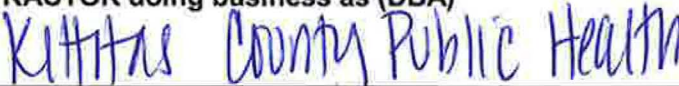

	<b>CONTRACT AMENDMENT</b> <b>ABCD Dental Services</b>	HCA Contract No.: K763  Amendment No.: 02
<b>THIS AMENDMENT TO THE CONTRACT</b> is between the Washington State Health Care Authority and the party whose name appears below, and is effective as of the date set forth below.		
<b>CONTRACTOR NAME</b> Kittitas County Public Health Department	<b>CONTRACTOR doing business as (DBA)</b> 	
<b>CONTRACTOR ADDRESS</b> 507 North Nanum Street, Suite 102, Ellensburg, WA 98926	<b>WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI)</b> 	

WHEREAS, HCA and Contractor previously entered into a Contract for increased utilization of dental services early in life, improved oral health, and Apple Health/Medicaid cost savings and;

WHEREAS, HCA and Contractor wish to amend the Contract pursuant to Section titled Period of Performance, and;

NOW THEREFORE, the parties agree that the Contract is amended as follows.

1. Section 3. Special Terms and Conditions. **Statement of Work.**

Changes to Section 3 Statement of work is hereby replaced in its entirety with Attachment 1.

2. Section 4. Special Terms and Conditions. **Consideration.**

The maximum consideration is hereby increased by \$4,750.

3. Section 5. Special Terms and Conditions. **Term.**

The period of performance is hereby extended from July 1, 2017 through December 31, 2017.

4. Section 6. Special Terms and Conditions. **Billing and Payment (a) and (b).**

Contractor must submit accurate invoices to the following address for all amounts to be paid by HCA via e-mail to: [Acctspay@hca.wa.gov](mailto:Acctspay@hca.wa.gov). Include the HCA Contract number in the subject line of the email.

Invoices must describe and document to HCA's satisfaction a description of the work performed, the progress of the project, and fees. If expenses are invoiced, invoices must provide a detailed breakdown of each type. Any single expense in the amount of \$50.00 or more must be accompanied by a receipt in order to receive reimbursement. All invoices will be reviewed and must be approved by the Contract Manager or his/her designee prior to payment.


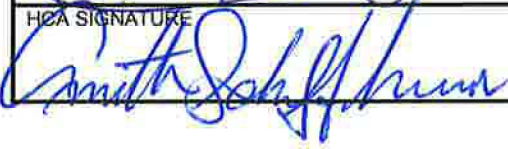
Contractor must submit properly itemized invoices to include the following information, as applicable:

HCA Contract number; K763-03  
Contractor name, address, phone number;  
Description of Services;  
Date(s) of delivery;  
Net invoice price for each item;  
Applicable taxes;  
Total invoice price; and  
Payment terms and any available prompt payment discount.

HCA will return incorrect or incomplete invoices to the Contractor for correction and reissue. The Contract Number must appear on all invoices, bills of lading, packages, and correspondence relating to this Contract.

5. Exhibit A, A1 and A2. ABCD Quarterly Outreach & Case Management Report, is hereby replaced in its entirety with Exhibit A3.
6. Exhibit B, B1 and B2. Community Outreach and Coordination of Care Report, is hereby replaced in its entirety with Exhibit B3.
7. Exhibit D, D1 and D2. Budget Tool, is hereby replaced in its entirety with Exhibit D3.
8. HCA contact is Janice Tadeo, Dental Program Administrator at [Janice.tadeo@hca.wa.gov](mailto:Janice.tadeo@hca.wa.gov)
9. This Amendment shall be effective July 1, 2017 ("Effective Date").
10. All capitalized terms not otherwise defined herein have the meaning ascribed to them in the Contract.
11. All other terms and conditions of the Contract remain unchanged and in full force and effect.

The parties signing below warrant that they have read and understand this Amendment and have authority to execute the Amendment. This Amendment will be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE 	PRINTED NAME AND TITLE Robin Read, Administrator	DATE SIGNED 9/12/17
HCA SIGNATURE 	PRINTED NAME AND TITLE ANNETTE SCHUPPENHAUER CHIEF LEGAL OFFICER	DATE SIGNED 9/27/17

## 1. **Statement of Work**

The Contractor shall provide the services and staff, and otherwise do all things necessary for or incidental to the performance of work, as set forth below:

- a. In accordance with deadlines in Exhibit A3, ABCD Outreach and Case Management Report, develop and implement an ABCD action plan in accordance with the ABCD program principles and submit corresponding budget, using Exhibit D3, Budget Tool. The ABCD program principles are outlined below.

