who will provide technical advising on workflow, billing, and other issues related to expanding preventative dental services and referrals in primary care settings	Susan Fisher Owens, MD MPH	175,000	17.5 %	15,313

Total Salary	$	94,238
Fringe Benefits (38%)	$	35,810
Total Personnel	$	130,048

Operating Expenses ***

Office Supplies and Printing	$ 300	
Data Network Recharge	$ 668	Required contribution for UCSF projects

Total Operating Expenses	$	968

Equipment

Total Equipment Expenses	$	0

Travel

Mileage Reimbursement	$200	Reimbursing staff for transportation expenses

Total Travel	$	200

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (20%)	**Indirect Costs**	$ 18,848

Annual Budget Total	**$**	150,064

* UCSF salaries increase by 3% (COLA) in Years 2-4 budgets
** UCSF FTE's decline in Years 2-4 from Year 1 levels as noted in each budget
*** These amounts vary slightly in Years 2-4 budgets

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment II – Year 2
UCSF Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Monitoring & Reporting Core Director	1	$ 10,506	20 %	$ 25,214
Monitoring and Reporting Core Co-Director	1	$ 9,598	10 %	$ 11,517
Dental Training and Technical Assistance Lead	1	$ 17,510	10 %	$ 21,012
Monitoring & Reporting Analyst	1	$ 6,285	20 %	$ 15,084
Monitoring & Reporting Project Director	1	$ 6,693	25 %	$ 20,079
Integration Technical Advisor	1	$ 15,021	15 %	$ 27,038
		Total Salary		$ 119,944
		Fringe Benefits (38%)		$ 45,579

Total Personnel $ 165,523

Operating Expenses

Office Supplies and Printing	$ 300
Data Network Recharge	$ 694

Total Operating Expenses $ 994

Equipment

Total Equipment Expenses $ 0

Travel

Mileage Reimbursement	$200

Total Travel $ 200

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (25%) **Indirect Costs** $ 23,989

Annual Budget Total **$** 190,706

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment II – Year 3
UCSF Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Monitoring & Reporting Core Director	1	$ 10,821	20 %	$ 25,971
Monitoring and Reporting Core Co-Director	1	$ 9,885	10 %	$ 11,863
Dental Training and Technical Assistance Lead	1	$ 18,035	10 %	$ 21,642
Monitoring & Reporting Analyst	1	$ 6,474	20 %	$ 15,537
Monitoring & Reporting Project Director	1	$ 6,894	25 %	$ 20,681
Integration Technical Advisor	1	$ 15,472	15 %	$ 27,849
			Total Salary	$ 123,542
			Fringe Benefits (38%)	$ 46,946

Total Personnel	$ 170,488

Operating Expenses

Office Supplies and Printing	$ 300
Data Network Recharge	$ 677
Total Operating Expenses	$ 977

Equipment

Total Equipment Expenses	$ 0

Travel

Mileage Reimbursement	$200
Total Travel	$ 200

Subcontracts

Total Subcontracts	$ 0

Other Costs

Total Other Costs	$ 0

Indirect Costs (25%)	**Indirect Costs** $ 24,708
	Annual Budget Total **$** 196,373

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment II – Year 4
UCSF Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Monitoring & Reporting Core Director	1	$ 11,146	20 %	$ 26,750
Monitoring and Reporting Core Co-Director	1	$ 10,182	10 %	$ 12,218
Dental Training and Technical Assistance Lead	1	$ 18,576	10 %	$ 22,292
Monitoring & Reporting Analyst	1	$ 6,668	20 %	$ 16,003
Monitoring & Reporting Project Director	1	$ 7,101	25 %	$ 21,302
Integration Technical Advisor	1	$ 15,936	15 %	$ 28,684

Total Salary	$	127,249
Fringe Benefits (38%)	$	48,354
Total Personnel	$	175,603

Operating Expenses

Office Supplies and Printing	$ 300		
Data Network Recharge	$ 620		
		Total Operating Expenses	$ 920

Equipment

	Total Equipment Expenses	$ 0

Travel

Mileage Reimbursement	$200		
		Total Travel	$ 200

Subcontracts

	Total Subcontracts	$ 0

Other Costs

	Total Other Costs	$ 0

Indirect Costs (25%)	**Indirect Costs**	$ 25,450
	Annual Budget Total	**$** 202,173

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment III – Year 1
SFUSD Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost – Year 1 6 month
Health Worker	1	$ 5,307	100 %	$ 31,840
Nurse Manager	1	$ 14,559	10 %	$ 8,735
			Total Salary	$ 40,575
			Fringe Benefits (35%)	$ 14,201

