

**Preventive Health & Health Services Block Grant (PHHSBG)**  
**Advisory Committee Teleconference**  
**Tuesday, March 17, 2015 – 2:00 P.M. – 4:00 P.M.**  
**1616 Capitol Avenue, Suite 74.463**  
**Kings River Conference Room, Sacramento, CA 95814**  
**Summary of Court Reporter Minutes**  
**DOCUMENT #3**

**Advisory Committee Members Present**

Wes Alles, Ph.D., Co-Chair  
Caroline Peck, MD, MPH, Co-Chair  
Manal J. Aboelata, M.P.H.  
Christy Adams, R.N., B.S.N, M.P.H  
Paul Glassman, D.D.S., M.A., M.B.A  
Ira Lubell, M.D., M.P.H  
Nathan Wong, Ph.D.  
Wilma Wooten, M.D., M.P.H.

**Additional Attendees**

Anita Butler, Block Grant Coordinator  
Daniel Kim, CDPH Deputy Director of Operations  
Dr. Kevin Sherin, Deputy Director, CDPH Center for Chronic Disease Prevention & Health Promotion (CCDPHP)  
Greg Oliva, Assistant Deputy Director, CDPH CCDPHP  
Mark Starr, Deputy Director, CDPH Center for Environmental Health  
Jacquie Duerr, Assistant Division Chief, CDPH Chronic Disease & Injury Control  
Karissa Anderson, CDPH  
Stacy Alamo-Mixon, CDPH  
Kama Brockman, CDPH  
Jami Chan, CDPH  
Sheila Chinn, CDPH  
Rosanna Jackson, CDPH  
Esther Jones, CDPH  
Miren Klein, CDPH  
Valerie Gutierrez-Poquiz, CDPH  
Kala Haley, CDPH  
Patricia Nelson, CDPH

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Jessica Nunez de Ybarra, CDPH

Thea Perrino, CDPH

Karen Ramstrom, CDPH

Mary Rodgers, CDPH

Shirley Shelton, CDPH

Pam Shipley, CDPH

Holly Sisneros, CDPH

Hannah Strom-Martin, CDPH

Teresa Tunstall, CDPH

Teri Harness, Emergency Medical Services Authority

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The meeting opened at 2:00 p.m.

**Welcome and Introductions – Anita Butler, Dr. Peck, and Dr. Alles**

Anita Butler took a roll call of the advisory committee members present. Seven of eleven voting advisory committee members were present.

Dr. Peck welcomed the Advisory Committee and thanked them for their commitment to the Committee. She also welcomed California Department of Public Health (CDPH) program staff members who were in attendance to answer program related questions. She also asked if there were members of the public in the room or on the phone. Members of the public were absent or choose not to identify themselves.

Dr. Alles welcomed the public and indicated there would be opportunities for public comment throughout the meeting. He stated the purpose of the meeting was to approve the May 20, 2014 Advisory Committee Meeting Minutes, approve the Advisory Committee Selection Criteria, and approve or revise the Federal Fiscal Year (FFY) 2015 Funding Allocation. He identified the documents that would be referenced during the meeting which were shared in advance of the meeting.

**Approval of the March 20, 2014 Minutes**

Dr. Alles asked for comments from the committee and the public. Hearing none, Ms. Aboelata moved to approve the Minutes as submitted, and Dr. Wooten seconded the motion. The Minutes were approved as submitted.

**Federal Fiscal Year 2015 and 2016 Update**

Dr. Peck presented the following updates:

**FFY 2015**

The FFY 2015 Federal Budget passed. FFY 2015 is funded at \$156.8 billion, and included \$6.9 billion for the Affordable Care Act (ACA). CDPH anticipates that programs and states will receive PHHSBG funding at the same level because of the approximately flat federal allocation.

Congress fully allocated the ACA mandated Prevention and Public Health Fund (PPHF) for only the second time in the program's history. As in past years, the FFY 2015 President's Budget proposed elimination of the PHHSBG, but it was fully restored by Congress.

CDC is expected to provide the PHHSBG Allocation to state public health agencies and territories as in prior years, but we have not received it. We expect to receive approximately \$10.5 million to use in State Fiscal Year (SFY) 15/16. We don't have an exact dollar amount now, but we anticipate it will be the same.