- (1) Provide outreach and recruitment of Apple Health/Medicaid-eligible children age's birth to six (6), in collaboration with other organizations, including, but not limited to:

- (a) Contact no less than ten (10%) of client list provided by HCA to the Contractor;

- i HCA shall email the Contractor's contact name identified on page 1. A list that shall include the following data elements: Client ID, name, address and telephone number of clients who have not gone to the dentist, as well the caregiver's name and preferred spoken language. HCA shall securely transmit client information and the Contractor shall be responsible to notify the Dental Program Manager within five (5) business days prior to the beginning of the quarter if they have not received this information.

Provide outreach by attending county health fairs, working with the smile mobile, visiting WIC offices, Headstart facilities, work with early learning coalition and visit day cares.

- (2) Convene Health Coalition/ABCD Steering committee or participate in a Coalition or Steering Committee focused on health care, access or early learning with ABCD as a quarterly agenda item. Provide care coordination, including:

- (a) Providing family orientation; including but not limited to sharing information about the value of a child going to the dentist, what activities will occur in the dentist's office;
  - (b) Connecting families with an ABCD certified dentist who accepts Apple Health/Medicaid, and providing information including, but not limited to, names and referrals to dentists, sharing information about interpreters and transportation benefits, and following up after an appointment, if appropriate;
  - (c) Assisting in scheduling dental appointments for eligible children and council on the importance of keeping the appointment;
  - (d) Identify and address family barriers to accessing oral health care; and
  - (e) Invite the ABCD program manager with Washington Dental Service Foundation and the Health Care Authority, Dental program administrator.

- (3) Coordinate with the local ABCD Dental Champion(s) to:

- (a) Identify and recruit dental providers who will take Apple Health/Medicaid clients through

the ABCD Program;

- (b) Maintain a list of active ABCD providers who accept Apple Health/Medicaid clients birth to six (6) years and monitor provider availability to accept new clients birth to six (6) years into their practice;
  - (c) Verify that the dental provider information contained in the HCA website is accurate for those providers working in the county or counties in which the Contractor provides services;
    - i Contractor shall review provider information available on the HCA "Find a Provider" website which shall be accessed to identify the ABCD provider names in the counties where the Contractor provides services. The Find a Provider website address is: <https://fortress.wa.gov/hca/p1findaprovider/>
    - (A) Contractor shall generate a list(s) of ABCD providers in their county(ies) from the aforementioned website.
    - (B) Contractor shall confirm that providers on the list generated from the HCA website are accepting new Apple Health/Medicaid clients.
    - (C) Contractor shall use Exhibit B3, List of ABCD Dental Providers, to provide the HCA Dental Program Manager a list of providers who should be added as a dental provider for Apple Health/Medicaid eligible children.
    - (D) Contractor shall use Exhibit C1 to provide the HCA Provider Enrollment Unit the names of providers who should be removed or added to the "Find a Provider" list each quarter.
  - (d) Support current ABCD providers by communicating program changes and policy updates through in-person meetings and written communication;
  - (e) Provide or assist in providing new ABCD provider trainings as needed;
  - (f) Assure certification process is completed;
  - (g) Provide Apple Health/Medicaid billing training assistance to ABCD offices/or arrange for billing assistance;
  - (h) Update dental society (or local dentists/study clubs in counties without a society) on the ABCD Program and encourage their continued recruitment of new Apple Health/Medicaid providers;
  - (i) Support the Dental Champion(s) participation in meetings and activities necessary to effectively conduct Apple Health/Medicaid provider outreach, recruitment and training, including financial support of attendance in development day.
- (4) As appropriate, identify and recruit primary care medical providers to participate in Apple Health/Medicaid, secure their training in preventive oral health techniques and build their role in referring Apple Health/Medicaid-eligible children to the ABCD Program. This may include oral health education, fluoride treatments, etc.