Total Personnel $ 54,776

Operating Expenses

Total Operating Expenses $ 0

Equipment

Total Equipment Expenses $ 0

Travel **Total Travel** $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (0%) **Indirect Costs** $ 0

Annual Budget Total **$** 54,776

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment III – Year 1 Budget Justification

SFUSD Subcontractor Budget
Year 1: 07/01/17 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

Position Title	Activities to be Accomplished	Name	Annual Salary	FTE %	Annual Cost* – Year 1 6 month
Health Worker	Coordinate dental care access for children ages 0-5 attending school in the San Francisco Unified School District	To be hired	63,680	100 %	31,840
Nurse Manager	Nurse who supervises health worker's children's dental coordination work	Catherine Fuller, RN, MSN, NP	174,708	10 %	8,735

Total Salary	$	40,575
Fringe Benefits (35%)	$	14,201
Total Personnel	$	54,776

Operating Expenses

Total Operating Expenses	$	0

Equipment

Total Equipment Expenses	$	0

Travel

Total Travel	$	0

Subcontracts

Total Subcontracts	$	0

Other Costs

Total Other Costs	$	0

Indirect Costs (0%)		
Indirect Costs	$	0
Annual Budget Total	**$**	54,776

* These amount double in Years 2-4 due to the 12 month year rather than 6 month Year 1 budget

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment III – Year 2
SFUSD Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Health Worker	1	$ 5,307	100 %	$ 63,680
Nurse Manager	1	$ 14,559	10 %	$ 17,470
			Total Salary	$ 81,150
			Fringe Benefits (35%)	$ 28,402

Total Personnel	$ 109,552
Total Operating Expenses	$ 0
Total Equipment Expenses	$ 0
Total Travel	$ 0
Total Subcontracts	$ 0
Total Other Costs	$ 0
Indirect Costs	$ 0
Annual Budget Total	**$** 109,552

Operating Expenses

Equipment

Travel

Subcontracts

Other Costs

Indirect Costs (0%)

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment III – Year 3
SFUSD Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Health Worker	1	$ 5,307	100 %	$ 63,680
Nurse Manager	1	$ 14,559	10 %	$ 17,470
			Total Salary	$ 81,150
			Fringe Benefits (35%)	$ 28,402

Total Personnel $ 109,552

Operating Expenses

Total Operating Expenses $ 0

Equipment

Total Equipment Expenses $ 0

Travel **Total Travel** $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (0%) **Indirect Costs** $ 0

Annual Budget Total **$** 109,552

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment III – Year 4
SFUSD Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
Health Worker	1	$ 5,307	100 %	$ 63,680
Nurse Manager	1	$ 14,559	10 %	$ 17,470
			Total Salary	$ 81,150
			Fringe Benefits (35%)	$ 28,402

Total Personnel $ 109,552

Operating Expenses

Total Operating Expenses $ 0

Equipment

Total Equipment Expenses $ 0

Travel **Total Travel** $ 0

Subcontracts

Total Subcontracts $ 0

Other Costs

Total Other Costs $ 0

Indirect Costs (0%) **Indirect Costs** $ 0

Annual Budget Total **$** 109,552

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment IV – Year 1
AFL Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost - Year 1- 2 month
QI Collaborative Director, MPH	1	$ 12,800	50 %	$ 12,800
QI Project Manager, BA	1	$ 6,400	60 %	$ 7,680
Administrative Assistant	1	$ 5,000	40 %	$ 4,000
			Total Salary	$ 24,480
			Fringe Benefits (25%)	$ 6,120
			Total Personnel	$ 30,600

Operating Expenses

Learning Session Logistics and Expenses ($20,000 5 practices, $40,000 15 practices)	$ 0	
Administrative Expenses (Intranet, Materials Production, Website, Conference Calls)	$ 5,000	
	Total Operating Expenses	$ 5,000

Equipment

Total Equipment Expenses	$ 0

Travel

Travel for Collaborative Director and Consultants (3 Learning Sessions/Collaborative, 8 Travelers @ $1,500 each)	$0	
	Total Travel	$ 0

Subcontracts

Improvement Advisor, PhD or MA

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 6,000						$ 6,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 4,000						$ 4,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 4,000						$ 4,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 4,000						$ 4,000

National Coach, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 3,000						$ 3,000

