California Department of Public Health

California Wellness Plan

2014

California Wellness Plan 2014

Inquiries regarding this Plan may be directed to:

Jessica M. Núñez de Ybarra, MD, MPH, FACPM
Director of Coordination
Coordinated Chronic Disease Prevention Section
Chronic Disease Control Branch
California Department of Public Health
MS 7208, PO Box 997377
Sacramento, CA 95899-7377
(916) 552-9900

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This Plan was supported by the Cooperative Agreement 3U58DP002007-03W2 from the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

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Message from the Director

February 12, 2014

The California Department of Public Health (CDPH) is committed to the coordination of chronic disease prevention efforts to achieve equity in health and wellness.

CDPH's chronic disease and risk factor programs aim to promote health and eliminate preventable chronic disease. These include programs addressing cardiovascular disease, cancer, stroke, diabetes, obesity, asthma, dental caries, Alzheimer's disease, arthritis, tobacco use, physical inactivity, poor nutrition, injury and violence prevention, and environmental/occupational health. These programs coordinate with other CDPH programs that promote Health in All Policies, school health, maternal child adolescent health, workforce development and public health accreditation, health statistics, and health informatics. Most importantly, these programs collaborate with local and state partners engaged in chronic disease prevention.

The California Wellness Plan (Plan) is the result of a statewide process led by CDPH to develop a roadmap with partners to create communities in which people can be healthy, improve the quality of clinical and community care, increase access to usable health information, assure continued public health capacity to achieve health equity, and empower communities to create healthier environments.

I am thankful to the many program staff and statewide partners involved in the development of this Plan. Through this coordinated effort, CDPH provides a venue to align public health chronic disease prevention and health promotion efforts to ensure the best possible population health outcomes for all Californians. I invite you to review the Plan and join in our ambitious effort to find common approaches to reduce the burden and impact of chronic disease in California.

Sincerely,

Ron Chapman, MD, MPH
Director and State Health Officer
California Department of Public Health

1 – Executive Summary

Chronic Disease Problem

Cardiovascular disease, cancer, stroke, diabetes, asthma, chronic obstructive pulmonary disease, obesity, mental health conditions, substance-use disorders, dental caries, arthritis, Alzheimer's disease, and unintentional injury are the leading causes of death, disability, and diminished quality of life in California. These chronic conditions impact some populations more than others, resulting in significant inequities in health outcomes and quality of life within California's population of approximately 38 million people.[1]

Fourteen million people in California are estimated to be living with at least one chronic condition; more than half of this group has multiple chronic conditions. Chronic disease and injury not only cause the majority of deaths, but also contribute to poor quality of life, disability, and premature death. The prevalence of chronic disease raises public health concerns and has significant economic impacts. And, the costs of chronic disease continue to rise. In 2002, the most recent year for which data is available, approximately $70 billion, or 80 percent of California's health care expenditures, was spent on people with chronic conditions.[2]

Chronic disease is defined broadly in this Plan, and includes chronic conditions, injuries, violence, and environmental, occupational, and infectious causes of chronic disease. Chronic disease prevention is inclusive of primary, secondary, and tertiary prevention, and involves addressing a broad array of risk factors using a Health in All Policies approach and a Life Course Perspective.

Prevention is Possible

Chronic diseases are largely preventable.[2] Up to 80 percent of cardiovascular disease, stroke, type 2 diabetes, and over 30 percent of cancers could be prevented by eliminating tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol. It is estimated that $10 per person per year invested in prevention would yield $1.7 billion annually in health care savings in California within 5 years, a return of $4.80 for every $1 spent.[3]

California's communities and health care systems have a significant impact on health. However, current laws and policies have led to community conditions that contribute to poor health, and health care systems geared to treat acute events (such as heart attacks) rather than prevent disease. Prevention includes interventions that keep disease at bay, diagnose disease early, prevent progression of disease through delivery of quality care, and provide care in the context of the community.

To improve the health of Californians, it is critical to increase the social desire and ability of communities to make changes to their environment, so that the healthy choice is the default choice. Only 5 of the 30 year life expectancy gain since the 1900s is attributable to better health care.[4] Health care provider recommendations for behavior change or prescriptions for medication and access to health care are not the only solutions needed. A focus only on disease ignores the common risk factors that are at the root of poor health. Prevention of chronic disease and improved health depends on an environment that supports healthful choices, in addition to access to quality, coordinated health systems.

Roadmap to Prevention

The Overarching Goal of the California Wellness Plan (Plan) is ***Equity in Health and Wellbeing***, with an emphasis on the elimination of preventable chronic disease. To attain this, the following four Goals were determined by partners through a collaborative statewide process. Statewide partners have proposed Focus Areas (under Goals) around which to align efforts for the next 2 years, as a means to achieve synergy and greater impact.

1. ***Healthy Communities***

    I. *Create healthy, safe, built environments that promote active transport, regular daily physical activity, healthy eating, and other healthy behaviors, such as by adoption of health considerations into General Plans*

2. ***Optimal Health Systems Linked with Community Prevention***

    I. *Build on strategic opportunities, current investments and innovations in the Patient Protection and Affordable Care Act, prevention, and expanded managed care, to create a systems approach to improving patient and community health*

3. ***Accessible and Usable Health Information***

    I. *Expand access to comprehensive statewide data with flexible reporting capacity to meet state and local needs*

4. ***Prevention Sustainability and Capacity***

    I. *Collaborate with health care systems, providers and payers to show the value of greater investment in community–based prevention approaches that address underlying determinants of poor health and chronic disease*
    II. *Explore dedicated funding streams for community-based prevention*
    III. *Align newly secured and existing public health and cross-sectoral funding sources to support broad community-based prevention*

The Plan includes 26 Priorities and Performance Measures determined by the Let's Get Healthy California Taskforce (LGHCTF) in 2012. It fits within the LGHCTF overarching framework under the first Strategic Direction: "Health Across the Lifespan," and Goal 2, "Living Well: Preventing and Managing Chronic Disease." The Plan includes evidence-based strategies, and identifies California Department of Public Health (CDPH) and partner chronic disease prevention Objectives, including performance measure baselines and targets. The Plan provides California with a roadmap to prevent chronic disease and promote equity for the largest number of Californians possible. As social determinants of health cannot be changed by individuals alone, collaborative, organized policy efforts at community, regional, and state levels are required to achieve equity in health status. This will be achieved through continuing communication, collaboration, and coordination with partners.

The Plan is intended to be dynamic as CDPH coordinates with partners, monitors population health outcomes, and adapts to changes in funding and policy. The "Advancing Prevention in the 21st Century" conference is scheduled to be held in February 2014 to further refine the Plan. The conference will bring together key partners from across the state to identify and commit to Focus Areas for aligned efforts over the next two years.

This public–private sector collaboration will strengthen California's infrastructure to improve health in both community and clinical settings. It illuminates the important role public health has in joint efforts to improve population outcomes, bend the medical care cost curve, and achieve health equity.

2 – Introduction

2.1 Chronic Disease in California

In 2007, approximately 14 million Californians were estimated to be living with chronic disease, and more than half of this group has two or more chronic diseases. Chronic disease is largely preventable, yet the prevalence and health/economic impacts of chronic disease are growing.[2] Most chronic diseases cannot be addressed effectively through health education and health care alone. Behavior change is difficult to sustain in the context of an unhealthy environment, even when an individual is aware of the health risks. Moreover, extending medical/dental insurance and quality clinical services to all does not guarantee the elimination of health disparities or the improvement of population health.[5] Without addressing the social, environmental, economic, and institutional conditions, community attitudes, and social norms that influence health, equity in health and wellbeing will not be achieved.

Cardiovascular disease, cancer, stroke, diabetes, asthma, chronic obstructive pulmonary disease, obesity, mental health conditions, substance use disorders, dental caries, arthritis, Alzheimer's disease, and unintentional injury are the leading causes of death, disability, and diminished quality of life in California.[2] Up to 80 percent of cardiovascular disease, stroke, and type 2 diabetes, and over 30 percent of cancers could be prevented by eliminating tobacco use, unhealthy diet, physical inactivity, and harmful alcohol use. Risk factors such as these can be partly attributed to community environments and neighborhood design. Where Californians live, work, learn, and play has a significant impact on wellbeing, health outcomes, and life expectancy.

The Burden of Chronic Disease and Injury, California 2012 Report[2] brings together data and reports compiled by CDPH programs, county health departments, non-governmental organizations, and research centers to provide a snapshot in time of the health status of Californians, including disparities in health outcomes. It is intended to guide state and local collaboration to improve the quality of life for all Californians. This report informed the development of the Plan.

- In 2010, over 187,000 deaths (80 percent) were caused by chronic disease and injury
- Heart disease, cancer, and stroke are the leading causes of death
- Diabetes is the leading cause of blindness, amputation, and kidney failure, and is a major contributor to heart attacks and strokes
- Thirty-eight percent of the state's residents live with at least one chronic condition
- Californians with chronic disease report more days of poor health, which can affect mental well-being and productivity in school or at work

All but one of the top 14 causes of death in California were chronic diseases or injuries. Table 1 lists the top causes of death in 2010, adjusted for age.

Table 1 Leading Causes of Death, 2010[6]

		Number of Deaths	Age-adjusted Rate (per 100,000 population)	Percent of All Deaths
1	Diseases of Heart	58,034	154.0	24.9
2	Malignant Neoplasms	56,124	149.7	24.1
3	Cerebrovascular Diseases	13,566	36.4	5.8
4	Chronic Lower Respiratory Diseases	12,928	35.5	5.5
5	Alzheimer's Disease	10,833	29.0	4.6
6	Unintentional Injury	10,108	25.7	4.3
7	Diabetes Mellitus	7,027	18.9	3.0
8	Influenza and Pneumonia	5,856	15.7	2.5
9	Chronic Liver Disease and Cirrhosis	4,252	10.6	1.8
10	Intentional Self Harm (Suicide)	3,835	9.7	1.6
11	Essential Hypertension/ Hypertensive Renal Disease	3,722	9.9	1.6
12	Nephritis	3,073	8.3	1.3
13	Parkinson's Disease	2,232	6.3	1.0
14	Assault (Homicide)	1,908	4.8	0.8

Almost half of all deaths can be attributed to a limited number of largely preventable behaviors and exposures, which are listed in Table 2. The most common of these (poor diet, tobacco, high blood pressure, high body mass index, physical inactivity, and high blood sugar), if eliminated or reduced, would decrease the rates of the leading causes of death. Healthy choices and behaviors are easiest in healthy environments. It is especially important to create healthy environments in communities with the highest health disparities.

Table 2 Number of Deaths Related to the Top 10 Risk Factors for Health Loss in the United States, 2010[7]

		Number of Deaths
1	Dietary Risks	678,282
2	Tobacco	465,651
3	High Blood Pressure	442,656
4	High Body Mass Index	363,991
5	Physical Inactivity	234,022
6	High Blood Sugar	213,669
7	High Total Cholesterol	158,431
8	Ambient Air Pollution	103,027
9	Alcohol Use	88,587
10	Drug Use	25,430

Table 3 lists the leading causes of disease burden. Interventions that focus on these causes and their risk factors, if successful, will improve the vigor of California's workforce, as conditions that occur at a younger age have a much greater impact on society. The measure of overall disease burden used, Disability Adjusted Life Years (DALYs), is expressed as the cumulative number of years lost due to ill health, disability, and early death.

Table 3 Leading Causes of Disease Burden in the United States, 2010[8]

		DALYs	Percent of total
1	Ischemic Heart Disease	7,849,540	10
2	Chronic Obstructive Pulmonary Disease	3,658,530	4
3	Low Back Pain	3,180,630	4
4	Lung Cancer	3,121,687	4
5	Major Depressive Disorder	3,048,890	4
6	Other Musculoskeletal Disorders	2,856,960	3
7	Stroke	2,573,980	3
8	Diabetes	2,557,220	3
9	Road Injury	2,246,220	3
10	Drug Use Disorders	2,136,120	3
11	Neck Pain	2,134,380	3
12	Alzheimer's Disease	2,022,330	2
13	Anxiety Disorders	1,866,060	2
14	Self-Harm	1,462,660	2
15	Falls	1,264,530	2
16	Cirrhosis	1,249,120	2
17	Chronic Kidney Diseases	1,190,530	1
18	Colorectal Cancers	1,146,830	1
19	Alcohol Use Disorders	1,144,640	1
20	Lower Respiratory Infections	1,093,030	1
21	Breast Cancer	1,052,950	1

The leading causes of death, life expectancy, and quality of life are a result of many risk factors and behaviors that in turn are a consequence of the environments in which individuals live. The health outcomes of individuals impact the overall health and economy of California.

2.2 Health Equity

Despite significant advances in reducing mortality from chronic conditions, health inequities persist in our communities. Achieving health equity is imperative for California. Health equity is defined as "efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives."[9] Attaining health equity requires explicit attention to addressing the avoidable and unjust social, environmental, economic, or institutional conditions that prevent communities from equally reaching health. These social determinants of health cannot be controlled by individuals alone and require systematic policy efforts at community, regional, and state levels to achieve health equity.

2.3 Disparities in Chronic Disease and Risk Factors

- Although heart disease mortality declined for all population groups from 2000 to 2008, African Americans continued to suffer considerably higher mortality, with age-adjusted rates of 203.5 per 100,000, compared to 141.4 for Whites, and 100.4 for Hispanics in California for 2008.[10]
- One in seven African Americans, one in nine American Indians/Alaskan Natives/Native Hawaiians/Other Pacific Islanders, one in ten Latinos, one in eleven Asian Americans, compared to one in fourteen White adults have diabetes in California.[11]
- Obesity among adults correlates directly with education, with 18.1 percent of college graduates being obese, compared to 33.8 percent of high school dropouts.[12,13]
- Life expectancy at birth for African American males living in California is 70.2 years, whereas for Whites it is 76.9 years; African American females have an average life expectancy of 76.4 years, as compared to their white counterparts, who can expect to live 81.7 years.[14]
- Education strongly relates to life expectancy. Recent data indicates that White women with less than 12 years of education are now expected to live to age 73.5; in 1990 that number was 5 years longer.[15]
- Californians who live in neighborhoods where educational achievement is low, unemployment is high, and where poverty is widespread die at a younger age and are often racial/ethnic minorities.[14]
- Adolescents and teens who live in neighborhoods with widespread poverty are more likely to be victims of violence; are at increased risk for tobacco, alcohol, and substance use; and are at greater risk for obesity.[16]
- Neighborhoods where poverty is widespread are less likely to have access to recreational facilities and full-service grocery stores and are more likely to have high concentrations of liquor/convenience stores and fast-food restaurants.[14]

2.4 Economic Burden of Chronic Disease

In 2002, chronic diseases cost California $70 billion, or 80 percent of California's health care expenditures, for the 38 percent of California's population with chronic disease.[2] According to State Controller John Chiang, "The economic cost to California of adults who are obese, overweight, and physically inactive is equivalent to more than a third of the State's total budget."[17] Without effective prevention and management strategies, these costs will continue to increase. Poor health increases direct medical costs (such as emergency room visits and hospitalizations) and indirect costs (lost productivity due to absenteeism), both of which have rapidly increased over the past decade. In a recent nationwide poll, 86 percent of full-time workers are above normal weight or have at least one chronic condition.[18] Ten dollars per person per year invested in prevention would yield $1.7 billion annually in health care savings in California within 5 years, a return of $4.80 for every $1 spent.[3]

A dynamic simulation model of the U.S. health system was used to test three proposed strategies to reduce deaths and improve the cost-effectiveness of medical interventions: (1) expand health insurance coverage (coverage), (2) deliver better preventive and chronic care (care), and (3) protect health by enabling healthier behavior via improving environmental conditions (protection). Each strategy alone could reduce deaths and provide good economic value, but are likely to be more effective in combination. Although coverage and care can save lives quickly, they tend to increase costs. Although the impact of protection is more gradual, it is a critical strategy over time to lower the number of deaths and reduce costs. Most importantly, only protection slows the growth in the prevalence of disease and injury, and thereby alleviates rather than exacerbates demand on limited primary care capacity. When protection was added to a simulated scenario with universal coverage and better health care over 25 years, an additional 4.3 million deaths would be prevented, and costs would be reduced by $40 billion annually.[19]

3 – Purpose

3.1 Mission and Vision of the California Department of Public Health

According to the Institute of Medicine's *The Future of Public Health* (1988), it is the mission of public health to assure the conditions in which people can be healthy.[20]

The mission of the Department is to optimize the health and well-being of the people in California by performing the three core functions and ten essential services of public health.

The vision of the Department is healthy individuals and families in healthful communities. CDPH recognizes that health is impacted by numerous social, environmental, economic, and institutional factors, which cannot be effectively addressed by any single organization. Therefore, CDPH is committed to partnering with multiple organizations from multiple sectors. Such cross-sector collaborations are most effective if they address the full spectrum of prevention, mobilize communities at the local level to create healthful environments, improve clinical–community

linkages, improve access to and quality of health services, share health data and information, and are sustainable. CDPH provides statewide leadership in (1) chronic disease surveillance and monitoring, (2) chronic disease programs and policies under statutory and regulatory authority (Appendix B), and (3) guidance and recommendations for chronic disease prevention. The CDPH Strategic Map 2012–2014[21] details how CDPH, as a performance-based agency, will function to achieve its mission and vision.

3.2 Purpose of the California Wellness Plan

This Plan represents a major change in how we address chronic disease prevention. The epidemic of chronic disease needs to be addressed in many sectors and on many levels, as the causes are multi-factorial and go beyond health care and traditional public health approaches. This marks the beginning of a new era in health, in which the gap between public health and health care narrows, and people from multiple sectors collaborate to address the chronic disease crisis in California.

The Plan aims to provide partners—chronic disease prevention and health promotion programs within CDPH, other state agencies, local health departments, and other health and non-health partners—with an opportunity to coordinate and collaborate on chronic disease prevention and health promotion efforts. The Plan delineates common Goals, Priorities, and Focus Areas for collaboration and/or alignment to improve health outcomes, decrease health disparities, and demonstrate prevention return on investment. This Plan provides guidance on evidence-based Strategies to prevent and optimally manage chronic disease in California. It describes the roles, responsibilities, and capacity CDPH and other agencies have for detecting and responding to the epidemic of chronic disease. This Plan establishes Objectives and provides a framework for the development of activities to implement the Objectives. This statewide Plan is intended to be dynamic, changing over time as CDPH monitors population health outcomes.

The Plan is intended for use by state and local partners, including community groups and organizations that are committed to working collaboratively to prevent chronic disease and promote health and wellness. It is meant for public dissemination.

4 – Theoretical Foundation

4.1 Social Determinants of Health

The circumstances in which people live, learn, work, and play—as well as the systems put in place to deal with illness—determine health. These circumstances are in turn shaped by a wider set of forces: social, environmental, economic, and institutional policies and politics. There is a social gradient of health; health correlates with education, income, and the place in which one lives. A person's social class affects the ability to influence events that impact their life, their sense of control over their lives, leading to chronic stress and its physiologic effects. This in turn leads to a greater risk of chronic disease and contributes to health disparities.[22]

Factors that influence health:

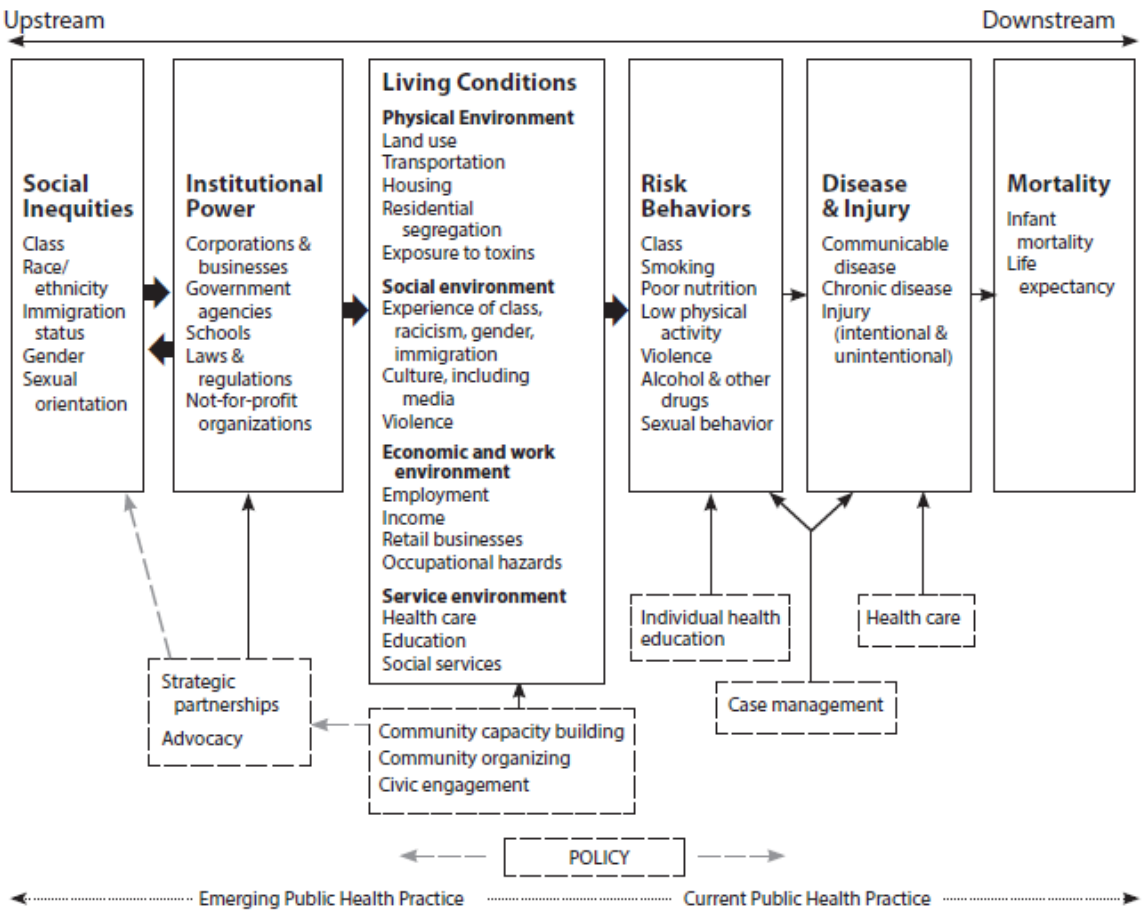
- Environment
  - Housing
  - Neighborhood
  - Healthy food and environment
- Educational Attainment and Employment
- Economic Status
- Social Support (family cohesiveness, sense of community)
- Social Norms and Attitudes
- Culture, Language
- Literacy
- Race/Ethnicity

Public health surveillance can monitor the size of disparities between more and less advantaged social groups and the changes in disparities over time in relation to the implementation of policies. Using the Healthy Communities Framework (Appendix C),[23] Healthy Community Indicators have been developed and are included in the Objectives.

4.2 BARHII Framework for Health Equity

The following conceptual framework in Figure 1 was developed by the Bay Area Regional Health Inequities Initiative (BARHII).[24] BARHII aims to move health equity from the periphery to the center of public health efforts. As health is dependent on wealth, it is necessary to include the socio-ecological model in addition to the medical model to fully understand the entire health continuum.

Figure 1 A Public Health Framework for Reducing Health Inequities

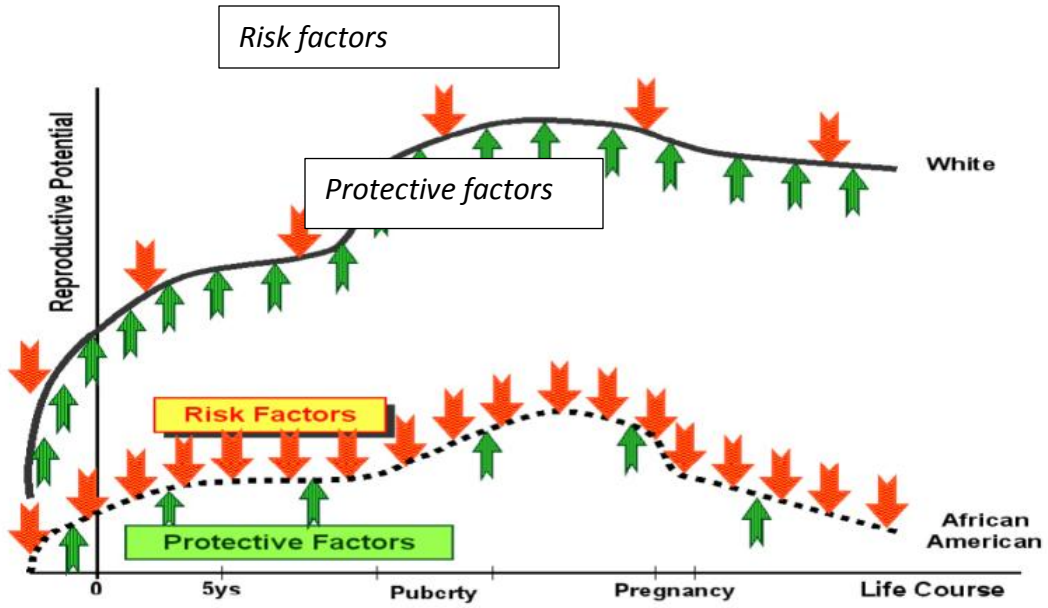


Source: Bay Area Regional Health Inequities Initiative, 2008

4.3 Life Course Perspective

The Life Course Perspective proposes that a complex interplay of biological, behavioral, psychological, and social protective/risk factors contribute to health outcomes during the span of a person's life.[25] It views life as an integrated continuum of different stages, and what happens in different life stages, including in utero, can influence health and function for life. For example, Figure 2 illustrates that differences in the number and magnitude of risk factors (downward arrows) and protective factors (upward arrows) between White and African American women over the life course affect reproductive potential and can contribute to disparities in birth outcomes.[26]

Figure 2 Life Course Perspective[25]



4.4 Health in All Policies

A Health in All Policies (HiAP) collaborative approach recognizes that health and prevention are affected by policies that are managed by non-health governmental and non-governmental entities, and that many strategies that improve health will also help to meet the policy objectives of other agencies.

