Application Checklist

DUE BY 5:00pm on Wednesday, September 20, 2017	
DATE OF SUBMISSION	14 September 2017
ORGANIZATION NAME	Mendocino County Health and Human Services Agency, Public Health

Application Contact Name: Ruth Lincoln, PHN, MA	**Phone Number: 707-472-2709**
E-mail Address: lincolnr@mendocinocounty.org	

The following documents must be completed and submitted with this Application Checklist by 5:00 pm on September 20, 2017, in hard copy and by E-mail.

APPLICATION CONTENTS:	**Please Check**
Application Checklist (This Form)	☒
Grantee Information Form (Document B)	☒
Narrative Summary Form (Document C)	☒
Scope of Work and Deliverables (Document D)	☒
Documentation Checklist for Established LOHPs only (Document E)	☐

Two hard copies and one original must be mailed to:

Regular Mail	*Express Delivery*
Oral Health Program California Department of Public Health P.O. Box 997377, MS 7208 Sacramento, CA 95899-7377	Oral Health Program California Department of Public Health 1616 Capitol Avenue, Suite 74.420 MS-7208 Sacramento, CA 95814 (916) 552-9900

Also e-mail the documents to: DentalDirector@cdph.ca.gov@cdph.ca.gov.

Grantee Information Form

Organization

This is the information that will appear in your grant agreement.

Federal Tax ID # 94-6000520

Name Mendocino County Health and Human Services Agency, Public Health

Mailing Address 1120 South Dora Street, Ukiah CA, 95482

Street Address (If Different) SAME

County Mendocino

Phone 707-472-2709 Fax 707-472-2735

Website www.mendocinocounty.org/government/health-and-human-services-agency

Grant Signatory

The ***Grant Signatory*** has authority to sign the grant agreement cover.

Name Anne Molgaard

Title Chief Operations Officer

If address(es) are the same as the organization above, just check this box and go to Phone ☐

Mailing Address 727 South State Street, Ukiah CA, 95482

Street Address (If Different) SAME

Phone 707-463-7885 Fax 707-472-2335

Email molgaardac@mendocinocounty.org

Project Director

The ***Project Director*** is responsible for all of the day-to-day activities of project implementation and for seeing that all grant requirements are met. This person will be in contact with Oral Health Program staff, will receive all programmatic, budgetary, and accounting mail for the project and will be responsible for the proper dissemination of program information.

Name Ruth Lincoln, PHN, MA

Title Deputy Director, Public Health Nursing

If address(es) are the same as the organization above, just check this box and go to Phone ☐

Mailing Address 1120 South Dora Street, Ukiah CA, 95482

Street Address (If Different) SAME

Phone 707-472-2709 Fax 707-472-2735

Email lincolnr@mendocinocounty.org

Funding

These are the annual **Funding** amounts your LHJ will accept for grant purposes.

Year 1 (FY 17/18)	$167,026
Year 2 (FY 18/19)	$167,026
Year 3 (FY 19/20)	$167,026
Year 4 (FY 20/21)	$167,026
Year 5 (FY 21/22)	$167,026

Narrative Summary Form

Mendocino County Health and Human Services Agency

Community Overview and Demographics. Rural Mendocino County (pop. 88,378) lies on California's Pacific coast 100 miles north of San Francisco, covering 3,506 square miles of mostly mountainous terrain. Geographically, Mendocino County is equal in size to the states of Delaware and Rhode Island combined, but has a population density of less than 25 persons/square mile. With a population of more than 40,000, the greater Ukiah community includes almost half of the county population, while 30% live in coastal communities. Ethnically, residents are 25% Hispanic, with about 9% being monolingual in Spanish. Racially, the county is 86% White, 6% Native American, 2% Asian, 1% Black, and 5% of other or multiple races.

One of every five residents lives in poverty, and 27% of children live in homes that are at or below the federal poverty level. The median household income of $42,980 is only 70% of the statewide median. Among children, 44.7% are enrolled in Medi-Cal, compared with 40.5% statewide, and 67.2% of local students participate in the free and reduced price meal program. The Cities of Ukiah (pop. 16,186) and Fort Bragg (pop. 7,672) are the primary service centers for inland and coastal communities, respectively. The California Family Economic Self-Sufficiency Standard quantifies the costs of basic needs for California's working families. As of 2014, the self-sufficiency standard for a single Mendocino County adult was $22,212, equivalent to a full-time income at $10.52 per hour. However, 21% of residents have incomes below the self-sufficiency standard.

