

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT
ADVISORY COMMITTEE MEETING

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REPORTER'S TRANSCRIPT OF PROCEEDINGS
TUESDAY, MARCH 17, 2015

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Held at:
1616 Capitol Avenue
Sacramento, California

Reported by: PHYLLIS MANK, CSR No. 5093

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1 documents. The first one is the committee members, the
2 second one was the agenda, the third is the minutes from
3 the previous meeting, the fourth are the selection
4 criteria, the fifth is the draft funding allocation from
5 the department, and the sixth is a description of the
6 programs that are funded by the department, and I think
7 those two should be kept together. Probably document
8 number two, which is the agenda, is the most important
9 trying to fit the pieces together, so it's kind of a
10 cohesive whole. If you have that document, that may be
11 the best help for you.

12 We have three action items. One is to approve
13 or not the minutes of the meeting we had previously last
14 May. The second is to approve or update the Advisory
15 Committee Selection Committee. That's document four.
16 And then the third is to approve or revise the federal
17 fiscal year 2015 funding allocation, which is document
18 number five.

19 So I want to welcome all of you. I know that
20 was a fair amount of reading, and we have done our work
21 pretty efficiently and effectively in the past using this
22 method of call in, and we'll try to keep us on track, not
23 only for time, but also in terms of the flow of the
24 conversation.

25 Also, you will have noticed that there were

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SACRAMENTO, CALIFORNIA
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4 DR. ALLES: Anita, why don't you go ahead and
5 take roll.

6 MS. BUTLER: Thank you, Dr. Alles.

7 Manal Aboelata? Are you on the phone, Manal?
8 Christy Adams?

9 MS. ADAMS: Present.

10 MS. BUTLER: Dr. Paul Glassman?

11 DR. GLASSMAN: Yes.

12 MS. BUTLER: Dr. Ira Lubell? Dr. Steve McCurdy?
13 Dr. Caroline Peck is in the room. Vicki Pinette? Dan
14 Spiess? Dr. Samuel Stratton? Dr. Wilma Wooten?

15 DR. WOOTEN: I am here.

16 MS. BUTLER: Dr. Nathan Wong? And someone else
17 joined late. Was that someone -- an Advisory Committee
18 member?

19 MS. ABOELATA: Yes. This is Manal Aboelata from
20 Prevention Institute.

21 MS. BUTLER: Thanks for joining us.

22 DR. ALLES: Welcome, Manal.

23 MS. BUTLER: I'll turn it back over to you, Dr.
24 Alles.

25 DR. ALLES: You should have received all six

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1 opportunities for public comments spread throughout the
2 agenda. That's important because we do want the public
3 from California to be able to have the opportunity to
4 comment, and I believe it's the case and it should be the
5 case that every time we offer the public the opportunity
6 for comment we want you to feel welcome, and we do it at
7 that place on the agenda so that they have an opportunity
8 to comment, not only on any of the documents, but also on
9 the comments that would have been made by the Advisory
10 Committee. They could comment to something that was
11 stated by a Committee member or some summary perhaps that
12 may have been presented.

13 So welcome. And, Caroline, it's always nice to
14 be on a call with you, and I'll see if you would welcome
15 the folks, also.

16 DR. PECK: Thank you so much, Dr. Alles. I
17 would like to welcome everyone who is here today. Our
18 Advisory Committee members, thank you so much for the
19 time you commit to helping the department allocate the
20 funds for this block grant. I also want to welcome all
21 of the program staff that are here today and are
22 available to answer questions if there are any.

23 I would like at this time to ask if we have any
24 members of the public on the phone or in the room? Okay.
25 Seeing none, thank you, Dr. Alles.

4

1 DR. ALLES: We'll continue to ask that question
2 about public comment; and if we don't hear any in a
3 moment or two after that question, then we'll assume that
4 there are still none. Has anybody else joined? I may
5 take a moment and just ask that person to identify as
6 well.

7 So the first item is the review and approval of
8 the meeting minutes from May 20 and, again, that is
9 attachment number three. I wonder -- I highlighted the
10 minutes and am prepared to read them, if necessary, but
11 you received these in time to be able to have gone
12 through them. Unless there's a request to read them,
13 I'll ask if anybody wanted to comment on any of the
14 points that were made during those minutes? Okay.
15 Hearing none, then I will ask if the public has any
16 comment related to the minutes?

17 And then we will move forward, and I will take a
18 motion and a second, see if anybody wants to make a
19 comment at that time. If not, we will take a vote and we
20 will do that by sound of the vote. If the sound is
21 close, we may need to go through a roll call, but
22 typically that doesn't happen.

23 Did somebody just join?

24 DR. LUBELL: Ira Lubell. Little technical
25 difficulty here.

5

1 DR. ALLES: I think it's age related. At least
2 for me it is.

3 MS. ABOELATA: Manal Aboelata. I move to
4 approve the minutes.

5 DR. WOOTEN: Wilma Wooten, second.

6 DR. ALLES: Any further discussion on the
7 minutes? All right. All in favor of approving the
8 minutes? Any opposed? Any abstention?