HiAP harnesses the power that non-health agencies can bring through their areas of expertise, has a focus on co-benefits and win–win strategies, and explores the use of health as a linking factor in bringing people together from across sectors to address the biggest issues that face our society.

Efforts to change health behaviors are most effective when they address the environments in which people make their daily choices.[27] However, public health agencies alone cannot change these environments since responsibility for the determinants of health generally falls under the realms of housing, transportation, education, air quality, parks, criminal justice, and employment agencies.[28] Thus, for public health agencies to achieve their mission—to improve the health of the population—they must work collaboratively with the many government agencies, businesses, and community-based organizations that are best positioned to create healthy communities.

4.5 Spectrum of Prevention

The Spectrum of Prevention is a broad framework that includes strategies designed to address complex, significant public health problems. These strategies take into account the multiple determinants of community health and can be used to develop a comprehensive approach to public health issues. This framework is useful for planning public health interventions and coordinating the activities of multiple programs or agencies, with a focus on specific public health campaigns. Although not all of the strategies will be appropriate for every issue, the Spectrum of Prevention provides a reminder that complex problems often require a range of approaches.[29]

The following strategies are included in the Spectrum of Prevention:

1. Influencing policy and legislation
2. Mobilizing neighborhoods and communities
3. Changing organizational practices
4. Fostering coalitions and networks
5. Educating providers
6. Promoting community education
7. Strengthening individual knowledge and skills
8. Assuring access to quality health care (Contra Costa County)

5 – Roadmap to Improved Health Outcomes

5.1 Outline: Goals, Priorities, Focus Areas

The Overarching Goal of the Plan is Equity in Health and Wellbeing, with an emphasis on the elimination of preventable chronic disease. To attain this, the following Goals were determined by partners through a collaborative statewide process.

1. Healthy Communities

2. Optimal Health Systems Linked with Community Prevention

3. Accessible and Usable Health Information

4. Prevention Sustainability and Capacity

The Plan includes Priorities determined by the Let's Get Healthy California Taskforce (LGHCTF) in 2012. It fits within the LGHCTF overarching framework under the first Strategic Direction: "Health Across the Lifespan," and Goal 2, "Living Well: Preventing and Managing Chronic Disease." The Priorities establish California's chosen outcomes for the next 10 years. Statewide partners have proposed Focus Areas around which to align efforts for the next two years, to achieve synergy and greater impact.

OVERARCHING GOAL: EQUITY IN HEALTH AND WELLBEING

GOAL 1: HEALTHY COMMUNITIES *Healthy Environments: Healthy Choices*	
Let's Get Healthy California Task Force Priorities	
1.1	Increase health status (Community Resilience, Education, Income, Life Expectancy, Equity)
1.2	Decrease adult and adolescent tobacco use
1.3	Increase adult and child fitness and healthy diets
1.4	Increase healthy food outlets
1.5	Increase walking and biking
1.6	Increase safe communities (Alcohol Misuse, Substance Abuse, Unintentional Injury, Violence, Water, Air Quality, Safe Worksites)
1.7	Decrease childhood trauma
1.8	Increase early learning
Focus Area 2014 – 2015	
1A	**Create healthy, safe, built environments that promote active transport, regular daily physical activity, healthy eating, and other healthy behaviors, such as by adoption of health considerations into General Plans**
GOAL 2: OPTIMAL HEALTH SYSTEMS LINKED WITH COMMUNITY PREVENTION *Quality Care at Lower Cost*	
Let's Get Healthy California Task Force Priorities	
2.1	Decrease the number of people without insurance
2.2	Increase access to primary and specialty care (Oral Health, Cancer, School Health Care, Arthritis, Alzheimer's Disease)
2.3	Increase coordinated outpatient care (Patient Centered Medical Home, Lifestyle Intervention Programs, Self-Management Programs) Increase the number of people receiving care in an integrated system (Medical, Mental, Behavioral)
2.4	Increase mental health and wellbeing
2.5	Decrease adult and childhood obesity and diabetes

2.6	Increase controlled high blood pressure and high cholesterol
2.7	Decrease adult and childhood asthma
2.8	Increase vaccinations
2.9	Decrease infant deaths
2.10	Increase culturally and linguistically appropriate services
2.11	Increase advance care planning
2.12	Increase hospital safety and quality of care
2.13	Increase palliative care and hospice care Decrease hospitalization during the end of life
Focus Area 2014 – 2015	
2A	**Build on strategic opportunities, current investments, and innovations in the Patient Protection and Affordable Care Act, prevention, and expanded managed care, to create a systems approach to improving patient and community health**
GOAL 3: ACCESSIBLE AND USABLE HEALTH INFORMATION *Shared Knowledge is Power*	
Let's Get Healthy California Task Force Priorities	
3.1	Increase transparent information on cost and quality of care
Focus Area 2014 – 2015	
3A	**Expand access to comprehensive statewide data with flexible reporting capacity to meet state and local needs**
GOAL 4: PREVENTION SUSTAINABILITY AND CAPACITY *Invest in Wellness*	
Let's Get Healthy California Task Force Priorities	
4.1	Increase affordable care and coverage
4.2	Increase payment policies that reward value
4.3	Decrease rate of growth in health care spending
Focus Areas 2014 – 2015	
4A	**Collaborate with health care systems, providers, and payers to show the value of greater investment in community–based prevention approaches that address underlying determinants of poor health and chronic disease**

4B	**Explore dedicated funding streams for community-based prevention**
4C	**Align newly secured and existing public health and cross-sectoral funding sources to support broad community-based prevention**

5.2 Outline: Strategies and Objectives

Strategies were informed by the National Prevention Strategy and statewide partner input. Evidence-based strategies from the U.S. Preventive Services Task Force and the Community Guide are listed in Appendix D.

Objectives developed by CDPH programs and statewide partners comprehensively identify chronic disease prevention program focus for activities, based on program resources and statutory authority. They include performance measure baselines and targets, and may align with partner activities. Each Goal has Strategies and Objectives that can be measured and reported on regularly and will serve as a guideline for California's current and future efforts.

- The program lead or partner for the Objective is listed by acronym in the second column; the Program Descriptions and List of Acronyms can be found in Appendices E and A, respectively. Disclaimer: agencies, programs and/or partners identified with an objective may be either data stewards and/or engaged in activities to achieve the target, but may not have adequate resources for statewide activities.
- Some Objectives do not have program leads, data sources, baselines, and/or targets at this time, but are included because they were a result of CDPH program or partner input and were felt to be important to the reduction of chronic disease incidence, prevalence, and health disparities. These Developmental Objectives will be updated as information becomes available, and invoke no obligation on local agencies.
- Healthy Community Indicators are a project of the CDPH Office of Health Equity and are a standardized set of statistical measures and tools that a broad array of sectors can use for planning healthy communities and evaluating the impact of plans, projects, policy, and environmental changes on community health.[30] Healthy Community Objective baselines and targets will vary according to locality, and are indicated by **HC**.
- LGHCTF performance measures are indicated by **LGH**.
- To focus efforts on those sub-groups that are most affected and often underrepresented, stratification by sub-population (race/ethnicity, gender, sexual orientation, language, geographic area, immigration status, language proficiency, etc.) is ideal if feasible to address health disparities.
- If the far left column is highlighted in grey, this indicates that over 75 percent of partners who responded to Plan surveys are working on or planning activities to meet this Strategy or Objective.
- All Objectives in the California Wellness Plan are as funding allows.

GOAL 1: HEALTHY COMMUNITIES

Strategies	
A	Focus strategically on communities at greatest risk
B	Facilitate social connectedness and community engagement throughout the lifespan
C	Enhance cross-sector collaboration to create social norm change that supports healthy and safe environments and lifestyles for all
D	Increase access to healthy foods, beverages, and water, and decrease the presence of unhealthy foods, beverages, and tobacco products in multiple sectors
E	Increase access to daily physical activity by promoting the adoption and implementation of physical education and/or physical activity in multiple sectors
F	Support built environment policies to create and maintain healthy communities, such as including health elements in General Plans, with tailored approaches for small rural counties
G	Integrate health criteria into decision making within multiple sectors using a Health in All Policies approach
H	Provide individuals, communities, schools, businesses, professionals, institutions, and policymakers with information and tools to make healthy choices
I	Encourage compliance with current guidelines, laws, and regulations

Partners
Business; Government: Education, Planning, Economic Development, Transportation, Housing, Childcare, Social Services; Universities; Nonprofit Organizations; Health Systems: Medical, Mental, Dental, Behavioral; Health Providers; Health Payers

1.1	**Increase Health Status**	
Short-term Objectives		**Data Source**
1 1.1.1S HiAP	By 2015, adopt health equity as a key consideration in five state guidance documents	*Reports, Office of Health Equity CDPH*

Intermediate Objectives			Data Source
		Community Resilience	
1	1.1.1I SACB	By 2018, increase the percentage of teens who agree with the statement "people in this neighborhood can be trusted" from 84 to 90 percent	*California Health Interview Survey, University of California Los Angeles*
2	1.1.2I	By 2018, increase the percentage of people who have done volunteer work or community service (Developmental)	*California Health Interview Survey, University of California Los Angeles*
3	1.1.3I SACB	By 2018, increase the percentage of people who have served as a volunteer on any local board, council, or organization that deals with community problems from 12.2 percent in 2011 to 15 percent	*California Health Interview Survey, University of California Los Angeles*
4	1.1.4I **HC**	By 2018, increase voter participation rate in statewide general elections from 72.36 percent in November 2012 to 80 percent	*Statewide General Election Historical Voter Registration and Voter Participation Statistics from 1910 to 2012, California Secretary of State*
		Education	
5	1.1.5I CDE **HC**	By 2018, increase the Academic Performance Index (API) score from 753 for Grades 9–11 to 800	*Academic Performance Index Report, California Department of Education*
6	1.1.6I CDE **HC**	By 2018, increase the percentage of the population that has high school or greater educational attainment from 80.8 percent in 2011 (5 year estimate) to 82.5 percent	*American Community Survey, U.S. Census Bureau; Integrated Postsecondary Education Data System, National Center for Educational Statistics; Data Archive, Department of Education*

		Income	
7	1.1.7I HC	By 2018, decrease the percentage of households in overcrowded (≥1.01 persons/room)and severely overcrowded (≥1.50 persons per room) conditions (Developmental)	*American Community Survey, U.S. Census Bureau; Data Archive, U.S. Housing and Urban Development Department; Building Blocks for Effective Housing Elements, California Department of Housing and Community Development*
8	1.1.8I HC	By 2018, decrease the degree of residential segregation (ratio of percent of non-white racial/ethnic groups in a specific geographic area to city or county average) (Developmental)	*American Community Survey, U.S. Census Bureau*
9	1.1.9I HC	By 2018, increase the housing-to-jobs ratio in communities with a ratio less than 1 (percent of the adult working population who could find a job that matches their general occupational qualifications within a specified travel radius of their residence) (Developmental)	*LODES: Longitudinal-Employer Household Dynamics Program, U.S. Census Bureau*
10	1.1.10I HC	By 2018, decrease the annual unemployment rate from 10.8 percent in 2012 to 7 percent	*Local Area Unemployment Statistics, U.S. Bureau of Labor Statistics; American Community Survey, U.S. Census Bureau; Data Archive, California Employment Development Department*
		Equity	
11	1.1.11I HC	By 2018, increase Neighborhood Completeness Index (< ½ mile radius for 8 of 11 common public services and nine of twelve common retail services) (Developmental)	*California Board of Equalization*

Long-term Objectives			Data Source
		Life Expectancy	
1	1.1.1L LGH	By 2022, increase the percentage of adults who report their overall health status to be good, very good, or excellent from 85 to 90 percent	*California Health Interview Survey, University of California Los Angeles*
2	1.1.2L	By 2020, increase the percentage of 24–64 year old adults in good or better health from 80.7 to 85 percent	*California Health Interview Survey, University of California Los Angeles; National Vital Statistics System, Centers for Disease Control and Prevention (CDC)*
3	1.1.3L	By 2020, increase the percentage of 15–45 year old women who report their overall health status to be good, very good, or excellent from 85 to 90 percent (Developmental)	*California Health Interview Survey, University of California Los Angeles*
4	1.1.4L	By 2020, increase the percentage of 65–84 year old adults in good or better health from 73.1 percent in 2011 to 80 percent	*California Health Interview Survey, University of California Los Angeles; National Vital Statistics System, CDC*
5	1.1.5L	By 2020, decrease percentage of adults in fair or poor health from 22.9 to 18 percent for African Americans, 28.4 to 23 percent for Hispanics, and 23.4 to 18 percent for American Indian/Alaska Natives	*California Health Interview Survey, University of California Los Angeles; National Health Interview Survey, CDC*
6	1.1.6L HDDPU	By 2020, increase the equity between counties in health-adjusted life expectancy (HALE) years (Developmental)	*Institute for Health Metrics and Evaluation, University of Washington*
		Community Resilience	
7	1.1.7L CDE	By 2020, increase the percentage of high school students (9th graders) who report opportunities for meaningful participation in their community from 44 percent in 2011 to 62 percent	*California Healthy Kids Survey, California Department of Education*

8	1.1.8L **HC**	By 2020, increase neighborhood stability (5-year change in number of households by income and race/ethnicity [neighborhood change or gentrification]) (Developmental)	*American Community Survey, U.S. Census Bureau*
9	1.1.9L **HC**	By 2020, increase the resilience index (composed of places with climate action and hazard mitigation plans and other Healthy Community Indicators such as unemployment, lacking health insurance, educational attainment, income inequality, and registered voters) (Developmental)	*American Community Survey, U.S. Census Bureau*
		Education	
10	1.1.10L **LGH**	By 2022, increase the percentage of third grade students whose reading skills are at or above the proficient level from 46 to 69 percent	*Standardized Testing and Reporting Results, California Department of Education*
		Income	
11	1.1.11L **HC**	By 2020, decrease the percentage of household income spent on travel (Developmental)	*Housing and Transportation Affordability Index, Center for Neighborhood Technology*
12	1.1.12L **HC**	By 2020, decrease Income Inequality: Gini coefficient (describing the amount of total annual community income generated by the number of households) (Developmental)	*American Community Survey, U.S. Census Bureau*
		Equity	
13	1.1.13L **HC**	By 2020, increase race/ethnicity equity score (composite of multiple core indicators, including median income) (Developmental)	*American Community Survey, U.S. Census Bureau*
14	1.1.14L **HC**	By 2020, increase place-based equity score (composite of multiple core indicators calculated for census tracts) (Developmental)	*American Community Survey, U.S. Census Bureau*

1.2		Decrease Adult and Adolescent Tobacco Use	
Short-term Objectives			**Data Source**
1	1.2.1S	By 2015, increase the number of hospitals, clinics, mental health facilities, and other health or social service programs that adopt smoke-free campus policies (Developmental)	*No known data source*
Intermediate Objectives			**Data Source**
1	1.2.1I CTCP	By 2018, increase successful quit attempts to or above 7 percent	*Behavioral Risk Factor Surveillance System, CDC*
2	1.2.2I CTCP	By 2018, increase public support for "cigarette butts are toxic to the environment" from 83 to 90 percent	*Behavioral Risk Factor Surveillance System, CDC*
3	1.2.3I CTCP	By 2018, maintain the "average" social norm index score about secondhand smoke and tobacco industry influences in low socioeconomic status populations in California at or above 84 percent	*Behavioral Risk Factor Surveillance System, CDC*
4	1.2.4I CTCP	By 2018, decrease the percent of indoor workers who report exposure to secondhand smoke in the workplace from 7.5 to 6.5 percent	*Behavioral Risk Factor Surveillance System, CDC*
5	1.2.5I CTCP	By 2018, increase workers' secondhand smoke exposure protections provided through Labor Code 6404.5 by eliminating the following exemptions: owner-operated bars, employee break rooms, retail tobacco shops, workplaces with five or fewer employees, and long-term care facilities	*CTCP Policy Database, CDPH*
6	1.2.6I CTCP	By 2018, increase the proportion of the population protected by local tobacco retail license policies from 40 percent in July 2013 to 50 percent	*CTCP Policy Database, CDPH*
7	1.2.7I CTCP	By 2018, increase the number of tobacco-free schools (Developmental)	*No known data source*

Long-term Objectives			Data Source
1	1.2.1L CTCP **LGH**	By 2022, decrease the percentage of adolescents who smoked cigarettes in the past 30 days from 10 to 5 percent	*California Student Tobacco Survey, CDPH*
2	1.2.2L CTCP **LGH**	By 2022, decrease the percentage of adults who are current smokers from 13 to 9 percent	*Behavioral Risk Factor Surveillance System, CDC*
3	1.2.3L CTCP	By 2020, decrease the proportion of Californians reporting exposure to secondhand smoke from 44.8 to 40 percent	*Behavioral Risk Factor Surveillance System, CDC*
1.3		**Increase Adult and Child Fitness and Healthy Diets**	
Short-term Objectives			**Data Source**
		Fitness	
1	1.3.1S NEOP	By 2015, increase the number of Early Care and Education organizations that adopt strategies to increase physical activity (Developmental)	*Emergency Medical Services Authority (child care only); Community Care Licensing Division, California Department of Social Services*
2	1.3.2S NEOP	By 2015, increase the percentage of schools that offer intramural activities or physical activity clubs for all students, including those with disabilities, from 73.1 percent in 2012 to 76 percent, as federal funding allows	*School Health Profiles, California Department of Education*
3	1.3.3S NEOP	By 2015, increase the percentage of schools in which at least one physical education teacher or specialist received professional development on physical education during the past two years from 72.5 percent in 2012 to 76 percent, as federal funding allows	*School Health Profiles, California Department of Education*

4	1.3.4S NEOP	By 2015, increase number of worksites that adopt strategies to increase physical activity (Developmental)	*No known data source*
5	1.3.5S	By 2015, increase the number of businesses that request technical assistance to implement the California FIT business kit (Developmental)	*No known data source*
		Water	
6	1.3.6S NEOP	By 2015, increase the percentage of schools that allow students to have a water bottle with them during the school day and offer free drinking water in the cafeteria during meal times from 85.2 percent in 2012 to 89 percent	*School Health Profiles, California Department of Education*
		Healthy Diets	
7	1.3.7S NEOP	By 2015, increase the percentage of schools that always offer fruits or non-fried vegetables in vending machines, school stores, and during celebrations when foods and beverages are offered from 14.2 percent in 2012 to 18 percent	*School Health Profiles, CDC*
8	1.3.8S NEOP	By 2015, increase the percentage of schools that prohibit all forms of advertising and promotion (e.g., contests and coupons) of less nutritious foods and beverages on school property from 71.5 percent in 2012 to 75 percent	*School Health Profiles, CDC*
9	1.3.9S NEOP	By 2015, increase the number of local education agencies where staff receive professional development and technical assistance on strategies to create a healthy school nutrition environment as federal funding allows (Developmental)	*No known data source*
10	1.3.10S NEOP & MCAH	By 2015, increase the number of labor and delivery facilities that provide recommended care for lactating mothers and their babies (i.e., Baby-Friendly) from 59 in 2013 to 90	*Healthy People 2020; California Breastfeeding Coalition; Baby Friendly USA website*
11	1.3.11S NEOP	By 2015, increase the number of community health clinics in California that provide professional and peer support for breastfeeding from 15 to 30	*California Obesity Prevention Program, CDPH*

Intermediate Objectives			Data Source
		Fitness	
1	1.3.1I NEOP	By 2018, increase the percent of children in Early Care and Education organizations who engage in levels of age-appropriate physical activity as recommended by Caring For Our Children (Developmental)	*No known data source*
2	1.3.2I NEOP	By 2018, increase the percentage of adolescents (12–17 years) who are physically active at least one hour a day from 16.1 percent in 2011 to 19 percent	*California Health Interview Survey, University of California Los Angeles*
3	1.3.3I NEOP	By 2018, increase the percentage of adolescents (12–17 years) who take physical education classes at least four days a week	*California Health Interview Survey, University of California Los Angeles*
4	1.3.4I	By 2018, increase the percentage of schools that, either directly or through a school district, have a joint use agreement for shared use of physical activity facilities (Developmental)	*School Health Profiles, CDC*
5	1.3.5I CAPP	By 2020, California will reduce the percent of adults with arthritis who are insufficiently active or inactive from 42.8 to 40.6 percent	*Behavioral Risk Factor Surveillance System, CDC*
		Healthy Diets	
6	1.3.6I NEOP	By 2018, increase the percent of schools that do not sell less healthy foods and beverages (soda pop or fruit drinks, sports drinks, baked goods, salty snacks, and candy) from 53.2 percent in 2012 to 60 percent	*School Health Profiles, California Department of Education*
7	1.3.7I NEOP	By 2018, increase the percentage of children (2–11 years) who eat five or more servings of fruits and vegetables a day from 52.6 percent in 2011 to 57 percent	*California Health Interview Survey, University of California Los Angeles*
8	1.3.8I NEOP LGH	By 2022, decrease the percentage of adolescents who drank two or more glasses of soda or other sugary drink yesterday from 27 to 17 percent	*California Health Interview Survey, University of California Los Angeles*

9	1.3.9I NEOP **LGH**	By 2022, increase the percentage of adolescents who have consumed fruits and vegetables five or more times per day from 20 to 32 percent	*California Health Interview Survey, University of California Los Angeles*
10	1.3.10I **LGH**	By 2022, decrease the percentage of adults who drank two or more sodas or other sugary drinks per day from 20 to 10 percent	*California Health Interview Survey, University of California Los Angeles*
11	1.3.11I NEOP **HC & LGH**	By 2022, increase the percentage of adults who have consumed fruits and vegetables five or more times per day from 28 to 34 percent	*Behavioral Risk Factor Surveillance System, CDC*
12	1.3.12I MCAH	By 2020, increase the percentage of women with recent live births who took a multivitamin, prenatal vitamin, or folic acid vitamin every day of the week during the month before pregnancy (Developmental)	*Maternal Infant Health Assessment Survey, CDPH*
13	1.3.13I MCAH	By 2018, increase the percentage of mothers who report exclusive breastfeeding 3 months after delivery (Developmental)	*Healthy People 2020; Maternal and Infant Health Assessment Survey, CDPH*
14	1.3.14I NEOP	By 2018, increase the proportion of infants breastfed at 6 months from 56.1 percent in 2012 to 62 percent	*Breastfeeding Report Card—U.S., CDC*
15	1.3.15I NEOP	By 2020, reduce average sodium intake for children (9–11 years) from 3.5 to 2.8 g/day	*California Children's Healthy Eating and Exercise Practices Survey (CalCHEEPS), CDPH*
16	1.3.16I HDDPU	By 2018, reduce consumption of sodium in the population aged 2 years and older from 3,641 mg in 2006 to 2,500 mg.	*National Health and Nutrition Examination Survey, CDC/NCHS*