Oral Health Status and Vulnerable Population Indicators. Local evidence makes it clear that vulnerable groups in the county, especially children in low-income homes, are suffering from poor dental health. This evidence is supported by the following indicators:

- At 950/100,000 population, the county's rate of preventable dental emergency room visits is more than three times the statewide rate of 298/100,000 population, and higher than all but 6 of the state's 58 counties.
- Seven of the county's census tracts are designated as Health Professional Shortage Areas (HPSA) for dental health.
- At averages of 95% for exclusive breastfeeding and 73.5% for any breastfeeding, Mendocino County ranks 28th among California counties for breastfeeding rates.
- In 2016, the county's rate of substantiated child abuse was 17.7/1,000, more than double the statewide rate of 7.8/1,000, and as of July 2016 the foster care rate of 13.9/1,000 was also more than double the statewide rate of 5.0/1,000.
- The California Health Interview Survey (CHIS) found that 87.8% of county children had visited a dentist in the past year.
- Mendocino County has an oral cancer rate of 12.3/100,000 population (6 among females and 18.8 among males), compared with 10.4 statewide.
- CHIS data show that 17.6% of county adults consume one or more cans of soda per day, compared with 17.4% statewide. Among county children, 21.3% (compared with 27% statewide) consume at least one soda daily.
- The ratio of dentists is 1 for 1,270 residents, slightly above the state ratio of 1:1,250 (equal to about 79 dentists/100,000 population).
- 13% of adults are smokers, slightly above the state average of 12%.

- Although state law requires schools to conduct dental health screenings, Mendocino County schools have not reported these data and it is not clear whether they are participating in required school screening at this time.

The 2006 Rural Health Information Survey found significant disparities in access to oral health care in the Redwood Coast Region that includes Mendocino County:

- People living in poverty were the least likely to have had their teeth professionally cleaned in the past year and 6.8 times more likely to have gone 5 or more years without professional teeth cleaning.
- Adult respondents living in households with children were less likely than adult respondents living in households without children to have their teeth cleaned.
- Respondents of color were less likely to have their teeth professionally cleaned than white respondents.
- Younger adult respondents (18-29 years) were the least likely to have their teeth professionally cleaned in the past year compared to older adults.
- Oral health care was a commonly reported reason for regularly leaving the county of residence for health services.

Local Oral Health Program (LOHP). The Mendocino County Health and Human Services Agency (HHSA) has yet to develop a focused effort for addressing and improving oral health. However, HHSA has undertaken the related activities described below and is looking forward to further developing this program through the proposed grant funds.

- Since October 2011, HHSA has been supporting a ReThink Your Drink campaign, focused on both reducing consumption of sugar-sweetened beverages and increasing consumption of water.
- In October 2017, HHSA will launch the Health Families America (HFA) Home Visiting Program, which is evidence-based and incorporates strategies for increasing breastfeeding and improving oral health.
- Mendocino County has an active Tobacco Control Program in place.

LOHP vision. HHSA is committed to carrying out a formal planning process that will lead to implementation of a comprehensive Local Oral Health Program resulting in better dental health for county residents. The planning process will be conducted in collaboration with a range of community partners, including local hospitals and clinics, through an advisory committee structure. Upon completion of community assessments, HHSA will have gained a clear understanding of the status of oral health among the general adult and child populations and among specific subgroups and vulnerable populations, as well as detailed information on specific indicators such as dental sealant rates. This information will be used to develop a five-year oral health improvement plan that incorporates clear surveillance procedures. At this point in the planning process, HHSA envisions a strong focus on the following areas:

- School screenings and preventive education
- Tobacco prevention education through dental offices
- Dental health education and promotion through community outreach
- HFA program that incorporates dental health education

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Scope of Work and Deliverables
FY 2017-2022

GOAL: The California Department of Public Health, Oral Health Program (CDPH/OHP) shall grant funds to Local Health Jurisdictions (LHJ) from Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Prop 56) for the purpose and goal of educating about oral health, dental disease prevention, and linkage to treatment of dental disease including dental disease caused by the use of cigarettes and other tobacco products. LHJs are encouraged to implement the strategies recommended in the California Oral Health Plan and shall establish or expand upon existing Local Oral Health Programs (LOHP) to include the following program activities related to oral health in their communities: education, dental disease prevention, linkage to treatment, surveillance, and case management. These activities will improve the oral health of Californians.