Total Subcontracts	$ 21,000

Other Costs

Scholarships for Dental Practices participating in Collaborative	$ 0
Recruitment of Dental Practices by San Francisco Community Clinic Consortium	$ 2,500
Recruitment of Dental Practices by SFDS for Collaborative Participation	$ 2,500
Total Other Costs	$ 5,000

Indirect Costs (0%) **Indirect Costs**	$ 0
Annual Budget Total	**$** 61,600

* Year 1 includes 2 months of planning beginning on November 1, 2017

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment IV – Year 1 Budget Justification

AFL Subcontractor Budget
Year 1: 07/01/17 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

Position Title	Activities to be Accomplished	Name	Annual Salary*	FTE %	Annual Cost** Year 1 2 month
QI Collaborative Director	Supports clinic teams, plans and executes learning session and action period activities, participates in recruiting new clinics	Colleen Lampron, MPH	153,600	50 %	12,800
QI Project Manager	Supports clinic teams, plans and executes learning session and action period activities, participates in recruiting new clinics	Becca Lipman, BA	76,800	60 %	7,680
Administrative Assistant	Administers scholarships for Access Collaborative participants and manages collaborative scheduling and invoicing	To be hired	60,000	40 %	4,000

Total Salary	$	24,480
Fringe Benefits (25%)	$	6,120
Total Personnel	$	30,600

Operating Expenses

Learning Session Logistics and Expenses	$ 0	$40,000 in Years 2-3 and $20,000 in Year 4
Administrative Expenses including Intranet, Materials Production, Website, Conference Calls	$ 5,000	$27,500 in Yr 2, $20,000 in Yr 3, $12,500 in Yr 4

Total Operating Expenses	$	5,000

Equipment

Total Equipment Expenses	$	0

Travel

Travel for Collaborative Director and Consultants including 3 Learning Sessions/Collaborative, 8 Travelers @ $1,500 each	$0	$48,000 in Yr 2, $36,000 in Yr 3, $24,000 in Yr 4

Total Travel	$	0

Subcontracts (Year 1 amounts included below, Year 2-4 amounts specified in included budgets)
Improvement Advisor, PhD or MA. Guides the Collaborative work and teaches and coaches the faculty and teams at the clinics in implementing the Breakthrough Series (BTS) method

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 6,000						$ 6,000

Expert Faculty, DDS, Advises coaching teams, defines improvements that are achievable within given timeframe

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 4,000						$ 4,000

Expert Faculty, DDS, Advises coaching teams, defines improvements that are achievable within given timeframe

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 4,000						$ 4,000

Expert Faculty, DDS, Advises coaching teams, defines improvements that are achievable within given timeframe

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 4,000						$ 4,000

National Coach, DDS, Provides 1:1 coaching to participating teams who need additional support

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 3,000						$ 3,000

Total Subcontracts $ 21,000

Other Costs

Scholarships for Dental Practices participating in Collaborative *** $ 0

Recruitment of Dental Practices by San Francisco Community Clinic Consortium $ 2,500 $5,000 in Years 2-3
SFCCC will host meetings and coordinate with FQHC's to communicate the value of participating in both the Dual User and Access Collaborative pilots

Recruitment of Dental Practices for Collaborative Participation $ 2,500 $2,500 in Years 2-3
SFDS will host meetings and coordinate with Dental Society members to Communicate the value of participation in the Access Collaboratives

Total Other Costs $ 5,000

Indirect Costs (0%) **Indirect Costs** $ 0

Annual Budget Total **$ 61,600**

* AFL salaries increase by 5% in Year 2-4 budgets
** Year 1 includes 2 months of planning beginning on November 1, 2017. Collaboratives begin in Year 2 with a compressed 6-month pilot in the first six months of 2018 followed by two yearlong Collaboratives.
*** Scholarships for participating in the Access Collaborative will offset the cost of having dentists and dental teams out of clinic. Scholarship is $6,000 per practice for attending three two-day Learning Sessions for six days outside of clinic ($1,000/day). In Year 1, no dental practices are participating. In Year 2, 5 dental practices will be attending during the first six months, and 15 new dental practices will be attending half of their sessions in Year 2. In Year 3, 15 practices will be completing the second half of their Access Collaborative, and 15 new dental practices will be entering the first half of their Access Collaborative. In Year 4, 15 dental practices will be completing the second half of their Access Collaborative by June 30.