9 Did somebody else just join us?

10 DR. WONG: Hi, Wes. This is Nathan Wong. I'm
11 sorry I'm a little bit late. I was looking for the call
12 in number and it took a while to get the link or to go to
13 training to find it.

14 DR. ALLES: Welcome. We're glad you're on. I'm
15 going to say we just started before you got here.

16 DR. WONG: I may not be able to stay the whole
17 time, probably just 45 minutes, but I'll stay as long as
18 I can.

19 DR. ALLES: Thank you for joining.

20 The next agenda item is the federal fiscal year
21 2015 and '16 department update. Caroline is prepared to
22 give a presentation on that.

23 DR. PECK: Thank you, Wes.

24 DR. ALLES: This is the top of sheet number
25 four, document four that she's going to talk about.

6

1 DR. PECK: So I'm happy to report that the
2 federal fiscal year 2015 budget passed. Federal fiscal
3 year 2015 is funded at \$156.8 billion, slightly more than
4 the federal fiscal year 2014 level, and includes \$6.9
5 billion for CAC. Because of the approximately flat
6 allocation we anticipate that programs and states will be
7 funded at the same level.

8 Congress fully allocated the Affordable Care Act
9 Mandated Prevention and Public Health Fund for only the
10 second time in the program's history. As in the past
11 years, the federal fiscal year 2015 president's budget
12 proposed elimination of the block grant, but it was fully
13 restored by congress.

14 CDC is expected to provide the block grant
15 allocation to state public health agencies as in prior
16 years, but we have not yet received it. We expect to
17 have approximately \$10.5 million to use in state fiscal
18 year '15-'16, and just a note that the federal fiscal
19 year '14 notice of grant award arrived on July 2nd, 2014.
20 So that is the update for federal fiscal year 2015. So
21 although we don't have the exact number now, we
22 anticipate it will be the same.

23 DR. ALLES: Okay. I suppose that's good news.

24 DR. PECK: It's very good news. So moving to
25 federal fiscal year '16, the president's budget, again,

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1 zeroed out the block grant for federal fiscal year 2016.
2 The additional item is that there is no agreement from
3 congress on total spending as there was for federal
4 fiscal year 2014 and '15. Remember, this was negotiated
5 at the end of 2014 by Senators Ryan and Murray.

6 The other point is that the sequester resumes in
7 federal fiscal year 2016 for a total of 91 billion in
8 cuts with nondefense discretionary programs to cut 37
9 billion and the remainder cuts to be made to defense.
10 Now, this may change if congress desires to mitigate the
11 54 billion to defense programs.

12 Both houses of congress are controlled by the
13 Republicans. So based on a policy call I was on today
14 with the National Association of Chronic Disease
15 Directors, both the House and the Senate are moving
16 towards determining the allocations for the budget at
17 this time. They are also starting to work on the labor,
18 health and human services and education bill. They are
19 taking requests from members of congress, and Dr. Freiden
20 will be speaking at a hearing on March 26.

21 So we would hope to have the budget signed by
22 October 1st, 2015. But, as in prior years, it will
23 depend whether the Republicans who passed the bills and
24 the president will agree to sign-off on the budget
25 proposed. If that fails, we may have a continuing

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1 resolution, but we are always hopeful.
2 And, again, as of before, the block grant is
3 still part of the Prevention and Public Health Fund of
4 the Affordable Care Act, and that does put it somewhat at
5 risk, but any CDC reports that -- on the conversations
6 they've had with members of congress so far where they've
7 been talking about the block grant, heart disease,
8 diabetes, obesity prevention, all of the congressional
9 members have been supportive of these topics for funding.
10 So we anticipate hearing more about federal fiscal year
11 '16, hopefully by the end of the year, perhaps not until
12 next spring, and hope for a notice of grant award either
13 in spring or summer of 2016.

14 DR. ALLES: Thank you very much. I wonder if
15 any of the Committee members have a question or comment
16 that you'd like to make related to either the '15 or '16
17 federal fiscal year budget? Okay. Thank you. Any
18 public comment?

19 So then we will move to a presentation by Anita,
20 and this is what I referenced a moment ago, which is
21 actually page four, which are the selection criteria, and
22 these are things that -- these are kind of principles for
23 allocation. The top section is by the Advisory
24 Committee, the middle section is from ASTHD and the third
25 is from the department. So, Anita.

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1 be used for evidence-based programs, ensure adequate
2 reporting and accountability for use of funds, link with
3 strategic goals of the State and Healthy People 2020,
4 support capacity such as development of quality
5 improvement and performance management, and ensure that
6 health equity cuts across funded programs.