Long-term Objectives			Data Source
		Fitness	
1	1.3.1L NEOP **HC & LGH**	By 2022, increase the percentage of "physically fit" children, who reach the "Healthy Fitness Zone" in six of the six test items on the required Fitness-gram: 25–36 percent for 5th graders, 32–46 percent of 7th graders, and 37–52 percent for 9th graders	*Fitnessgram, California Department of Education*
2	1.3.2L NEOP **LGH**	By 2022, increase the percentage of adolescents who meet physical activity guidelines for aerobic physical activity from 15 to 24 percent	*California Health Interview Survey, University of California Los Angeles*
3	1.3.3L NEOP **HC & LGH**	By 2022, increase the percentage of adults who meet physical activity guidelines for aerobic physical activity from 58 to 66 percent	*Behavioral Risk Factor Surveillance System, CDC*
1.4		**Increase Healthy Food Outlets**	
Short-term Objectives			**Data Source**
1	1.4.1S CCCCP	By 2015, increase the percentage of farmers markets that accept electronic benefits transfers (EBTs) for payment by 50 percent, from 6.6 percent in 2009 to 10 percent	*EBT Project, California Office of Systems Integration; State Health Facts*
Intermediate Objectives			**Data Source**
1	1.4.1I NEOP **HC & LGH**	By 2022, increase the number of healthy food outlets as measured by Retail Food Environment Index from 11 to 21 percent	*State Indicator Report on Fruits and Vegetables 2009 and Children's Food Environment State Indicator Report 2011, CDC*
2	1.4.2I NEOP	By 2015, increase the number of corner stores that sell healthier food options in underserved areas (Developmental)	*No known data source*
3	1.4.3I **HC**	By 2018, increase the percentage of households within ½-mile of a full-service grocery store, fresh produce market, or store with fresh produce (Developmental)	*California Board of Equalization*

4	1.4.4I **HC**	By 2018, decrease the average weekly cost of a market basket for food items relative to income (Developmental)	*Official USDA Food Plans: Cost of Food at Home at Four Levels, [national data only: at least expensive level $127.30 for a U.S. family of four for a week (in June 2013)]*
Long-term Objectives			**Data Source**
1	1.4.1L	By 2020, employ behavioral economic strategies, such as food placement, in x retail outlets to promote healthy purchasing (Developmental)	*No known data source*
2	1.4.2L	By 2020, implement Nutrition Network program in x additional highly utilized food stores (Developmental)	*No known data source*
3	1.4.3L	By 2020, increase the number of farmers markets, community supported agriculture, or farm stands on public facilities in low income/food insecure communities (Developmental)	*No known data source*
4	1.4.4L	By 2020, increase the percentage of local and state government agencies that have adopted healthy food procurement standards and policies that promote purchase of more fruits, vegetables, and water, and less high-sodium foods and sugary sweetened beverages (Developmental)	*No known data source*
5	1.4.5L	By 2020, increase the percentage of youth-serving community sites and organizations that adopt healthy eating and vending guidelines and policies, including state-licensed childcare facilities, after-school and teen programs (Developmental)	*No known data source*
6	1.4.6L	By 2020, increase the proportion of food service entities (purchasers, suppliers, and/or vendors) that purchase, secure, or sell nutritious foods and beverages, including low-sodium foods (Developmental)	*No known data source*

7	1.4.7L	By 2020, increase the adoption of procurement policies and practices that limit non-nutritious foods and beverages, including high sodium, in government-purchased food in worksites and schools (Developmental)	*No known data source*
1.5		**Increase Walking and Biking**	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	
Intermediate Objectives			**Data Source**
1	1.5.1I NEOP, SACB **LGH**	By 2022, increase the annual number of walk trips per capita from 184 to 230	*National Household Travel Survey—California Add-on sample, California Department of Transportation*
2	1.5.2I NEOP, SACB **LGH**	By 2022, increase the percentage of children who walk/bike/roll to school from 43 percent in 2009 to 51 percent	*California Health Interview Survey, University of California Los Angeles*
3	1.5.3I NEOP **HC**	By 2018, increase the percentage of commuters who use active transportation (walk, bicycle, and/or public transit) to travel to work from 9.1 to 11 percent	*American Community Survey, U.S. Census Bureau*
4	1.5.4I NEOP **HC**	By 2018, increase the percentage of the population aged 16 years or older by time walking and biking to work ≥ 10 minutes/day from 3.9 to 5 percent	*American Community Survey, U.S. Census Bureau*
5	1.5.5I NEOP **HC**	By 2018, increase the percentage of residents within ½ mile of park, beach, open space, or coastline (Developmental)	*California Protected Areas Database, GreenInfo Network*
6	1.5.6I NEOP **HC**	By 2018, increase the acres of tree canopy coverage in urban areas (Developmental)	*National Land Cover Database, U.S. Geological Survey*

7	1.5.7I NEOP **HC**	By 2018, increase acres of parkland (usable walkable green space) per 1,000 residents (Developmental)	*California Protected Areas Database, GreenInfo Network*
Long-term Objectives			**Data Source**
1	1.5.1L	By 2020, increase the number of municipalities that have adopted local policies, ordinances, engineering solutions, or other strategies that promote safe, walkable, and bikeable communities, particularly in low-income, underserved communities (Developmental)	*No known data source*
2	1.5.2L	By 2020, increase the percentage of municipal General Plans that contain a health element with language specific to environments that promote daily physical activity (Developmental)	*No known data source*
1.6		**Increase Safe Communities**	
Short-term Objectives			**Data Source**
1	1.6.1S DHCS	By 2015, increase the number of local health departments participating in their jurisdictions' General Plan development (Developmental)	*No known data source*
Intermediate Objectives			**Data Source**
		Alcohol Misuse	
1	1.6.1I DHCS	By 2018, decrease the percentage of youth between 9th and 11th grades who reported binge drinking during the past two weeks (Developmental)	*Monitoring the Future Survey, National Institutes of Health*
2	1.6.2I DHCS	By 2018, decrease the percentage of adults ages 18 years and older who reported that they engaged in binge drinking during the past 30 days (Developmental)	*National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration*
3	1.6.3I **HC**	By 2018, decrease the density of on-site and off-site alcohol outlets (Developmental)	*Reports, California Department of Alcoholic Beverage Control*

		Substance Abuse	
4	1.6.4I	By 2018, decrease the percentage of youth ages 12 to 17 years who have used marijuana or nonmedical use of prescription drugs in the past 30 days (Developmental)	*National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration*
		Water	
5	1.6.5I DWP **HC**	By 2018, increase the percentage of the population served by community water systems that receives water meeting all health-based standards of the Safe Drinking Water Act from 98 to 99 percent	*2007 Annual Compliance Report for Public Water Systems, CDPH*
6	1.6.6I OH	By 2018, increase the percentage of the population served by community water systems with optimally fluoridated water from 62.1 to 76.9 percent	*Water Fluoridation Reporting System, CDC*
		Air Quality	
7	1.6.7I CEHTP **HC**	By 2018, decrease the percentage of households/population near busy roadways from 60 to 50 percent	*American Community Survey, U.S. Census Bureau; California Environmental Health Tracking Program, CDPH; CalTrans Highway Performance Monitoring System*
8	1.6.8I **HC**	By 2018, increase the percentage of cities and counties with adopted climate action plans and FEMA-approved local hazard mitigation plans (Developmental)	*Annual Planning Survey, Governor's Office of Planning and Research*
9	1.6.9I CB, CEHTP **HC**	By 2018, decrease the number of days per year (in non-attainment air basin or county) that exceeds ambient air standards for criteria pollutants for ozone and for PM2.5 (Developmental)	*Aerometric Data and Analysis System, California Air Resources Board; California Environmental Health Tracking Program, CDPH*
10	1.6.10I NEOP	By 2018, increase the percentage of residents who do not drive a personal car to work from 27 to 30 percent	*American Community Survey, U.S. Census Bureau*

11	1.6.11I NEOP **HC**	By 2018, increase the percentage of the population located < ½ mile of a regional bus/rail/ferry and < ¼ mile local bus/light rail (Developmental)	*Transit asset inventories: ULTRANS, University of California Davis; SafeTREC, UC Berkeley*
		Safe Worksites	
12	1.6.12I CCR	By 2018, enable the California Cancer Registry to add occupational data to registry files to assist in tracking occupational causes of cancer	*California Cancer Registry, CDPH*
Long-term Objectives			**Data Source**
1	1.6.1L SACB **LGH**	By 2022, increase the percentage of adults who report they feel safe in their neighborhoods all or most of the time from 91 percent in 2007 to 96 percent	*California Health Interview Survey, University of California Los Angeles*
		Alcohol Misuse	
2	1.6.2L SACB	By 2020, decrease the rate of fatalities due to alcohol impaired driving (Developmental)	*Fatality Analysis Reporting System, U.S. Department of Transportation*
		Unintentional Injury	
3	1.6.3L SACB	By 2020, decrease the annual incidence rate of fall-related deaths among adults age 65 and older in California from 39 to 29 per 100,000	*Vital Statistics, Death Statistical Master Files, EpiCenter—Injury Data Online, CDPH*
4	1.6.4L SACB **HC**	By 2020, decrease the annual number of all non-fatal injuries from collisions in California from 152,716 in 2010 to 140,000	*Statewide Integrated Traffic Records System: Department of Transportation, California Highway Patrol, Office of Traffic Safety; EpiCenter—Injury Data Online, CDPH*

5	1.6.5L SACB **HC**	By 2020, decrease pedestrian non-fatal hospitalization injury annual incidence rates in California from 10.2 to 8 per 100,000 population	*California Office of Statewide Health Planning and Development* *Crash Medical Outcomes Data (CMOD) System, EpiCenter—Injury Data Online, CDPH*
6	1.6.6L SACB	By 2020, decrease the annual incidence rate of unintentional injury deaths in California from 27 to 20 per 100,000	*National Vital Statistics System, CDC, Vital Statistics, Death Statistical Master Files, EpiCenter—Injury Data Online, CDPH*
7	1.6.7L SACB **HC**	By 2020, decrease the annual incidence rate of motor vehicle related deaths in California from 0.84 to 0.50 per 100 million miles of travel	*Statewide Integrated Traffic Records System: Department of Transportation, California Highway Patrol, Office of Traffic Safety*
		Violence	
8	1.6.8L SACB **HC**	By 2020, decrease the annual number of adults aged 18–65 years who report physical or sexual violence by an intimate partner in California (i.e., domestic violence calls for assistance) from 157,634 to 125,000.	*Uniform Crime Reports, California Department of Justice*
9	1.6.9L SACB	By 2020, decrease the annual incidence rate of homicides in California from 5 to 4 per 100,000	*National Vital Statistics System, CDC; Vital Statistics, Death Statistical Master Files, CDPH*
10	1.6.10L SACB **HC**	By 2020, decrease the annual incidence rate of homicides in California among African American males aged 15–29 years from 57.5 to 40 per 100,000	*Vital Statistics, Death Statistical Master Files, EpiCenter—Injury Data Online, CDPH*

		Air Quality	
11	1.6.11L	By 2020, decrease annual per capita Greenhouse Gas emissions to 1990 levels from 450 to 431 million metric tons of carbon dioxide equivalent (MMTCO2e), pursuant to AB32 and the First Update to the Climate Change Scoping Plan	*Aerometric Data and Analysis System, California Air Resources Board*
		Safe Worksites	
12	1.6.12L SACB **HC**	By 2020, decrease the annual incidence rate of nonfatal occupational injuries in California from 2.3 to 2 per 100 full-time workers across industries	*Data Archive, California Department of Industrial Relations*
13	1.6.13L OHB	By 2020, reduce incidence of non-fatal work-related injuries and illnesses reported by private-sector employees from 3,700 workers per 100,000 in 2010 to 3,330 workers per 100,000	*Annual Survey of Occupational Injuries and Illnesses, U.S. Bureau of Labor Statistics*
14	1.6.14L OHB	By 2020, reduce incidence of work-related musculoskeletal disorders reported by private-sector employees, from 317 workers per 100,000 workers in 2010 to 285 workers per 100,000 workers	*Annual Survey of Occupational Injuries and Illnesses, U.S. Bureau of Labor Statistics.*
15	1.6.15L OHB	By 2020, reduce incidence of hospitalizations for work-related lower back disorders from 16.1 workers per 100,000 workers in 2010 to 14.5 workers per 100,000 workers	*Hospital Patient Discharge Data System, California Office of Statewide Planning and Development*
16	1.6.16L OHB	By 2020, reduce the number of workers with elevated blood lead levels above 10ug/dL from 1,450 (2012) to 1,305	*Occupational Blood Lead Registry, CDPH*
17	1.6.17L OHB	By 2020, reduce incidence of work-related hospitalizations (payment by workers' compensation) from 77.5 workers per 100,000 workers in 2010 to 69.8 workers per 100,000 workers	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*

18	1.6.18L OHB	By 2020, reduce incidence of work-related asthma from 637 new cases in 2009 to 573	*Workers' Compensation Information System, Doctors' First Reports of Occupational Illness and Injury, California Office of Statewide Health Planning and Development*
19	1.6.19L OHB	By 2020, reduce incidence of hospitalizations for work-related heat illness (Developmental)	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
20	1.6.20L OHB	By 2020, reduce incidence of traumatic work-related fatalities among Latinos from 2.7 workers per 100,000 workers in 2010 to 2.4 workers per 100,000 workers	*Fatalities Assessment Control and Evaluation*
21	1.6.21L OHB	By 2020, reduce incidence of work-related fatal traumatic injuries from 2.2 workers per 100,000 workers in 2010 to 2.0 workers per 100,000 workers	*Census of Fatal Occupational Injuries, U.S. Bureau of Labor Statistics*
1.7		**Decrease Childhood Trauma**	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	
Intermediate Objectives			**Data Source**
		No objectives have been identified at this time	
Long-term Objectives			**Data Source**
1	1.7.1L SACB **LGH**	By 2022, decrease the percentage of respondents indicating at least one type of Adverse Childhood Experience from 59 to 45 percent	*Behavioral Risk Factor Surveillance System, CDC*
2	1.7.2L SACB **HC & LGH**	By 2022, reduce the (reported and substantiated) incidence rate of child maltreatment (including physical, psychological, neglect) per 1,000 children from 53.1 to 50 and 9.2 to 8, respectively	*Child Welfare System/Case Management Services Dynamic Report System, California Department of Social Services*

3	1.7.3L SACB	By 2020, decrease the rate of child maltreatment deaths from 1.4 to 1.25 per 100,000	*Vital Statistics, Death Statistical Master File, CDPH; SB 39 reports, California Department of Social Services*
1.8		**Increase Early Learning**	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	
Intermediate Objectives			**Data Source**
1	1.8.1I	By 2018, increase the percentage of children enrolled in preschool (Developmental)	*No known data source*
Long-term Objectives			**Data Source**
1	1.8.1L CDE	By 2020, increase the percentage of third grade students whose reading skills are at or above the proficient level from 46 to 69 percent	*Standardized Testing and Reporting (STAR) Results, California Department of Education*
2	1.8.2L CDE **HC**	By 2020, increase the percentage of children who are kindergarten ready (not available statewide) (Developmental)	*Annual Reports, California Children and Families Commission (First Five)*

GOAL 2: OPTIMAL HEALTH SYSTEMS LINKED WITH COMMUNITY PREVENTION

Strategies	
A	Provide equitable and affordable access to high-quality health care using a patient centered approach
B	Increase delivery of clinical preventive services and early identification of medical, mental, dental, and behavioral health needs
C	Expand modalities of primary care services to include reimbursable email, phone-based care, web portals for self-management, group visits, and integrated medical and behavioral health visits
D	Enhance coordination and integration of medical, mental, dental, and behavioral care within and between health care systems, public health, and the community

E	Increase implementation of quality improvement processes within and between health systems and the community to improve systems of care
F	Reduce barriers to and support implementation of community preventive services and enhance clinical–community linkages
G	Expand public and private insurance coverage of and reimbursement authority for community preventive services per evidence-based guidelines
H	Provide individuals and families with information and tools to be able to follow providers' advice in daily life, such as health literacy, health system navigation, and self-care in the community
I	Promote awareness of cardiovascular disease prevention: aspirin/Hemoglobin A1C/ alcohol, blood pressure, cholesterol, diet, exercise, smoking
J	Encourage compliance with current guidelines, laws, and regulations

Partners

Health System: Medical, Mental, Dental, Behavioral; Health Providers; Health Payers; Business; Government: Education, Planning, Housing, Social Services; Universities; Non-Governmental Organizations

2.1		**Decrease the Number of People without Insurance**	
Short-term Objectives			**Data Source**
1	2.1.1S Covered CA	By 2015, increase culturally and linguistically appropriate public outreach campaigns promoting enrollment for health insurance through Covered California to uninsured individuals eligible for subsidy (Developmental)	*Covered California*
Intermediate Objectives			**Data Source**
1	2.1.1I Covered CA	By 2018, increase enrollment of uninsured individuals eligible for subsidy through Covered California into health insurance (Developmental)	*Covered California*
2	2.12I DPAC	By 2018, CDPH will adopt one policy to add type of insurance to relevant data sets collected in the Department	*Policies, Information Technology Services Division, CDPH*

Long-term Objectives			Data Source
1	2.1.1L Covered CA **HC & LGH**	By 2022, decrease the rate of uninsured Californians (who are federal subsidy eligible) from 56 percent (estimated in January 2014) to 24 percent	*California Health Interview Survey, University of California Los Angeles; Covered California*
2.2		**Increase Access to Primary and Specialty Care**	
Short-term Objectives			**Data Source**
		Oral Health	
1	2.2.1S OH & DHCS	By 2015, increase the percentage of low-income children and adolescents ages 1–20 years enrolled in Medi-Cal for at least 90 continuous days who received any preventive dental service from 36.9 percent in 2011 to y percent	*U.S. Centers for Medicare and Medicaid (CMS-416-form); Medi-Cal, Department of Health Care Services*
2	2.2.2S OH & DHCS	By 2015, increase the percentage of low-income children ages 6–9 years enrolled in Medi-Cal for at least 90 continuous days who received a dental sealant on a permanent molar from 16.1 percent in 2011 to y percent	*U.S. Centers for Medicare and Medicaid (CMS-416 form); Medi-Cal, Department of Health Care Services*
		Cancer	
3	2.2.3S CCCCP & DHCS EWC	By 2015, increase the prevalence of women 40 years and older who report having both a mammogram and a clinical breast exam within the prior two years by 7.5 percent, from 79.1 percent in 2010 to 85 percent	*Behavioral Risk Factor Surveillance System, CDC*
4	2.2.4S C4P	By 2015, increase colorectal cancer screening rates among people 50 and older using one of the screening options recommended by the 2008 U.S. Preventive Services Task Force Guidelines by 15 percent, from 68.1 percent in 2009 to 78.3 percent	*California Health Interview Survey, University of California Los Angeles*

Intermediate Objectives			Data Source
1	2.2.1I **LGH**	By 2022, increase the percentage of patients receiving care in a timely manner from primary care physicians and specialists (Developmental)	*Integrated Healthcare Association, California Pay for Performance Program, Measurement Year 2011 P4P Manual*
2	2.2.2I Covered CA	By 2018, decrease the percentage of individuals who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines (Developmental)	*Medical Expenditure Panel Survey, U.S. Agency for Healthcare Research and Quality*
		Oral Health	
3	2.2.3I Covered CA, DHCS, & OH	By 2018, increase the proportion of adults in Medi-Cal who used the oral health care system in the past year (Developmental)	*Denti-Cal, Department of Health Care Services; Behavioral Risk Factor Surveillance System, CDC; California Health Interview Survey, University of California Los Angeles*
		Cancer	
4	2.2.4I CCCCP & DHCS EWC	By 2015, increase the proportion of early-stage diagnoses of breast cancer among all women by 29 percent, from 69 percent in 2008 to 89 percent	*California Cancer Registry, CDPH; Every Woman Counts database*
5	2.2.5I C4P	By 2015, decrease the proportion of late-stage diagnoses of colorectal cancer among Californians by 15 percent, from 47.1 percent in 2008 to 40 percent	*California Cancer Registry, CDPH*
6	2.2.6I CCCCP	By 2015, decrease the proportion of late-stage diagnoses of colorectal cancer among African Americans and Asian and Pacific Islanders by 20 percent: from 51.5 percent in 2008 to 41.2 percent for African Americans, and from 51.8 percent in 2008 to 41.4 percent for Asian and Pacific Islanders	*California Cancer Registry, CDPH*

		School Health Care	
7	2.2.7I NEOP	By 2018, increase the number of school-based health centers in K-12 public schools (Developmental)	*Reports, California School Health Centers Association*
		Arthritis	
8	2.2.8I CAPP	By 2018, decrease the percentage of adults with arthritis who report arthritis-attributable activity limitations from 49.7 to 47.2 percent	*Behavioral Risk Factor Surveillance System, CDC*
9	2.2.9I CAPP	By 2018, decrease the percentage of working-age adults with arthritis who indicate arthritis-attributable work limitation from 38.3 to 36.3 percent	*Behavioral Risk Factor Surveillance System, CDC*
10	2.2.10I CAPP	By 2018, decrease the proportion of adults with arthritis reporting severe pain (≥ 7 out of 11 point scale) from 26.8 to 25.4 percent	*Behavioral Risk Factor Surveillance System, CDC*
		Chronic Obstructive Pulmonary Disease	
11	2.2.11I	By 2020, decrease hospitalizations for Chronic Obstructive Pulmonary Disease (Developmental)	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
Long-term Objectives			**Data Source**
		Cancer	
1	2.2.1L CCCCP	By 2015, reduce the mortality rate of female breast cancer by 10 percent, from 21.4 per 100,000 in 2008 to 19.3 per 100,000	*California Cancer Registry, CDPH*
2	2.2.2L C4P	By 2015, decrease the mortality rate of colorectal cancer by 17.5 percent, from 14.5 per 100,000 in 2008 to 12.0 per 100,000	*California Cancer Registry, CDPH*
3	2.2.3L CCCCP	By 2015, decrease the mortality rate of prostate cancer by 10 percent, from 21.7 per 100,000 in 2008 to 19.5 per 100,000	*California Cancer Registry, CDPH*

4	2.2.4L CCCCP	By 2015, decrease the mortality rate of prostate cancer among African American (non-Hispanic black) men by 10 percent, from 51.6 per 100,000 in 2008 to 46.4 per 100,000	*California Cancer Registry, CDPH*
5	2.2.5L CCR	By 2020, decrease the mortality rate of lung cancer from 36.2 to 32.6 per 100,000	*California Cancer Registry, CDPH*
6	2.2.6L CTCP	By 2020, decrease the incidence of lung cancer from 16,911 to 16,000 per 100,000	*California Cancer Registry, CDPH*
2.3		**Increase Coordinated Outpatient Care** **Increase People Receiving Care in an Integrated System**	
Short-term Objectives			**Data Source**
		Patient Centered Medical Home	
1	2.3.1S CCCCP	By 2015, increase the number of cancer patients who have received an aftercare plan after completing treatment by 10 percent, from 71.9 percent in 2010 to 79.1 percent	*Behavioral Risk Factor Surveillance System, CDC*
		Lifestyle Intervention Programs	
2	2.3.2S HDDPU & WW	By 2015, increase the proportion of WISEWOMAN participants in evidence-based lifestyle intervention programs, including those addressing social and emotional support, who were referred by a health care provider from 1,300 women in 2013 to 1,800 women, as federal funding allows	*WW Minimum Data Elements, CDPH*
3	2.3.3S HDDPU & DHCS	By 2015, increase the percentage of Medi-Cal recipients with pre-diabetes or at high risk for type 2 diabetes who have access to evidence-based lifestyle intervention programs (Developmental)	*Medi-Cal Managed Care Plan Data, Department of Health Care Services*

		Self-Management Programs	
4	2.3.4S HDDPU, CAPP, CTG & CDA	By 2015, increase the number of participants with a chronic health condition and/or disability who attend evidence-based chronic disease self-management programs in California from 15,149 from 2008 to 2012 to 25,000 from 2013 to 2017	*Data repositories, California Department of Aging, CDPH*
5	2.3.5S HDDPU, CAPP, & CDA	By 2015, increase the number of counties with evidence-based chronic disease self- management programs from 38 to 44, as federal funding allows	*Data repositories, California Department of Aging, CDPH*
6	2.3.6S HDDPU & DHCS	By 2015, increase the percentage of Medi-Cal recipients with diabetes who have access to Diabetes Self-Management Education (DSME) (Developmental)	*Medi-Cal Managed Care Plan Data, Department of Health Care Services*
7	2.3.7S HDDPU	By 2015, increase the number of DSME programs from 159 to 176	*Data repositories, Heart Disease and Diabetes Prevention Unit, CDPH*
8	2.3.8S HDDPU	By 2015, increase the proportion of counties with DSME programs from 66 to 76 percent, as federal funding allows	*Data repositories, Heart Disease and Diabetes Prevention Unit, CDPH*
9	2.3.9S HDDPU & DHCS	By 2015, increase number of smokers in the Medi-Cal program who call the California Smokers' Helpline (Quitline) though the Medi-Cal Incentives to Quit Smoking Project from approximately 17,500 callers to 25,000 callers annually	*California Smokers' Helpline, DHCS*
Intermediate Objectives			**Data Source**
		Patient Centered Medical Homes	
1	2.3.1I DHCS	By 2018, increase the percentage of Medi-Cal members in a patient-centered medical home (Developmental)	*No known data source*
2	2.3.2I LGH	By 2022, increase the percentage of people in population managed health plans from 48 to 61 percent	*California Health Interview Survey, University of California Los Angeles*

