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# General Questions

1. **Is a board resolution required by CDPH OOH?**

Board resolutions or motions are required and must accompany signed grant agreements.

1. **Can we have a copy of the slides?**

They are available at <https://oralhealthsupport.ucsf.edu/moving-california-oral-health-forward-rfa-2022-2027>.

1. **When do you anticipate that we will have our contract to take to the Board of Supervisors for approval?**  
     
   Grant agreements ready for signature are expected to be sent out by early January 2022.
2. **Do you know the name of the software LHJs will be using for referral management?**  
     
   Not yet. We are working through the procurement process. Once it is approved, we will have the name of the software.
3. **Are there any plans for the state to support LOHPs when facing complications internally from the county when trying to move OOH-approved activities forward?**

We’re not clear on what the “complications internally” might mean. However, you’re welcome to reach out to us to set up an appointment to discuss how we can help. We’re always here to support you and to help find answers to the questions you have, so you can move forward with the activities and achieve the goals.

1. **There is a bit of confusion in dental offices between the July 26 State health order (vax and testing, including dental offices) and the August 5 State health order (required vax, dental office not included). We receive many inquiries for clarification. (NEW)**

The July 26 state health order is what the dental offices should be looking at. The August 5th order is for providers who come in contact with Covid patients. By screening, dental offices are not supposed to see Covid patients. However, there are some counties (such as LA and San Francisco) where the August 5th order is applicable.

1. **What are the regional consortium models, especially for those underserved counties without any dental providers? (NEW)**

Initially, the regional consortium model was built into the first RFA. However, there weren’t any local health jurisdictions that opted for that model. Please contact OOH if you would like to submit an application that includes a regional or multi-county approach. When the Medicaid dental transformation program was released, there was a consortium of five counties that got together and submitted a joint application. CHEAC said they would like all state programs to allow one grant application on behalf of several counties. We strongly encourage a consortium if there are no providers in your county. You can work collaboratively even without a consortium in place.

# Application Documents and Process

1. **Is the supplemental submission the budget?**

Yes, the supplemental submission will be the budget, which is due Jan. 31, 2022.

1. **The previous objectives were limited to grades K-6. If the plan's goal, as described by Dr. Kumar, is to improve outcomes for pregnant women and young children and to reduce caries by 50% by 2030 in school age children, would you consider adding the preschool population (Head Start) and/or 0-3, such as other school readiness or WIC programs to be served by the LOHP? The children are already coming into kindergarten full of caries. Is there a way for us to focus on pregnant women and young children or at least include them so we can make an earlier impact?**  
     
   Yes, the 2022-2027 work plan includes improving outcome measures of dental visits during pregnancy, early care toothbrushing programs, medical/dental integration with primary care providers providing dental screenings and fluoride varnish applications for children under 5. The work plan also includes developing and implementing a plan to identify and recruit key partners that work with underserved populations: County First 5 Commission, County Office of Education, local Child Health and Disability Prevention, Women, Infants, and Children, Early Head Start/Head Start, Maternal, Child, and Adolescent Health, Black Infant Health, schools, community-based organizations (CBOs), and Home Visiting (HV) Programs.
2. **Will the OOH provide a template for the LOI, or do we just create something at the local level on letterhead and submit?**  
     
   The OOH has developed a template for the Letter of Intent. It’s Appendix 15 and is available on the COHTAC website: <https://oralhealthsupport.ucsf.edu/moving-california-oral-health-forward-rfa-2022-2027.>
3. **Does the Key Partners in Objective 3 refer specifically to KOHA?**  
     
   No, the key partners in 3.2 refers to promoting oral health by increasing our reach to underserved populations by integrating oral health in primary care or other non-dental settings through oral health education, assessment, counseling, and linkage to care in the community (referral, and follow-up for oral health care).
4. **Will there be a link sent to the LOHP's for the application process with the necessary forms?**  
     
   Yes. All RFA appendices and documents can also be found by accessing: <https://oralhealthsupport.ucsf.edu/moving-california-oral-health-forward-rfa-2022-2027>
5. **Will there be any changes to the budget template and budget modification template for the next funding cycle?**  
     
   The budget template has been modified slightly from the prior version.
6. **Is it suggested to provide preventive dental screenings/varnish in Pre-K programs or focus on elementary school age children for the actual school-based programs?**  
     
   Objective 2 Community Clinical Linkages is referring to elementary school age children. Your LOHP can choose the model of your school dental program; school-based or school-linked depending on the resources available. School-linked would entail dental screenings with a robust, trackable referral system as outlined in the work plan. School-based sealant programs is considered evidenced based intervention and is the goal. You can plan to expand the school dental program to include preventive services and implement when feasible.
7. **The Appendix-15 Letter of Intent available on the COHTAC website is not in a fillable format. Can you please provide us with one that is?**

The fillable Word version is available [here](https://oralhealthsupport.ucsf.edu/sites/g/files/tkssra861/f/wysiwyg/Appendix%2015%20-%20Letter%20of%20Intent.docm).