7 The last group are the CDPH selection criteria.
8 Rank priority provided by centers, public health
9 re-investment perspective, previous federal or general
10 fund cuts sustained, marginal utility, in other words,
11 more bang for the buck, availability of alternate funding
12 sources, potential to fund internally, year-end general
13 fund savings for one-time costs and incorporate in
14 distributed overhead, outcome of PHEP/HPP budget revision
15 process, input from Advisory Committee and public
16 hearing, ease of implementation in required time frame
17 and scalability.

18 DR. ALLES: I would say these have been
19 accumulated over the years and we have used these as our
20 criteria. There are a lot of them, so it gets difficult
21 to prioritize them, but I think it has been an effective
22 list that kind of draws our attention to important items.

23 First of all, I want to ask if the Committee has
24 any questions that you'd like to ask Anita about any of
25 those selection criteria? Is there anybody in the public

11

1 MS. BUTLER: Thank you, Dr. Alles. As you
2 mentioned, the very first group of criteria is based on
3 the Advisory Committee selection. The first emphasizes
4 primary and secondary prevention programs. Primary
5 prevention includes prevention of future injury among the
6 injured population. You also recommended that we fund
7 each program for at least three years, do not transfer
8 monies out of the block grant and prioritize using these
9 criteria:

10 Condition severity, size of the problem or
11 condition, equity in health status, community concern,
12 programs engage communities at the local level, the cost
13 of the condition, cost effectiveness of interventions,
14 concordance with Healthy People objectives, other
15 resources available to address the conditions,
16 performance on program metrics, the needs of EMSA should
17 be considered, innovation in areas for which there are
18 few proven interventions, ability to cross sectors and
19 disciplines, HIAP, leverage of other funds, impact of
20 terminating program, appropriate balance between
21 infrastructure versus program services, history/longevity
22 of program and reconfiguration/modification of program.
23 These aren't in any particular order.

24 The next group of criteria were from ASTHD.
25 Maintain flexibility for use of funds, encourage funds to

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1 who would like to ask a question?

2 DR. LUBELL: This is Ira. The use of these
3 funds to replace funds that were used in a previous
4 program, is there any contraindication to that when a
5 program may have been funded by some other source before
6 and, even though it fits our goals, it's now being
7 shifted into this?

8 DR. PECK: That has been a topic of discussion
9 in the past. We have said that no state funds -- or
10 these federal funds cannot be used to supplant state
11 funds, and I think there's up to 50 percent of whatever
12 the state was supporting it at the year prior. There's
13 also certain things things like we can't spend it on
14 research, direct clinical services. Is there anything
15 else I'm forgetting? But those are the two main ones.

16 DR. LUBELL: I was looking at the new program
17 and wondering if any of them had been operational before.

18 DR. PECK: Yes, they may have been operational
19 and, for example, funding may have been cut or some of
20 them are brand new, and Anita is going to get into
21 talking about the new proposed programs for this next
22 year. So we'd be happy to address that as we go through
23 each program.

24 DR. LUBELL: Thank you.

25 DR. PECK: We are also having our legal take one

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1 more look at the block grants federal statute to make
2 sure that the programs we're funding really align with
3 the federal law.

4 DR. LUBELL: Thank you very much.

5 DR. ALLES: That's a great question, Dr. Lubell.
6 Thank you.

7 Are there other questions you'd like to ask
8 about the priorities? Okay. Then is Dr. Dan Kim on the
9 call yet? Has he arrived?

10 MS. BUTLER: We were expecting him at about
11 2:30.

12 DR. ALLES: Let's see if there's any further
13 discussion. I was hoping -- I think we put it in there
14 to have further discussion after we heard from Dr. Kim.
15 He's the Chief Deputy Director and --

16 DR. PECK: Dr. Alles, may I suggest that while
17 we wait for Dan that Anita could go over in more detail
18 the programs that the Director proposes to fund this next
19 year.

20 DR. ALLES: Sure. That would be item number
21 five, right?

22 MS. ABOELATA: This is Manal. I would like to
23 make a comment or two about these. So I'm just hoping if
24 we can loop back to that when the time is right.

25 DR. ALLES: We will have some discussion and

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1 that will be an action item, so we will absolutely do
2 that.

3 DR. WOOTEN: This is Wilma, San Diego. I was
4 just looking again at the principles for allocation and
5 maybe I missed it, but is there anything on here that
6 speaks to alignment with state priorities like, Let's Get
7 Healthy California?

8 DR. PECK: Yes, it's under ASTHO recommended
9 criteria. Link with strategic goals of the state and
10 Healthy People 2020. Midway through the document, Wilma.

11 DR. WOOTEN: I see it. Thank you.

12 DR. PECK: So if we take the Let's Get Healthy
13 California task force as our strategic goals then --

14 DR. WOOTEN: I see it now. Thank you.

15 DR. ALLES: So other questions before we go to
16 the next item? So, Anita, I'll turn it back to you then
17 to give us some information on document five here.