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FFY 2016

The PHHSBG was zeroed out in the President's Budget for FFY 2016. Additionally, there isn't an agreement from Congress on the total spending, as there was for FFY 2014 and FFY 2015. Another point is that the sequester resumes in FFY 2016 for a total of \$91 billion in cuts, with nondefense discretionary programs to cut \$37 billion and the remaining cuts to be made to defense programs. This may change if Congress mitigates the \$54 billion to defense programs. The House and Senate are moving towards determining the allocations for the budget. They are also starting to work on the labor health and human services and education appropriations bill. They are taking requests from members of congress, and Dr. Freiden will be speaking at a hearing on March 26, 2015. We hope the budget is signed by October 1, 2015. However, as in prior years, it will depend on whether the Republicans who passed the bills and the president will agree to sign off on the proposed budget. If that fails we may have a Continuing Resolution. The PHHSBG is still part of the PPHF of the ACA, and that does put it somewhat at risk, but we believe Congress has been supportive of funding the PHHSBG, heart disease, diabetes, and obesity prevention.

California is hopeful we'll hear more about FFY 2016 by the end of 2015, perhaps not until next spring, and we hope for a Notice of Grant Award either in the spring or summer of 2016.

Dr. Alles asked if committee members or the public had questions or comments related to the FFY 2015 or FFY 2016 Budget. Hearing none, he transitioned into the next topic.

**Advisory Committee Selection Criteria**

Dr. Alles referenced Document #4 and indicated the criteria are the principles for allocation. He oriented attendees to the document by stating the top section of the form is the Advisory Committee Criteria, the middle section is the Association of State and Territorial Health Officials (ASTHO) Criteria, and the third is CDPH's Criteria.

**Ms. Butler described the Selection Criteria as follows:**

*Advisory Committee Criteria:* Emphasize primary and secondary prevention programs (primary prevention includes prevention of future injury among the injured population), fund each program for at least three years, and don't transfer funds out of the PHHSBG.

Prioritize using these criteria (not in any particular order): Ability to cross sectors and disciplines (Health in All Policies), appropriate balance between infrastructure vs. program services, community concern, concordance with Healthy People Objectives, condition severity, cost-effectiveness of interventions, cost of the condition, equity in health status, history/longevity of

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the program, impact of terminating program, innovation in areas for which there are few proven interventions, leverage other funds, programs engage communities at the local level, other resources available to address the conditions, performance on program metrics, reconfiguration/modification of the program, size of the problem/condition, and the needs of EMSA should be considered.

*(ASTHO) Recommended Criteria:* Encourage funds to be used for evidence based programs, ensure adequate reporting and accountability for use of funds, ensure that health equity cuts across funded programs, link with strategic goals of the State and Healthy People 2020, maintain flexibility for use of funds, and support capacity such as the development of Quality Improvement and performance management.

*CDPH Selection Criteria:* availability of alternate funding sources, ease of implementation (in required timeframe), input from Advisory Committee and public, marginal utility (“bang for the buck”), potential to fund internally {year-end General Fund (GF) savings for one-time costs, incorporate in distributed overhead}, outcome of the PHEP/HPP budget revision process, previous Federal or GF cuts sustained, public health reinvestment perspective, rank priority provided by Centers within CDPH, and scalability.

Dr. Alles indicated the Advisory Committee Criteria has accumulated over the years and they have effectively used it to draw the Advisory Committee’s attention to important items. He asked if the public had any questions or comments; and invited committee discussion.

There were a few questions and suggestions from the Advisory Committee.

Ms. Aboelata suggested identifying broader clusters of criteria to better organize the list and reduce its size. For example: condition severity and size of the problem/condition could be combined or added under a cluster around prevalence; and leverage of other funds and other resources available to address the condition could be combined.

Dr. Alles asked Dr. Peck and Ms. Butler to see if they could come up with an organizing structure and distribute it to the Advisory Committee for review and comment.

Dr. Peck and Ms. Butler agreed to attempt to revise it.

Dr. Wong said the second item read “primary prevention includes prevention of future injury among the injured population”. He asked if that was meant to read secondary prevention instead because prevention of future injury is like prevention of recurrent heart attack.

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Dr. Peck confirmed that it should read “secondary”. The Selection Criteria was subsequently updated.

Dr. Wong also asked if geographic representation should be a criterion because it didn't seem to be listed, i.e., operating a program that impacts broadly among many communities within the state would be preferred over a program that's implemented in one or two locales.