		Self-Management Programs	
3	2.3.3I HDDPU	By 2018, increase the proportion of people with diabetes in targeted settings who have at least one encounter at a DSME program per year (Developmental)	*No known data source*
4	2.3.4I CTCP & WW	By 2018, increase the number of calls to the California Smokers' Helpline referred from health care providers from 14,221 to 15,000	*California Smokers' Helpline, CDPH; WW Minimum Data Elements, CDPH*
		Medical, Mental and Behavioral Health	
5	2.3.5I DHCS	By 2018, increase the percentage of adults screened for alcohol misuse and provide brief counseling (Developmental)	*Medi-Cal, Department of Health Care Services*
Long-term Objectives			**Data Source**
		Patient Centered Medical Homes	
1	2.3.1L **LGH**	By 2022, increase the percentage of patients whose doctor's office helps coordinate their care with other providers or services from 67 to 94 percent for children/adolescents and 75 to 94 percent for adult health maintenance organization patients (Developmental)	*California Pay for Performance Program, Integrated Healthcare Association*
2.4		**Increase Mental Health and Wellbeing**	
Short-term Objectives			**Data Source**
		Alzheimer's Disease	
1	2.4.1S ADP & Alzheimer's Association	By 2015, update the Guideline for Alzheimer's Disease Management	*Reports, Alzheimer's Association*

Intermediate Objectives			Data Source
1	2.4.1I	By 2018, increase policies and protocols used to screen for mental illness (Developmental)	*No known data source*
		Alzheimer's Disease	
2	2.4.2I ADP	By 2018, California Alzheimer's Disease Centers increase training and education to professionals and students from 35,298 per year in 2010 to 60,000 per year	*Training and Education Reports, California Alzheimer's Disease Centers, CDPH*
3	2.4.3I ADP	By 2018, California Alzheimer's Disease Centers increase training and education to caregivers, patients and community members from 16,100 per year in 2010 to 32,000 per year	*Training and Education Reports, California Alzheimer's Disease Centers, CDPH*
		Depression	
4	2.4.4I	By 2018, increase the percentage of primary care physician office visits in Medi-Cal that use a standardized evidence-based tool to screen adults and youth for depression (Developmental)	*National Ambulatory Medical Care Survey, CDC*
Long-term Objectives			**Data Source**
1	2.4.1L ADP	By 2020, decrease the percentage of adults age 60 and over reporting increased confusion or memory loss from 17 to 16.5 percent	*Behavioral Risk Factor Surveillance System, CDC*
2	2.4.2L CAPP	By 2020, decrease the percentage of adults with arthritis that report anxiety from 17.4 to 15.6 percent	*Behavioral Risk Factor Surveillance System, CDC*
3	2.4.3L	By 2020, reduce opiate related morbidity and mortality (Developmental)	*Vital Statistics, Death Statistical Master Files, CDPH*
		Depression	
4	2.4.4L **LGH**	By 2022, decrease the frequency of sad or hopeless feelings in the past 12 months from: 28 to 25 percent of 7th graders, 31 to 24 percent of 9th graders, and 32 to 27 percent of 11th graders	*California Healthy Kids Survey, California Department of Education*

5	2.4.5L CAPP	By 2020, decrease the percentage of adults with arthritis that report depression from 15 to 13.5 percent	*Behavioral Risk Factor Surveillance System, CDC*
6	2.4.6L **LGH**	By 2022, decrease the percentage of adolescents (12–17 years) and adults (≥ 18 years) who experience a major depressive episode from 8 to 7 percent and 6 to 5 percent, respectively	*National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration*
2.5		**Decrease Adult and Childhood Obesity and Diabetes**	
Short-term Objectives			**Data Source**
1	2.5.1S WIC	By 2015, decrease the obesity rate among 4 year old children participating in WIC by 1 percent from 20 percent overweight in 2012 to 19 percent	*WIC Integrated Statewide Information System, CDPH*
2	2.5.2S HDDPU	By 2015, increase awareness of pre-diabetes so that the prevalence of people who self-report having pre-diabetes increases from 9 percent in 2011 to 12 percent	*National Nutrition and Health Examination Survey, CDC; California Health Interview Survey, University of California Los Angeles*
Intermediate Objectives			**Data Source**
1	2.5.1I HDDPU & WW	By 2018, increase the proportion of WW participants with diabetes in adherence to medication regimens from 63 percent in 2012 to 69 percent, as federal funding allows	*Medi-Cal EHR Incentive Program, Department of Health Care Services; National Quality Forum; WW Minimum Data Elements, CDPH*
2	2.5.2I HDDPU	By 2018, decrease the proportion of people with diabetes who have Hemoglobin A1C > 9 (Developmental)	*Medi-Cal EHR Incentive Program, Department of Health Care Services; National Quality Forum*
3	2.5.3I DHCS & DSS	By 2018, increase annual CalFresh Enrollment among Eligible Medi-Cal members by 5 percent each year (Developmental)	*Medi-Cal MIS; DSS Data Warehouse; DSS MEDS database*

Long-term Objectives			Data Source
1	2.5.1L NEOP **LGH**	By 2022, decrease the percentage of children and adolescents who are overweight and obese, respectively from: 12 to 10 percent (2–5 years), 12 to 11 percent for (6–11 years), and 18 to 15 percent (12–19 years)	*California Health Interview Survey, University of California Los Angeles*
2	2.5.2L NEOP & WW **LGH**	By 2022, decrease the percentage of adults who are obese from 24 to 11 percent	*Behavioral Risk Factor Surveillance System, CDC; WW Minimum Data Elements, CDPH*
3	2.5.3L MCAH	By 2020, increase the proportion of mothers who achieve a recommended weight gain (per IOM standards) during their pregnancies (Developmental)	*Vital Statistics, Birth Statistical Master Files, Maternal and Infant Health Assessment Survey, CDPH*
4	2.5.4L	By 2020, decrease the prevalence of diagnosed gestational diabetes mellitus in hospital deliveries (Developmental)	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
5	2.5.5L HDDPU & WW **LGH**	By 2022, decrease the prevalence of diagnosed diabetes, in adults, from 9 to 8 per 100	*Behavioral Risk Factor Surveillance System, CDC; California Health Interview Survey, University of California Los Angeles*
6	2.5.6L HDDPU	By 2020, decrease the age-adjusted hospital discharge rate for diabetes as any-listed diagnosis for persons with diabetes from 337 per 1,000 in 2008 to 275 per 1,000	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
2.6		**Increase Controlled High Blood Pressure and High Cholesterol**	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	

Intermediate Objectives			Data Source
1	2.6.1I HDDPU & WW	By 2018, increase the number of adults who have been screened for high blood pressure within the previous 2 years from 91 percent in 2008 to 93 percent	*National Health Interview Survey, CDC; California Health Interview Survey, University of California Los Angeles; WW Minimum Data Elements, CDPH*
2	2.6.2I HDDPU & WW	By 2018, increase the number of adults who have been screened for high cholesterol in the previous 5 years from 86 percent in 2008 to 88 percent	*National Health Interview Survey, CDC; California Health Interview Survey, University of California Los Angeles; WW Minimum Data Elements, CDPH*
3	2.6.3I	By 2018, increase the number of employed community health workers in California (Developmental)	*U.S. Bureau of Labor Statistics*
Long-term Objectives			**Data Source**
1	2.6.1L HDDPU & WW	By 2020, decrease the prevalence of high blood pressure from 26 percent in 2009 to 23 percent	*National Health and Nutrition Examination Survey, CDC; California Health Interview Survey, University of California Los Angeles*
2	2.6.2L HDDPU **LGH**	By 2022, increase the percentage of adults diagnosed with hypertension that have controlled high blood pressure from: 79 to 87 percent for Medicare patients, 50 to 70 percent for PPO patients, and 78 to 86 percent for HMO patients	*California Pay for Performance Program, Integrated Healthcare Association*
3	2.6.3L HDDPU & WW	By 2020, decrease the prevalence of high cholesterol from 22 percent in 2005 to 20 percent	*National Health and Nutrition Examination Survey, CDC; California Health Interview Survey, University of California Los Angeles*

4	2.6.4L HDDPU **LGH**	By 2022, increase the percentage of adults diagnosed with high cholesterol who are managing the condition from: 76 to 91 percent for Medicare patients, 50 to 70 percent for PPO patients, and 78 to 86 percent for HMO patients	*California Pay for Performance Program, Integrated Healthcare Association*
5	2.6.5L HDDPU & WW	By 2020, decrease rate of hospitalization with acute stroke as principal diagnosis from 5.7 to 5.1 per 1,000	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
6	2.6.6L HDDPU & WW	By 2020, decrease rate of hospitalization with acute myocardial infarction as primary diagnosis from 15.8 to 14.2 per 1,000	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
7	2.6.7L HDDPU	By 2020, decrease the rate of hospitalizations for adults 65 and over with heart failure as the principle diagnosis from 10.2 to 9.2 per 1,000	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
8	2.6.8L HDDPU & WW	By 2020, decrease stroke mortality rate from 36.9 to 29.5 per 100,000	*Vital Statistics, Death Statistical Master Files, CDPH*
9	2.6.9L HDDPU & WW	By 2020, decrease heart disease mortality rate from 120.5 to 96.4 per 100,000	*Vital Statistics, Death Statistical Master Files, CDPH*
10	2.6.10L HDDPU & WW	By 2020, decrease heart failure mortality rate from 12.5 to 10 per 100,000	*Vital Statistics, Death Statistical Master Files, CDPH*
2.7		**Decrease Adult and Childhood Asthma**	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	

Intermediate Objectives			*Data Source*
1	2.7.1I CB	By 2018, increase the number of healthcare payers that cover and reimburse for comprehensive asthma management, including self-management education, the use of certified asthma educators, and home visits by nurses, community health workers, etc. (Developmental)	*No known data source*
Long-term Objectives			**Data Source**
1	2.7.1L CB	By 2020, reduce the number of school days missed due to asthma from 1.4 to 1.2 million in the past 12 months	*National Health Interview Survey, CDC; California Health Interview Survey, University of California Los Angeles*
2	2.7.2L CB **LGH**	By 2022, reduce the asthma emergency department visit rate for ages 0–17 years from 73 to 53 per 10,000	*Emergency Department Data System, California Office of Statewide Health Planning and Development*
3	2.7.3L CB	By 2020, reduce the asthma hospitalizations for ages 0–18 years from 11 to 8 per 10,000	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
4	2.7.4L CB	By 2020, reduce the disparity between African American and White asthma emergency department visit rates from 4 to 3 times higher	*Emergency Department Data System, California Office of Statewide Health Planning and Development*
5	2.7.5L CB	By 2020, reduce the disparity between African American and White asthma hospitalization rates from 3.8 to 3 times higher	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
2.8		**Increase Vaccinations**	
Short-term Objectives			**Data Source**
1	2.8.1S IZB	By 2015, increase the number of sites enrolled with California Immunization Registry (CAIR) by 20 percent from 2,000 to 2,400	*California Immunization Registry, CDPH*

2	2.8.2S IZB	By 2015, increase the number of sites registered at the new Immunization Messaging Portal for data exchange from 0 to 1,000	*Immunization Messaging Portal, CDPH*
3	2.8.3S IZB	By 2015, increase the percentage of all vaccine doses entering CAIR via electronic data exchange from 35 to 60 percent	*California Immunization Registry, CDPH*
4	2.8.4S IZB	By 2015, increase the percentage of children (0–5 years) with two or more vaccine doses in CAIR from 58 to 70 percent	*California Immunization Registry, CDPH*
5	2.8.5S IZB	By 2015, increase the percentage of Californians with two or more vaccine doses in CAIR from 23.6 to 35 percent	*California Immunization Registry, CDPH*
Intermediate Objectives			**Data Source**
1	2.8.1I CCCCP	By 2015, increase the percentage of girls (13–17 years) that have completed the HPV vaccine three-shot series by 60 percent, from 21.8 percent in 2009 to 35 percent	*National Health Interview Survey, National Immunization Survey: Teen, CDC*
2	2.8.2I IZB	By 2018, have fully consolidated the 7 CAIR regions managed by CDPH, installed and implemented the new CAIR software, and established interoperable connectivity to the three independent immunization registries	*California Immunization Registry, CDPH*
3	2.8.3I IZB	By 2018, have fully implemented real-time HL7 query/response data exchange between CAIR and data partners	*California Immunization Registry, CDPH*
Long-term Objectives			**Data Source**
1	2.8.1L CCCCP	By 2015, decrease the incidence rate of cervical cancer by 15 percent, from 8.2 per 100,000 in 2008 to 7.0 per 100,000	*California Cancer Registry, CDPH*

2.9		Decrease Infant Deaths	
Short-term Objectives			**Data Source**
1	2.9.1S MCAH	By 2015, increase the number of families enrolled in CDPH California Home Visiting Program from 0 to 2,200 and increase number of home visits from 0 to 25,000, as federal funding allows	*California Home Visiting Program, CDPH*
2	2.9.2S	By 2015, increase the percentage of teen mothers and infants referred for follow-up care, education and support, including Early Head Start (Developmental)	*No known data source*
3	2.9.3S MCAH	By 2015, increase percentage of women with a usual source of pre-pregnancy health care (Developmental)	*Maternal Infant Health Assessment Survey, CDPH*
Intermediate Objectives			**Data Source**
1	2.9.1I MCAH	By 2018, increase the percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester (Developmental)	*National Vital Statistics System, CDC; Vital Statistics, Birth Statistical Master Files, CDPH*
2	2.9.2I MCAH	By 2018, decrease the birth rate for teenagers (15–17 years) (Developmental)	*Vital Statistics, Birth Statistical Master Files, CDPH*
3	2.9.3I DHCS OSPHD MCAH	By 2018, reduce the non-medically indicated singleton elective deliveries before 39 weeks gestational age (Developmental)	*Vital Statistics, Birth Statistical Master Files, CDPH; Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development*
Long-term Objectives			**Data Source**
1	2.9.1L MCAH	By 2020, decrease the percentage of live singleton births weighing less than 1500 grams (Developmental)	*National Vital Statistics System, CDC; Vital Statistics, Birth Statistical Master Files, CDPH*

2	2.9.2L MCAH **LGH**	By 2022, decrease the infant mortality rate (Developmental)	*Vital Statistics, Birth and Death Statistical Master Files, CDPH*
3	2.9.3L MCAH	By 2020, decrease the ratio of black to white infant mortality rate (Developmental)	*Vital Statistics, Birth and Death Statistical Master Files, CDPH*
4	2.9.4L MCAH	By 2020, decrease the pregnancy-related mortality rate (Developmental)	*Vital Statistics, Birth and Death Statistical Master Files, CDPH*
2.10		**Increase Culturally and Linguistically Appropriate Services**	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	
Intermediate Objectives			**Data Source**
1	2.10.1I CDPH & DHCS	By 2018, incorporate equity and cultural competency standards (Cultural and Linguistically Appropriate Services) into chronic disease prevention programs, processes, and publications (Developmental)	*Publications, CDPH and Department of Health Care Services*
Long-term Objectives			**Data Source**
1	2.10.1L DHCS	By 2020, increase the percentage of persons who report their health care provider always listens carefully (Developmental)	*Medical Expenditure Panel Survey, U.S. Agency for Healthcare Research and Quality*
2	2.10.2L DHCS	By 2020, increase the percentage of persons who report their health care provider always explained things so they could understand them (Developmental)	*Medical Expenditure Panel Survey, U.S. Agency for Healthcare Research and Quality*
3	2.10.3L	By 2020, create a statewide training and certification program for Patient Navigators (Developmental)	*No known data source*

2.11		Increase Advance Care Planning	
Short-term Objectives			**Data Source**
1	2.11.1S	By 2015, increase the percentage of health systems and providers with established systems within their organization for consistently and reliably soliciting, documenting and honoring patient treatment preferences (Developmental)	*No known data source*
Intermediate Objectives			**Data Source**
1	2.11.1I	By 2018, increase the percentage of adults who have a current Physician Orders for Life Sustaining Treatment (POLST) (Developmental)	*No known data source*
Long-term Objectives			**Data Source**
		No objectives have been identified at this time	
2.12		**Increase Hospital Safety and Quality of Care**	
Short-term Objectives			**Data Source**
1	2.12.1S L & C	By 2015, publish the "Adverse Events in Hospitals Underreporting Study" on the CDPH website	*Reports, University of California Davis, CDPH*
2	2.12.2S L & C	By 2015, publish regulations clarifying the definitions and reporting requirements for adverse events in hospitals on the CDPH website	*California Code of Regulations for CDPH*
Intermediate Objectives			**Data Source**
1	2.12.1I L & C	By 2018, publish "Adverse Events in Hospitals" by individual hospital on the CDPH website	*Adverse Event Report, CalHeart website, CDPH*
		Cardiovascular Disease	
2	2.12.2I HDDPU	By 2018, increase the proportion of adults who access rapid emergency care for an acute heart attack by 10 percent from 60 percent in 2011 to 66 percent	*Emergency Management Services Authority*

3	2.12.3 I HDDPU	By 2018, increase the percentage of adults who access rapid emergency care for an acute stroke by 10 percent from 57 percent in 2012 to 63 percent	*California Stroke Registry , CDPH; Get with The Guidelines–Stroke Module (GWTG–Stroke), American Heart Association/American Stroke Association*
4	2.12.4I HDDPU	By 2018, increase the percentage of eligible patients with acute heart attacks who receive percutaneous coronary intervention (PCI) within 90 minutes of hospital arrival from 89 to 98 percent	*Acute Coronary Treatment and Intervention Outcomes Network Registry—Get with the Guidelines (ACTION-GWTG), American Heart Association/American College of Cardiology*
5	2.12.5I HDDPU	By 2018, increase the proportion of eligible patients with acute heart attacks who receive fibrinolytic therapy within 30 minutes of arrival to non-PCI capable hospital from 47 percent in 2011 to 55 percent	*Acute Coronary Treatment and Intervention Outcomes Network Registry—Get with the Guidelines (ACTION-GWTG), American Heart Association/American College of Cardiology*
6	2.12.6I HDDPU	By 2018, increase the proportion of eligible patients with acute ischemic stroke who receive reperfusion therapy within the recommended therapeutic time window of 180 minutes from symptom onset from 89 percent in 2012 to 98 percent	*California Stroke Registry, CDPH; Get with The Guidelines–Stroke Module (GWTG–Stroke), American Heart Association/American Stroke Association.*
7	2.12.7I EMSA	By 2018, adopt two policies to improve the quality of emergency response for acute heart attack and stroke	*Reports, Emergency Management Service Authority*

Long-term Objectives			Data Source
1	2.12.1L DHCS & OSPHD **LGH**	By 2022, decrease the 30-day All-Cause Unplanned Readmission Rate (Unadjusted) (Developmental)	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development; Medi-Cal, Department of Health Care Services*
2	2.12.2L L & C **LGH**	By 2022, reduce the incidence of measurable hospital-acquired conditions (further composite metrics will be developed so target to be determined) (Developmental)	*Hospital Patient Discharge Data System, California Office of Statewide Health Planning and Development; Agency for Healthcare Research and Quality, Prevention Quality Indicators; Medi-Cal, Department of Health Care Services*
3	2.12.3L L & C	By 2020, decrease adverse events in hospitals (Developmental)	*Adverse Event Report, CalHeart website, CDPH*
2.13		**Increase Palliative Care and Hospice Care Decrease Hospitalization during the End of Life**	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	
Intermediate Objectives			**Data Source**
1	2.13.1I DHCS	By 2018, provide pediatric palliative care services to allow children who have a CCS-eligible medical condition with a complex set of needs and their families the benefits of hospice-like services, in addition to state plan services during the course of an illness, in order to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family (Developmental)	*Pediatric Palliative Care Waiver, Department of Health Care Services*

Long-term Objectives		Data Source
	No objectives have been identified at this time	

GOAL 3: ACCESSIBLE AND USABLE HEALTH INFORMATION

Strategies	
A	Improve data collection, analysis and reporting in order to plan, prioritize and allocate resources to identify and address inequities
B	Expand use of health information technology and integrated data systems
C	Promote standardization and cross-system electronic information exchange of data, including electronic reporting
D	Expand web-based access to understandable and usable local data and information
E	Promote the use of social media as an outreach and engagement tool
F	Foster consistent health messages

Partners
Health Systems: Medical, Mental, Dental, Behavioral; Health Providers; Health Payers; Business; Government; Universities; Nonprofit Organizations

3.1	Increase Transparent Information on Cost and Quality of Care

Short-term Objectives			Data Source
1	3.1.1S HDDPU & DHCS OHIT	By 2015, increase the proportion of health care providers participating in Medi-Cal EHR Incentive Program who have certified electronic health records (Developmental)	*Medi-Cal EHR Incentive Program, Department of Health Care Services*
2	3.1.2S HDDPU	By 2015, increase the proportion of health care providers who report on the percentage of adults with adequately controlled blood pressure (National Quality Forum Measure 18) (Developmental)	*Medi-Cal Managed Care Plan data, Department of Health Care Services*

3	3.1.3S HDDPU	By 2015, increase the proportion of health care providers participating in Medi-Cal EHR Incentive Program who report on the percentage of adults with diabetes who have Hgb A1C > 9 percent (National Quality Forum Measure 59) (Developmental)	*Medi-Cal Managed Care Plan data, Department of Health Care Services*
4	3.1.4S Covered CA, DHCS	By 2015, Covered CA and the Department of Health Care Services will develop a state multi-payer claims database or participate in an existing All Payers Claims Database (Developmental)	*No known data source*
5	3.1.5S CDE	By 2015, collect statewide weighted Youth Risk Behavior Surveillance System data	*Youth Risk Behavior Surveillance System, CDC*
6	3.1.6S CHSI & ITSD	By 2015, increase the number of health systems that contribute electronic health data to population based health registries (i.e. immunizations, cancer, etc.) (Developmental)	*Health Information Exchange Gateway, CDPH*
7	3.1.7S CHSI & ITSD	By 2015, CDPH will develop one federated data system or unified data warehouse with central repository host with aggregated data from different sectors to support health information exchange and population health surveillance for use at the state or local level (Developmental)	*Health Information Exchange Gateway, CDPH*
Intermediate Objectives			**Data Source**
1	3.1.1I HDDPU	By 2018, increase the percentage of medical practices that use electronic health records from 71 percent in 2011 to 90 percent	*National Ambulatory Medical Care Survey, CDC; Physician Survey, California Health Care Foundation*
2	3.1.2I HDDPU	By 2018, increase proportion of providers that adopt electronic provider reminder/recall, clinical decision support, and provider assessment and feedback systems (Developmental)	*No known data source*
3	3.1.3I CSR	By 2018, expand the California Stroke Registry to include annual stroke cases in California from 21 percent in 2009 to 50 percent, as federal funding allows	*California Stroke Registry, CDPH*

4	3.1.4I Parkinson's Institute and Clinical Center & UCLA	By 2018, expand the California Parkinson's Disease Registry from 4 counties in California to 58, as outside funding allows (Developmental)	*California Parkinson's Disease Registry, CDPH, Parkinson's Institute and Clinical Center, University of California, Los Angeles*
5	3.1.5I OH	By 2018, develop one oral health burden of disease report for California	*No known data source*
Long-term Objectives			**Data Source**
1	3.1.1L DMHC	By 2020, the 10 largest health plans in California will achieve the National 90th percentile in performance of HEDIS control measures for hypertension, heart disease and diabetes (Developmental)	*California Office of the Patient Advocate*

GOAL 4: PREVENTION SUSTAINABILITY AND CAPACITY

Strategies	
A	Maintain a skilled, cross-trained, and diverse prevention workforce, including persons with competence in economics, business, and health informatics
B	Mobilize partners to sustain public health efforts, including organizations which focus on community empowerment and youth development
C	Communicate public health concepts in both the context and language of other sectors
D	Develop and communicate the business case for prevention; use business plans, marketing, return on investment, and/or health impact assessments
E	Encourage shared responsibility for health
F	Model health system payment and reimbursement mechanisms to encourage delivery of clinical and community preventive services – value not volume
G	Develop a long-term chronic disease prevention sustainability plan
Partners	
Health Systems: Medical, Mental, Dental, Behavioral; Health Providers; Health Payers; Business; Government	

4.1		Increase Affordable Care and Coverage	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	
Intermediate Objectives			**Data Source**
1	4.1.1I	By 2018, begin or increase community preventive services (lifestyle intervention, self-management, and/or worksite wellness programs) (Developmental)	*No known data source*
Long-term Objectives			**Data Source**
1	4.1.1L **LGH**	By 2022, decrease health care cost (Total premium + out of pocket) as percent of median household income from: 22 to 23 percent for families and 13 to 13 percent for individuals	*American Community Survey, U.S. Census Bureau; Employer Surveys, Kaiser Family Foundation/ California HealthCare Foundation; Medical Expenditure Panel Survey (MEPS) Consolidated Data File, U.S. Agency for Health Care Research and Quality*
4.2		**Increase Payment Policies that Reward Value**	
Short-term Objectives			**Data Source**
		No objectives have been identified at this time	
Intermediate Objectives			**Data Source**
1	4.2.1I	By 2018, implement Accountable Care Community models and publish outcomes that use business models in which all members of the care team assume fiscal risk and obtain fiscal benefit from patient outcomes (Developmental)	*No known data source*
2	4.2.2I	By 2018, increase the percentage of health systems providers and payers that implement patient-centered medical home supplemental per member per month payment (Developmental)	*No known data source*

3	4.2.3I	By 2018, increase the percentage of health systems, providers and payers that adopt Triple Aim Pay for Performance (Developmental)	*No known data source*
Long-term Objectives			**Data Source**
		No objectives have been identified at this time	
4.3		**Decrease Rate of Growth in Healthcare Spending**	
Short-term Objectives			**Data Source**
1	4.3.1S	By 2015, increase the number of local health departments participating in nonprofit hospital community benefit health assessments and improvement plans (Developmental)	*No known data source*
Intermediate Objectives			**Data Source**
1	4.3.1I	By 2018, increase the number of local public health departments nationally accredited by the Public Health Accreditation Board (Developmental)	*Public Health Accreditation Board*
Long-term Objectives			**Data Source**
1	4.3.1L **LGH**	By 2022, decrease the Compound Annual Growth Rate (CAGR) by total health expenditures and per capita costs from total—7 percent, per capita—6 percent, and Gross State Product (GSP)—4 percent: to no greater than CAGR for GSP	*Data Navigator, U.S. Centers for Medicare and Medicaid Services*

6 – Call to Action

6.1 Case for Synergy

Given the economic state of affairs of the federal and state government, maintaining the current health infrastructure is not sustainable. In this era of limited resources, this Plan aims to call attention to public health opportunities to collaborate, align, and/or work in parallel with statewide partners to achieve our collective goals through innovative and/or evidence-based strategies. Joint efforts can leverage statewide public health and health care infrastructure, strengthen the public health workforce, enhance state and local public health services, and expand and strengthen partnerships. Selection of focus areas, alignment of efforts, and prioritizing activities to maximize the impact of multiple funding sources (federal, state, local, non-

governmental organizations, etc.) will be more efficient and effective, and lead to population health improvements and reduction in health inequities.