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment IV – Year 2
AFL Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
QI Collaborative Director, MPH	1	$ 13,440	50 %	$ 80,640
QI Project Manager, BA	1	$ 6,720	60 %	$ 48,384
Administrative Assistant	1	$ 5,250	40 %	$ 25,200
			Total Salary	$ 154,224
			Fringe Benefits (25%)	$ 38,556

Total Personnel $ 192,780

Operating Expenses

Learning Session Logistics and Expenses ($20,000 5 practices, $40,000 15 practices)	$ 40,000
Administrative Expenses (Intranet, Materials Production, Website, Conference Calls)	$ 27,500

Total Operating Expenses $ 67,500

Equipment

Total Equipment Expenses $ 0

Travel

Travel for Collaborative Director and Consultants (3 Learning Sessions/Collaborative, 8 Travelers @ $1,500 each)	$48,000

Total Travel $ 48,000

Subcontracts

Improvement Advisor, PhD or MA

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 36,000						$ 36,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 24,000						$ 24,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs

$ 24,000						$ 24,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 24,000						$ 24,000

National Coach, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 18,000						$ 18,000

Total Subcontracts	$ 126,000

Other Costs

Scholarships for Dental Practices participating in Collaborative	$ 75,000
Recruitment of Dental Practices by San Francisco Community Clinic Consortium	$ 5,000
Recruitment of Dental Practices by SFDS for Collaborative Participation	$ 2,500

Total Other Costs	$ 82,500

Indirect Costs (0%)	**Indirect Costs** $ 0

Annual Budget Total	**$** 516,780

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment IV – Year 3
AFL Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
QI Collaborative Director, MPH	1	$ 14,112	50 %	$ 84,672
QI Project Manager, BA	1	$ 7,056	60 %	$ 50,803
Administrative Assistant	1	$ 5,513	40 %	$ 26,460
			Total Salary	$ 161,935
			Fringe Benefits (25%)	$ 40,484
			Total Personnel	$ 202,419

Operating Expenses

Learning Session Logistics and Expenses ($20,000 5 practices, $40,000 15 practices)	$ 40,000	
Administrative Expenses (Intranet, Materials Production, Website, Conference Calls)	$ 20,000	
	Total Operating Expenses	$ 60,000

Equipment

Total Equipment Expenses	$ 0

Travel

Travel for Collaborative Director and Consultants (3 Learning Sessions/Collaborative, 8 Travelers @ $1,500 each)	$36,000	
	Total Travel	$ 36,000

Subcontracts

Improvement Advisor, PhD or MA

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 36,000						$ 36,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 24,000						$ 24,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 24,000						$ 24,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 24,000						$ 24,000

National Coach, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 18,000						$ 18,000

Total Subcontracts $ 126,000

Other Costs

Scholarships for Dental Practices participating in Collaborative	$ 90,000
Recruitment of Dental Practices by San Francisco Community Clinic Consortium	$ 5,000
Recruitment of Dental Practices by SFDS for Collaborative Participation	$ 2,500

Total Other Costs $ 97,500

Indirect Costs (0%) **Indirect Costs** $ 0

Annual Budget Total **$** 521,919

SF HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Exhibit B Attachment IV – Year 4
AFL Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Personnel

Position Title	# of Staff	Monthly Salary	FTE %	Annual Cost
QI Collaborative Director, MPH	1	$ 14,818	50 %	$ 44,453
QI Project Manager, BA	1	$ 7,408	60 %	$ 26,672
Administrative Assistant	1	$ 5,788	40 %	$ 13,892
			Total Salary	$ 85,016
			Fringe Benefits (25%)	$ 21,254

Total Personnel $ 106,270

Operating Expenses

Learning Session Logistics and Expenses ($20,000 5 practices, $40,000 15 practices)	$ 20,000
Administrative Expenses (Intranet, Materials Production, Website, Conference Calls)	$ 12,500

Total Operating Expenses $ 32,500

Equipment

Total Equipment Expenses $ 0

Travel

Travel for Collaborative Director and Consultants (3 Learning Sessions/Collaborative, 8 Travelers @ $1,500 each)	$24,000

Total Travel $ 24,000

Subcontracts

Improvement Advisor, PhD or MA

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 18,000						$ 18,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 12,000						$ 12,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 12,000						$ 12,000

Expert Faculty, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 12,000						$ 12,000

National Coach, DDS

Personnel	Operating Expenses	Travel	Subcontracts	Other Costs	Indirect Costs	Total Costs
$ 9,000						$ 9,000