- (5) Participate in statewide ABCD Coordinators group meetings to remain current with ABCD policies, practices and opportunities.
- (6) Identify an ABCD coordinator within the contracting organization who will develop and maintain a desk manual that outlines the expected ABCD contractual deliverables and how the contractor meets each deliverable. The coordinator will utilize this manual to fulfill the contractual requirements. If the contractor's coordinator leaves the contractor is responsible to notify the Health Care Authority within two weeks, of the coordinators departure or as soon as possible and share the contractor's developed work plan that outlines how the expected contract deliverables will be met. The contractor will share with HCA the contact information of the newly hired or appointed coordinator and coordinate with HCA to assure a smooth transition of the expected contracted work deliverables.

b. Each quarter complete and submit via email;

- (1) Community Outreach and Coordination of Care summary, which shall include
  - (a) Exhibit A3, ABCD Quarterly Outreach & Case Management Report for the specific quarter
  - (b) Exhibit B3, Community Outreach and Coordination of Care Report
  - (c) Exhibit C1, List of ABCD Dental Providers
  - (d) Exhibit D3, Budget Tool, as applicable to the requirements contained in Exhibit A3
  - (e) Exhibit E, End of Year Summary Report, as applicable to the requirements contained in Exhibit A3.
- (2) Reports and billing must be submitted no later than January 31, 2018, unless otherwise mutually agreed by both parties.



**Exhibit A3 – ABCD Quarterly Outreach & Case Management Report**  
**ABCD Outreach & Case Management Contract Reporting**  
**Contract Period: July 1, 2017 through December 31, 2017 • 1<sup>st</sup> Quarter Report**

Please complete and submit report electronically to:  
 Janice Tadeo, Dental Program Administrator  
 Division of Health Care Services, Washington State Health Care Authority  
 PO Box 45506, Olympia, WA 98504-5506  
 Phone: (360) 725-1583 Email: [Janice.Tadeo@HCA.WA.GOV](mailto:Janice.Tadeo@HCA.WA.GOV)

Organization: Kittitas County Public Health Department	Email Address: <a href="mailto:tristen.lamb@co.kittitas.wa.us">tristen.lamb@co.kittitas.wa.us</a>		
ABCD Contact Person: Tristen Lamb			
Phone: 509-962-7029			
<b>Report Due: 10/31/2017</b>	<b>1st Quarter 7/1/2017 - 9/30/2017</b>		
<b>Performance Category</b>	<b>Yes/No</b>	<b>Maximum \$\$ available for this deliverable</b>	<b>Brief description (for events, provide date held/attended/ for staff assignments, provide name and title) - no more than 100 words (complete Exhibit A1 and attach supporting document if providing additional detail)</b>
Allocate staff and review contract to plan and create the year 1 action plan.		\$470	Include attached budget (Exhibit D3) and copy of your plan.
Attend and participate in ABCD Coordinator/Program Meeting		\$500	
Community Outreach		\$690	Complete Exhibit B3
Coordinate Care		\$215	Complete Exhibit B3
Convene Health Coalition/ABCD Steering committee or participate in a Coalition or Steering Committee Focused on Health Care, Access or Early Learning with ABCD as a Quarterly Agenda Item.		\$500	Provide outcome information such as minutes, copies of information provided or list of items provided, examples of type of Organizations attended, what were outcomes or next steps for ABCD. *Send invitation and report back any concerns/issues to HCA Dental Program Administrator & ABCD Administrator

**Exhibit A3 – ABCD Quarterly Outreach & Case Management Report**  
**ABCD Outreach & Case Management Contract Reporting**  
**Contract Period: July 1, 2017 through December 31, 2017 • 2<sup>nd</sup> Quarter Report**

Please complete and submit report electronically to:

Janice Tadeo, Dental Program Administrator

Division of Health Care Services, Washington State Health Care Authority

PO Box 45506, Olympia, WA 98504-5506

Phone: (360) 725-1583 Email: [Janice.Tadeo@HCA.WA.GOV](mailto:Janice.Tadeo@HCA.WA.GOV)