Objectives 1-5 below represent public health best practices for planning and establishing new LOHPs. LHJs are required to complete these preliminary Objectives before implementing Objectives 6-11 outlined below. LHJs that have completed these planning activities may submit documentation in support of their accomplishments. Please review the LOHP Guidelines for information regarding the required documentation that must be submitted to CDPH OHP for approval.

Objective 1: Build capacity and engage community stakeholders to provide qualified professional expertise in dental public health for program direction, coordination, and collaboration.

Create a staffing pattern and engage community stakeholders to increase the capacity to achieve large-scale improvements in strategies that support evidence-based interventions, health system interventions, community-clinical linkages, and disease surveillance and evaluation. At a minimum an Oral Health Program Coordinator position should be developed to coordinate the LOHP efforts. Recruit and engage key stakeholders to form an Advisory Committee or task force. Convene and schedule meetings, identify goals and objectives, and establish communication methods. This group can leverage individual members' expertise and connections to achieve measurable improvements in oral health.

Objective 2: Assess and monitor social and other determinants of health, health status, health needs, and health care services available to California communities, with a special focus on underserved areas and vulnerable population groups.

Identify partners and form a workgroup to conduct an environmental scan to gather data, create an inventory of resources, and plan a needs assessment. Conduct a needs assessment to determine the need for primary data, identify resources and methods, and develop a work plan to collect missing data. Collect, organize, and analyze data. Prioritize needs assessment issues and findings, and use for program planning, advocacy, and education. Prepare a report and publish widely.

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Objective 3: Identify assets and resources that will help to address the oral health needs of the community with an emphasis on underserved areas and vulnerable population groups within the jurisdiction.

Take an inventory of the jurisdiction's communities to identify associations, organizations, institutions and non-traditional partners to provide a comprehensive picture of the LHJ. Conduct key informant interviews, focus groups, and/or surveys, create a map, and publish the assets identified on your website or newsletter.

Objective 4: Develop a Community Health Improvement Plan (CHIP) and an action plan to address oral health needs of underserved areas and vulnerable population groups for the implementation phase to achieve local and state oral health objectives.

Identify a key staff person or consultant to guide the community oral health improvement plan process, including a timeline, objectives, and strategies to achieve the California Oral Health Plan. Recruit stakeholders, community gatekeepers, and non-traditional partners identified in the asset mapping process and members of the AC to participate in a workgroup to develop the CHIP and the Action Plan. The Action Plan will a timeline to address and implement priority objectives and strategies identified in the CHIP. The workgroup will identify the "who, what, where, when, how long, resources, and communication" aspects of the Action Plan.

Objective 5: Develop an Evaluation Plan that will be used to monitor and assess the progress and success of the Local Oral Health Program.

Participate with the CDPH OHP to engage stakeholders in the Evaluation Plan process, including those involved, those affected, and the primary intended users. Describe the program using a Logic Model, and document the purpose, intended users, evaluation questions and methodology, and timeline for the evaluation. Gather and analyze credible evidence to document the indicators, sources, quality, quantity, and logistics. Justify the conclusions by documenting the standards, analyses, interpretation, and recommendations. Ensure that the Evaluation Plan is used and shared.

Objective 6: Implement evidence-based programs to achieve California Oral Health Plan objectives.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to increase the number of low-income schools with a school-based or school-linked dental program; increase the number of children in grades K-6 receiving fluoride supplements, such as fluoride rinse, fluoride varnish, or fluoride tablets; increase the number of children in grades K-6 receiving dental sealants and increase or maintain the percent of the population receiving community fluoridated water.

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Objective 7: Work with partners to promote oral health by developing and implementing prevention and healthcare policies and guidelines for programs, health care providers, and institutional settings (e.g., schools) including integration of oral health care and overall health care.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: convene partners (e.g., First 5, Early Head Start/Head Start, Maternal Child and Adolescent Health (MCAH), Child Health and Disability Prevention (CHDP), Black Infant Health (BIH), Denti-Cal, Women, Infant and Children (WIC), Home Visiting, schools, community-based organizations, etc.) to improve the oral health of 0-6 year old children by identifying facilitators for care, barriers to care, and gaps to be addressed; and/or increase the number of schools implementing the kindergarten oral health assessment by assessing the number of schools currently not reporting the assessments to the System for California Oral Health Reporting (SCOHR), identifying target schools for intervention, providing guidance to schools, and assessing progress.