Dr. Peck asked if Dr. Wong was referring to statewide reach.

Dr. Wong confirmed he was referring to statewide reach as opposed to operating programs in a few communities.

Dr. Wooten indicated it would be a universal versus targeted approach.

Dr. Peck asked the Advisory Committee if they wanted to create universal versus targeted clusters and incorporate subsets of it, i.e., geographic, low income, etc. or if they specifically wanted to identify statewide reach as a criteria.

Dr. Wooten thought the discussion ended on statewide reach versus localized reach.

Dr. Alles reminded the group that they had a previous conversation about this in the past; and the Advisory Committee wanted programs that are delivered locally, but that the funding would go to those communities through the Department for the specific purposes that are identified; and the intent was that the reach be statewide. He also said the Advisory Committee spoke about flexibility on the part of the Department because it may require shifting of funds or there may have been other funds that came in after the Advisory Committee's decision about funding allocations and the Department has more current information.

Ms. Aboelata suggested we ask if the selection criteria will really work or how do we get more specificity. For example: “other resources available to address the condition” could be defined more clearly. She suggested moving towards having a few descriptive words about how the committee should use the principles to make a decision. In addition to clustering the criteria, she suggested including a lead statement indicating the Committee prefers X, Y, and Z or the Committee is interested in elevating this condition, if some of the criteria is a little too neutral.

Dr. Peck offered to discuss the issue with Ms. Aboelata at their monthly meeting.

Ms. Aboelata agreed.

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Dr. Alles asked Dr. Peck and Ms. Butler to ensure the clustered topics and subsets include Ms. Aboelata's, Dr. Wong's, and Dr. Wooten's suggestions. He also asked them to distribute the revised list to the Advisory Committee for review and comment as soon as possible.

Dr. Alles indicated it was probably desirable they vote on the selection criteria today with the sensitivity to the grouping of things and to the aforementioned comments.

Dr. Alles asked if there were additional comments from the Advisory Committee or public comments/questions.

Dr. Lubell asked if there was any contraindication to using PHHSBG funds to replace funds that were used in a previous program when a program may have been funded by some other source before and, even though it fits our goals, is now being shifted to the PHHSBG.

Dr. Peck indicated his question had been a topic of discussion in the past. We have said that these federal funds cannot be used to supplant state funds, and the state must maintain up to 50% of the amount it used to fund the program in the prior year. There are also certain things that we cannot expend the PHHSBG on, i.e., research and direct clinical services. Dr. Peck stated CDPH was having the CDPH Office of Legal Services take another look at the federal statute for the PHHSBG to ensure the funded programs really align with federal law.

Dr. Lubell asked if any of the new programs had been operational before.

Dr. Peck's responded "yes". Programs may have been operational before and funding may have been cut or some of the new programs are brand new. Ms. Butler indicated PHHSBG funds will likely be reduced or eliminated if a program receives alternate funding. For example: the Black Infant Health Program received PHHSBG funding in FFY 2014. However, the program recently received GF dollars and therefore will not receive PHHSBG funding in FFY 2015.

Dr. Wooten asked if the Advisory Committee Selection Criteria spoke to aligning state priorities like Let's Get Healthy California.

Dr. Peck indicated that criterion is under the ASTHO Recommended Criteria "Link with strategic goals of the state and Healthy People 2020.

**Presentation of the FFY 2015 PHHSBG Draft Programs, Anita Butler**

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Ms. Butler referred to Document 5 listing the FFY 2015 draft funded programs for State Fiscal Year 15/16. The following seven programs have been operational for at least two years (i.e., legacy programs). These programs will receive flat funding.

❖ California Active Communities (CAC)	\$387,788
❖ California Community Water Fluoridation Initiative	\$215,007*
❖ Cardiovascular Disease Prevention Program	\$524,819
❖ Nutrition Education and Obesity Prevention Branch	\$468,039**
❖ Office of Health Equity	\$188,508
❖ Preventive Medicine Residency Program/Cal EIS	\$442,564 ***
❖ Safe and Active Communities Branch	\$244,919

\*Program funding augmented by approximately \$65,000, per the recommendation of Dr. Paul Glassman.

\*\* Program funding reduced by approximately \$117,000, based on recommendation by the CDPH Executive Management.

\*\*\* Program funding increased by approximately \$122,000, per the recommendation of the CDPH Executive Management.