Organization: Kittitas County Public Health Department	Email Address: <a href="mailto:tristen.lamb@co.kittitas.wa.us">tristen.lamb@co.kittitas.wa.us</a>		
ABCD Contact Person: Tristen Lamb			
Phone: 509-962-7029			
<b>Report Due: 1/31/2018</b>	<b>2nd Quarter 10/1/2017 - 12/31/2017</b>		
<b>Performance Category</b>	<b>Yes/No</b>	<b>Maximum \$\$ available for this deliverable</b>	<b>Brief description (for events, provide date held/attended/ for staff assignments, provide name and title) - no more than 100 words (complete Exhibit A1 and attach supporting document if providing additional detail)</b>
Contact at least 10% of client list		\$450	Complete Exhibit B3
Review "find a provider" list on the HCA website and provide updated information		\$195	Complete Exhibit C1
Community Outreach		\$940	Complete Exhibit B3
Coordinate Care		\$290	Complete Exhibit B3
Convene Health Coalition/ABCD Steering committee or participate in a Coalition or Steering Committee Focused on Health Care, Access or Early Learning with ABCD as a Quarterly Agenda Item.		\$500	Provide outcome information such as minutes, copies of information provided or list of items provided, examples of type of Organizations attended, what were outcomes or next steps for ABCD. *Send invitation and report back any concerns/issues to HCA Dental Program Administrator & ABCD Administrator

**Exhibit B3 - Community Outreach and Coordination of Care Report  
 ABCD Outreach & Case Management Contract Reporting  
 Contract Period: July 1, 2017 through December 31, 2017**

**COORDINATE CARE**

<b>Family Orientation (indicate how provided, in-person, phone, mail, etc/.)</b>	<b>How Many</b>	<b>How</b>	<b>Location &amp; Date</b>
<b>Clients contacted from List (10%) (indicate how provided, mail, phone, call email, etc.)</b>	<b>How Many</b>	<b>Delete box from here down</b>	<b>Delete box from here down</b>
<b>Assisted with client with initial Dental Appointments and provide follow-up (if applicable)</b>	<b>How Many</b>		
<b>Referrals To Dental Home</b>	<b>How Many</b>		
<b>Barriers to Care Identified (interpreter services, transportation, etc)</b>	<b>How Many</b>		



**Exhibit B3 - Community Outreach and Coordination of Care Report (continued)**  
**ABCD Outreach & Case Management Contract Reporting**  
**Contract Period: July 1, 2017 through December 31, 2017**

**COMMUNITY OUTREACH**

Type of Outreach/Place	Date	How many reached	

\*Examples – County health fairs, coordination with Smile Mobile, WIC offices, Headstart, Early Learning Centers, Day Cares.

**WORK WITH CHAMPION/RECRUIT PROVIDERS**

Activity	How Many	
New Providers Certified		
Provider Trainings Held	Date	How many in attendance
Provider Recruitment	Place and Date	How many in Attendance

ProviderOne Find a Provider Modification Form	
Provider Name: _____	
NPI: _____	
Would you like to be listed in our ProviderOne Find a Provider site as a provider accepting new patients?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>
Signature: _____	Date: _____
Print Name Here: _____	
<small>*This form is to comply with Washington Administrative Code (WAC) 182-502-0016 and the Core Provider Agreement which requires providers to notify the agency of any changes to the provider's application or contract. For any additional changes please contact provider enrollment at 1-800-562-3022 Ext 16137 or <a href="mailto:providerenrollment@hca.wa.gov">providerenrollment@hca.wa.gov</a>.</small>	

**Please email this form to [providerenrollment@hca.wa.gov](mailto:providerenrollment@hca.wa.gov)**

**Exhibit D3, Budget Tool**  
**ABCD Outreach & Case Management Contract Reporting**  
**Contract Expenses (estimated)**  
**Contract Period: July 1, 2017 through December 31, 2017**