Objective 8: Address common risk factors for preventable oral and chronic diseases, including tobacco and sugar consumption, and promote protective factors that will reduce disease burden.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: increase the number of dental offices providing tobacco cessation counseling; and/or increase the number of dental office utilizing Rethink Your Drink materials and resources to guide clients toward drinking water, especially tap water, instead of sugar-sweetened beverages.

Objective 9: Coordinate outreach programs, implement education and health literacy campaigns, and promote integration of oral health and primary care.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: increase the number of dental offices, primary care offices, and community-based organizations (CBO) (e.g., Early Head Start/Head Start, WIC, Home Visiting, BIH, CHDP, Community Health Worker/Promotora programs, etc.) using the American Academy of Pediatrics' Brush, Book, Bed (BBB) implementation guide; and/or increase the number of dental offices, primary care clinics, and CBOs using the Oral Health Literacy implementation guide to enhance communication in dental/medical offices; and/or increase the number CBOs that incorporate oral health education and referrals into routine business activities.

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Objective 10: Assess, support, and assure establishment and improvement of effective oral healthcare delivery and care coordination systems and resources, including workforce development and collaborations to serve vulnerable and underserved populations by integrating oral health care and overall health care.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: regularly convene and lead a jurisdiction-wide Community of Practice comprised of Managed Care Plans, Federally Qualified Health Centers, CBOs, and/or Dental Offices focused on implementing the Agency for Health Care Research and Quality's Design Guide for Implementing Warm Handoffs in Primary Care Settings or the ; and/or identifying a staff person or consultant to facilitate quality improvement coaching to jurisdiction-wide Community of Practice members focused on increasing the number of at-risk persons who are seen in both a medical and dental office; and/or improve the operationalization of an existing policy or guideline, such as the increasing the number of infants who are seen by a dentist by age 1; and/or promote effectiveness of best practices at statewide and national quality improvement conferences.

Objective 11: Create or expand existing local oral health networks to achieve oral health improvements through policy, financing, education, dental care, and community engagement strategies.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: create a new (or expand an existing) Oral Health Network, Coalition, or Partnership by identifying key groups and organizations; planning and holding meetings; defining issues and problems; creating a common vision and shared values; and developing and implementing an Action Plan that will result in oral health improvements. LHJs are also encouraged, where possible, to collaborate with local Dental Transformation Initiative (DTI) Local Dental Pilot Projects to convene stakeholders and partners in innovative ways to leverage and expand upon the existing momentum towards improving oral health. LHJs that are currently implementing local DTI projects should develop complementary, supportive, but not duplicative activities.

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DELIVERABLES/OUTCOME MEASURES: LHJs are encouraged to implement the strategies recommended in the California Oral Health Plan. Funds are made available through Prop 56 to achieve these deliverables. The activities may include convening, coordination, and collaboration to support planning, disease prevention, education, surveillance, and linkage to treatment programs. To ensure that CDPH fulfills the Prop 56 requirements, LHJs are responsible for meeting the assurances and the following checked deliverables. Deliverables not met will result in a corrective action plan and/or denial or reduction in future Prop 56 funding.

Local Health Jurisdiction Deliverables

Deliverable	Activities	Selected deliverable
Deliverable 1 *Objective 1*	Develop Advisory Committee/Coalition/Partnership/Task Force (AC) and recruit key organizations/members representing diverse stakeholders and non-traditional partners. A. List of diverse stakeholders engaged to develop and mentor the Community Health Improvement/Action Plan. B. List number of meetings/conference calls held to develop a consensus of AC to determine best practice to address priorities and identify evidence-based programs to implement. C. Develop communication plan/methods to share consistent messaging to increase collaboration. D. Develop a consensus on how to improve access to evidence based programs and clinical services.	☒
Deliverable 2 *Objective 1*	Document staff participation in required training webinars, workshops and meetings.	☒
Deliverable 3 *Objective 2 & 3*	Conduct needs assessment of available data to determine LHJs health status, oral health status, needs, and available dental and health care services to resources to support underserved communities and vulnerable population groups.	☒
Deliverable 4 *Objective 4*	Five-year oral health improvement plan (the "Plan") and an action plan (also called the "work plan"), updated annually, describing disease prevention, surveillance, education, linkage to treatment programs, and evaluation strategies to improve the oral health of the target population based on an assessment of needs, assets and resources.	☒
Deliverable 5 *Objective 5*	Create a program logic model describing the local oral health program and update annually	☒
Deliverable 6 *Objective 5*	Coordinate with CDPH to develop a surveillance report to determine the status of children's oral health and develop an evaluation work plan for Implementation objectives.	☒