1. **Would there be an opportunity for a new county to engage with a legacy county of similar size to discuss their 2018-22 project scope, budget, staff time over the five-year workplan, etc.? Would love to get some perspective before letter of intent is due.**

Great idea! Please email us regarding your technical assistance need to [DentalDirector@cdph.ca.gov](mailto:DentalDirector@cdph.ca.gov). We will put you in touch with a legacy program.

1. **For the community linkage objective, will CDPH continue to approve software costs?**

Yes. The LOHP will have the opportunity to subscribe to the State’s procured referral management software which will be available in the new fiscal year. The LOHP will also have the option to purchase a referral management software system that works best for them within their budget.

1. **Will the state have LHJs evaluate the objectives the same way during this grant cycle?**   
     
   Yes, each LOHP will utilize the Evaluation Plan they developed to evaluate the work plan objectives.

1. **Should the application documents that are not fillable PDF be converted to Word for us to have our working documents, then re-saved as PDF for submitting? Specifically, document A, B, and C, as well as the work plan.** (**NEW**)

We will re-save these as Word documents and have them available on COHTAC for LOHPs to access.

1. **Given “The goal of the LOHP is to create and expand capacity at the local level to educate, prevent, and provide linkages to treatment programs, including dental disease caused by the use of cigarettes and other tobacco products." Does this mean a greater focus on adults? Dental Offices? Medical Offices? (NEW)**

For objective 8 and tobacco cessation, since tobacco use is related to so many issues of oral health, it is a focus and most of the time involves adults. As LOHPs develop relationships with dental providers, we’re asking them to address things like RYD and tobacco cessation. This would be at that level to encourage dental providers to provide screenings, tobacco cessation information and general information. Our focus for this objective does include adults. It could include medical offices as well as dental offices. We want to ensure dental offices have the resources to provide for tobacco cessation. We anticipate LOHPs will collaborate with tobacco control and NEOPB funded programs in this process. These funded programs have scopes of work that cover their communities. However, they may not address oral health. It is our goal for LOHPs to partner with these programs to integrate oral health messages and/or partner in activities that promote oral health and tobacco cessation or reducing sugar sweetened beverages. It is not our intention for LOHPs to work independently or duplicate efforts.

1. **For the school-based programs, there are options (school-based, linked, sealant, etc.) Do we choose one? (NEW)**

Yes, but it depends as each LOHP varies by population and resources. We’re looking for, at a minimum, a school-linked program where oral hygiene counseling, screenings, and referrals are provided, and a robust referral program is in place to follow up and ensure kids are getting linked to a dental home. Ideally, a school sealant program would be implemented, as that’s the evidence-based approach. School-based options could add other preventive services like cleanings and comprehensive care. Initially, LOHPs with limited resources may start with a school-linked program and expand over the years with different elements, as possible (resources, partnerships, sealants, other preventive services) to a full school-based program, if possible. However, hybrid models would also be acceptable; some LOHPs may already have some schools participating in a school-based program but due to limited resources may not be able to expand to other schools at this time in their local health jurisdiction. They may determine the school-linked model would be offered for those schools until additional capacity is established.

1. **Can we use a previous payee form if information still current? (NEW)**

Yes. You can submit a prior payee form if current.

1. **In the application packet it's stated that, “The target for community-clinical linkages will be that a minimum of 50% of eligible schools will have a dental program by 2027.” What constitutes a “dental program”? Does the KOHA count as a dental program since we’re working with schools and children? (NEW)**

KOHA is done in two ways, primarily. One is the SF model where there is a partnership with schools and dental society and local public health program. We consider that a program. The other model is what San Diego does where they have a performance management system and track everything. That we also consider as a program. If the school is distributing the assessment forms on their own and dentists/dental hygienists are filling out the forms and sending to schools and your role is limited, we don’t count that as a program. See how these models fit with your county and decide if it’s a program or not.

1. **On the Grant Activity Form, do we just check the objectives 1-7. Or is there more to it? Do we select activities of our choice? (NEW)**

As you read down through the objectives, check the ones you are doing as either a new program or a legacy program. Read through them, mark the boxes 1-7 and submit that form with your application.