Total Subcontracts $ 63,000

Other Costs

Scholarships for Dental Practices participating in Collaborative	$ 45,000
Recruitment of Dental Practices by San Francisco Community Clinic Consortium	$ 0
Recruitment of Dental Practices by SFDS for Collaborative Participation	$ 0

Total Other Costs $ 45,000

Indirect Costs (0%) **Indirect Costs** $ 0

Annual Budget Total **$** 270,770

Exhibit B Attachment V – Years 1 - 4

Community Taskforce #1 Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Annual Budget Total	**$**	10,000

Community Taskforce #1 Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Annual Budget Total	**$**	10,000

Community Taskforce #1 Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Annual Budget Total	**$**	10,000

Community Taskforce #1 Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Annual Budget Total	**$**	10,000

Exhibit B Attachment VI – Years 1-4

Community Taskforce #2 Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Annual Budget Total	**$**	10,000

Community Taskforce #2 Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Annual Budget Total	**$**	10,000

Community Taskforce #2 Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Annual Budget Total	**$**	10,000

Community Taskforce #2 Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Annual Budget Total	**$**	10,000

Exhibit B Attachment VII – Years 1-4

Community Taskforce #3 Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Annual Budget Total	**$**	10,000

Community Taskforce #3 Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Annual Budget Total	**$**	10,000

Community Taskforce #3 Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Annual Budget Total	**$**	10,000

Community Taskforce #3 Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Annual Budget Total	**$**	10,000

Exhibit B Attachment VIII – Years 1-4

Community FQHC Organization #1 Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Annual Budget Total	**$**	0

Community FQHC Organization #1 Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Annual Budget Total	**$**	72,000

Community FQHC Organization #1 Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Annual Budget Total	**$**	72,000

Community FQHC Organization #1 Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Annual Budget Total	**$**	72,000

Exhibit B Attachment IX – Years 1-4

Community FQHC Organization #2 Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Annual Budget Total	**$**	0

Community FQHC Organization #2 Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Annual Budget Total	**$**	0

Community FQHC Organization #2 Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Annual Budget Total	**$**	216,990

Community FQHC Organization #2 Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Annual Budget Total	**$**	216,990

Exhibit B Attachment X – Years 1-4

Community FQHC Organization #3 Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Annual Budget Total	**$** 0

Community FQHC Organization #3 Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Annual Budget Total	**$** 0

Community FQHC Organization #3 Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Annual Budget Total	**$** 0

Community FQHC Organization #3 Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Annual Budget Total	**$** 23,400

Exhibit B Attachment XI – Years 1-4

Community FQHC Organization #4 Subcontractor Budget
Year 1
07/01/17 through 12/31/17

Annual Budget Total	**$** 0

Community FQHC Organization #4 Subcontractor Budget
Year 2
01/01/18 through 12/31/18

Annual Budget Total	**$** 0

Community FQHC Organization #4 Subcontractor Budget
Year 3
01/01/19 through 12/31/19

Annual Budget Total	**$** 0

Community FQHC Organization #4 Subcontractor Budget
Year 4
01/01/20 through 12/31/20

Annual Budget Total	**$** 21,600

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Exhibit B Attachment XII – Years 1-4
Pilot 5 FQHC Dual User Incentive Allocations
Year 1: 07/01/17 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

Pilot 5 provides incentives to increase the proportion of FQHC Medi-Cal primary care beneficiaries ages 0-5 who also access dental care at the same FQHC site.

Practices achieving a 10% relative improvement goal will receive 50% of the incentive available, and practices reaching a 20% relative improvement goal will receive 100% of the incentive available in each year.

Examples of 10% relative improvement goal achievement (closing the gap to 100% by 10%):

A practice currently dual-serving 0% of children would earn it by increasing from 0% to 10% of children receiving primary care also receiving dental care.

A practice currently providing dental care to 20% of medical patients would earn it by increasing from 20% to 28% of children receiving dental care.

A practice currently providing dental care to 40% of medical patients would earn it by increasing from 40% to 46% of children receiving dental care.

A practice currently providing dental acre to 60% of medical patients would earn it by increasing from 60% to 64% of children receiving dental care.

Considerations:

San Francisco currently has 9 FQHC sites operating that offer both medical and dental care to children ages 0-5. Eight of these were offering services to children in 2015 and are included on this budget.

2 FQHC sites eligible in year 2
4 FQHC sites eligible in year 3 (2 new)
8 FQHC sites eligible in year 4 (4 new)
Only Medi-Cal clients aged 0-5 will be included in the QI measure (both numerator and denominator)

Data and Assumptions used to Calculate Incentive Amounts on Following Table:

$60,000 average incentive payment budgeted per FQHC participating, per year (2 + 4 + 8 = 14) * $60,000 = $840,000 in total incentive funding available for Pilot 5. This is adjusted to $839,520 on the next page.