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Deliverable	Activities	Selected deliverable
Deliverable 7 *Objective 6* School- Based/ School Linked	Compile data for and report annually on educational activities, completing all relevant components on the Data Form: A. Schools meeting criteria of low-income and high-need for dental program (>50% participation in Free or Reduced Price Meals (FRPM) participating in a fluoride program. B. Schools, teachers, parents and students receiving educational materials and/or educational sessions. C. Children provided preventive services.	☒
Deliverable 8 *Objective 6* School-Based/ School-Linked	Compile data for and report annually on School-based/linked program activities, completing all relevant components on the Data Form: A. Schools meeting criteria of low-income and high-need for dental program (>50% participation in Free or Reduced Price Meals (FRPM) participating in a School-based/linked program. B. Schools, teachers, parents and students receiving dental sealant educational materials and/or educational sessions. C. Children screened, linked or provided preventive services including dental sealants.	☒
Deliverable 9 *Objective 6* Fluoridation	Compile data for and report annually on Community Water Fluoridation program activities, completing all relevant components on the Data Form: A. Regional Water District engineer/operator training on the benefits of fluoridation. B. Training for community members who desire to educate others on the benefits of fluoridation at Board of Supervisor, City Council, or Water Board meetings. C. Community-specific fluoridation Education Materials D. Community public awareness campaign such as PSAs, Radio Advertisements	☒

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Deliverable	Activities	Selected deliverable
Deliverable 10 *Objective 7* Kinder-Assessment	Compile data for and report annually on kindergarten oral health assessment activities, completing all relevant components on the Data Form: A. Schools currently not reporting the assessments to SCHOR B. Champions trained to promote kindergarten oral health assessment activities C. Community public relations events and community messages promoting oral health. D. New schools participating in the kindergarten oral health assessment activities. E. Screening linked to essential services. F. Coordination efforts of programs such as kindergarten oral health assessment, WIC/Head Start, pre-school/school based/linked programs, Denti-Cal, Children's Health and Disability Prevention Program, Home Visiting and other programs.	☒
Deliverable 11 *Objective 7*	Compile data for and report annually on tobacco cessation activities, completing all relevant components on the Data Form: A. Assessment of readiness of dental offices to provide tobacco cessation counseling. B. Training to dental offices for providing tobacco cessation counseling. C. Dental offices connected to resources	☒
Deliverable 12 *Objective 8*	Compile data for and report annually on Rethink Your Drink activities, completing all relevant components on the Data Form: A. Assessment of readiness of dental offices to implement Rethink Your Drink materials and resources for guiding patients toward drinking water. B. Training to dental offices for implementing Rethink Your Drink materials. C. Dental offices connected to resources	☐
Deliverable 13 *Objective 9*	Compile data for and report annually on health literacy and communication activities, completing all relevant components on the Data Form: A. Partners and champions recruited to launch health literacy campaigns B. Assessments conducted to assess opportunities for implementation C. Training and guidance provided D. Sites/organizations implementing health literacy activities	☐

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Deliverable	Activities	Selected deliverable
Deliverable 14 Objective 10	Compile data for and report annually on health care delivery and care coordination systems and resources, completing all relevant components on the Data Form: A. Assessments conducted to assess opportunities for implementation of community-clinical linkages and care coordination B. Resources such as outreach, Community of Practice, and training developed C. Providers and systems engaged	☐
Deliverable 15 *Objective 11*	Compile data for and report annually on community engagement activities, completing all relevant components on the Data Form: A. Develop a core workgroup to identify strategies to achieve local oral health improvement. B. Provide a list of community engagement strategies to address policy, financing, education, and dental care.	☒
Deliverable 16 *Objective 1-11*	**Progress reporting:** submit bi-annual progress reports describing in detail progress of program and evaluation activities and progress towards completing deliverables. Provide documentation in sufficient detail to support the reported activities on planning and intervention activities for required and selected objectives.	☒
Deliverable 17 *Objective 1-11*	**Expense documenting:** submit all expenses incurred during each state fiscal year with the ability to provide back-up documentation for expenses in sufficient detail to allow CDPH-OHP to ascertain compliance with Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Likewise, provide biannual Progress Reports describing in detail the program activities conducted, and the ability to provide source documentation in sufficient detail to support the reported activities.	☒