6.2 Historic Opportunities for Collaboration

6.2.1 Meaningful Use

The Health Information Technology for Economic and Clinical Health Act of 2009, or the "HITECH Act," provides authority to establish programs to improve health care quality, safety, and efficiency of patient care through the promotion and meaningful use of health information technology (HIT).[31] These include qualified electronic health records (EHRs) and secure electronic health information exchange. Under the EHR Incentive Program, eligible health providers, eligible hospitals and critical access hospitals receive incentive payments when they have shown that they are able to implement certified EHR technology and demonstrate “meaningful use” as defined by Centers for Medicare and Medicaid Services. This EHR technology must meet required standards, implementation specifications and certification criteria established by the Office of the National Coordinator for Health Information Technology.[32]

6.2.2 Patient Protection and Affordable Care Act

The advent of the Affordable Care Act (ACA) of 2010 provides an opportunity for public health to further collaborate with health systems to prevent chronic disease. As more people are covered by some form of health/dental insurance, there is an opportunity to expand clinical and community preventive services, especially to vulnerable populations with disparities in health. The expansion of health/dental insurance will require planning, organizational change and new partnerships at the state and local level. While there is a great deal of information collected about chronic conditions, expanded access to this information is needed to target and evaluate public health interventions and policies to improve population health. In addition, ACA includes the federal Prevention and Public Health Fund (PPHF), intended to expand and sustain investment in prevention and public health programs.

6.2.3 Public Health Accreditation

Public health accreditation is a national, voluntary process for state, local, tribal, and territorial health departments to have their performance measured against a set of nationally recognized, practice-focused, and evidence-based standards. Accreditation aims to improve and protect the health of the public by advancing the quality and performance of health departments.[33]

7 – Commitment to Collaboration

7.1 Role of the California Department of Public Health

CDPH's aim is to provide leadership to guide a coordinated public health response to chronic disease prevention in California. CDPH has provided leadership and expertise to work collaboratively across chronic disease and risk factor programs and partners to develop a shared agenda, which is displayed in this Plan. CDPH intends to continue to provide leadership as the Plan is implemented. The CDPH programs that have contributed to the Plan operate under statutory and regulatory authority (Appendix B) to protect the public from chronic diseases and their risk factors. Program descriptions and links to their websites can be found in Appendix E.

Despite the end of the Coordinated Chronic Disease Prevention Program grant (CCDPP) in March 2014, CDPH will continue to coordinate state chronic disease prevention programs, communicate with partners, convene partners for coordination as funding allows, disseminate data and information regularly, and provide training and technical assistance. These Plan implementation activities will be completed using federal funds. The primary sources are the CDC State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health Grant (cycle ends in 2018) and the Preventive Health and Health Services Block Grant (annual appropriation).

7.1.1 Health Assessment

The Burden of Chronic Disease and Injury Report for California will be updated every three years as funding allows, and communicated to partners according to CDPH policies and procedures. The Report will include disease incidence and prevalence and will highlight disparities.

7.1.2 Health Economic Assessment

The "Economic Burden of Chronic Disease and Injury in California" Report is in development to determine the cost of preventing, detecting, and treating chronic diseases in California in local health jurisdictions, and the lost productivity that results from chronic disease in California. As only 10 percent of the gains in life expectancy over the past 100 years have been due to improved medical care, and health care costs are rising rapidly, evidence-based public health interventions to prevent and optimally manage chronic disease are critical to reverse the trend in decreasing life expectancy faced by California's children. As 86 percent of Californians are above normal weight or have at least one chronic condition, there is a need to prevent and optimally manage disease to assure California has a vigorous workforce. Rising health costs and debilitated workers are bad for California's economy. Public health expertise can determine areas of need, guide resource allocation to improve community and population health, and evaluate the quality of community interventions and clinical services. Public health can assure resources are being used effectively, contribute to improved health outcomes and, when possible, decreased costs.

7.1.3 Resource Webpage

As part of the implementation of this Plan, CCDPP has developed a training and technical assistance webpage as a resource for partners to increase capacity in cross-cutting public health skills. It can be accessed at http://www.cdph.ca.gov/programs/cdcb/Pages/TrainingandTechnicalAssistanceResourceList.aspx

The webpage has resources on:

- Affordable Care Act
- Communications
- Community-Clinical Linkages
- Cultural Competency
- Epidemiology/Surveillance
- Evaluation
- Health Equity and Social Justice
- Health Care Systems Change/Interventions
- Health Informatics/Health Information Exchange/Health Information Technology
- Policy/Environmental Change
- Workforce Development

Training and technical assistance needs assessments are in process. The response from CDPH chronic disease prevention staff and partners throughout California will establish a baseline of current capacity and identify gaps. Results of the needs assessments will be published on the CDPH website and will guide its expansion and future trainings.

7.2 Role of Partners

Chronic disease prevention partners were involved in the development of the Plan over the past two years. They were invited periodically to advise CDPH on the planning efforts to ensure that the Goals, Focus Areas, Strategies, and Objectives met the needs of the public and partner organizations. (Appendix F)

CDPH coordination efforts have included other agencies and organizations that have similar prevention goals. Partners include leaders from public health, local health departments, voluntary organizations, foundations, chronic disease advocacy organizations, hospitals, health professional organizations, health care organizations, academia, education agencies, tribal governments, business, state and community organizations, and other state agencies. Moving forward, partners will:

- Commit to Plan Focus Areas, Strategies, and/or Objectives that align with their mission, capacity, and area of expertise within the Spectrum of Prevention

- Reach out to affected populations to ensure they are included and actively participate in chronic disease prevention, including planning efforts
- Promote the Plan
- Implement activities that align with the Focus Areas, Strategies, and/or Objectives
- Engage in the development of future versions of the Plan

7.2.1 Department of Health Care Services

CDPH had the benefit of close collaboration with DHCS throughout the development of the Plan. DHCS's mission is to provide low-income Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and long term care, through programs emphasizing prevention-oriented health care that promotes health and well-being. DHCS also focuses on improving the health of all Californians by enhancing quality and the patient care experience, while appropriately reducing the per capita costs of health care programs. Examples include the implementation of the Centers for Medicaid and Medicare Services five-year Section 1115 Medicaid Waiver, "A Bridge to Reform," that seeks to improve clinical quality through better coordination of care for vulnerable populations, care delivery redesign, population-focused interventions, and enhanced patient safety. CDPH has aligned the Plan with the DHCS Strategy for Quality Improvement in Health Care.[34]

7.2.2 Strategic Growth Council

In September 2008, SB 732 was signed into law, creating the Strategic Growth Council (SGC). The Council is a cabinet level committee tasked with coordinating the activities of state agencies to:

- Improve air and water quality
- Protect natural resources and agriculture lands
- Increase the availability of affordable housing
- Promote public health
- Improve transportation
- Encourage greater infill and compact development
- Revitalize community and urban centers
- Assist state and local entities in the planning of sustainable communities and meeting AB 32 goals

The Council is composed of Agency secretaries from Business, Transportation, and Housing Agencies; California Health and Human Services Agency; California Environmental Protection Agency; California Natural Resources Agency; the Director of the Governor's Office of Planning and Research; and public member Robert Fisher (appointed by the Governor).[35]

7.2.3 Statewide Coalitions

Rather than develop a new Coalition to provide input to the Plan, CDPH joined four already existing statewide Coalitions headed by chronic disease prevention partners.

The Health Happens Here with Prevention Partnership is a voluntary collaboration of prominent health and non-health organizations with aligned values and priorities for improving health through population-level prevention, primarily chronic disease prevention. Formed in 2011, the Partnership is convened by The California Endowment, and promotes the "Health Happens Here" frame that asserts health is not as much the product of medical encounters as it is the product of personal and societal efforts to support healthy behaviors, policies, and environmental conditions.[36] Partnership members include American Heart Association, American Cancer Society, American Diabetes Association, American Lung Association of California, United Way, American Association of Retired Persons, Mission Readiness, Service Employees International Union, California Pan Ethnic Health Network, Public Health Institute, Prevention Institute, Change Lab Solutions, and Kaiser Permanente Community Benefits. Partnership members have informed the LGHCTF Report, the California Statewide Innovation Model for payment reform, the California Wellness Plan, and have advocated for preservation of the ACA PHPF. CDPH serves in an advisory capacity and participates in monthly meetings.

The California Chronic Care Coalition is a unique alliance of more than 30 leading consumer health organizations and provider groups that promote the collaborative work of policy makers, industry leaders, providers, and consumers to improve the health of Californians with chronic conditions. In 2007, at the request of Governor Arnold Schwarzenegger, nonprofit health advocacy organizations representing chronic conditions formed a working group. CCCC envisions a system of care that is accessible, affordable, high-quality, and emphasizes prevention, coordinated care, and patient wellness and longevity.[37]

The Right Care Initiative[38] is a public–private collaboration led by the California Department of Managed Health Care and the University of California, Berkeley, School of Public Health. Its members come from organizations such as health plans, medical groups, community clinics, university experts, foundations, consumer and health associations, health industry leaders, and sister state and local health agencies. Its purpose is to improve patient outcomes in disease areas that contribute greatly to preventable disability and death, where evidence for interventions is strong, but health outcomes remain poor. It meets every month in three major metropolitan areas of the state. An annual statewide full-day meeting is held for medical directors to review health plan performance data and learn about evidence-based practices. CDPH has participated in both Sacramento Right Care University of Best Practices monthly meetings and Annual Right Care Leadership Summits.

The California Dialogue on Cancer (CDOC) was established by California's Comprehensive Cancer Control Program in 2002. CDOC is a dynamic coalition of individuals and organizations working

together to reduce the burden of cancer in the State of California. CDOC was created specifically to develop and implement California's Comprehensive Cancer Control Plan (the state cancer plan). The state cancer plan is a strategic plan to reduce the cancer burden in the state and is designed to provide guidance to individuals and organizations spanning a wide range of health and social disciplines that can play a role in reducing the burden of cancer. Through a coordinated and integrated approach, CDOC implements planned strategies outlined in the state cancer plan to reduce cancer in California. CDOC is comprised of representatives from state and local governments; private and nonprofit organizations; health, medical, and business communities; academic institutions; researchers; cancer survivors; caregivers; and advocates. CDOC is administered by CDPH and funded by CDC.[39]

California Healthier Living Coalition (CHLC) seeks to expand the availability and access of evidence-based chronic disease self-management education (CDSME) programs. Coalition members receive technical assistance and support in implementing CDSME programs and share tools, resources, and strategies. Organizational and Associate Membership is voluntary.[40]

7.2.4 Local Health Agencies

California Conference of Local Health Officers (CCLHO)
CCLHO is a statutorily mandated statewide organization of physician health officers in the 58 County and three City public health jurisdictions. It was established in 1947 to consult with, advise, and make recommendations to CDPH, other departments, boards, commissions, and officials of federal, state, and local government, the Legislature, and any other organization or association on matters affecting health.

County Health Executives Association of California (CHEAC)
CHEAC is a statewide organization of county and city Health Department and Agency Directors, who are responsible for the administration, oversight, and delivery of a broad range of local public health and indigent health care services. Members represent a variety of administrative and health professional disciplines.

CCLHO Chronic Disease Committee
This Committee has taken a leadership role in engaging local health departments, CDPH, CHEAC, and non-governmental organizations on chronic disease prevention policy, environmental change, and evidence-based approaches to improving population health. One of their initiatives is the CCLHO/CHEAC Chronic Disease Prevention Leadership Project, which has assisted CDPH in gaining statewide community input to the Plan. In addition, the Project is the co-lead for the February 2014 conference, "Advancing Prevention in the 21st Century" (P21) which will launch the Plan, identify statewide priorities, and highlight commitments from partners to align efforts.

7.2.4 Community Transformation Grants

Community Transformation Grants awarded to California agencies provide tools, training, and guidance to expand efforts in tobacco-free living, active living, healthy eating, quality clinical and community preventive services, and healthy and safe physical environments. Partners from multiple sectors, including education, transportation, and business, are engaged in this process. Since 2011, California has received over $57 million in federal funds to implement broad, sustainable strategies in the areas described above that aim to create healthier environments and access to healthier options, and reduce health disparities. These funds will end in September 2014, but have laid a foundation for future public health activities at the local level.

- *Implementation Grants: States and Communities*
  - Public Health Institute (rural counties and all other non-funded counties)
  - San Francisco Department of Public Health
  - County of San Diego Health and Human Services Agency
  - Los Angeles County Department of Public Health
- *Capacity-Building Grants: States and Communities*
  - County of Kern, Public Health Services Department
  - Fresno County Department of Public Health
  - Sierra Health Foundation
  - Stanislaus County Health Services Agency
  - Ventura County Public Health
- *Tribes and Territories*
  - Toiyabe Indian Health Project (California)
- *Small Communities*
  - Community Health Councils, Inc.
  - County of Sonoma
  - St. Helena Hospital, Clear Lake
  - County of Santa Clara

8 – Plan Development

8.1 Coordinated Chronic Disease Prevention and Health Promotion Program

In September 2011, CDPH was awarded a grant from CDC to establish an infrastructure to support and facilitate coordination of chronic disease prevention and health promotion efforts and collaborate across programs, partner organizations, and non-traditional sectors. The primary grant deliverable was the creation of a chronic disease prevention plan, developed in conjunction with statewide partners. CCDPP staff have led the internal and external processes to build support for preventing chronic disease in a coordinated way and to gain input for a coordinated statewide plan. The processes include (1) Advisory Committee, composed of state managers in chronic

disease prevention programs, to understand the concept, share with staff, and provide input and guidance to the plan; (2) Workgroups, composed of program staff in cross-cutting disciplines, to share current activities and identify common goals, partners and opportunities for coordination; (3) External Partner Meetings, via teleconference, webinar, and in person, composed of partners statewide that work across sectors and the Spectrum of Prevention in chronic disease prevention. The meetings shared the concept, strengthened the CDPH internal coordination processes, and obtained input and guidance to the Goals, Focus Areas, Strategies, and Objectives of the Plan.

8.2 Overarching Performance Objectives

The Plan's development is guided by the CDC's overarching performance objectives:

1. Reduce age-adjusted mortality due to chronic diseases
2. Reduce prevalence of disabling chronic diseases
3. Improve quality of life and health outcomes by promoting strategies that support and reinforce healthful behaviors pertaining to nutrition, physical activity, and clinical preventive services related to chronic disease prevention, early detection, and management
4. Promote education and management skills for those diagnosed with or at risk for chronic disease

8.3 Chronic Disease Prevention and Health Promotion Domains

Domain 1: Environmental Approaches

Environmental approaches promote health and support and reinforce healthy behaviors. They have broad reach, sustained health impact, and offer a promising return on investment for public health.

Domain 2: Health System Interventions

Health system interventions improve the use and effective delivery of clinical preventive services to prevent disease, detect diseases early, reduce or eliminate risk factors, and mitigate or manage complications. Health system interventions also improve the clinical environment to more effectively deliver quality care.

Domain 3: Clinical–Community Linkages

Clinical-community linkages ensure that clinics refer patients to community programs that improve management of chronic conditions and that resources exist for these community programs. Such interventions ensure those with or at high risk for chronic disease have access to quality community resources to best manage their conditions, prevent, delay, or optimally manage chronic conditions once they occur.

Domain 4: Epidemiology and Surveillance

Epidemiology, surveillance, and evaluation are skills in which data and information are collected, analyzed, and disseminated to develop and deploy effective interventions, identify and address gaps in program delivery, and monitor and evaluate progress in achieving program goals. Data and information are critical to inform decision makers and

the public of the burden of chronic diseases and their associated risk factors, and the public health impact of programs and policies. (Appendix G)

8.4 Let's Get Healthy California Task Force

In May 2012, Governor Jerry Brown established the LGHCTF through Executive Order B-19-12. LGHCTF was formed to identify ways to alleviate the impact of preventable chronic diseases in California by establishing a collaborative of 23 California health and health care leaders and 19 expert advisors. LGHCTF was charged to develop a ten-year plan for "improving the health of Californians, controlling health care costs, promoting responsibility for individual health, and advancing health equity." LGHCTF successfully completed a Report in December 2012.[41] The Plan fits within the LGHCTF overarching framework under the first Strategic Direction: "Health Across the Lifespan," which includes Goal 2, "Living Well: Preventing and Managing Chronic Disease." It aims to increase the impact of the previous collaborative efforts by identifying common goals, priorities, strategies, and objectives for chronic disease prevention that CDPH programs and partners can commit to achieving.

8.5 Process

This Plan builds on efforts currently underway throughout California, focusing on opportunities to create synergy across chronic disease prevention efforts and maximize the impact of funding from multiple sources.

A variety of information sources informed the development of the Plan, including the National Prevention Strategy; the National Strategy for Quality Improvement in Health Care; the Health in All Policies Taskforce Recommendations; the Prevention Institute Spectrum of Prevention; the Robert Wood Johnson Foundation, A New Way to Talk About Social Determinants of Health; the Let's Get Healthy California Task Force Report; California Conference of Local Health Officers-County Health Executives Association of California Chronic Disease Prevention Framework, and state plans of state-administered programs addressing specific chronic diseases and/or risk factors. Plan Assumptions are listed in Appendix H.

Input was provided by statewide partners, such as CDPH programs, other state agencies, local health departments, and other non-governmental organizations, and guided by common principles. (Appendix I) A series of statewide partner meetings, webinars, and online surveys were conducted; reports detailing the processes used and the input received were completed. A full listing of the materials used to inform development of this Plan can be found in Appendix J.

9 – Plan Continuation

The Plan is a dynamic document maintained by the CDPH Director of Coordination in the Chronic Disease Control Branch. Future versions will be developed, at least every five years, with input from CDPH programs and administration, other state agencies, and most importantly, the partners who contributed to this Plan.

9.1 Maintenance

Plan Maintenance includes the following:

- Conducting evaluation of Plan development and continuation processes
- Updating Plan due to changes in statutory authority, or funding availability/requirements
- Monitoring progress of Plan Objectives and publishing regular reports on outcomes
- Conducting webinars and surveys to communicate outcomes and solicit partner input
- Releasing future versions of the Plan

9.2 Updates and Future Versions

The Director of Coordination ensures the Plan reflects changes in statutory authority or funding availability/requirements, by updating the Plan as needed. At a minimum, the CDPH Chronic Disease Control Branch Chief ensures the Plan is reviewed in conjunction with partners every five years to assess the need for a new version. As funding permits and partners agree, a process to create a new version of the Plan will be developed and implemented, overseen by the Director of Coordination. The process will capture observations and recommendations based on lessons learned from Plan implementation efforts and from which updated priorities and evidence-based strategies can be determined. The process will identify specific revisions, assign them to responsible parties and establish targets dates for completion. This review process will be consistent with the CDC and Evaluation Program guidelines.

Triggers for reviewing the Plan sooner than the five year cycle include, but are not limited to:

- Major changes to CDPH authority (Appendix B)
- Major changes in federal and/or state funding, guidance, or requirements

The Plan, including any updates, will be posted on the CDPH website. Any future versions of the Plan developed in conjunction with partners will also be available to the public on the CDPH website.

10 – Summary

This Plan provides partners—CDPH programs, other state agencies, local health departments, and non-governmental organizations—with an opportunity to coordinate, align, and/or work in parallel toward the shared goals of chronic disease prevention and equity in health and wellness. This Plan received input from statewide partners, identifies ambitious, long-term goals and uses a health in all policies approach to chronic disease prevention. It is intended to be dynamic, changing over time as population health outcomes are monitored. This Plan is a roadmap with California goals, priorities, focus areas, evidence-based strategies, and achievable objectives to improve population health outcomes, bend the medical care cost curve, and achieve health equity in California.

Inquiries regarding this Plan may be directed to:

Jessica M. Núñez de Ybarra, MD, MPH, FACPM
Director of Coordination
Coordinated Chronic Disease Prevention Section
Chronic Disease Control Branch
California Department of Public Health
MS 7208, PO Box 997377
Sacramento, CA 95899-7377
(916) 552-9900

Suggested Plan Citation: Nuñez de Ybarra JM, Weiss R, Pendleton L, Wittenberg R, Rousseve M, Van Court J, Logan J, Lewis M, Lee A, Conroy S, Maizlish N, Peck C. The California Wellness Plan, 2014. Sacramento, CA: California Department of Public Health, 2014.