1. **Related to tobacco cessation, can you link the "state" or "COHTAC" training cited in the work plan? Would UCSF be able to help us be able to offer those CEU units to our provider offices? (NEW)**

Dr. Chaffee shared the following information. Most of our formal trainings to date have been live and the availability of CDE units has varied depending on the sponsor of the event. Therefore, the Online Toolkit we've been developing is intended to serve as asynchronous training content. UCSF is also putting together a one-hour, online training session that can be taken anytime (with CDE units available!). We are hoping to have the online Training and the Toolkit unveiled at the same time.

*“One caveat on CDE units - there is effort required on our end to continue offering credit after the online course is launched. We may not be able to provide that service if there's not support for it in the next iteration of COHTAC.”*

While we are waiting for the final version of the Toolkit (which is now with a UCSF designer for beautification) and work to finalize the online Training with CDE, we do have several resources on our COHTAC website available right now: [https://oralhealthsupport.ucsf.edu/our-programs/tobacco-cessation/resources](https://urldefense.com/v3/__https:/oralhealthsupport.ucsf.edu/our-programs/tobacco-cessation/resources__;!!AvL6XA!li3MCg0LqPURa9fHG6kuVO5WvEj8UvXAGFCtQI18xBpya_J6QlZBrdz94z-GO_2GjwYEw_s$)

The resources include:

* One webinar we recorded a few years back with the CA Smokers Helpline (now KickIt California),
* A brief video we produced for dental professionals on the 5As
* Multiple toolkits and facts sheets from outsides sources (and some from us!)
* There's also a survey template for dental professionals that we created and tested that could be applied in other settings

Plus, as part of COHTAC, we have published several articles about tobacco, cannabis, e-cigarettes, and tobacco cessation with a clinician audience in mind. All of these are freely available online, including in the CDA Journal, compiled here: [https://tobacco.ucsf.edu/publications/journal-california-dental-association-0](https://urldefense.com/v3/__https:/tobacco.ucsf.edu/publications/journal-california-dental-association-0__;!!AvL6XA!li3MCg0LqPURa9fHG6kuVO5WvEj8UvXAGFCtQI18xBpya_J6QlZBrdz94z-GO_2GMDALQ5Q$).

1. **Are we able to modify the Grant Activities to fit with our 5-year plan within our county? (NEW)**

For this next grant cycle, grant activities were not meant to be modified. However, we built flexibility into the work plan. That said, we can consider modifications on a case-by-case basis. If you have an idea for something that might fit within your county plan, we can consider it. Please reach out to your program consultant to let us know what you have in mind.

1. **Regarding this statement: “The strategies and activities should decrease tooth decay and untreated tooth decay and increase sealant prevalence by ten percentage points.” Does this need to be accomplished by a school sealant program or can we use data from local dental offices to show increased sealant placement due to our promotion and education around the importance of sealants? (NEW)**

Yes. This is a statewide goal. When we do the statewide survey, it’s a random sampling of children, which would include kids that have private dental insurance. They may go to FQHCs or use a school sealant program. Sealants are one of the items that the community guide included in its evaluation. Regarding education and promotion efforts, the Community Preventive Services Task Force (CPSTF) recommendation was that there was insufficient evidence to support education as a community strategy. Education alone is not likely to work. The CDC recommends school-based or school-linked program as having strong evidence for effectiveness.

1. **Are partnering dental providers allowed to bill for sealant or fluoride varnish services at school sites? (NEW)**

Yes. Dental providers can bill for sealants and varnishes at school sites. The role of the LOHP is as a facilitator and coordinator to start more of these services. We’re not allowed to use Prop 56 funds to pay for these services because the dental providers can bill for these services. When the provider bills for treatment services, they will create a sustainable school dental program.

1. **Is the goal to reduce by 10 percentage points (20% vs 10%) or by 10% (20% vs. 18%)? (NEW)**

Our intention is always 10 percentage points. It’s included in the workplan under reporting/outcome measures. Another way to put it is, whatever is higher is what we want to achieve.