In order budget the amount available to each FQHC in advance, 2015 figures of the number of age 0-5 Medi-Cal children seen in primary care at each FQHC are used in the calculations. Table on next page.

FQHC	2015 Medi-Cal 0-5 Children	Year 2 Eligible	Year 3 Eligible	Year 4 Eligible	Subtotal of Denominators	Year 2 Incentive*	Year 3 Incentive	Year 4 Incentive	Total Incentive
SFDPH FQHC site #1	348	348	348	348	1,044	31,320	31,320	31,320	93,960
SFDPH FQHC site #2	235		235	235	470		21,150	21,150	42,300
SFDPH FQHC site #3	68			68	68			6,120	6,120
SFDPH FQHC site #4	24			24	24			2,160	2,160
Community FQHC #1	800	800	800	800	2,400	72,000	72,000	72,000	216,000
Community FQHC #2 (2 sites included)	2,411		2,411	2,411	4,822		216,990	216,990	433,980
Community FQHC #3	260			260	260			23,400	23,400
Community FQHC #4	240			240	240			21,600	21,600
Totals		1,148	3,794	4,386	9,328				839,520

* Annual incentive amounts are calculated by multiplying the number of eligible Medi-Cal children in the denominator at each FQHC by $90

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5.3 Budget

Pilot	4-Year Cost	Year 1 Impact	Year 2 Impact	Year 3 Impact	Year 4 Impact
All Pilots Combined	***$5,835,453***	***All Pilots Combined***	***All Pilots Combined***	***All Pilots Combined***	***All Pilots Combined***
Administrative and Monitoring (SFDPH & UCSF)	$2,280,749	DTI monthly meetings, project management, and evaluation	DTI monthly meetings, project management, and evaluation	DTI monthly meetings, project management, and evaluation	DTI monthly meetings, project management, and evaluation
Pilot 1: Access Quality Improvement Collaborative	$1,371,069	Two months of development work for the 2018 6-month collaborative	Estimated 720 children may receive better prevention and retention from 5 initial practices participating in first Collaborative	Additional 2,160 children may be reached through 15 additional practices added with second Collaborative	Additional 2,160 children may be reached through 15 additional practices completing the third Collaborative
Pilot 2: Care Coordination	$1,067,878	700 children care coordinated into dental appts by 2 SFDPH and 1 SFUSD HW's	2,310 children care coordinated into dental appts by 2 SFDPH and 1 SFUSD HW's	2,541 children care coordinated into dental appts by 2 SFDPH and 1 SFUSD HW's	2,795 children care coordinated into dental appts by 2 SFDPH and 1 SFUSD HW's
Pilot 3: Culturally Appropriate Messaging to Caregivers of Children Ages 0-5	$120,000	Three culturally diverse taskforces will be funded (through RFP process) to develop effective messaging campaigns	The taskforces will continue to develop and refine messaging to address caregiver barriers to receiving early preventative dental care for children ages 0-5	Many caregivers of Denti-Cal beneficiaries in San Francisco will be reached with culturally appropriate messaging	Many caregivers of Denti-Cal beneficiaries in San Francisco will be reached with culturally appropriate messages that will be shared with Denti-Cal

Pilot	4-Year Cost	Year 1 Impact	Year 2 Impact	Year 3 Impact	Year 4 Impact
Pilot 4: Increase Inter-professional Collaborative Practice	$156,237	Integration Technical Advisor will assist primary care practices in setting up data systems for dental referrals, estimated 469 children referred	Integration Technical Advisor will assist primary care practices in setting up data systems for dental referrals, estimated 1,547 children referred	Integration Technical Advisor will assist primary care practices in setting up data systems for dental referrals, estimated 1,702 children referred	Integration Technical Advisor will assist primary care practices in setting up data systems for dental referrals, estimated 1,873 children referred
Pilot 5: Incentives to Increase FQHC Dual-users	$839,520	No incentives in Year 1	2 FQHC sites will participate and approximately 140 additional children will receive co-located dental and primary care services	2 additional FQHC sites will participate (for a total of 4) and approximately 460 additional children (on top of 140 from previous year) will receive co-located dental and primary care services	4 additional FQHC sites will participate (for a total of 8) and approximately 530 additional children (on top of 600 from previous two years) will receive co-located dental and primary care services