Editing and cover design: Mary N. Rodgers

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This Plan was supported by the Cooperative Agreement 3U58DP002007-03W2 from the CDC. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

Other sources of funding that supported staff who worked on the Plan:

- CDC categorical program grants and the Preventive Health and Health Services Block Grant
- Health Resources Services Administration Preventive Medicine Residency Grant and Title V
- U.S. Department of Agriculture SNAP-Ed and WIC Programs
- U.S. Centers for Medicaid and Medicare Services
- California state funds, including General Fund and Proposition 99 (California Tobacco Health Protection Act of 1988)

California Wellness Plan

Appendices

Appendix A – List of Acronyms

Appendix B – Authority for Chronic Disease Prevention and Health Promotion

Appendix C – Healthy Community Framework

Appendix D – Evidence-Based Strategies by Priority

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Appendix J – Reference Documents, Reports, and Plans

Appendix K – Relationship to Other Initiatives

Appendix L – Glossary

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Appendix A – List of Acronyms

ACA	Patient Protection and Affordable Care Act
ADP	Alzheimer's Disease Program
AG	California Office of the Attorney General
ARB	Air Resources Board
BLS	Bureau of Labor Statistics
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CADC	California Alzheimer's Disease Centers
CAIR	California Immunization Registry
CalFire	California Department of Forestry and Fire Protection
CalTrans	California Department of Transportation
CAPP	California Arthritis Partnership Program
CARB	California Air Resources Board
CB	California Breathing
CBO	Community-Based Organization
CCCCP	California Comprehensive Cancer Control Program
C4P	California Colon Cancer Control Program
CCDPP	Coordinated Chronic Disease Prevention and Health Promotion Program
CCLD/CDSS	Community Care Licensing Division/California Department of Social Services
CCLHO	California Conference of Local Health Officers
CCR	California Cancer Registry
CCS	California Children's Services
CDA	California Department of Aging
CDC	Centers for Disease Control and Prevention
CDCR	California Department of Corrections and Rehabilitation
CDE	California Department of Education
CDFA	California Department of Food and Agriculture
CDOC	California Dialogue on Cancer
CDPH	California Department of Public Health
CDSMP	Chronic Disease Self-Management Program
CEHTP	California Environmental Health Tracking System
CHDP	Child Health and Disability Prevention Program

CHHS	California Health and Human Services Agency
CHIS	California Health Interview Survey
CHS	Center for Health Statistics
CHSI	Center for Health Statistics and Informatics
CHPI	California Healthcare Performance Information System
CMMS	Centers for Medicaid and Medicare Services
CMS	Children's Medical Services
COE	County Office of Education
COPP	California Obesity Prevention Program
Covered CA	Covered California
CPR	Cardiopulmonary Resuscitation
CSD	California Department of Community Services and Development
CSR	California Stroke Registry
CTCP	California Tobacco Control Program
CTG	Community Transformation Grants
CVD	Cardiovascular Disease
DGS	Department of General Services
DDWEM	Division of Drinking Water and Environmental Management
DEODC	Division of Environmental and Occupational Disease Control
DFDRS	Division of Food, Drug and Radiation Safety
DGS	Department of General Services
DHCS	Department of Health Care Services
DHHS	U.S. Department of Health and Human Services
DMHC	Department of Managed Health Care
DPAC	Data Policy Advisory Committee
DOF	Department of Finance
DOR	Department of Rehabilitation
DSME	Diabetes Self-Management Education
DWP	Drinking Water Program
EBT	Electronic Benefit Transfer
EHLB	Environmental Health Laboratory Branch
EHR	Electronic Health Record
EMSA	Emergency Medical Services Authority

EPSDT	Early Periodic Screening, Diagnosis, and Treatment Program
EWC	Every Woman Counts
FDB	Food and Drug Branch
FDLB	Food and Drug Laboratory Branch
GIS	Geographic Information Systems
HCD	California Department of Housing and Community Development
HDDPU	Heart Disease and Diabetes Prevention Unit (California Diabetes Program and Heart Disease and Stroke Prevention Program)
HEDIS	Heathcare Effectiveness Data and Information Set
Hgb A1C	Hemoglobin A1C
HiAP	Health in All Policies
HIT	Health Information Technology
HITECH Act	Health Information Technology Act
IT	Information Technology
ITSD	Information Technology Services Division
IT&T	Information Technology & Telecommunications
IZB	Immunization Branch
LEA	Local Education Agency
L&C	Licensing and Certification
LHD	Local Health Department
LGH	Let's Get Healthy California Task Force performance measure
LGHCTF	Let's Get Healthy California Task Force
MCAH	Maternal, Child, and Adolescent Health Program
MEPS	Medical Expenditure Panel Survey
NCHS	National Center for Health Statistics
NEOP	Nutrition Education and Obesity Prevention Branch
NGO	Non-Governmental Organization
NQF	National Quality Forum
OHB	Occupational Health Branch
OHE	Office of Health Equity
OHIT	Office of Health Information Technology
OPA	Office of Public Affairs
OPR	Governor's Office of Planning and Research

OSHPD	Office of Statewide Health Planning and Development
PCP	Primary Care Provider
PHPF	Prevention and Public Health Fund
SACB	Safe and Active Communities Branch
SafeTREC	Safe Transportation Research and Education Center
SGC	Strategic Growth Council
SHC	School Health Connections
STD	Sexually Transmitted Disease
UC	University of California
UCB CCS	University of California, Berkeley Center for Cities and Schools
UCLA	University of California, Los Angeles
ULTRANS	Urban Land Use and Transportation Center
US	United States of America
USDA	United States Department of Agriculture
USPSTF	United States Preventive Services Task Force
VPD	Vaccine-Preventable Disease
WIC	Women, Infants, and Children Program
WISEWOMAN	Well-Integrated Screening and Evaluation for Women Across the Nation
WW	Well-Integrated Screening and Evaluation for Women Across the Nation
YRBSS	Youth Risk Behavior Surveillance System

California Statute:

Business and Professions Code:
§1750.1
§22950-22963
§22973.2
§22974.8
§22978
§22979.3

Civil Code:
§1798.24

Education Code:
§49452.8

Relevant California Department of Education Authorities:
§33350—Establishment of courses in physical education
§33352—Monitoring provision of physical education instruction
§51220–22—Student participation in physical education
§51223—Required minutes for elementary school in physical education
§51225.3—Graduation requirement course in physical education
§60800—Physical performance test
§51202; 51210(f); 51880–81.5(b); 51890; 51911; 51913–14—Comprehensive health education
§49427—LEA to maintain fundamental school health services
§48211–13, 48980, 4945–51—Communicable disease control measures
§49450—Requires confidentiality of health screening records
§49494–96—Establish nutrition services standards

Health and Safety Code:§38020 (a) & (b)

§38070
§38071
§38072 (a) (13)
§100290
§100295
§100325
§100330
§103860
§103865
§103875–103885
§104100–104140

§104150
§104322
§104325–104330
§104350–104415
§104440–104445
§104465–104466
§104475
§104480
§104500–104545
§104575
§104650–104655
§104750–104765
§100925
§100950
§116409–116415
§125275–125285
§131019.5
§131050–131135

Penal Code:
§11174.34

Revenue and Taxation Statute Code:
§18761–18766
§30121–30130
§30461.6

Welfare and Institutions Code:
§10850
§16800.7 (c)
§18285 (e)(1)

California Regulations:

California Code of Regulations, Title 17:
§2593

Appendix C – Healthy Community Framework

A Healthy Community provides for the following through all stages of life:

Meets basic needs of all

- Safe, sustainable, accessible, and affordable transportation options
- Affordable, accessible, and nutritious foods and safe, drinkable water
- Affordable, high-quality, socially integrated and location-efficient housing
- Affordable, accessible, and high-quality health care
- Complete and livable communities including quality schools, parks, and recreational facilities; child care; libraries; financial services; and other daily needs
- Access to affordable and safe opportunities for physical activity
- Able to adapt to changing environments, resilient, and prepared for emergencies
- Opportunities for engagement with arts, music, and culture

Quality and sustainability of environment

- Clean air, soil, and water; and environments free of excessive noise
- Tobacco- and smoke-free
- Green and open spaces, including healthy tree canopy and agricultural lands
- Minimized toxics, greenhouse gas emissions, and waste
- Affordable and sustainable energy use
- Aesthetically pleasing

Adequate levels of economic and social development

- Living wage, safe and healthy job opportunities for all, and a thriving economy
- Support for healthy development of children and adolescents
- Opportunities for high-quality and accessible education

Health and social equity

Social relationships that are supportive and respectful

- Robust social and civic engagement
- Socially cohesive and supportive relationships, families, homes, and neighborhoods
- Safe communities, free of crime and violence

GOAL 1: HEALTHY COMMUNITIES

1.1 Increase health status

- Implement health communication campaigns that include mass media and health-related product distribution to influence health behaviors [Community Guide: Health Communications and Social Marketing 1]
- Implement tenant-based rental assistance programs to provide financial assistance to allow low-income families more housing options [Community Guide: Social Environment C1]

1.2 Decrease adult and adolescent tobacco use

- Mobilize communities to reduce youth access to tobacco products [Community Guide: Tobacco D2]
- Increase smoke-free worksite policies implemented by public and private employers [Community Guide: Tobacco E1]
- Increase worksite-based incentives and competitions used in conjunction with other tobacco cessation interventions to reduce tobacco use [Community Guide: Tobacco E2b]
- Develop strategies to increase the unit price of tobacco products [Community Guide: Tobacco A1]
- Expand use of mobile-phone–based tobacco cessation interventions [Community Guide: -Tobacco A6]
- Maintain or expand tobacco cessation quit line interventions [Community Guide: Tobacco B11]
- Ensure that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products [US Pv Services TF: A/B Recommendation 41]

1.3 Increase adult and child fitness and healthy diets

- Build, strengthen, and maintain social networks that support physical activity [Community Guide: Physical Activity Behavior/Social Change 2]
- Enhance physical education curricula to make physical education classes longer and/or to have students spend more time engaging in moderate to vigorous activity in physical education class [Community Guide: Physical Activity Behavior/Social Change 4]
- Increase availability of worksite nutrition and physical activity programs [Community Guide: Obesity 4a]
- Increase availability of interventions in community settings to improve knowledge, attitudes, or skills to reduce screen time (television, video games, DVDs, etc.) [Community Guide: Obesity 1]
- Increase use of point-of-decision prompts to encourage use of stairs in worksites [Community Guide: Worksite Health Promotion 10]

1.4 Increase healthy food outlets

1.5 Increase walking and biking

- Develop street-scale urban design land use strategies and practices [Community Guide: Physical Activity Environmental/Policy Change 4]

- Develop community-scale urban design land use strategies and practices [Community Guide: Physical Activity Environmental/Policy Change 1]
- Promote environment change strategies that create or enhance access to places for physical activity combined with information outreach activities [Community Guide: Physical Activity Environmental/Policy Change 2]

1.6 Increase safe communities

- Implement community-wide campaigns to increase use of child safety seats [Community Guide: Motor Vehicle Injury A2]
- Increase availability of child safety seat incentive and education programs [Community Guide: Motor Vehicle Injury A4]
- Increase availability of child safety seat distribution and education programs for parents and guardians [Community Guide: Motor Vehicle Injury A2]
- Develop strategies to limit hours of sale of alcohol [Community Guide: Alcohol 5]
- Develop strategies to fluoridate community water sources to prevent tooth decay [Community Guide: Oral Health A1]
- Mobilize communities to implement multi-component interventions to reduce alcohol-impaired driving [Community Guide: Motor Vehicle Injury C6]
- Increase provision of school-based health education programs to reduce alcohol-impaired driving [Community Guide: Adolescent Health 4]
- Implement mass media campaigns to reduce alcohol-impaired driving [Community Guide: Motor Vehicle Injury C5]
- Provide group-based comprehensive risk-reduction interventions for adolescents [Community Guide: Adolescent Health 9]
- Expand use of assessments of health risks with feedback in worksites to change employees' health [Community Guide: Worksite Health Promotion 6]
- Enhance enforcement of laws prohibiting alcohol sales to minors [Community Guide: Adolescent Health 1]
- Develop strategies to establish limits on days of sale for alcohol [Community Guide: Alcohol 4]
- Develop strategies to hold servers or owners of alcohol retail establishments legally responsible for harms inflicted by customers [Community Guide: Alcohol 1]
- Enhance alcohol enforcement programs to initiative or increase the frequency of retailer compliance checks for laws against alcohol sales to minors [Community Guide: Alcohol 10]
- Increase provision of school-based health education programs to reduce alcohol-impaired driving [Community Guide: Adolescent Health 4]
- Expand use of early childhood home visitation to prevent childhood maltreatment [Community Guide: Violence Prevention 1]

1.7 Decrease childhood trauma

1.8 Increase early learning

- Increase the availability of publicly-funded comprehensive preschool programs designed to improve cognitive and social development of children ages 3 to 5 years, who are at risk due to poverty [Community Guide: Social Environment A1]
- Increase availability of full-day kindergarten programs in low-income communities [Community Guide: Health Equity 1]

GOAL 2: OPTIMAL HEALTH SYSTEMS LINKED WITH COMMUNITY PREVENTION

2.1 Decrease the number of people without insurance

2.2 Increase access to primary and specialty care

- Expand use of small media (videos and print materials) to inform and motivate people to be screened for breast, cervical, and/or colorectal cancer [Community Guide: Cancer Prevention & Control Ai3]
- Expand use of one-on-one education to increase breast, cervical, and colorectal cancer screening [Community Guide: Cancer Prevention & Control Ai6]
- Encourage men ages 45 to 79 years of age to use aspirin when potential benefit of a reduction in myocardial infarctions outweighs the potential harm due to gastrointestinal hemorrhage [US Pv Services TF: A/B Recommendation 4]
- Encourage women age 55 to 79 years of age to use aspirin when the potential benefit outweighs the potential harm of an increase in gastrointestinal hemorrhage [US Pv Services TF: A/B Recommendation 5]
- Provide screening mammographies to women 40 years and older every 1–2 years with or without clinical breast examination [US Pv Services TF: A/B Recommendation 10]
- Provide cervical cancer screening in women who have been sexually active and have a cervix [US Pv Services TF: A/B Recommendation 12]
- Increase colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years [US Pv Services TF: A/B Recommendation 19]
- Ensure primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride [US Pv Services TF: A/B Recommendation 20]
- Reduce non-economic structural barriers or obstacles that make it difficult to access breast, cervical, and colorectal cancer screening [Community Guide: Cancer Prevention and Control Ai7]

2.3 Increase coordinated outpatient care

Increase people receiving care in an integrated system

- Increase provision of electronic screening and brief interventions in health care systems and other settings [Community Guide: Cancer Prevention & Control Ai5]
- Increase use of team-based care in health systems [Enhanced FOA; domain 3, strategy 2]
- Support use of technology to facilitate or mediate interactions between coaches/counselors and individuals/groups to reduce weight and/or to maintain weight loss [Community Guide: Obesity 3a & 3b]
- Increase use of tobacco cessation provider reminder systems [Community Guide: Tobacco B7]
- Educate and prompt providers to identify and intervene with tobacco using clients [Community Guide: Tobacco B8]
- Expand use of client reminders to increase screening for breast, cervical, and colorectal cancer [Community Guide: Cancer Prevention and Control Ai1]
- Expand use of provider assessment and feedback to increase breast, cervical, and colorectal cancer screening [Community Guide: Cancer Prevention and Control Aii1]

- Expand use of provider reminder recall systems to increase breast, cervical, and colorectal cancer [Community Guide: Cancer Prevention and Control Aii3]
- Expand use of team-based care to improve blood-pressure control [Community Guide: Cardiovascular Disease 1]
- Expand and enhance disease management approaches in health care delivery for persons with diabetes [Community Guide: Diabetes 2]
- Expand and enhance disease management approaches in health care delivery for persons with diabetes [Community Guide: Diabetes 2]
- Expand use of case management in improving glycemic control for persons with diabetes [Community Guide: Diabetes 1]
- Implement school-based and school-linked dental sealant delivery programs [Community Guide: Oral Health 3]
- Maintain or expand tobacco cessation quit-line interventions [Community Guide: Tobacco B11]
- Ensure that clinicians inform patients of potential benefits and harms of chemoprevention [US Pv Services TF: A/B Recommendation]
- Expand use of group education to increase breast cancer screening [US Pv Services TF: A/B Recommendation 9]
- Increase provision of electronic screening and brief interventions in health care systems and other settings [Community Guide: Cancer Prevention & Control Ai5]
- Increase provision of one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked [Community Guide: Alcohol 2]
- Increase provision of screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings [US Pv Services TF: A/B Recommendation 1]
- Ensure clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products [US Pv Services TF: A/B Recommendation 2]
- Reduce out-of-pocket costs for evidence-based tobacco cessation treatments [US Pv Services TF: A/B Recommendation 41]

2.4 Increase mental health and wellbeing

- Increase provision of screening of adolescents (12–18) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up [US Pv Services TF: A/B Recommendation 21]
- Expand use of cognitive-behavioral therapy in children and adolescents exposed to or who have experienced traumatic events [Community Guide: Violence Prevention A2]
- Implement or expand collaborative care for management of depressive disorders by adopting collaborative care models [Community Guide: Mental Health 1]
- Increase availability of home-based depression care management for adults 60 years of age or older [Community Guide: Mental Health 3]
- Increase availability of clinic-based depression care for adults 60 years and older [Community Guide: Mental Health 4]

2.5 Decrease adult and childhood obesity and diabetes

- Provide screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (treated or untreated) greater than 135/80 mm Hg [US Pv Services TF: A/B Recommendation 23]

- Provide obesity screening for children ages 6 years and older and refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status [US Pv Services TF: A/B Recommendation 35]

2.6 Increase controlled high blood pressure and high cholesterol

- Provide universal screening for high blood pressure in adults 18 and older [US Pv Services TF: A/B Recommendation 7]
- Provide screening for lipid disorders in men aged 35 and older [US Pv Services TF: A/B Recommendation 15]
- Provide screening for lipid disorders in men aged 20 to 35 at an increased risk for coronary heart disease [US Pv Services TF: A/B Recommendation 16]
- Provide screening for lipid disorders in women aged 45 and older who are at an increased risk for coronary heart disease [US Pv Services TF: A/B Recommendation 17]
- Provide screening for lipid disorders to women aged 20 to 45 who are at increased risk for coronary heart disease [US Pv Services TF: A/B Recommendation 18]
- Provide intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular- and diet-related chronic disease [US Pv Services TF: A/B Recommendation 27]

2.7 Decrease adult and childhood asthma

- Provide home-based multi-trigger, multi-component environmental interventions for children and adolescents with asthma [Community Guide: Asthma]

2.8 Increase vaccinations

2.9 Decrease infant deaths

- Increase provision of routine screening for iron deficiency anemia in asymptomatic pregnant women [US Pv Services TF: A/B Recommendation 3]
- Increase provision of screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit , if later [US Pv Services TF: A/B Recommendation 6]
- Increase provision of interventions during pregnancy and after birth to promote and support breastfeeding [US Pv Services TF: A/B Recommendation 11]
- Provide chlamydial infection screenings for all pregnant women aged 24 and younger and for older pregnant women at increased risk [US Pv Services TF: A/B Recommendation 14]
- Encourage all women planning or capable of pregnancy to take a daily supplement containing 0.4 to 0.8 mg of folic acid [US Pv Services TF: A/B Recommendation 24]
- Provide viral hepatitis B screening in pregnant women at their first visit [US Pv Services TF: A/B Recommendation 30]
- Ensure that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke [US Pv Services TF: A/B Recommendation 42]

2.10 Increase culturally and linguistically appropriate services

2.11 Increase advance care planning

2.12 Increase hospital safety and quality of care

2.13 Increase palliative care and hospice care

Decrease hospitalization during the end of life

GOAL 3: ACCESSIBLE AND USABLE HEALTH INFORMATION

3.1 Increase transparent information on cost and quality of care

GOAL 4: PREVENTION SUSTAINABILITY AND CAPACITY

4.1 Increase affordable care and coverage

- Expand use of vouchers, reimbursements, and reduced co-pays to remove economic barriers to accessing breast [recommended], cervical, and colorectal [insufficient evidence] cancer screening services [Community Guide: Cancer Prevention and Control Ai8]
- Increase access to and use of mental health services by ensuring that mental health services are covered through all health insurance plans [Community Guide: Mental Health 2]

4.2 Increase payment policies that reward value

4.3 Decrease rate of growth in health care spending

Appendix E – Programs

California Department of Public Health (CDPH)

The mission and vision of CDPH can be found in Section 3.1 of this Plan. The following link to the CDPH website further details the roles and services of CDPH programs: http://www.cdph.ca.gov/programs/Pages/default.aspx

Alzheimer's Disease Program (ADP)
In 1984, legislation was enacted that established ADP. To meet the legislative mandates of relieving the human burden and economic cost of Alzheimer's disease and related dementias, and to assist in ultimately discovering the cause and treatment of these diseases, the Program established and administers a statewide network of ten California Alzheimer's Disease Centers (CADCs) at university medical centers, and the Alzheimer's Disease Research Fund, which has awarded over $20 million to 116 scientists engaged in the study of Alzheimer's disease and related disorders.

California Arthritis Partnership Program (CAPP)
CAPP is dedicated to improving the quality of life of Californians affected by arthritis and other rheumatic conditions by increasing access to and use of evidence-based physical activity and self-management interventions through working with local public health departments, community-based organizations, and health systems; strengthening partnerships with other chronic disease and risk-factor programs; educating various audiences on the burden and impact of arthritis, and delivering key public health messages.

California Breathing (CB)
CB is an asthma program that addresses the burden of asthma in California with a holistic, public health perspective by promoting strategies outlined in the Strategic Plan for Asthma in California—a roadmap developed collaboratively by government agencies, asthma experts, community groups, and others to improve and advance asthma prevention, treatment, policy, data collection, and public education. CB is a statewide and national leader in asthma prevention and control, known best for its asthma data collection, strong partnerships, focus on disparities, facilitation of high-performing collaborations, and ability to convene diverse groups of stakeholders. CB is funded through a cooperative agreement with CDC and through Proposition 99 (California Tobacco Health Protection Act of 1988) allocation.

California Colon Cancer Control Program (C4P)
Established in 2009, C4P's key message is that colorectal cancer (CRC) is preventable, treatable, and beatable. The key objectives of the program are to increase public awareness of CRC, and the importance of early detection through screening; collaborate with existing health organizations and community partners to improve access to screening, diagnosis, and treatment; measure screening success; and promote provider education and awareness regarding the U.S. Preventive Services Task Force CRC screening guidelines and evidence-based interventions and practices. C4P provides the following services: community outreach and

education; professional education for medical providers; collaboration with health insurers, nonprofit groups, and other stakeholders.

California Comprehensive Cancer Control Program (CCCCP)
CCCCP is housed in the Chronic Disease Surveillance and Research Branch of CDPH. CCCCP functions as a collaborative process through which California pools resources to reduce the burden of cancer, resulting in risk reduction, early detection, better treatment, and enhanced survivorship. CDC provides funding for CCCCP to accomplish the following objectives: to establish a comprehensive cancer control coalition, the California Dialogue on Cancer (CDOC); to assess the burden of cancer in the State in order to determine priorities and to develop and implement a statewide comprehensive cancer control plan. The mission of CCCCP and its statewide coalition, CDOC, is to reduce the burden of cancer on the residents of California.

California Diabetes and Pregnancy Program (CDAPP) Sweet Success
CDAPP Sweet Success Resource and Training Center provides technical support and education to medical personnel and community liaisons to assist in promoting improved pregnancy outcomes for high-risk pregnant women with pre-existing diabetes and women who develop diabetes while pregnant (gestational diabetes mellitus [GDM]). These medical providers who undergo standardized training and provide direct patient care to women with diabetes while pregnant become known as CDAPP Sweet Success Affiliates.

California Tobacco Control Program (CTCP)
The mission of CTCP is to improve the health of all Californians by reducing illness and premature death attributable to the use of tobacco products. Through leadership, experience, and research, CTCP empowers statewide and local health agencies to promote health and quality of life by advocating social norms that create a tobacco-free environment.

Center for Health Statistics and Informatics (CHSI)
CHSI is responsible for state vital records and department-wide initiatives to improve effectiveness through better health information systems, increased application of epidemiologic methods of analysis, strong liaisons with public health organizations and schools of public health, and effective partnerships with local health agencies and professionals.

Chronic Disease Surveillance and Research Branch (CDSRB)
CDSRB is committed to serving the public by collecting statewide data about cancer and cancer risk factors, conducting surveillance and research into the causes, cures, and controls of cancer, and communicating the results to the public. CDSRB coordinates these activities by directing, managing, and monitoring the state-mandated Ken Maddy California Cancer Registry, CDPH (CCR), the Survey Research Group (SRG), and California's Comprehensive Cancer Control Program (CCCCP). CCR is the cornerstone for a substantial amount of cancer research with more than 450 funded research projects and over 2,000 publications that have relied on CCR data. SRG specializes in conducting scientific health-related surveys.

Coordinated Chronic Disease Prevention Program (CCDPP)
CCDPP's purpose is to build and strengthen CDPH's capacity and expertise to effectively prevent chronic disease and promote health. CCDPP focuses on four key areas: (1) Advance environmental strategies for healthful communities; (2) Improve health care systems; (3) Expand community clinical linkages; and (4) Increase regular access to chronic disease and risk factor epidemiologic information.

Division of Environmental and Occupational Disease Control (DEODC)
The mission of DEODC is to prevent or reduce disease and injury related to environmental and occupational factors. Our staff employs a variety of methods to identify and understand health problems that may be caused or made worse by exposure to hazards in the workplace or in the environment. We track and investigate cases of illness and injury to understand contributing factors and develop prevention strategies. We share what we have learned with community members and stakeholders. DEODC programs also carry out specific activities mandated by the Governor or California Legislature.

Environmental Health Investigations Branch (EHIB)
EHIB works to protect the health of Californians by studying how the environment affects health and by educating and informing the public. EHIB responds to emerging environmental health problems, clusters of non-infectious disease, and disasters associated with environmental agents by conducting preliminary investigations and follow-up studies. When health concerns suggest the need for surveillance, EHIB monitors trends in the distribution of environmental exposures and health indicators in California.