18 MS. BUTLER: So this very first page shows the
19 seven CDPH Legacy Programs funded at 100 percent. The
20 first one is the California Active Communities, and last
21 year they were funded at 387,788 and they will be funded
22 at the same amount this year. So, in other words, that's
23 flat funding.

24 The next one is the California Community Water
25 Fluoridation Initiative, also flat funded for 215,007.

14

1 The Cardiovascular Disease Program, flat funded at
2 524,819. The Nutrition Education and Obesity Prevention
3 Program received a funding decrease this year, and their
4 allocation is 468,039, and the reduction was 117,010.

5 The Office of Health Equity, their base funding is
6 188,508, and we'll get to their augmentation a little
7 later because these are just the Legacy Programs. The
8 Preventive Medicine Residency Program and California EIS
9 fellowship received flat funding and they were augmented,
10 so the flat funding was 442,564, and we'll talk about the
11 augmentation a little later. The Safe and Active
12 Community Branch stayed the same at 244,919. Down below
13 here, PMRP/Cal EIS received a slight increase of about
14 122,000, so that's one of the programs that were
15 augmented.

16 Then the second page identifies the Black Infant
17 Health Program as being defunded, so they will not
18 receive any funds for federal fiscal year 2015, and the
19 reason why is because they received general funds. So
20 that goes to Dr. Lubell's question. So in the event that
21 programs received alternate funding, their block grant
22 funding will likely be reduced or cut altogether.

23 So this next group are the eight continuing
24 programs from federal fiscal year '14. The first one is
25 the California Health Alert Network. It would receive

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1 flat funding at 500,000. The California Wellness Plan
2 Implementation, that was funded at 600,000 last year and
3 it received a slight increase of 55,000, making the total
4 655,000 this year, and that will be --

5 DR. WOOTEN: This is Wilma, San Diego. The
6 California Health Alert Network, for 2014 it's 500,000,
7 but for 2015 it's 375. Did I miss something?

8 MS. BUTLER: Actually, it is 500. The
9 difference between the two columns is -- the 375 is what
10 we're planning to use from the federal fiscal year 2015
11 award and the difference of the 125 is what we're
12 planning to use from some level of savings from the
13 current grant or from the '16 Grant. So basically their
14 total allocation will remain flat at 500,000. The
15 difference in the two columns is how it will be
16 allocated.

17 DR. WOOTEN: Thank you.

18 DR. ALLES: They're all flat funded?

19 MS. BUTLER: Correct. Just to clarify, on the
20 Wellness Plan Implementation, the additional \$55,000 will
21 be used to partner with CCLHO and CHEAC.

22 The next one is HIV Care. That one is flat
23 funded at 500,000. Local Tribal Accreditation, flat
24 funded at \$250,000. The Office of Health Equity
25 Assessment is flat funded at 404,240. Select Agent

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1 Biosafety is flat funded at 200,000. The California
2 Active Communities Older Prevention Falls, that is funded
3 at 300,000. That is also flat funding. And Valley Fever
4 is flat funded at 426,000.

5 This next group are the five newly proposed
6 programs. The first one is Accountable Communities for
7 Health Pilot. The total funding on that is 320,000. Buil
8 the Let's Get Healthy California Website and Dashboard,
9 that's 400,000. Food and Drug Branch proposes to do some
10 food surveillance -- sampling surveillance activities and
11 that's for 200,000. Opioid Drug Prescription is funded
12 at 200,000. And the Receptor Binding Assay Program is
13 funding at 275,000.

14 Were there any questions on that?

15 DR. WOOTEN: Wilma Wooten, San Diego, again. I
16 don't see anything on accreditation.

17 MS. BUTLER: The accreditation is going to be on
18 page two of four, and it's under the continuing --

19 DR. WOOTEN: Local tribal continuing
20 accreditation, got it.

21 MS. BUTLER: Were there other questions?

22 DR. ALLES: Were you going to cover anything
23 beyond that then in the next section?

24 MS. BUTLER: I think I'd like to take a moment
25 to see if Dan has joined us. Are you on the line, Dan?

17

1 and by Legacy Programs, I mean any program that we've
2 been funding for two years or more -- also submit a
3 proposal. So what we did was review those proposals as
4 an executive committee comprised of our Committee members
5 which are Deputy Directors within all our centers.

6 We asked a number of questions and got some
7 feedback from program staff and then we kind of culled
8 down the list of proposals. We came up with roughly
9 \$11.6 million worth of approved proposals.

10 But we also understand that we only expect to
11 get \$10.5 million in our federal fiscal year 2015 award,
12 so the 11.6 is -- \$1.16 million is in excess of that
13 amount. We also recognize that we will get some federal
14 fiscal year 2016 year award. We hope to -- we anticipate
15 that will happen, but we can't fully expect that to
16 happen.