The next eight programs began in FFY 2014 and will continue in FFY 2015 programs. They will be funded at approximately 75%.

➤ California Wellness Plan Implementation (CWPI)	\$600,000*
➤ Re-engagement in HIV Care	\$500,000
➤ Local Health Department/Tribal Accreditation	\$250,000
➤ CAC Older Adult Falls Prevention	\$300,000
➤ Select Agent and Biosafety	\$200,000
➤ Valley Fever	\$426,000

\*Program funding was augmented by \$55,000, per the recommendation of the CDPH Executive Management Team.

The final group includes five newly proposed programs. All of these programs are brand new and will be funded at approximately 75%:

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▪ CWPI Accountable Communities for Health Pilot	\$320,000
▪ Build the Let's Get Healthy Website and Dashboard	\$400,000
▪ Food Surveillance Sampling	\$200,000
▪ Opioid Drug Prescription	\$200,000
▪ Receptor Binding Assay	\$275,000

Ms. Butler asked if there were any questions.

Dr. Wooten asked if we were funding accreditation efforts.

Ms. Butler stated the Local Health Department/Tribal Accreditation Program will support accreditation. She indicated the program is listed on Document #5, Page 2 of 4.

Dr. Wooten also asked why there were two funding columns listed on Document #5 for each program. For example: why was the budget for the California Health Alert Network (CAHAN) \$500,000 in FFY 2014 and \$375,000 in FFY 2015.

Ms. Butler clarified that CAHAN's FFY 2015 Allocation is \$500,000 which would be funded at approximately 75% or \$375,000. The remaining \$125,000 would be funded by some level of savings from the FFY 2014 or FFY 2015 grants since the program is included in both State Plans.

CDPH Vision – Daniel Kim, CDPH Chief Deputy Director of Operations

Mr. Kim provided an overview of the process by which the Department came up with the PHHSBG funding proposals. One thing that we did this year that was maybe a little different than other years was we required all of the centers within CDPH to develop funding proposals for the PHHSBG.

The CDPH Executive Staff, comprised of Deputy Directors within each CDPH Center, reviewed the proposals based on whether the purposes were consistent with the intent of the federal funds, by looking at the Advisory Committee, ASTHO, and CDPH Criteria. We wanted to ensure we expend these funds on innovative and evidenced based projects. Executive staff asked a number of questions, solicited feedback from program staff, and culled down the list of proposals.

We came up with roughly \$11.6 million worth of approved proposals. However, we understand that we only expect to receive \$10.5 million so \$1.6 million is in excess of that amount. Given the \$10.5 million cap, we would submit a State Plan where the legacy programs would be funded at 100% of their funded amount, and any continuing or new program would be funded at 75% of their funded amount. This approach gets us to the \$10.5 million cap. During the course of the year, we'll find out what our actual FFY 2015 award is. It may be more or less than the amount we anticipate receiving. We will also be reviewing our actual spending patterns because we anticipate that some of the programs might be underspending and some of the programs that we've ramped up may actually be spending at a rate greater than 75% and we will adjust accordingly.

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Other principles are any new programs we'd like to fund for a three year period to ensure the program has ample time to ramp up and can demonstrate its effectiveness. If we find that a program is really not that effective we will have the option to cut it. Similarly, we aren't necessarily going to consider maintaining the funding level at that same level. We hope that some of these projects will be innovative and we can find other funding sources, incorporate those activities into existing programs, or use other federal or state funds.

Dr. Alles asked if the public had questions or comments.

Brief Summary of FFY 2015 (SFY 15/16) Draft Programs – Anita Butler

Legacy programs have been in operation for at least two years. They will be funded at 100% in the FFY 2015 State Plan. Continuing Programs began in SFY 14/15 and will be funded at approximately 75%.