1. **We are seeing pushback/hesitancy from school district officials on providing assessment and school-based services because of COVID and/or no time because it is seen as not as important as the education time happening in classrooms. Can there be a letter or a memo in collaboration with the department of education to help push the collaboration at the local level and importance of linking kids to a dental home? (NEW)**

It’s true there is hesitancy in the schools related to Covid safety. We’re seeing more schools opening now. The “no time” has always been an issue with schools. A good tip is to go into the local area schools and get buy-in from school district nurses and superintendents. OOH held a prior webinar on working with schools. A colleague from Santa Clara County went to some of the school district nurse meetings and laid out data on how many days children missed due to dental problems and how much it cost the schools due to those problems. We’re trying to bring services to where people are. If you bring services to schools, the child will miss less school than if the parent has to pull the child out of school to go to a dentist or keep the child home due to dental pain. The child would be missing whole school days in those scenarios. It will take a little time to see a reduction in absenteeism but stay with the education process. It is a priority for the California Department of Education to reduce chronic absenteeism. This is one area where it would be mutually beneficial to collaborate. Also, schools are incentivized to address disparities to increase overall student performance and success.

Please visit the COHTAC website to read Santa Clara County’s advice on connecting with school district nurses. Please also refer to all the resources for KOHA: [KOHA Toolkit | California Oral Health Technical Assistance Center (ucsf.edu)](https://oralhealthsupport.ucsf.edu/our-programs/school-programs/kindergarten-oral-health-assessment/koha-toolkit).

There is a current letter from the state superintendent posted on the CDE website encouraging schools on the KOHA and the importance of oral health. We are trying to get another letter, but this is the most current letter. [Here is a link to the website](https://www.cde.ca.gov/nr/el/le/yr21ltr0107.asp). You can share this with your local schools and partners to show them that oral health is an area of importance recognized by the state superintendent. The state superintendent’s letter was sent in January. But the link to the CDE website and form is 2008, not the new one. OOH is hoping the new forms will be posted in the next few weeks. In addition, the letter states the forms are effective immediately but since they will be issued after the new school started, SCOHR will continue to accept the old forms until the end of the 2021-2022 school year.

Stats about missed school days is gathered as part of California Health Interview Survey. About 440 school days are missed because of dental problems. This is the number one problem. Number two is asthma.

Angela Martin shared a suggestion during the Q & A for schools that state they have no time: LOHPs might be more successful focusing on after-school programs until schools recognize the value of oral health. Consider offering oral health care services to after-school programs as they are there to promote resources for students to increase students’ overall performance in school and help to promote school readiness.

1. **Please share the source that speaks about 4x lower GPA for students with oral pain. (NEW)**

Students with a toothache are 4x more likely to have a lower grade point average.

Source: Pourat N and Nicholson G. Unaffordable Dental Care Is Linked to Frequent School Absences. Los Angeles, CA: UCLA Center for Health Policy Research, 2009.

Available at: http://healthpolicy.ucla.edu/publications/Documents/PDF/Unaffordable%20Dental% Seirawan H, Faust S, Mulligan R. The impact of oral health on the academic performance of disadvantaged children. American journal of public health. 2012;102(9):1729-34.

Pourat, N., & Nicholson, G. Affordability of Needed Dental Care is linked to Frequent School Absences, pre-publication manuscript. Los Angeles: UCLA Center for Health Policy Research, Oct 2009.

1. **Please share the CHIS data about time missed in schools. (NEW)**

Dental problems are a leading cause of school absenteeism, 874,000 days /year, costing school districts an estimated $29.7 million annually in California. Also, Smile, CA has a slide with this data as part of their Back Tooth School campaign. The slide says more than 60% of students have experienced tooth decay by third grade. One in five kids have untreated tooth decay. Approximately 440,000 children missed at least one day of school due to a dental problem in 2018.

2018, California Health Interview Survey, UCLA Center for Health Policy Research. [California Health Interview Survey | UCLA Center for Health Policy Research](http://healthpolicy.ucla.edu/chis/Pages/default.aspx)

# Funding and Budget

1. **LOHP’s that fall under less than $200K are responsible for the same objectives as those agencies receiving $200-400K?**

Yes, funding amounts have been determined using the estimated low-income population based on the U.S. Census Bureau, 2015 American Community Survey 5-Year Estimates, which can be found at: 2015-2019 ACS 5-year Estimates ([census.gov](https://www.census.gov/programs-surveys/acs/data.html)). The funding formula was developed with input from CCLHO and CHEAC. The formula was not changed for this funding cycle.

1. **If LHJ’s decline the funding, will CDPH distribute those funding to other LHJ’s?**

No, any remaining funding will not be redistributed.

1. **If a county opts out of the funding, does it still stay in the county (i.e., funding is offered to a CBO or FQHC)?**  
     
   It would be determined if the LHJ opted to not continue. Please review the Guidelines on page 5. However, it is recommended by the OOH Advisory Committee that established LOHP programs continue with their LHJ.
2. **I have a question about Administrative Cost and Indirect Cost. Could you please elaborate if the administrative cost still applies to this cycle?**  
     
   Revenue and Taxation Code 30130.57(f) states: (f) Not more than 5 percent of the funds received pursuant to this article shall be used by any state or local agency or department receiving such funds for administrative costs.