17 So what we've decided to do or propose to do is,
18 given our \$10.5 million cap, we would submit a proposal
19 where our Legacy Programs would be funded at 100 percent
20 of the amount they required previously, that any new
21 program or program that started a year ago or any
22 augmentation to an existing program would be funded at
23 the 75 percent of the amount that they requested or we
24 approved. That gets us to the \$10.5 million cap.

25 Now, during the course of the year we'll find

19

1 He just walked in.

2 DR. ALLES: Dr. Kim, welcome to our conference
3 call. I'm glad you're here today to be able to talk
4 about the department's vision.

5 MR. KIM: I wish I were Dr. Dan, but I couldn't
6 pass biology. I'm Dan Kim, Chief Deputy Director of
7 Operations, kind of filling in for the Director's Office.

8 What I was asked to do is provide an overview of
9 the process by which our department came up with our
10 block grant proposals. So if you don't mind, I'll go
11 ahead and do that.

12 One thing that we did this year that was maybe a
13 little different than other years was we required all the
14 centers to come up with proposals for the block grant,
15 and what we asked them to do was a couple things.

16 One, that we would weigh or review them based on
17 whether their purposes were consistent with the intent of
18 the federal funds. And by that, we looked at what the
19 Advisory Committee had come up with as far as criteria.
20 We also looked at what ASTHO came up with as criteria and
21 internally our own view. We also wanted to make sure
22 that whatever we did with these funds was for purposes
23 that was innovative and evidence based and we would be
24 able to determine as effective.

25 So we also requested that the Legacy Programs --

18

1 out what our actual federal fiscal year 2015 award is.

2 It may be more. It may be less. We will also be
3 reviewing our actual spending patterns because we
4 anticipate that some of the programs might be
5 under-spending and some of the programs that we've ramped
6 up may actually be spending at a rate greater than 75
7 percent and we will adjust accordingly.

8 Some other principles we came up with.
9 Generally speaking, any new program we'd like to continue
10 funding for a three-year period just to ensure that --
11 because oftentimes, if we fund it for only a year, they
12 just started to ramp up and we're not going to see a lot
13 of outcomes. If we find that a program is really not
14 that effective, we have an option to cut it.

15 Similarly, our intent is not to -- once we award
16 funds, we aren't necessarily going to consider
17 maintaining the funding level at that level. We hope
18 that some of these projects will be innovative and we can
19 find our funding sources or, otherwise, doing those
20 through our existing programs or initial state or federal
21 funding. Any questions?

22 DR. ALLES: Is there a member of the public who
23 would like to ask a question or make a comment? Okay.
24 Thank you very much, Dan.

25 MR. KIM: Thank you.

20

1 DR. ALLES: So we talked about the selection
2 criteria and we went through the proposed allocations,
3 and what I'd like to do now is to invite conversation,
4 discussions from the Committee first about the selection
5 criteria, and then this is an action item so we would
6 need to take a vote on that afterwards. I think somebody
7 had asked if we would come back to the selection
8 criteria.

9 MS. ABOELATA: This is Manal. I really was -- I
10 think, looking at the long list that we have, wondering
11 if just sort of as a matter organization we could
12 identify some broader clusters so we didn't have such a
13 big list. So, for example, I think condition severity,
14 size of the problem condition could be combined or added
15 under a cluster around prevalent or something like that.
16 Similarly, the cost ones. I think some of them -- and I
17 like that these are called principles of allocations, but
18 I think as an earlier comment indicated, maybe it wasn't
19 an earlier comment, but I think, for example, that some
20 of them are not exactly straightforward as selection
21 criteria, per se, so other resources available to address
22 the condition and leverage of other funds, could those be
23 combined together. We also talk about innovation in
24 where through -- you approve an intervention and then we
25 also talk about some things related to that work. So I

21

1 think we may want to think about clustering a little bit
2 to get a little organization in our list here.

3 DR. ALLES: That's a great suggestion. I'd ask
4 Anita and Dr. Peck if you would take a look at that and
5 see if you can come up with an organizing structure and
6 send that out maybe for review and comment.

7 DR. WONG: This is Nathan. I got a couple of
8 questions. First of all, the second item, primary
9 prevention includes prevention of future injury among the
10 injured population. Was that meant to read secondary
11 prevention instead? Because prevention of future injury
12 among injured is like prevention of recurrent heart
13 attack. It should be secondary, right?

14 DR. PECK: Yes.

15 DR. WONG: The other question I had is whether
16 geographic representation should be a criteria. That
17 doesn't seem to be listed here. Like doing a program
18 that impacts broadly among many communities in the state
19 would be preferred over a program that's just done in one
20 or two locales.

21 DR. ALLES: Can you comment on that?

22 DR. PECK: Are you talking about a statewide
23 reach?

24 DR. WONG: Yeah, more of a statewide reach as
25 opposed to something that is just doing programs in a few

22

1 communities. Sometimes we have a lot of, you know, local
2 programs done here and there by one of the funders versus
3 something that is done more widely.