1. The Rape Prevention Program receives \$832,969 as a set-aside allocation which funds programs to prevent sexual violence at California's 63 Rape Crisis Centers, including 12 My Strength Clubs in local high schools. These clubs address the social norms that tolerate negative behaviors toward women and encourage young men to be leaders in the movement to prevent sexual violence.
2. The Emergency Medical Services Authority (EMSA) receives 30 percent (or **\$2,565,783**) of California's Block Grant allocation annually after the rape prevention set-aside and the Block Grant Administration are reduced from the total award. It currently funds California's Emergency Medical Services Authority. EMSA conducts emergency medical services for children, trauma and quality improvement programs in California; and the Health Information Exchange which began in FFY 2014.
3. The California Active Communities (CAC) – Older Adult Falls Prevention Program - \$612,788 to fund activities that address physical inactivity and its associated injuries, chronic diseases and disabilities, including mobility and fall prevention for older Californians and that foster environmental and policy change strategies that increase opportunities for safe everyday physical activity. The budget is \$387,788. The remaining \$225,000 is to fund the continuing component of CAC's Senior Falls Project, which was implemented in SFY 14/15 and will be funded at 75%. This funding provides technical assistance to eight local health departments to conduct Tai Chi, Moving for Better Balance and Stepping On program workshops in high risk communities. It will also be used to produce a return on investment report to inform state and local policy makers and health plans about the cost-benefit of implementing fall prevention programs in California and to conduct training on universal design and older adult mobility issues among local public health and government staff.

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4. The Cardiovascular Disease Prevention Program (CDPP) - \$524,819 funds measures to reduce premature death and disability from the most deadly and costly health care problems, heart disease and stroke. CDPP program interventions directly address public health objectives for heart disease, stroke, heart failure, high blood pressure, high cholesterol and other vascular-related disorders. This is a legacy program and will be funded at 100%.
5. The CA Community Water Fluoridation Initiative (CCWFI) - \$260,560 funds activities to increase the number of California citizens with access to fluoridated drinking water. For many years, California ranked near the bottom in the nation in terms of state populations with access to fluoridation. This initiative aims to reduce oral health disparities among Californians. The budget is comprised of \$215,007 flat funding (legacy program) and \$45,553 augmented funding (75% of total increase \$65,075).
6. The California Health Alert Network is \$358,550 to fund the official alerting and notification systems for state and local public health and funds 50 percent of CAHAN system costs. This system allows information sharing about urgent public health incidents with federal, state and local officials, practitioners, clinicians and other public health and medical stakeholders. This is a continuing program.
7. The California Wellness Plan Implementation Program, including CDPH commitments made at "P21, Advancing Prevention in the 21st Century," - \$488,500 to fund state level coordination capacity, including continued facilitated meetings with partners to advance the chronic disease prevention agenda. These funds will also support economic analysis capacity in the department and surveillance questions associated with the Wellness Plan. This is continuing that received a slight augmentation.
8. Re-engagement in Human immunodeficiency virus (HIV) Care and Partner Services Using HIV Surveillance data. This \$375,000 will fund the third to fifth highest prevalence counties, San Diego, Alameda and Orange, and it will replicate the Los Angeles (LA) and San Francisco county programs. These programs use HIV surveillance data to offer partner services to all persons newly diagnosed with HIV and assist people with HIV who have fallen out of care to re-engage in HIV care. This is a continuing program.
9. Local Health Department/Tribal Accreditation Readiness Assistance Program - \$187,500 to fund state-level capacity to provide technical assistance with local and tribal health department accreditation and to improve the California Performance Improvement Network website, otherwise known as CalPIM. This is a continuing program.

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10. The Nutrition Education and Obesity Prevention Branch received \$468,039 to advance evidence-based and evidence-informed obesity prevention across the state. Projects include support for improved nutrition such as increased fruit and vegetable consumption, reduced sodium intake, and increased physical activity in local communities, schools, early care and education sites, work sites and at CDPH. The federal fiscal year 2015 allocation was decreased by a total of \$117,010. This is a legacy program.
11. The Office of Health Equity (OHE) received \$491,688 to provide the key leadership role to reduce health and mental health disparities in California (legacy component) and to fund state level capacity to assess health equity within CDPH programs (continuing component).
12. The Preventive Medicine Residency Program (PMRP), Cal EIS Fellowship - \$528,464 to pay for training for California trained, board certified public health physicians. PRMP achieves this through recruiting promising residents and providing them with appropriate training and skills directly within local health departments or state public health programs. It also trains entry level epidemiologists within local and 21 state public health programs. This is a legacy program that received an augmentation.
13. The Safe and Active Communities Branch - \$244,919 to fund programs that promote prevention of domestic violence, vehicle occupancy safety, safe routes to school and injury surveillance and epidemiology. The Senior Injury Prevention Project funds evidence-based strategies to prevent senior falls, including project evaluation, in collaboration with other state entities. This is a legacy program.
14. Select Agent and Biosafety Program - \$\$150,000 to fund state-level capacity to maintain the only California Tier 1 public health laboratory that handles bio-threat agents, such as those that cause anthrax, botulism and plague. This is a continuing program.
15. The Enhanced Laboratory Capacity to address Valley Fever program received \$319,500 to fund state-level capacity to address drug resistance, assist local communicable disease response to the outbreaks and restore testing for fungal infections such as Valley Fever. This is a continuing program.