The department negotiates the maximum indirect cost rate (ICR) an LHJ can charge in agreements, but that does not supersede requirements in RTC 30130.57(f). The statute limitation is based on the total amount received annually, which is different than how the ICR is figured. Additionally, not all the indirect costs will be considered administrative costs, so it is recommended you determine what is included in this line item and then confer with your legal office to ensure compliance with the statute.

The definition at State level to calculate these costs is: Costs incurred by CDPH for administrative functions performed by Human Resources Division, Financial Management Branch, Program Services Branch, Information Technology Division, Office of Legal Services, Director’s Office and the department’s indirect costs rate. These costs do not include OOH program costs related to administering OOH, including issuing Requests for Proposals (RFP)/Applications (RFA), Inter-Agency Agreements, contracts, grants and monitoring those contracts and agreements.

1. **Could you elaborate on Sponsorship (Appendix 12)? Is it separate funding? For example, if LHJs sponsor a dental screening event for going back to school events, do LHJs fill out a separate request or should we build in budgets ahead of time?**

Follow the guidelines in [Appendix 12 - Sponsorship.pdf (ucsf.edu)](https://oralhealthsupport.ucsf.edu/sites/g/files/tkssra861/f/wysiwyg/Appendix%2012%20-%20Sponsorship.pdf). It is not separate funding. If you plan to sponsor an event, then yes, build it into the budget. If an opportunity occurs following budget approval, submit it at the next budget approval. In both cases you will submit your project idea to OOH through your Program Consultant and [DentalDirector@cdph.ca.gov](mailto:DentalDirector@cdph.ca.gov) for prior approval.

1. **We have been allowed to use grant funds for KOHA incentives. Can we continue to do so?**

Yes, please submit your request to your Program Consultant so that we can review and ensure it follows the guidelines.

1. **For Legacy Programs, are the budget revision dates the same (i.e., April and September)? What about invoice dates?**

Yes, the deliverable dates are the same for all the LOHPs.

1. **With the disruption of program activities and remote learning because of the pandemic, will program evaluation carry over to the new grant cycle for legacy programs to better evaluate outcomes as in-person schooling fully resumes over the next year?**  
     
   No, funding from the 2017-2022 grant term will not carry forward to the new 2022-2027 grant term. However, LOHPs will be allowed to carry forward unused funds in the new term from year 1 to year 2 and so on if State funding is available.

# Stipends

1. **Schools have reported that a barrier to entering KOHA data into the SCOHR database is cost of personnel to do this work. Will LOHP be able to provide a stipend to schools with higher FRLP rates, to promote data entry?**

Initially when the law was passed there was a specific amount. When the Department of Education, in addressing local control, developed a new system of pooled funding and a new locally controlled funding plan and formula. As part of that if community members, parents, stakeholders attend those funding discussions, they can advocate that funding for KOHA completion and personnel be dedicated for that purpose.We are interested in discussing more with LOHPs pilot projects or propositions. Let us know before you submit your application what a potential incentive or pilot project you’d like to start.

1. **The instructions were clear that the stipends needed to be in the budget revision, but the additional instructions were a bit confusing…**   
     
   **"2. Submit a stipend request to your Program Consultant (PC) and cc the Dental Director and include:**

**- the cost per dental professional (include if the cost is hourly or per day)**

**- total cost  
- number of children screened**

**- total # of kindergartener children in your jurisdiction . . . "**

For auditing purposes, OOH needs a record of the details for the cost and number of children reached. In addition, OOH needs to review the overall plan to determine if the use of stipends is appropriate.

1. **Do the stipends need to be preapproved via an email submission or, if the budget is approved, then the stipends outlined are considered approved?**

Please submit your proposed plan for stipends provided as outlined in the guidelines to your Program Consultant and [DentalDirector@cdph.ca.gov](mailto:DentalDirector@cdph.ca.gov) for approval. Although, the amount is included in the budget, specific details may be unknown at the time the budget is submitted.

1. **How do stipends work and what are the limits per day for DDS?**  
     
   Please refer to the guidance document emailed on 9/28/2021, Guidance for KOHA Stipends. If you feel that you did not receive the email, please email [DentalDirector@cdph.ca.gov](mailto:DentalDirector@cdph.ca.gov) and it will be forwarded to you.