Heart Disease and Diabetes Prevention Unit (HDDPU: California Heart Disease and Stroke Prevention Program (CHDSP); California Diabetes Program (CDP)
The mission of the CHDSP Program is to reduce premature death and disability from heart disease and stroke among Californians. The CHDSP Program targets Californians at risk for heart disease and stroke, including persons with high blood pressure, high cholesterol, and multiple risk factors as well as persons with prior heart attack or stroke. Interventions with these populations directly address *Healthy People 2010* objectives for heart disease and stroke (through June 2013).

The California Diabetes Program works in partnership with organizations in California and nationwide to improve the quality of care in health care delivery systems; provide communications to increase awareness about diabetes; offer leadership, guidance, and resources for community health interventions; conduct surveillance to monitor statewide diabetes health status and risk factors; and guide public policy to support people with and at risk for diabetes (through June 2013). After July 1, 2013, Program became *Prevention First.*

Immunization Branch (IZB)
IZB provides leadership and support to public- and private-sector efforts to protect the population against vaccine-preventable diseases. Leadership and support include vaccine

provision and distribution, technical support and guidance, surveillance of vaccine-preventable diseases, and the development of materials and communications to assist with these efforts.

Licensing and Certification Program (L&C)
Health care facilities in California are licensed, regulated, inspected, and/or certified by a number of public and private agencies at the state and federal levels, including the CDPH L&C Program and the U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services (CMS). These agencies have separate—yet sometimes overlapping—jurisdictions. L&C is responsible for ensuring health care facilities comply with state laws and regulations. In addition, L&C cooperates with CMS to ensure that facilities accepting Medicare and Medi-Cal (in California, Medicaid is referred to as Medi-Cal) payments meet federal requirements. L&C also oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

Maternal, Child, and Adolescent Health Program (MCAH)
MCAH develops systems with the goal to help promote, protect and improve the health of California's reproductive age women, infants, children, adolescents, and their families. To accomplish this mission, MCAH maintains partnerships, contracts, and agreements with state, federal, and local agencies in both public and private sectors.

Nutrition Education and Obesity Prevention (NEOP) Branch
The mission of NEOP is to foster collaborative partnerships that engage Californians, especially low-income families, to create environments that encourage healthy eating and physical activity and thus reduce obesity and chronic diseases and improve overall health. NEOP programs work across all sectors—government, schools, community, worksites, health care—and partner with business, private, nonprofit, and public organizations and agencies at community, state, and national levels to advance efforts to make active living and healthy eating the easy choice in California.

Occupational Health Branch (OHB)
OHB promotes healthy workplaces for all Californians. Prevention activities include investigating and evaluating workplace hazards; tracking selected injuries and illnesses to identify high risk industries and occupations; providing information, training, and technical assistance; developing safer ways to work; and recommending protective workplace standards. OHB currently collects 20 occupational health indicators (OHIs) (http://www.cdph.ca.gov/programs/ohsep/Pages/IndicatorsList.aspx) annually, based on available data sources.

Office of Health Equity (OHE)
OHE was established to provide a key leadership role to reduce health and mental health disparities to vulnerable communities. A priority of this groundbreaking office will be the building of cross-sectoral partnerships. The work of OHE will be directed through their advisory committee and stakeholder meetings. The office will consult with community-based

organizations and local governmental agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

Office of Quality Performance and Accreditation (OQPA)
OQPA is responsible for providing leadership and coordinating department-wide initiatives that seek to continually improve the quality and performance of programs and processes within CDPH. These initiatives include quality improvement, strategic planning, leadership development and succession planning. OQPA will provide the leadership and coordination of efforts necessary to achieve and maintain National Public Health Accreditation status.

Oral Health Unit (OHU)
OHU operates within the CDPH Chronic Disease Control Branch; its mission is to promote, assure, and protect the oral health of the people of California, including reducing the incidence and prevalence of dental caries and other diseases and conditions through organized community efforts.

Prevention First (PF)
The PF grant will implement activities within various settings to promote and reinforce healthy behaviors to create healthier communities and schools for all Californians, with an emphasis on populations at an increased risk for adverse health outcomes from diabetes, heart disease, obesity, and associated risk factors. (Starting July 2013)

Safe and Active Communities Branch (SACB)
(SACB) is the focal point for the California Department of Public Health's injury prevention efforts, both epidemiological investigations and implementation of prevention programs to reduce intentional and unintentional injuries. Prevention efforts include epidemiological surveillance, planning and consensus building, interventions, policy development, professional education and training, and public information.

Sexually Transmitted Diseases Control Branch (STDCB)
The mission of STDCB is to reduce the transmission and impact of sexually transmitted diseases and viral hepatitis in California. STDCB supports prevention efforts through providing statewide leadership, guidance, training, technical assistance, surge capacity, and safety net support for delivering services throughout the State. STDCB carries out this mission by collaborating with local health jurisdictions and stakeholders in the public and private sectors.

Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN)
The California WISEWOMAN (or WW) Program helps underserved women reduce the risk of cardiovascular disease (CVD) through timely, high-quality screening, education, and intervention for elevated cholesterol, glucose, and high blood pressure, as well as, education on the signs and symptoms of heart attack and stroke, and when to call 911. The goal of this project is to reduce the risk of morbidity and mortality from cardiovascular disease in women

who are also enrolled in the Every Woman Counts Program. These women are aged 40–64, have low income, and are uninsured or underinsured.

Women, Infants, and Children Program (WIC)
WIC is a federally funded health and nutrition program for women, infants, and children. WIC helps families by providing checks for buying healthy supplemental foods from WIC-authorized vendors, nutrition education, and help finding health care and other community services. Participants must meet income guidelines and be pregnant women, new mothers, infants, or children under age five. In California, 84 WIC agencies provide services locally to over 1.45 million participants each month at over 650 sites throughout the State.

Department of Health Care Services (DHCS)

The mission of the California Department of Health Care Services (DHCS) is to provide low-income Californians with access to affordable, high-quality health care, including medical, dental, mental health, substance use disorder services, and long-term services and supports. DHCS' mission is to preserve and improve the physical and mental health of all Californians. DHCS works closely with federal officials, health care professionals, legislators, county governments, and health plans to provide an accessible health care safety net for individuals in need. DHCS programs serve more than 8.5 million Californians. One in five people in the state receive health care services financed or organized by DHCS, making the department the largest health care purchaser in California. DHCS invests approximately $70 billion in public funds to provide health care services for low-income families, children, pregnant women, seniors, and persons with disabilities, while helping to maintain the health care delivery safety net. Further details regarding DHCS Programs can be found at http://www.dhcs.ca.gov/Pages/default.aspx.

California Children's Services (CCS)

CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the health care and services they need. CCS connects families with doctors and trained health care people who know how to care for children with special health care needs. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae. CCS also provides medical therapy services that are delivered at public schools. http://www.dhcs.ca.gov/SERVICES/CCS/Pages/default.aspx

Child Health and Disability Prevention Program (CHDP)
CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local

health departments, community clinics, managed care plans, and some local school districts. http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
EPSDT is the child health component of Medicaid. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services. CHDP oversees the screening and follow-up components of the federally mandated EPSDT program for Medi-Cal eligible children and youth.

Every Woman Counts (EWC)
EWC is a state and federally funded program that provides free clinical breast exams, mammograms, pelvic exams, and Pap tests to California's uninsured and low income women. The mission of the EWC is to save lives by preventing and reducing the devastating effects of cancer for Californians through education, early detection, diagnosis and treatment, and integrated preventive services, with special emphasis on the underserved. EWC is administered through DHCS. http://dhcs.ca.gov/EveryWomanCounts.

First Five California Commission

The California Children and Families Act, passed by voters in 1998, called for the formation of a State Commission to oversee and support the funding of education, health, and child care programs for children ages 0 to 5 and their families. This Commission, also known as First 5 California, works with 58 First 5 county commissions statewide to develop and fund programs for young children that are tailored to the needs of local communities.

Appendix F – Partner Organizations

Active Living Research
Afterschool Alliance
Alzheimer's Association
American Cancer Society
American Heart Association
American Lung Association in California
Arthritis Foundation
Asian American Network for Cancer Awareness
Bay Area Regional Health Inequities Initiative (BARHII)
Breakthrough Communities
California Asthma Partner, Breathe L.A.
California Bicycle Coalition
California Black Women's Health Project
California Breast Cancer Research Program, University of California
California Center for Public Health Advocacy
California Coalition Against Sexual Assault
California Chronic Care Coalition
California Colorectal Cancer Coalition
California Conference of Local Health Data Managers
California Conference of Local Health Department Nutritionists
California Conference of Local Health Officers
California Dental Association
California Department of Aging
California Department of Education
California Department of Health Care Services
California Department of Motor Vehicles
California Department of Parks and Recreation
California Department of Transportation
California Diabetes Coalition
California Dialogue on Cancer
California Emergency Management Agency
California Governor's Office of Planning and Research
California Healthcare Foundation
California Health Care Safety Net Institute
California Health Collaborative
California Healthier Living Coalition
California Hepatitis Alliance
California Hepatitis C Task Force
California League of Cities
California Medical Association
California Medical Association Foundation
California Office of Emergency Services

California Office of Traffic Safety
California Pan-Ethnic Health Network (CPEHN)
California Park and Recreation Society
California Partnership to End Domestic Violence
California Primary Care Association
California Radiological Society
California Research Bureau
California Rural Indian Health Board
California Rural Legal Assistance
California School Health Centers Association
California State Association of Counties
California Transportation Commission
California WALKS
Cancer Survivors Network
CANFIT
Center for Oral Health
Centers for Disease Control and Prevention
Central California Regional Obesity Prevention Program
ChangeLab Solutions
Children Now
Cities, Counties, Schools Partnership
City of Long Beach Health Department
County Health Executives Association of California
Colon Cancer Alliance
Community Transformation Grant (CTG) Initiatives
Contra Costa Health Services
Coordinated Student Support and Adult Education Division, California Department of Education
Dairy Council of California
Del Norte County Department of Health and Human Services
DentaQuest Foundation
Diabetes Coalition of California
Elk Grove Unified School District
First 5-California
First 5-Los Angeles
First 5-Sacramento
Glenn County Health and Human Services Agency
G.O.A.L.S. For Women
Health Services Advisory Group
Humboldt County
Institute for Local Government
Institute for Population Health Improvement, UC Davis Health System
Kaiser Permanente
Lassen County Public Health Department

Latina Breast Cancer Agency
Latinas Contra Cancer Board
LIFT Levántate
Local Government Commission
Los Angeles County Department of Public Health
Los Angeles County Community and Senior Services
Medical Board of California
Molecular Devices
Monterey County Health Department
Nevada County Health and Human Services Agency
National Opinion Research Center at the University of Chicago
Nutrition Services Division, CDE
Office of Statewide Health Planning and Development
Office of Women's Health Advisory Council
Orange County Health Care Agency
Palo Alto Medical Foundation
Partners in Advocacy (American Congress of Obstetricians and Gynecologists)
Partnership for the Public's Health
Pinnacle Trading
PolicyLink
Prevention Institute
Public Authority
Public Health Institute
Rails-to-Trails Conservancy, Western Region
RAND Corporation
Regional Asthma Management and Prevention Initiative
ResMed
Riverside County Department of Public Health
Safe Routes to School National Partnership
Salvation Army
San Diego State University
San Francisco Department of Public Health
San Louis Obispo Health Department
San Mateo County Health Department
Santa Clara County Health and Hospital System
Shasta County Health and Human Services, Public Health Branch
Sierra Health Foundation
Silicon Valley Leadership Group
Solano County Public Health Department
Sonoma County Department of Health Services
Survey Research Group Section, Cancer Surveillance and Research Branch
Susan G. Komen for the Cure/Orange County
Sutter County Public Health

The California Endowment
The California Wellness Foundation
The Children's Partnership
The G.R.E.E.N. Foundation
The Parkinson's Institute and Clinical Center
University of California, Berkeley
University of California, Berkeley Center for Weight and Health
University of California Cooperative Extension
University of California, Davis
University of California, Los Angeles, Center for Health Policy Research
University of California, Los Angeles, School of Dentistry
University of California, Los Angeles, School of Public Health
University of California, Los Angeles, School of Public Health and Jonsson Comprehensive Cancer Center
University of California, San Diego/California Smokers' Helpline (Quitline) and Center for Tobacco Cessation
University of California, San Francisco
University of California, San Francisco, Dental School
University of California, San Francisco, Institute for Health and Aging
University of the Pacific–Arthur A. Dugoni Dental School
U.S. National Oral Health Alliance
YMCA

Disclaimer: Partners listed here are for reference only and reflect organizations that have historically conducted work in the area of chronic disease prevention and health promotion. This Partner listing does not imply an organizational endorsement of this Plan by any listed entity.

Appendix G – Centers for Disease Control and Prevention Domains

Epidemiology and Surveillance Activities

- Collect appropriate data to monitor risk factors and chronic conditions of interest through surveillance systems (such as the BRFSS, NPCR and other cancer screening data systems, Vital Statistics, and Medicare data sets), rapidly develop and disseminate data reports in easy-to-use and understand formats, describe multiple chronic conditions, and use data to drive state and local public health action.
- Conduct surveillance of behavioral risk factors, social determinants of health, and monitor environmental change policies related to healthful nutrition, physical activity, tobacco, community water fluoridation, and other areas.
- Collect cancer surveillance data to assess cancer burden and trends, identify high risk populations, and guide planning and evaluation of cancer control programs (e.g., prevention, screening and treatment efforts).
- Conduct youth and adult surveillance of tobacco-related knowledge, attitudes and behaviors; translate and disseminate data and information for action.
- Collect, use, and disseminate data on oral diseases and risk factors and use of preventive oral health services.
- Examine administrative datasets for factors associated with risk for all-cause and cardiovascular disease mortality.
- Conduct surveillance of health behaviors and policies for women before, during, and after pregnancy using the Pregnancy Risk Assessment Monitoring System to translate and disseminate data for action and collaborate with state PRAMS coordinators in using findings for program strategies and policies as appropriate.
- Link administrative, vital records, and hospital discharge data to conduct surveillance on the prevention of preterm births and pregnancy complications.

Environmental Approach Activities

Expand access to and availability of healthy foods and beverages through a variety of strategies, including:

- Nutrition standards for food and beverages offered in settings, including state, local, and tribal governments; private sector businesses; schools, child care and education facilities; and senior centers and other facilities serving older adults.
- Accessible, available, and affordable healthful foods in communities, including provision of full service grocery stores, farmers markets, small store initiatives, mobile vending carts, and restaurant initiatives.
- Comprehensive school strategies to promote healthful nutrition, such as:
    - Implementing Institute of Medicine recommendations on competitive foods (e.g., vending or a la carte items);
    - Increasing access to healthy foods and beverages in schools through a variety of strategies, such as offering drinking water free of charge throughout the day and implementing farm-to-school initiatives.

Promote increased physical activity through a variety of strategies, including:

- Increasing the amount of daily, quality physical education in schools;
- Increasing the amount of daily physical activity through standards in early care/after school settings;
- Increasing access to physical activity for employees through worksite wellness initiatives;
- Facilitating shared use agreements to increase the number of safe, accessible places for physical activity in communities;
- Implementing strategies for the built environment that promote active transportation (e.g., complete street designs, safe routes to school programs, promoting bicycling as a mode of transportation, health impact assessments).

Reduce tobacco use, preventing youth initiation, and eliminating exposure to secondhand smoke through a variety of evidence-based strategies, including:

- Comprehensive smoke-free air policies in workplaces and public places; smoke-free policies in multi-unit housing and outdoor areas; and tobacco-free campus policies for colleges, workplaces, and health care settings, among others;
- Strategies to reduce youth access to tobacco products (e.g., reducing the affordability, availability, and visibility of tobacco products).

Increase the proportion of the U.S. population served by community water systems with optimally fluoridated water.

Health System Intervention Activities

- Delivery of high-quality screening for breast, cervical, and colorectal cancers that promotes high rates of appropriate use, including timely referral and follow-up.
- Organized systems of care to deliver high-quality clinical and other preventive services (as recommended by the U.S. Preventive Services Task Force and the Community Guide):
  - Electronic health records with registry function, decision support, and electronic reminders;
  - Team-based care;
  - Population care across panel of patients;
  - Systems to ensure adequate follow-up of abnormal screening tests, and timely treatment;
  - Patient-centered medical and dental home.
- Health care information systems with automated physician prompts or patient reminder letters for screening and follow-up clinical counseling or referral.
- Quality improvement of clinical care for cancer screening and control of Hgb A1C, blood pressure, BMI, and cholesterol.
- Birthing hospitals using Baby Friendly Hospital Initiative policy recommendations and implementing “Ten Steps for Successful Breastfeeding in Hospitals.”
- Delivery of smoking cessation services and treatments—including providing quitline coaching and cessation treatments as covered benefits.
- Increase access to and use of clinical and preventive oral health services

- Provision of quality, accessible and confidential family planning services, including contraceptive methods and services.

Clinical–Community Linkage Activities

- Available, accessible arthritis, diabetes, chronic disease self-management education programs, including physical activity programs, to reach at-risk populations in community settings, such as worksites, YMCA/YWCAs, schools, senior centers, among other local organizations.
- Increase use of the CDC-approved evidence-based lifestyle change program to prevent or delay onset of type 2 diabetes among people at high risk.
- Implement systems to increase provider referrals of people with pre-diabetes or multiple diabetes risk factors to sites offering the CDC-approved lifestyle change program.
- Use of allied health professionals to enhance management of high blood pressure/cholesterol, Hgb A1C (e.g., pharmacist and/or dental provider model).
- Use of allied health providers (nurses, dentists, etc.), community health workers, and/or patient navigators in team-based care to support control of high blood pressure, high cholesterol, and Hgb A1C.
- Develop guidelines and systems within clinical care and community settings to address cancer survivorship by ensuring appropriate follow up care and promoting lifestyle interventions to reduce risk of recurrence.
- Effective outreach to the population to increase use of clinical and other preventive services.
- Delivery of school-based dental sealant programs.
- Safe and effective use of contraception appropriate for women and men with chronic medical conditions.
- Coverage/reimbursement for diabetes self-management education and chronic disease self-management education, and other care coordination activities by Community Health Workers.

Appendix H – Plan Assumptions

The Plan assumes the following about the impact of chronic disease:

1. Chronic disease is likely to affect everyone in California at some point in their life, directly or indirectly;
2. California's economy is impacted by chronic disease, through the burden of health care costs and diminished productivity of the workforce.
3. Non-pharmaceutical interventions such as a healthy diet, physical activity, and tobacco cessation are known to prevent chronic disease, but difficult for many individuals to maintain over time.
4. The health care system is not optimally designed to provide the full spectrum of chronic disease prevention for all Californians, including needed linkages between the clinical setting and the community.
5. The use of pharmaceutical interventions can have negative consequences, such as high cost, limited access, overdose, difficulties with adherence, and side effects, as well as environmental contamination.
6. The increasing size of the aging population, coupled with the prevalence of chronic disease, will pose a challenge to the health care and public health systems.
7. Climate change will worsen impact of chronic disease due to extreme weather conditions, impacting food availability and safety, access to water, and threats to environmental and community health.

Appendix I – Plan Guiding Principles

Following are the guiding principles that were used in development of this Plan:

1. Improve overall health outcomes in those diagnosed with one or more chronic disease and/or chronic disease risk factors.
2. Develop cross-cutting strategies that support and reinforce healthy behaviors and have the greatest public health impact.
3. Ensure a strategic focus on Californians who have the greatest chronic disease risk and are most affected by chronic diseases.
4. Reduce differences in access to quality clinical and community care and ensure that all Californians have equal access.
5. Use data to identify and address differences in health status and health outcomes across different population groups in California.
6. Emphasize dissemination and implementation of evidence- and practice-based interventions.
7. Assure sustainability by identifying opportunities to set priorities and use existing resources more efficiently.
8. Ensure communication, coordination, and collaboration between internal and external partners.
9. Embrace the Center for Disease Control & Prevention's Principles of Community Engagement[42]
   a. *Be clear about the purposes or goals of the engagement effort, and the populations and/or communities you want to engage.*
   b. *Become knowledgeable about the community in terms of its economic conditions, political structures, norms and values, demographic trends, history, and experience with engagement efforts. Learn about the community's perceptions of those initiating the engagement activities.*
   c. *Go into the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community.*
   d. *Remember and accept that community self-determination is the responsibility and right of all people who comprise a community. No external entity should assume it can bestow on a community the power to act in its own self-interest.*
   e. *Partnering with the community is necessary to create change and improve health.*
   f. *All aspects of community engagement must recognize and respect community diversity. Awareness of the various cultures of a community and other factors of diversity must be paramount in designing and implementing community engagement approaches.*
   g. *Community engagement can only be sustained by identifying and mobilizing community assets, and by developing capacities and resources for community health decisions and action.*
   h. *An engaging organization or individual change agent must be prepared to release control of actions or interventions to the community, and be flexible enough to meet the changing needs of the community.*
   i. *Community collaboration requires long-term commitment by the engaging organization and its partners.*

National

1. Community Guide to Preventive Services
   http://www.thecommunityguide.org/index.html
2. County Health Rankings
   http://www.countyhealthrankings.org/
3. Healthy People 2020
   http://www.healthypeople.gov/2020/default.aspx
4. National Prevention Strategy
   http://www.surgeongeneral.gov/initiatives/prevention/strategy/
5. National Strategy for Quality Improvement in Health Care
   http://www.ahrq.gov/workingforquality/nqs/nqs2013annlrpt.htm
6. U.S. Preventive Services Task Force
   http://www.uspreventiveservicestaskforce.org/

State

1. BARHII Framework
   http://www.barhii.org/programs/framework_in_action.html
2. The Burden of Chronic Disease and Injury, California 2013
   http://www.cdph.ca.gov/programs/cdcb/Pages/CoordinatedChronicDiseasePreventionProgram.aspx
3. California Arthritis Fact Sheets
   http://www.cdph.ca.gov/programs/CAPP/Pages/default.aspx
4. California's Comprehensive Cancer Control Plan, 2011–2015
   http://www.cdph.ca.gov/programs/Pages/cdic.aspx
   http://www.cdph.ca.gov/programs/csrb/Pages/California'sComprehensiveCancerControlPlan.aspx
5. California Conference of Local Health Officers/County Health Executives Association of California Chronic Disease Framework
   http://www.cdph.ca.gov/programs/cclho/Documents/ChronicDiseaseReportFINAL.pdf
6. California Department of Health Care Services Baseline Assessment of Quality Improvement Activities, August 2013
   http://www.dhcs.ca.gov/services/Documents/FinalBaseline082013.pdf
7. California Department of Health Care Services Strategy for Quality Improvement in Health Care, August 2012
   http://www.dhcs.ca.gov/services/Pages/DHCSQualityStrategy.aspx
8. California Department of Health Care Services Strategic Plan (pending publication in 2013)
9. California Department of Mental Health 2009–2014 Strategic Plan
   http://www.dmh.ca.gov/docs/2009–2014_DMH_Strategic_Plan.pdf
10. California Department of Public Health Strategic Map: 2012–2014
    http://www.cdph.ca.gov/Documents/CDPH_Strategic_Map_2012.pdf

11. California's Master Plan for Heart Disease & Stroke Prevention & Treatment, 2007–2015 http://www.cdph.ca.gov/programs/cvd/Documents/CHDSP-MasterPlan-LowRes.pdf
12. California Obesity Prevention Plan: A Vision for Tomorrow, Strategic Actions for Today http://www.cdph.ca.gov/programs/COPP/Documents/COPP-ObesityPreventionPlan-2010.pdf.pdf
13. California's Plan for Diabetes: A Coordinated Plan to Help Guide our Work in Diabetes, 2003–2007 http://www.caldiabetes.org/content.cfm?contentID=91&CFID=5335545&CFTOKEN=28450599
14. California's Plan for Supplemental Nutrition Assistance Program Education, October 2012–September 30, 2013, Network for a Healthy California NEOP 3-year implementation plan
15. California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution http://www.mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf
16. Filling the Gaps: Strategic Directions for a Safe California, 2010–2014 http://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/Strategic%20Directions%20for%20a%20Safe%20CA.2010–2014.Oct.2010.pdf
17. Health in All Policies Task Force Report to the Strategic Growth Council, December 3, 2010 http://www.sgc.ca.gov/hiap/publications.html
18. Healthy California 2020 http://www.cdph.ca.gov/data/indicators/Pages/HP2020Planning.aspx
19. Let's Get Healthy California Task Force, December 2012 http://www.chhs.ca.gov/SiteCollectionDocuments/__Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf
20. Maternal, Child and Adolescent Health Needs Assessment for the California Maternal and Child Health Services Title V Block Grant 2011–2015 http://www.cdph.ca.gov/programs/mcah/Documents/MO-MCAH-NeedAssessment-v6-10-15.pdf
21. Saving Lives, Saving Money: Toward a Tobacco-Free California 2012–2014 http://www.cdph.ca.gov/services/boards/teroc/Documents/Full%20Master%20Plan-Web.pdf
22. Strategic Plan for Asthma in California, 2008–2012 http://www.cdph.ca.gov/programs/caphi/Documents/AsthmaStrategicPlan.5-5-08.pdf
23. Strategic Plan to Address COPD in California http://www.lung.org/associations/states/california/programs/copd-programs/

Appendix K – Relationship to Other Initiatives

This Plan integrates and is in compliance with the chronic disease prevention plans of the United States Department of Health and Human Services (U.S. DHHS) Centers for Disease Control and Prevention (CDC), and other federal agencies.