4 DR. WOOTEN: I think it's universal versus
5 targeted.

6 DR. PECK: Maybe we'll cluster that together.

7 DR. WONG: And I wasn't sure if it was noted
8 somewhere else.

9 MS. ABOELATA: I thought universal versus
10 targeted was a little different than what I'm hearing in
11 this comment. This one is saying -- what I'm hearing
12 more about is that pilot is limited to similar
13 geographies. What target versus universal could, in my
14 interpretation, mean the whole state but just, for
15 example, targeted to the low income Latinos.

16 DR. WONG: Yeah, and targeted to --

17 DR. WOOTEN: It could also be geographically
18 targeted --

19 THE REPORTER: I can't tell who's speaking.

20 MS. BUTLER: Excuse me. So we have a court
21 reporter, and if you all could, before you mention your
22 comment, state your name so she can take correct notes,
23 that would be great.

24 DR. WONG: Yes. This is Nathan Wong from
25 University of California at Irvine.

23

1 MS. BUTLER: Thank you.

2 DR. PECK: So I guess I will ask you, as the
3 Advisory Committee, we're going to add a broad type of --
4 do we think we need to add something else to this list of
5 criteria or can we incorporate it in universal versus
6 targeted thinking there could be many subsets of that,
7 whether it's low income or geographic, or did you want to
8 go with explicitly calling out statewide reach?

9 DR. WOOTEN: I think the discussion ended up on
10 a statewide reach versus localized reach.

11 DR. ALLES: I think we did have previous
12 conversation in years past about that, that we want local
13 programs, we want programs that are delivered locally,
14 but that the funding would come to those communities
15 through the department for the specific purposes that are
16 identified. So by saying that -- there was an intent
17 that the reach would be statewide. And, of course, we
18 also did talk about flexibility on the part of the
19 department and it was one of the things that Anita
20 mentioned, that there could be flexibility because it may
21 require shifting of funds or there may have been other
22 funds that came in after our decision about the funding
23 allocations and the department has more current
24 information.

25 So I guess I would feel comfortable knowing that

24

1 you have in your mind what Nathan, Manal and Wilma
2 presented and that you would add that in in a way that
3 would satisfy them. So maybe after -- are you still
4 thinking about clustering them?

5 DR. PECK: Yes, we'll make an attempt.

6 DR. ALLES: If you do that, maybe send it to
7 those three and ask them if that takes care of the issue.
8 If not, then we can put it out to the entire Committee
9 and just kind of get a vote one direction or the other.
10 So for the three who spoke, does that seem like a
11 satisfactory way to handle that?

12 DR. WOOTEN: Yes. Yes.

13 MS. ABOELATA: This is Manal, and I also agree
14 yes. I do think, as you're doing that, that an eye
15 towards, is this really going to work for us as a
16 selection criteria or how do we get more specificity.
17 So, for example, one that says other resources available
18 to address the condition, I think we might want to define
19 that a little more clearly because I could imagine that
20 could be defined anyway. So I do think maybe we want
21 to -- it doesn't have to happen this year maybe, but
22 moving towards having a few words of descriptor about how
23 the committee should use these principles to make a
24 decision. So a lot of this is implied I think, but maybe
25 to get to a little more clarity we might think about, in

25

1 addition to the clustering, say something like the
2 Committee prefers X, Y and Z or looking for -- or, you
3 know, would like to elevate this condition. Because some
4 of them sound a little too neutral.

5 DR. PECK: Manal, I have a suggestion. Maybe at
6 our monthly meeting maybe we could discuss this
7 further --

8 MS. ABOELATA: I'd be happy to.

9 DR. PECK: -- just to make sure we meet your
10 needs.

11 DR. ALLES: Because of the comments that were
12 just made, I think it might be helpful actually to send
13 the changes that you make out to the whole Committee
14 asking if they feel comfortable with them. I think it's
15 probably desirable that we still take a vote today on the
16 selection criteria but with a sensitivity to the grouping
17 of things and to the comments that were made in these
18 areas. So if you would send that out -- as soon as you
19 get them done, send them out so we have a fresher
20 recollection what the issues were that were brought up.

21 Are there other comments or questions? Let me
22 ask, is there anybody from the public who joined who
23 would like to make a comment on the selection criteria?
24 Anita, when you covered the allocations, does that cover
25 the item here, priorities for fiscal year 2015

26

1 anticipated funding? Is that one in the same, or would
2 you like to add anything to what you've said?

3 MS. BUTLER: So I'd like to call your attention
4 to document number six, which is a brief description of
5 each of the programs, and basically this goes hand in
6 hand with document number five. That particular document
7 just gave the fiscal information, but this gives fiscal
8 as well as a description of the program activities. So
9 I'd just like to go through these briefly.