**New Programs:**

16. Accountable Communities for Health (ACH) Pilot Program will receive \$224,000 to support the development of an assessment tool to evaluate the current landscape and identify ACH or similar types of projects that support the nexus of population health, health insurance coverage and clinical health care in California. The evaluation would

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focus on the structure and functioning of an ACH "Backbone Organization" and the funding mechanisms of a Wellness Trust that supports population health innovations and it's also a key concept in the California Wellness Plan. The data gathered from the evaluation would be used to develop tool kits for ACH sites and Wellness Trusts, support scaling up of existing or establishing new ACH sites and development of a Health Care Cooperative Extension Service "Regional Hub." The tool kit focusing on the Wellness Trusts could also be leveraged for the development of a State level wellness Trust that supports a network of County level Wellness Trusts. All tool kits and best practices would be shared at a public health focused convening during year two of the funding period.

17. Build the Let's Get Healthy Website and Dashboard will receive \$280,000 to lead the development and maintenance of the Let's Get Healthy California Website and Dashboard on behalf of the California Health and Human Services Agency. This project involves coordinating with multiple departments under the agency, including gathering external data and working with innovative partners.
18. Commodity-Specific Surveillance: Food and Drug Branch (FDB) - \$140,000 to reinstitute the surveillance sampling of ready-to-eat foods such as sprouts, leafy greens, sesame seeds, nut butters and other such foods that could be potentially contaminated with bacterial pathogens. Re-implementing the surveillance sampling will facilitate the identification of contaminated food items before they cause an outbreak and reduce the incidence of food borne illnesses. According to CDC, 1 in 6 Americans (or 48 million people) get sick, 128,000 are hospitalized, and 3,000 die of foodborne diseases each year. FDB proposes collecting 400 – 450 ready-to-eat samples per year for the next three years and submitting them to the Food and Drug Laboratory Branch for microbial evaluation. Contaminated foods that are identified through lab evaluation will be embargoed and FDB will work with the responsible firms to recall the products from the marketplace and work with the impacted firms to ensure corrective actions are taken to prevent future contamination.
19. Receptor Binding Assay (RBA) Monitoring - \$192,500 to develop the RBA as a humane alternative to the Mouse Bioassay (MBA) for detection of paralytic shellfish poisoning (PSP) toxins. Funding will be used to conduct a 3-year pilot study of RBA implementation for PSP toxin testing in California shellfish. This pilot study will include systematic validation work and submission of application(s) to the Interstate Shellfish Sanitation Conference (ISSC) to achieve regulatory cognizance and approval of the RBA.

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20. Prescription Drug Overdose Surveillance Program - \$140,000 to support a multi-agency coalition to address the opioid overdose problem; build and sustain the necessary surveillance infrastructure to compile, prepare, and analyze internal data sources on the health consequences of prescription drug use, misuse and overdoses; work with external data partners to link data sources (e.g., California Department of Justice's Prescription Drug Monitoring Program - CURES); and, prepare actionable information for our state agency partners and local health departments.

Ms. Butler stated program staff were available to answer questions and asked if there were any questions.

Dr. Alles had a question regarding the HIV Care and Partner Services Program which funds three counties to replicate the programs in LA and San Francisco. He thought his question might relate to the targeted versus statewide discussion we had during the Selection Criteria Topic. He asked if this is a demonstration project such that there will be outcome measures that will determine whether this kind of program should be implemented statewide or are we funding these three counties because they have higher than usual incidents, and therefore are our efforts are targeted.

Kama Brockman - Office of Aids Prevention Surveillance Integration Specialist responded. She indicated San Diego, Alameda and Orange County represent the largest prevalence of people with HIV after San Francisco and LA in the 61 local health jurisdictions. LA and San Francisco have had success with these projects because they've been relatively focused on various geographic areas in those counties. The program wanted to see if they could replicate those programs in these other counties, and then once they know it's feasible, they will move this project to other high and medium prevalence jurisdictions outside of those five counties, i.e., Riverside, San Bernardino, other larger places, and high to medium prevalence HIV programs.