A

Alzheimer's Disease: is the most common cause of dementia, accounting for the majority of all diagnosed cases. Dementia is the loss of cognitive functioning to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Alzheimer's Disease is a progressive brain disorder that gradually destroys a person's memory and ability to learn, reason, make judgments, communicate, and carry out daily activities such as bathing and eating. There are no known treatments to prevent, cure, delay the onset, or slow the progression of Alzheimer's Disease. However there is much that can be done to manage symptoms, improve functioning, and aid the family in caring for patients at home. Several factors determine the risk of developing dementia, including age and family history. Alzheimer's disease is the fifth leading cause of death among adults aged 18 years and older. Recent evidence suggests that higher glucose levels may be a risk factor for dementia, even among persons without diabetes.[43]

Arthritis: a term used to describe more than 100 rheumatic diseases and conditions that affect joints. Common symptoms of arthritis include pain, aching, stiffness, and swelling in and around the joint. Some forms of arthritis can affect multiple organs and cause widespread symptoms. The most common forms of arthritis are osteoarthritis, fibromyalgia, gout, rheumatoid arthritis, and systemic lupus erythematosus.

Asthma: a chronic disease that affects the lungs by inflaming and narrowing the airways of the lungs. It causes wheezing, breathlessness, chest tightness, and coughing, making breathing difficult. The symptoms of asthma can lead to decreased physical activity, which increases risk of obesity and other chronic diseases. Asthma can be managed with medications that control symptoms and avoiding "triggers." Asthma triggers are different for everyone who has asthma. Asthma triggers include tobacco smoke, dust mites, outdoor air pollution, cockroaches, pets, mold, smoke from burning wood or gas, allergies, infections like flu, physical activity, certain medications, certain weather conditions, certain foods, fragrances, and strong emotions that can lead to rapid breathing (hyperventilation).

B

Breast cancer: cancer that forms in the breast tissue and occurs in both men and women, although it is very rare in men. Breast cancer is the most common type of cancer in women in California. Risk factors for breast cancer include gender, age, personal or family history of breast cancer, heredity, radiation therapy to the chest or face before age 30, diagnosis with non-cancerous (benign) breast conditions, race/ethnicity, being overweight or obese, lack of regular physical activity, alcohol use, smoking, poor nutrition, menstrual history, giving first birth over age 30, never giving birth, breastfeeding history, dense breast tissue, hormone replacement therapy, alcohol, and race. Factors that affect chance of recovery in those diagnosed with breast cancer include age, general health, whether menopause has occurred, stage of cancer, type of breast cancer, estrogen or progesterone levels in tumor tissue, speed of tumor growth, and whether cancer is recurring.

C

California Healthcare Performance Information System (CHPI): a new voluntary, multi-payer claims database managed by the Pacific Business Group on Health. The new platform, the nonprofit CHPI, will pool claims and other data from California health plans and CMS. CHPI has been certified as a Medicare Qualified Entity so that it can include Medicare claims data (on California's Medicare beneficiaries). CHPI will produce physician, group, and hospital performance ratings using quality, efficiency, and appropriateness measures. For more information, visit www.chpis.org

Cancer: refers to a large group of diseases characterized by uncontrolled growth and spread of abnormal (malignant) cells, which results in death if not controlled. Many cancers can be prevented through changes in lifestyle and many can be cured through early detection and treatment. Cancers are the second leading cause of death in California. Some preventable and/or treatable cancers include lung and tobacco related cancers, colorectal cancer, breast cancer, cervical cancer, and prostate cancer.

Case Fatality Rate/Ratio: Number of deaths per number of cases of disease (over a typically limited time period) times 100 (i.e., percentage/proportion).

Cervical cancer: a slow-growing cancer that forms in the tissue of the cervix. This type of cancer is almost always caused by the human papilloma virus (HPV) and may not have symptoms. It is detected through regular Pap tests. Other risk factors for cervical cancer include smoking, having HPV, giving birth to three or more children, oral contraceptives, and a weakened immune system. Factors that affect chance of recovery if diagnosed with cervical cancer include age, general health, having a certain type of HPV, the stage of cancer, the type of cervical cancer, and size of tumor.

Chronic disease: chronic diseases are long-lasting or recurrent medical conditions that progress slowly. Chronic diseases and injury are the leading causes of death, disability, and diminished quality of life in California. Chronic diseases such as heart disease, cancer, stroke, asthma, chronic obstructive pulmonary disease, diabetes mellitus, arthritis, oral health conditions, mental health conditions, and substance use disorders are manageable. The chance of recovery (prognosis) increases when chronic diseases are detected early and controlled through clinical interventions or medical treatments and through lifestyle changes and disease management.

Chronic Obstructive Pulmonary Disease (COPD): this term refers to two diseases, chronic bronchitis and emphysema, both of which make breathing difficult. Symptoms of COPD include constant coughing, shortness of breath, and wheezing. COPD develops slowly and can get worse over time. When it is severe it can prevent basic tasks, such as bathing and dressing. COPD can be managed with medications that control symptoms and by avoiding triggers. COPD triggers include tobacco smoke, air pollutants, dust, and infections such as flu. Smoking is the leading cause of COPD; other risk factors include long-term exposure to air pollution, chemical fumes, second-hand smoke, or dust.

Colorectal cancer: refers to cancers of the colon and rectum. Colon cancer forms in the tissues of the longest part of the large intestine. Rectal cancer forms in the tissues of the rectum. Risk factors for colorectal cancers that cannot be changed include age, personal or family history of colorectal cancer, personal or family history of bulging tissue in the colon or rectum, personal or family history of breast, ovarian, or endometrial cancers. Risk factors that can increase the risk for cancer or decrease the chance of survival (prognosis) once diagnosed with cancer include tobacco use, poor nutrition, and lack of regular physical activity.

Community Health Workers: also known as community health advocates, lay health educators, community health representatives, peer health promoters, community health outreach workers, and in Spanish, *promotores de salud*—are "community members who work almost exclusively in community settings. They serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care."[44] Community Health Workers assist individuals and communities in adopting healthy behaviors in paid positions or as volunteers. They conduct outreach for medical personnel or health organizations to implement programs in the community that promote, maintain, and improve individual and community health. They may provide information on available resources, provide social support and informal counseling, advocate for individuals and community health needs, and provide services such as first aid and blood pressure screening. They also may collect data to help identify community health needs.

Congestive heart failure: "fluid congestion"—extra fluid—in the blood as a result of heart failure. When the heart is unable to pump enough blood through the body, certain organs and tissues, such as the kidneys do not get enough oxygen and nutrients. The kidneys do not filter as much fluid from the blood into urine, leaving extra fluid. This extra fluid builds up in the lungs, liver, and other tissues and can cause fatigue and breathing problems.

Coronary artery disease: This is a slow, progressive disease that may begin as early as childhood. This disease results from plaque build-up (atherosclerosis) in the blood vessels that bring oxygen to the heart (arteries). Plaque build-up is the result of fat, cholesterol, and other products in the blood sticking to the walls of arteries, thickening and hardening them. Plaque build-up can partially or completely block the blood flow through an artery. Because atherosclerosis limits or blocks oxygenated blood from getting to the heart, it can cause heart attack or stroke.

> Preventive factors: include good nutrition, maintaining a healthy body weight, and regular physical activity. However, other risk factors can be changed to prevent coronary artery disease, such as: high cholesterol and triglycerides in the blood (hyperlipidemia), high blood pressure, smoking, diabetes mellitus, stress, and alcohol abuse.

Coronary heart disease: results from coronary artery disease when the blood flow to the heart becomes limited (ischemia), increasing the risk of heart attack. Risk factors for coronary heart disease are the same as those for coronary artery disease.

D

DALY (Disability-Adjusted Life Year): Metric for quantifying the burden of disease from mortality and morbidity. One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability. DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences.

Data Steward: Updates and maintains the current primary data source and/or expert in secondary data source use.

Diabetes: a chronic medical condition that occurs when the body cannot produce or properly use the hormone that controls blood sugar (insulin). Insulin is produced by the pancreas and travels through the bloodstream to deliver glucose to cells, so they can convert it into energy. Problems with insulin production and/or insulin use prevent blood sugar (glucose) from entering cells and being used as energy. This increases the amount of glucose in the bloodstream. Diabetes is the leading cause of blindness, amputation, and kidney failure, and also contributes to heart attacks and strokes. There are several types of diabetes:

> *Type 1 diabetes:* previously known as juvenile diabetes, an unpreventable autoimmune chronic disease that affects the body's ability to produce enough insulin. When the body does not produce enough insulin, glucose builds up in the bloodstream instead of entering cells, thus not allowing the body to use all of the glucose for energy. Insulin therapy and other treatments enable those with type 1 diabetes to manage the condition and live long, healthy lives.
>
> *Type 2 diabetes:* a preventable, chronic disease characterized by elevated blood sugar (glucose) levels. It is caused when the body is unable to produce or use the hormone that controls glucose (insulin), resulting in a build-up of sugar in the blood (hyperglycemia). Type 2 diabetes usually begins as insulin resistance. Symptoms of diabetes may take years to emerge and include fatigue, hunger, increased thirst, increased urination, infections (bladder, kidney, skin, and others) that are frequent or heal slowly, blurred vision, erectile dysfunction, and pain or numbness in hands or feet.
>
> *Gestational diabetes:* High blood sugar that starts or is diagnosed during pregnancy. Gestational diabetes occurs in pregnant women who have never previously had diabetes but have higher than normal blood glucose levels during pregnancy. Immediately after pregnancy, 5 percent to 10 percent of women with gestational diabetes are found to have diabetes, usually type 2. Women who have had gestational diabetes have a 35 percent to 60 percent chance of developing diabetes in the next 10–20 years.[45]

Diabetes Self-Management Education (DSME): the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life." [46]

E

Epidemiology: The study of the patterns, causes, and effects of health and disease conditions in defined populations; focused on the distribution and causes of disease in human populations.

Evaluate: To determine the significance, worth, value, or condition of, usually by careful appraisal and study. Evaluation is often conducted to assess effectiveness of interventions, demonstrate the need for interventions, identify ways to improve the intervention, fulfill accountability to funders and other key stakeholders, and to enhance program sustainability.

F

Fibrinolytic therapy: Administration of a drug to stabilize and dissolve blood clots.

G

Goal: high-level, general statement of intent

H

Hazard: Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Health: Physical health (oral as well as medical conditions) and mental health are not just the absence of disease but the full range of health status, that is, not only morbidity and mortality, but functional status or disability, suffering, and quality of life.

Health disparities: Differences in health that are systematically associated with being socially disadvantaged (e.g., being poor, a member of a disadvantaged racial/ethnic group, and/or female), putting those disadvantaged groups at further disadvantage.

> **Health and mental health disparities:** Differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors

Health equity: Efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives. Striving to eliminate health disparities strongly associated with social disadvantage; striving for equal opportunities for all social groups to be as healthy as possible with selective focus on improving conditions for those groups who have had few opportunities, such as the poor, disadvantaged racial/ethnic groups, women, and/or persons who historically have faced more obstacles to realizing their health or human rights.

> **Determinants of equity**: social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.

Health and mental health inequities: Disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

Heart attack (myocardial infarction): damage or death of part of the heart muscle. This results when blood flow to the heart is blocked or severely limited (ischemia) and the heart muscle is deprived of oxygen and nutrients. Ischemia may be chronic, resulting from coronary artery disease (plaque narrowing the arteries over time) or it may be sudden (acute) when a plaque bursts and a blood clot forms around it, blocking the artery. Plaque is a build-up of cholesterol and fats (lipids) on the walls of blood vessels and it limits or blocks blood flow. Heart attacks can be prevented through healthy behaviors, such as good nutrition and physical activities, and through management of heart disease or health conditions (e.g. high blood pressure, glucose or cholesterol).

Heart disease: all diseases of the heart and blood vessels. Numerous conditions fall under this term, such as coronary artery disease, high cholesterol and high triglycerides (hyperlipidemia), high blood pressure (hypertension), congestive heart failure, heart attack, and stroke. Heart disease is the leading cause of death in California.

Heart failure: a serious, chronic, and progressive condition where the heart "fails" to pump as much blood as the body needs. The heart compensates by enlarging its chambers, increasing its muscle mass, and/or pumping faster. The blood vessels may narrow to maintain blood pressure and blood is diverted away from less important tissues or organs to protect the most vital organs such as the heart and brain. Over time, symptoms such as fatigue and breathing problems may emerge. Heart failure can be managed with medication and lifestyle changes, such as: not smoking, losing weight or maintaining a healthy weight, tracking fluid intake, avoiding alcohol, avoiding or limiting caffeine, good nutrition, regular physical activity, and monitoring blood pressure.

High blood pressure (hypertension): there are two forces that create blood pressure: blood pumping through the arteries out of the heart and the rest periods between heartbeats. The arteries stretch as blood pressure increases, to enable blood to flow through. When blood pressure is high, too often, over time, arteries lose their elasticity, become scarred, and/or become clogged. Eventually, these problems in the arteries can result in damage to the heart tissue or heart failure.

High cholesterol and high triglycerides (hyperlipidemia): Cholesterol and triglycerides are types of fat (lipids) in the blood. High levels of these fats can result in plaque build-up (clogs) in the arteries, which can lead to coronary artery disease. Good nutrition and physical activity increase the chance of lowering the levels of these fats in the blood, which also reduces the risk of coronary artery disease.

I

Injury: intentional or unintentional damage to the body by accident or violence. Injuries often lead to premature death and disability. Accidental injuries are the leading cause of death in Californians ages 1 to 44 years of age. Intentional injuries, such as suicide, are among the leading causes of fatal injuries.

Insulin resistance: Insulin resistance is when cells become "resistant" to insulin, meaning they no longer absorb and convert glucose into energy. As a result, the amount of fat and glucose in the blood increases. Insulin resistance increases risk of coronary artery disease, stroke, and diabetes. Risk factors for insulin resistance include age, family history, hormone changes, being overweight or obese, and not being physically active on a regular basis.

J

Jurisdiction: The range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority for incident mitigation. Jurisdictional authority at an incident can be political/geographical (e.g., special district, city, county, state or federal boundary lines), or functional (e.g., police department or health department).

L

Liaison: A form of communication for establishing and maintaining mutual understanding and cooperation.

Local Agency: Government Code 8680.2 defines local agencies as any city, city and county, county, school district, or special district.

Local Government: A county, municipality, city, town, township, local public authority, school district, special district, intrastate district, council of governments (regardless of whether the council of governments is incorporated as a nonprofit corporation under STATE law), regional or interstate government entity, or agency or instrumentality of a local government; an Indian tribe or authorized tribal entity, or in Alaska a Native village or Alaska Regional Native Corporation; a rural community, unincorporated town or village, or other public entity. See Section 2 (10), Homeland Security Act of 2002, Pub. L. 107−296, 116 Stat. 2135 (2002).

Local Public Health Department: The agency, department, or office having primary responsibility for administration of public health services in a county.

Lung cancer: cancer that forms in the tissues of the lungs. It is the deadliest type of cancer for men and women and kills more people each year than breast, colon, and prostate cancers combined. There are two main types of lung cancer. The most common type is non-small cell lung cancer and the other type is small cell lung cancer. When lung cancer is both types, it is called mixed small cell/large cell cancer. When lung cancer spreads to other parts of the body, it is called metastatic cancer of the lung. Cigarette smoking is the leading cause of lung cancer, though it also occurs in people who have never smoked. Other risk factors for lung cancer include secondhand cigarette smoke, asbestos, exposure to cancer-causing chemical, family history of lung cancer, high levels of air pollution, high levels of arsenic in drinking water, radiation therapy to the lungs, and radon gas.

M

Myocardial infarction: Medical term for an event commonly known as a heart attack.

N

National Diabetes Prevention Program (NDPP): "The CDC-led NDPP is designed to bring to communities evidence-based lifestyle change programs for preventing type 2 diabetes. It is based on the Diabetes Prevention Program research study led by the National Institutes of Health and supported by CDC. The lifestyle program in this study showed that making modest behavior changes, such as improving food choices and increasing physical activity to at least 150 minutes per week, helped participants lose 5 to 7 percent of their body weight. These lifestyle changes reduced the risk of developing type 2 diabetes by 58 percent in people at high risk for diabetes. People with pre-diabetes are more likely to develop heart disease and stroke."[47]

P

Percutaneous coronary intervention: Also known as angioplasty -- a procedure to treat narrowed arteries in the heart.

Physical activity: Bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure, including exercise, sport, dance, and other movement forms.

Physical education: The sequential educational program that teaches students to:

- Understand and participate in regular physical activity that assists in developing and maintaining physical fitness throughout their lifetimes.
- Understand and improve their motor skills.
- Enjoy using their skills and knowledge to establish a healthy lifestyle.
- Understand how their bodies work.

Preventive factor: A factor that improves health and decreases the chance of getting a disease. Preventive factors do not guarantee a disease will not be acquired. Some examples of preventive factors for chronic disease are: good nutrition, regular physical activity, healthy weight, avoiding cigarette smoke and tobacco use, avoiding excessive alcohol consumption, and avoiding other drug use.

Promotores de Salud: Some *Promotores* serve in their communities as part of their work, under many titles (see Community Health Worker definition) and others. Other *promotores* serve as volunteers in agencies in their communities. But, a *Promotor* does not have to be an employee associated with an agency. A *Promotor* is a person who other people look to naturally for advice, support, or help.[48,49].

Prostate cancer: refers to several cancers with different causes. There are both slow-growing prostate cancers and aggressive and fatal types. Prostate cancers form in the tissues of the prostate gland and mainly affect older men. Risk factors include age, family history, race, smoking, lack of vegetables in the diet, being overweight or obese, height, lack of regular physical activity, and exposure to Agent Orange.

Q

QALY (Quality-Adjusted Life-Year): A metric that takes into account both the quantity and quality of life generated by health-care interventions. It is the arithmetic product of life expectancy and a measure of the quality of the remaining life-years. A QALY places a weight on time in different health states. A year of perfect health is worth 1 and a year of less than perfect health is worth less than 1. Death is considered to be equivalent to 0; however, some health states may be considered worse than death and have negative scores. QALYs provide a common currency to assess the extent of the benefits gained from a variety of interventions in terms of health-related quality of life and survival for the patient. When combined with the costs of providing the interventions, cost–utility ratios result; these indicate the additional costs required to generate a year of perfect health (one QALY). Comparisons can be made between interventions, and priorities can be established based on those interventions that are relatively inexpensive (low cost per QALY) and those that are relatively expensive (high cost per QALY).

R

Recess: an essential component of a comprehensive school physical activity program. Recess provides children with discretionary time to engage in physical activity that helps them develop healthy bodies and enjoyment of movement. It also allows children the opportunity to practice life skills such as cooperation, taking turns, following rules, sharing, communication, negotiation, problem solving, and conflict resolution. Recess does not replace physical education class. Physical education provides sequential instruction to enhance the development of motor skills, movement concepts, and physical fitness. Recess provides unstructured play opportunities that allow children to engage in physical activity.

Reperfusion therapy: Medical treatment to restore blood flow through blocked arteries.

Risk factor: anything that increases the chance of getting a disease. Having a risk factor associated with a disease does not mean the disease will be acquired. Many risk factors are common across chronic diseases. Some are inherent, and some are modifiable. Risk Factors: high blood pressure, high cholesterol, insulin resistance, pre-diabetes, poor nutrition (high-sodium foods, sugar sweetened beverages, high-fat foods, high-calorie/low nutritional value foods, low vegetable/fruit consumption); lack of physical activity; obesity; smoking/tobacco use; poor air quality; harmful alcohol use and other substance abuse.

> Inherent risk factors: risk factors that are beyond an individual's control and cannot be modified. Examples are age, family history/heredity, personal history, race/ethnicity, and exposure to chemicals or environmental pollutants.
>
> Modifiable risk factors: risk factors that can be modified. Some examples of modifiable risk factors for chronic diseases are being overweight or obese, lack of regular physical activity, unhealthy diet/poor nutrition, tobacco use, alcohol use, and other drug use.

S

School Health education: Health is a planned, sequential, Kindergarten-through-Grade-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.

SMART Objectives: Specific, measurable, achievable, relevant, and time-bound objectives. Objectives are meant to be realistic targets for the program or project. Objectives are written in an active tense and use strong verbs like plan, write, conduct, produce, etc. rather than learn, understand, feel.

Social determinants of health: The circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

Strategy: general plan of action that encompasses many activities.

Stroke: A disease in which blood flow to the brain is interrupted due to narrowed or blocked blood vessels (ischemic stroke) or because a blood vessel bursts (hemorrhagic stroke). Stroke causes the part of the brain affected to start to die, potentially resulting in death or disability. Stroke is the third leading cause of death in California. Inherent risk factors for stroke include age, family history, race, or gender. Modifiable risk factors for stroke include high blood pressure, high cholesterol, tobacco use, poor nutrition, lack of regular physical activity, being overweight or obese, alcohol and other drug abuse, uncontrolled diabetes, sickle-cell disease, other heart or arterial diseases and disorders, and heart failure.

Surveillance: The ongoing tracking of patterns of disease.

T

Ten Essential Public Health Services: The Ten Essential Public Health Services describe the public health activities that all communities should undertake. The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. The committee included representatives from U.S. Public Health Service agencies and other major public health organizations.

Public health systems should:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Threat: An indication of possible violence, harm, or danger.

Three Core Public Health Functions: The three core functions of public health, as defined by the Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine in 1988, are assessment, assurance, and policy development.

Tobacco-related cancers: these are cancers that are primarily caused from use of tobacco products, such as cigarette smoke, cigars, and chewing tobacco. Tobacco-related cancers include lung cancer, cancers of the mouth, nasal cavities, larynx, pharynx, esophagus, stomach, liver, pancreas, kidney, bladder, cervix, and certain blood cells.

Tribal: Any Indian tribe, band, nation, or other organized group or community, including any Alaskan Native Village as defined in or established pursuant to the Alaskan Native Claims Settlement Act (85 stat. 688) [43 U.S.C.A. and 1601 et seq.], that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

V

Vulnerable communities: Include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities, or combinations of these populations.

Vulnerable places: Places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

Appendix M – Acknowledgments

Thank you to:

Health and Human Services Agency
- California Department of Public Health
  - Center for Chronic Disease Prevention and Health Promotion
    - Division of Chronic Disease and Injury Control
      - California Tobacco Control Branch
      - Chronic Disease Control Branch
        - Alzheimer's Disease Program
        - California Arthritis Partnership Program
        - California Colon Cancer Control Program
        - California Community Fluoridation Program
        - California Coordinated Chronic Disease Prevention and Health Promotion Program
        - Heart Disease and Diabetes Prevention Unit (California Heart Disease and Stroke Prevention Program and California Diabetes Program, now Prevention First Program)
        - WISEWOMAN Program
      - Chronic Disease Surveillance and Research Branch
        - California Cancer Registry
        - California Comprehensive Cancer Control Program
      - Nutrition Education and Obesity Prevention Branch
        - California Obesity Prevention Program
        - School Health Connections
      - Safe and Active Communities Branch
    - Division of Environmental and Occupational Disease Control
      - Occupational Health Branch
      - Environmental Health Investigations Branch
        - California Breathing (Asthma)
        - Environmental Health Tracking Program
  - Center for Family Health
    - Maternal, Child, and Adolescent Health Division
    - Women, Infants and Children Program
  - Center for Health Care Quality
    - Licensing and Certification Program
  - Center for Health Statistics and Informatics
  - Center for Infectious Diseases
    - Division of Communicable Disease Control
      - Immunization Branch
      - Sexually Transmitted Diseases Control Branch

- Office of Health Equity
  - Health in All Policies Program
  - Climate Change Program
- Office of Quality Performance and Accreditation

California Department of Health Care Services
- Office of the Medical Director
- Office of Health Information Technology
- Every Woman Counts Program
- Mental Health Program
- Alcohol and Drug Program

Covered California

California Department of Aging

California Department of Education

California Department of Managed Health Care

California State University, Sacramento, College of Continuing Education

Emergency Services Medical Authority

Office of Statewide Health Planning and Development

Pump Handle Group

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