Exhibit A
Application Checklist

DUE: Wednesday, September 20, 2017 (extended to Oct. 4 2017 by Angela Wright OHP Staff)	
DATE OF SUBMISSION	Oct. 4, 2017
ORGANIZATION NAME	San Francisco Department of Public Health
Application Contact Name: Margaret Fisher	**Phone Number: 415-575-5719**
E-mail Address: margaret.fisher@sfdph.org	

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

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

One copy 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.

Grantee Information Form

Organization

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

Federal Tax ID # 94-6000417

Name San Francisco Dept. of Public Health

Mailing Address 101 Grove St.

Street Address (If Different)

County San Francisco

Phone (415) 554-2500 Fax 415 554-2710

Website https://www.sfdph.org/dph/default.asp

Grant Signatory

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

Name Barbara Garcia

Title Director of Public Health

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

Mailing Address

Street Address (If Different)

Phone 415-554-2526 Fax 415 554-2710

Email Barbara.Garcia@sfdph.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 Margaret Fisher

Title Dental Hygienist – CHDP Oral Health Consultant

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

Mailing Address 30 Van Ness Ave. Suite 210

Street Address (If Different)

Phone 415-575-5719 Fax 415-558-5905

Email Margaret.fisher@sfdph.org

Funding

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

Year 1 (FY 17/18)	$ 308,879
Year 2 (FY 18/19)	$308,879
Year 3 (FY 19/20)	$308,879
Year 4 (FY 20/21)	$308,879
Year 5 (FY 21/22)	$308,879

Narrative Summary Form

San Francisco Department of Public Health

Overview of SF current status of oral health: Despite a steady decline in the past 10 years, dental decay remains a prevalent local health problem in San Francisco, In 2015–16, **35 %** of San Francisco Unified School District (SFUSD) kindergarteners had experienced caries, **18 %** had untreated decay.

Vulnerable and/or underserved population(s): Consistent with nationwide patterns and trends, disparities in oral health persist in San Francisco. Low-income and minority children have higher tooth decay rates. In San Francisco, low-income, Black\African American, Latino, and Asian children continue to be twice as likely to experience dental decay as higher-income and White children). Caries experience clusters by neighborhood in the: Chinatown/North Beach, Tenderloin/South of Market, Mission, Bayview Hunters Point, and Visitacion Valley neighborhoods in San Francisco (District 10). The percentage of SF Unified School District (SF's only public school district) students eligible for Free or Reduced Price School Meals (a marker for low-income families) in 2015 was 64.3%, higher than the state average of 58.6%. Almost a quarter of SF children (0-17) live in poverty, while 30.7% of SF Children 0-21 are enrolled in Medi-Cal.

Access: Declines in caries experience from 2009 and 2014 are attributed to suspension of adult Denti-Cal services. During this time dentists who accept Denti-Cal patients accepted more children as child Denti-Cal services remained available. This 5-year period of relatively improved access to pediatric dental care ended with the restoration of adult dental services and expansion of the Affordable Care Act (ACA). Medi-Cal dental provider reimbursement rates continue to be the lowest in the nation and are significantly below the fees most dentists charge. This low rate of reimbursement coupled with the high cost of doing business in SF, has resulted in many private dental offices is continuing their acceptance of Denti-Cal patients. The wait times for dental appointments in San Francisco community clinics have increased dramatically in the past year. This has resulted in less than ⅓ of eligible Medi-Cal children having any kind of dental visit in the past year, while the percentage of preventive Denti-Cal annual visits has declined in the past few years.

Demographics: San Francisco is home to 58,000 families with children (approximately 114,000 children under the age of 18), 29 % of which are headed by single parents. Although the overall number of children under 18 decreased 7 % in the last 20 years, the number of school-aged children is projected to rise by 28 % by 2020. Almost 1 in 3 San Franciscans (211,000 people) live below 200% of the federal poverty level. There is significant inequality in household income between races. White household median income is over $100k Black/African American household median income is $30k. San Francisco has the highest income inequality in California. Between 2007 and 2014, the widening income gap was driven primarily by increasing incomes among the highest earners while incomes among lower earners stagnated. The wealthiest 5% of households in SF earn 44 times more than the poorest 20% of households. Low income impacts lifetime health, beginning with pregnancy and birth. Lower-income children in San Francisco experience higher rates of asthma, hospitalization, obesity, and dental caries.

Preventive Denti-Cal visits for 0-10 y.o.s	Total eligible <10	Total Preventive visits	Percentage
Total 2011 CY	22,059	6,845	31%
Total 2015 CY	38,040	10,334	27%

Geography: San Francisco is the cultural and commercial center of the Bay Area and is the only consolidated city and county jurisdiction in California. At 47 square miles, it is the smallest county, and most densely populated large city in California (population density of 18,187 residents per sq. mile) and the second most densely populated major city in the

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.

Scope of Work and Deliverables
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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 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	☒
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.	☒

Scope of Work and Deliverables
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	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. G. Identify prevention and healthcare policies and guidelines implemented.	
Deliverable 11 *Objective 8*	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	☐
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	☒

Scope of Work and Deliverables
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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.	☒

Documentation Checklist for Established LOHPs Only

DUE BY 5:00pm on Wednesday, September 20, 2017	
DATE OF SUBMISSION	Oct. 4, 2017
ORGANIZATION NAME	City and County of San Francisco Public Health Department
Application Contact Name: Margaret Fisher	**Phone Number:** 415-575-5719
E-mail Address: margaret.fisher@sfdph.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**
Objective 1 documentation:	
Organizational chart showing where the LOHP resides within the City/County structure	☒
Detailed staffing pattern of the LOHP	☒
Member list of the LOHP advisory group/task force	☒
Objective 2 documentation:	
Member list of workgroup that performed needs assessment	☒
Copy of published needs assessment results document, including data gaps identified, data gaps filled, and prioritized issues and findings	☒
Logic model	☒
Evaluation questions and conclusions	☒
Objective 3 documentation	
Inventory of assets and resources	☒
Survey instruments used	☒
Mapping	☒
Objective 4 documentation:	
Key staff member identified for guiding the community health improvement plan process.	☒
The Action Plan document, including a timeframe, objectives, strategies, resources needed, and communication.	☒
Member list of the workgroup engaged in the design of the Action Plan.	☒
Objective 5 documentation:	
Evaluation Plan	☒

Documentation Checklist for Established LOHPs Only

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.