<b>EXPENSES</b>	<b>1<sup>st</sup> Quarter July 1, 2017- September 30, 2017</b>	<b>2<sup>nd</sup> Quarter October 1, 2017- December 31, 2017</b>
<b>Staffing/Salary &amp; Benefits</b> — add a column to identify % and hours per week for each year		
Program Coordinator (x hrs/week = .X FTE) <i>4 hrs/week = 0.10 FTE</i>	<i>1552.50</i>	<i>1552.50</i>
Outreach Staff (x hrs/week = .X FTE)		
Program Manager (x hrs/week = .X FTE)		
Support Staff (clerical, IT, finance, communications/pr staff, other x hrs/week = .X FTE)		
Administration (x hrs/ week (.X FTE)		
<b>Salary &amp; Benefits Subtotal</b>	<i>1552.50</i>	<i>1552.50</i>
<b>Operating Expenses</b>		
Advertising/Marketing (print, broadcast ads; cable TV time, movie ads, weekly newspaper, billboards, social media)		
Office Equipment (Copier, Fax)		
Meeting Expenses (steering committee room, food, etc.)		
Postage		
Printing (Outside Vendors)		
Professional Services		
Office Supplies		
Operating Supplies	<i>350.00</i>	<i>350.00</i>
Telephone	<i>15.00</i>	<i>15.00</i>
ABCD Certification Training/dentists and staff (room, audiovisuals, food, thank you to participating families, promotion, etc.)		
Travel (Per Diem, Transportation, Mileage/airfare, accommodations as required) for 3x annual ABCD Coordinators meeting – 2 Seattle, 1 Central WA; and for 1x annual Dental Champion(s) travel/expenses to Development Day, Seattle (Coordinator participation in this meeting optional but recommended)		
Computer Support/Tech Services		
Rent/Insurance/Janitorial/Maintenance		

*(12)*

Utilities		
<b>Operating Expenses Subtotal</b>	365.00	365.00
Indirect Costs	457.50	457.50
<b>TOTAL EXPENSES</b>	2375.00	2375.00
<b>FUNDING SOURCES</b>	<b>Year One</b>	<b>Year Two</b>
WDS Foundation Grant (if still within funding period)		
Other Funding (United Way, Foundations, Community Development Block Grant, etc.)		
Agency Funds and/or In-Kind		
Health Care Authority Contract (7/2013-on)	2375.00	2375.00
<b>TOTAL FUNDING</b>		

# Kittitas County Review Form Grants & Contract Agreement



#40027

Today's Date 07/28/2017	Agenda Date <u>9/5/2017</u>
Fund/Department 116-Public Health	

## Contract/Grant Information

Contract /Grant Agency: Health Care Authority Amendment 2(K763)	
Period Begin Date: 07/01/2017	Period End Date: 12/31/17
Total Grant/Contract Amount: \$4750.00	
Grant/Contract Number:	
<p>Contract/Grant Summary:</p> <p>The purpose of the Health Care Authority (HCA) contract outlines the Statement of Work for the Kittitas County Public Health Department to assist the HCA to reduce dental decay and improve oral health in those Medicaid-eligible children birth to six years by increasing the utilization of dental services among the population in Washington.</p> <p>The Health Care Authority Amendment 2 extends the period of performance, replaces the Statement of Work, and increases the total maximum consideration by \$4750.00.</p>	

## Recommendation for Board of Health and Board of Health Review on \_\_\_\_\_

Department Head Signature: <u></u> Administrator	Date: <u>9/12/17</u>
--	----------------------

## Kittitas County Prosecutor, Auditor, and Board of Health Review and Comment:

### APPROVED AS TO FORM:

	<u>8-7-17</u>
Signature of Prosecutor's Office	Date
	<u>8/11/17</u>
Signature of Auditor's Office	Date
_____ Signature of Board of Health member	_____ Date

## Financial Information

Total Amount \$4750.00	State Funds \$2375.00	Federal Funds \$2375.00
Percentage County Funds	Matching Funds \$	CFDA#93.778

	In-Kind \$ Explain
Is Equipment being purchased?	Who owns equipment?
New Personnel being hired?	Contact HR hiring – reporting requirements
Future impacts or liability to Kittitas County:	

### Budget Information

Budget Amendment Needed?	Yes <input type="checkbox"/> attach budget form	No <input checked="" type="checkbox"/> Why not Included in 2017 budget
New Division Created?		
Revenue Code 116-612.24.1.333.93.778 - \$2375.00 116-612.24.1.334.06.901 - \$2375.00		

### Pass Through Information

Agency to Pass Through	
Amount to Pass Through	\$
Sub-Contract Approved	Date:

### Prosecutor Review

Has the Prosecutor reviewed this agreement?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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### County Departments Impacted

Auditor	Facilities Maintenance
Information Services	Human Resource
Prosecutor	Treasurer

### Submitted

Signature:	Date:
Department:	

### Assignment of Tracking Information

Auditor's Office	
Human Resource	
Prosecutor's Office	
Who Signed the grant application	

Reviewer	Date
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