10 The very first program listed is the Rape
11 Prevention Program, and it receives \$832,969 as a
12 set-aside allocation and it funds programs to prevent
13 sexual violence at California's 63 rape crisis centers,
14 including 12 My Strength Clubs in local high schools.
15 These clubs address the social norms that tolerate
16 negative behaviors toward women and encourage young men
17 to be leaders in the movement to prevent sexual violence.

18 The next one is the Emergency Medical Services
19 Authority or EMSA. They receive 30 percent or 2.6
20 million of California's Block Grant allocation annually
21 after the rape prevention set-aside and the Block Grant
22 Administration are reduced from the total award. It
23 currently funds California's Emergency Medical Services
24 Authority. EMSA conducts emergency medical services for
25 children, trauma, quality improvement and Health

27

1 Information Exchange. Health Information Exchange just
2 began this last fiscal year.

3 The next one is the California Active
4 Communities Program. They receive \$387,788 to fund
5 activities that address physical inactivity and its
6 associated injuries, chronic diseases and disabilities,
7 including mobility and fall prevention for older
8 Californians and that foster environmental and policy
9 change strategies that increase opportunities for safe
10 everyday physical activity. The California Active
11 Communities implemented its Senior Falls Project last
12 year and that allocation was \$300,000, and it provides
13 funding and technical assistance to eight local health
14 departments so they may conduct Tai Chi, Moving for
15 Better Balance and Stepping On program workshops in high
16 risk communities. This funding also is to produce a
17 return on investment report to inform state and local
18 policy makers and health plans about the cost-benefit of
19 implementing these fall prevention programs in
20 California. The third thing is to conduct training on
21 universal design and older adult mobility issues among
22 local public health and government staff. So the
23 California Active Communities total budget is \$687,788.

24 The next one is the Cardiovascular Disease
25 Prevention Program. The budget is \$524,819. It's to

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1 fund measures to reduce premature death and disability
2 from the most deadly and costly health care problems,
3 health disease and stroke. CDDP program interventions
4 directly address public health objectives for heart
5 disease, stroke, heart failure, high blood pressure, high
6 cholesterol and other vascular-related disorders.

7 The next one is the California Community Water
8 Fluoridation Initiative. This is 215,000, and it's to
9 fund activities to increase the number of California
10 citizens with access to fluoridated drinking water. For
11 many years, California ranked near the bottom in the
12 nation in terms of state populations with access to
13 fluoridation. This initiative aims to reduce oral health
14 disparities among Californians.

15 The California Health Alert Network is 500,000
16 to fund the official alerting and notification systems
17 for state and local public health and funds 50 percent of
18 CAHAN system costs. This system allows information
19 sharing about urgent public health incidents with federal,
20 state and local officials, practitioners, clinicians and
21 other public health and medical stakeholders.

22 The California Wellness Plan Implementation
23 Program, including CDPH commitments made at "P21,
24 Advancing Prevention in the 21st Century," that's 655,000
25 to fund state level coordination capacity, including

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1 continued facilitated meetings with partners to advance
2 the chronic disease prevention agenda. These funds will
3 also support economic analysis capacity in the department
4 and surveillance questions associated with the Wellness
5 Plan. They received 600,000 last year, and it was
6 augmented slightly by 55,000 this year.

7 Program 8 is Re-engagement in HIV Care and
8 Partner Services Using HIV Surveillance data. This
9 500,000 will fund the third to fifth highest prevalence
10 counties, San Diego, Alameda and Orange, and it will
11 replicate the L.A. and San Francisco county programs.
12 These programs use HIV surveillance data to offer partner
13 services to all persons newly diagnosed with HIV and
14 assist people with HIV who have fallen out of care to
15 re-engage in HIV care.

16 The next one is the local Health
17 Department/Tribal Accreditation Readiness Assistance
18 Program, and this is 250,000 to fund state-level capacity
19 to provide technical assistance with local and tribal
20 health department accreditation and to improve the
21 California Performance Improvement Network website,
22 otherwise known as CalPIM.

23 The Nutrition Education and Obesity Prevention
24 Branch received 468,039 to advance evidence-based and
25 evidence-informed obesity prevention across the state.

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1 Projects include support for improved nutrition such as
2 increased fruit and vegetable consumption and reduced
3 sodium intake, and increased physical activity in local
4 communities, schools, early care and education sites,
5 work sites and at CDPH. The federal fiscal year 2015
6 allocation was decreased by a total of 117,010.

7 The Office of Health Equity received 188,508 to
8 provide the key leadership role to reduce health and
9 mental health disparities in California. In 14/15 OHE
10 received \$404,240 to conduct a Health Equity Assessment
11 to fund state level capacity to assess health equity
12 within CDPH programs. OHE's total budget is 592,748.