Dr. Alles asked if there would be a metrics that would determine success.

Ms. Brockman indicated the metrics wasn't identified the program description, but the number of people have been re-linked to care, how many people have identified partners and then those partners have been notified and those partners then get tested for HIV, so what is the prevalence of those partners that were tested. Results typically indicate if they are testing someone who has already been the partner of someone who has been tested for HIV, the positivity of those partners is higher than the general public HIV positivity rate. So it's a way to target your resources to people that you know have been engaged in high risk activity with someone who has HIV.

Dr. Alles requested additional clarification. He was particularly interested in the more rural counties, and wondered if there's a plan that would take what's known from the demonstration projects and identify modifications that might need to be made that could be done perhaps with the assistance of the county public health director to speak for

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kind of a different paradigm, or is it the case that the paradigm of size of the population or population density is less important than the products that were delivered or the programs that were delivered in the largest counties.

Ms. Brockman responded that it is somewhat of a paradox in that it's easier to keep track in the smaller counties, a medium or lower prevalence county through the surveillance program, participants who are in care and who is receiving and who, say, has a new Sexually Transmitted Disease diagnosis because you just have fewer people in these larger counties. It's more difficult to do that because there are more people with HIV there. But we will be using what we learn from these larger counties and this prevention surveillance integration is an ongoing project of the Office of Aids and so we're not just doing this project in these three counties and waiting for the information to come back from that before we're working with medium or lower prevalence counties. We're working with them all at the same time. We think the things we learn from San Diego, Alameda and Orange and, obviously, LA, and San Francisco as well, will help make this kind of case finding more robust for us and all the local health jurisdictions.

Dr. Alles indicated it was a great response and asked the people (Dr. Wooten, Ms. Aboelata, and Dr. Wong) who raised the issue about targeting versus statewide, would this fall within the construct or would it violate the construct they raised earlier? He asked Dr. Wooten to start.

Dr. Wooten requested clarification.

Dr. Alles clarified his question. He said the issue about targeting the counties or targeting areas and part of it had to do with geography versus statewide initiatives, the responses that were given. He asked if they were comfortable in the design of the program and the allocation of the funds for the program based on the comments that she, Dr. Wong, and Ms. Aboelata made?

Dr. Wooten said she was absolutely comfortable with the allocation, for many reasons, and it's probably obvious. From a nonbiased standpoint, the rationale for that allocation makes sense. And as Dr. Alles stated, once the demonstration project, thinking about the HIV project, focused on those three jurisdictions where the prevalence of HIV is highest next behind LA and San Francisco, that allocation made sense to her with the understanding that in future years there will be funding based on what's learned from these projects that are disseminated or allocated to other jurisdictions.

Dr. Alles asked Manal to comment.

Ms. Aboelata said this really highlights how it would be so helpful to say something like, the committee aims to have statewide impact in cases, and then maybe add a sub point on geographic targeting -- in cases where for whatever reasons the resources are limited, the need for targeting because of phase approach based on prevalence is

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needed, the expectation of the committee and that where appropriate there is a process for learning and bringing to scale. She thought it made sense and spoke to her about how we might refine the selection criteria to explain why they make a decision

Dr. Alles asked Dr. Wong to respond.

Dr. Wong totally agreed with the last two comments that were made and certainly appropriate justification, all those things need to be considered. He thought in this case it certainly made a lot of sense.

Dr. Alles asked if there were other questions or comments on the proposed allocations or the program description.

Dr. Glassman had a couple of questions about the Community Water Fluoridation Program. He indicated he was a little concerned the PHHSBG funding for this program. He stated the governor's budget restored a long dormant position of a State Dental Director and he wondered if CDPH could assure him that the PHHSBG funds that have been used for Community Water Fluoridation would not be redirected to support the position of State Dental Director.

Dr. Peck indicated this funding primarily supports Roseanna Jackson who will continue to work on Community Water Fluoridation activities. The intent is the PHHSBG will continue funding those activities.

Dr. Glassman's thanked Dr. Peck her for response and stated that in many states across the country where community water fluoridation is under attack, those who oppose fluoridation have changed tactics from trying to block new cities from being fluoridated to going back to cities previously fluoridated and trying to undo that. This new approach seems to be picking up steam in California. There have been contracts that have been very useful for a long time in helping to support local communities in providing information and education and advice about dealing with new implementation and retracting fluoridation from cities who are fluoridated. He wondered if he could also be assured that the contract will be able to continue in a system which the efforts are getting more expensive and funding is flat.

Dr. Peck said that may be problematic. As Dr. Glassman knows, the water fluoridation allocation was cut several years back during the decreases and was never augmented. So we are functioning at a lower level right now and the University of San Francisco contract has been very useful, and it's possible we do want to continue that, but it may not be possible. Given that the Dental Director may be coming on to take on some of those roles or release Rosanna to spend 100 percent of her time on fluoridation, we'll just have to see what the budget is. But we will take that into consideration that you feel strongly about it.

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Dr. Glassman said he thought the program description said that California used to be near the bottom in water fluoridation supply, but you could read that as saying we're doing really well, but we're not doing well. We've got a long way to go under a reduced budget, a huge state. He's concerned that funding -- it seems great to not be losing funding, but in a situation where we're doing so poorly and things are getting more expensive and the attacks are sort of picking up steam, he would urge the department to look for ways to be able to augment the fluoridation activity.

Dr. Peck indicated we'd request additional funds for fluoridation activities next year (SFY 16/17). We'll convey what Dr. Glassman was saying right now regarding this allocation. She thought the real benefit from this additional money from the state GF is that Rosanna right now has been doing everything, including water fluoridation, and now she will be able to focus 100 percent on that once our new staff comes on board. It's a huge issue. We're only at 64 percent right now. It's a big issue for California.

Dr. Glassman added that California's fluoridation efforts are ranked in the bottom third of the states across the country.

Dr. Peck asked Dr. Glassman if he had a recommendation for funding amounts he wanted us to bring back to the CDPH Director's Office.

Dr. Glassman suggested Dr. Peck consult with Ms. Jackson as she is likely the person most closely tied to the amount needed for these activities. He was concerned about the issue getting more complicated California being behind, and flat funding wouldn't be adequate.

Dr. Peck agreed to consult with Ms. Jackson to identify the amount of augmented funding that would be requested for SFY 15/16.

Dr. Alles spoke to Dr. Glassman's question about potentially redirecting PHHSBG funds to the new Dental Director position that's funded out of the GF. He said that would violate one of the principles the Advisory Committee has, which is that the money should be directed towards programs that are within the block grant. He was happy Dr. Glassman asked the question and was especially happy with Dr. Peck's response.

Dr. Alles asked the committee and public if there were any additional questions or comments about any of the described programs or the Selection Criteria.

Approval of the Selection Criteria

Dr. Alles requested a motion and a second from Dr. Wong, Dr. Wooten, and Ms. Aboelata to approve the Selection Criteria.

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Dr. Wooten moved to approve the Selection Criteria.

Dr. Wong seconded the motion.

The Selection Criteria was approved.

**Approval of the Draft Funding Proposals**

Dr. Alles requested a motion and a second from to approve the anticipated funding amounts. He wanted to particularly note the comments about the Fluoridation Program because we need to reflect the need to do better in that area.

Dr. Wooten moved to approve the funding allocations.

Christy Adams seconded the motion.

The Draft Funding Proposals were approved.

Dr. Alles asked if any member of the Committee wanted to make a comment to the Department. He also requested public comment.

Dr. Alles asked Dr. Peck if she wanted to revisit any of the issues or say anything to the Committee.

Dr. Peck thanked the Committee and expressed CDPH's gratitude for their continued participation and helping guide the Department as we make decisions about how to allocate the funds. She also thanked CDPH Program Staff for attending.

Dr. Alles thanked Dr. Peck for her comments.

Dr. Alles asked when the next teleconference would be held.

Ms. Butler indicated the next meeting would be in May 2015 and the purpose would be to approve the State Plan.

**Adjourn**

The meeting was adjourned at 3:25 p.m.

**Post Advisory Committee Meeting Information**

California's PHHSBG Allocation was reduced from \$10,508,099 in SFY 14/15 to \$10,335,868 in SFY 15/16 (approximately \$172,000 reduction).

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The Community Water Fluoridation Program was augmented by \$65,000, per Dr. Glassman's recommendation.

The Accountable Communities for Health Pilot was incorporated into the California Wellness Plan Implementation Program.