13 The Preventive Medicine Residency Program, Cal
14 EIS Fellowship is 565,279, and this program -- the funds
15 pay for training for California-trained, board certified
16 public health physicians. PRMP achieves this through
17 recruiting promising residents and providing them with
18 appropriate training and skills directly within local
19 health departments or state public health programs. It
20 also trains entry level epidemiologists within local and
21 state public health programs. The program received
22 442,564 last year and it was augmented by 122,715 this
23 year. That's state fiscal year 15/16.

24 The Safe and Active Communities Branch received
25 244,919 to fund programs that promote prevention of

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1 domestic violence, vehicle occupancy safety and safe
2 routes to school and injury surveillance and
3 epidemiology. The Senior Injury Prevention Project funds
4 evidence-based strategies to prevent senior falls,
5 including project evaluation, in collaboration with other
6 state entities.

7 The next one is the Select Agent and Biosafety
8 Program. They receive 200,000 to fund state-level
9 capacity to maintain the only California Tier 1 public
10 health laboratory that handles bio-threat agents, such as
11 those that cause anthrax, botulism and plague.

12 The Enhanced Laboratory Capacity to address
13 Valley Fever program received 426,000 to fund state-level
14 capacity to address drug resistance, assist local
15 communicable disease response to the outbreaks and
16 restore testing for fungal infections such as Valley
17 Fever.

18 The next group of five programs are the brand
19 new programs. The first one is the Accountable
20 Communities for Health Pilot Program. They received
21 320,000 to support the development of an assessment tool
22 to evaluate the current landscape and identify
23 Accountable Communities for Health, or ACH, or similar
24 types of projects that support the nexus of population
25 health, health insurance coverage and clinical health

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

16 The next new program is Build the Let's Get
17 Healthy Website and Dashboard. This received 400,000 to
18 lead the development and maintenance of the Let's Get
19 Healthy California Website and Dashboard on behalf of the
20 California Health and Human Services Agency. This
21 project involves coordinating with multiple departments
22 under the agency, including gathering external data and
23 working with innovative partners.

24 The Food and Drug Branch received 200,000 to
25 reinstitute the surveillance sampling of ready to eat

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1 foods such as sprouts, leafy greens, sesame seeds, nut
2 butters and other such foods that could be potentially
3 contaminated with bacterial pathogens. Over the last
4 decade, there have been numerous outbreaks and product
5 recalls due to bacterial contamination in these types of
6 products. Re-implementing the surveillance sampling,
7 especially with today's advanced lab testing technology,
8 will facilitate the identification of contaminated food
9 items before they cause an outbreak and reduce the
10 incidence of food borne illnesses. According to CDC, one
11 in six Americans, or 48 million people, get sick, 128,000
12 are hospitalized and 3,000 die of food borne diseases
13 each year. The Food and Drug Branch proposes collecting
14 500 to a thousand ready to eat samples per year for the
15 next three years and submitting them to FDLB for
16 microbial evaluation. contaminated foods that are
17 identified through lab evaluation will be embargoed and
18 FDB will work with the responsible firms, including out
19 of state food processors, to recall the products from the
20 marketplace and work with the impacted firms to ensure
21 corrective actions are taken to prevent future
22 contamination.

23 The next one is the Food Sampling Drinking Water
24 and Radiation Laboratory Branch. They received 275,000
25 to develop the Receptor Binding Assay as a humane

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1 alternative to the Mouse Bioassay for detection of
2 paralytic shellfish poisoning toxins. Funding will be
3 used to conduct a three-year pilot study of RBA
4 implementation for PSP toxin testing in California
5 shellfish. This pilot study will include systematic
6 validation work and submission of applications to the
7 Interstate Shellfish Sanitation Conference to achieve
8 regulatory cognizance and approval of the RBA. I won't
9 read the rest of this, but it is available in the
10 documents that you received earlier.

11 In the interest of time, the last one is the
12 CDPH Director's Opioid Prescription Drug Overdose
13 Workgroup. This workgroup has provided strong
14 leadership, developed a multi-agency coalition and
15 created a road map for intervention to address the opioid
16 overdose problem. This program will receive 200,000 and
17 will allow CDPH to create the programmatic infrastructure
18 to implement the proposed strategies to impact
19 prescribing policies and practices of health plans,
20 health care systems and physicians. Having a strong CDPH
21 commitment to supporting a sustainable infrastructure
22 will position us to be successful with external funding
23 requests. We are currently applying for a CDC grant and
24 this will help us support implementation of these
25 strategies at the state and in local levels. SACB will

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1 take the lead in developing the programmatic and
2 surveillance infrastructure to address the opioid
3 prescription drug overdose problem by building upon the
4 existing efforts of the Director's Work Group.

5 The remaining paragraph is just some additional
6 information. I apologize. There is one more. I take
7 that back. The Drinking Water Receptor Binding Site, I
8 already did that. That's a duplicate, and I'll revise
9 that.

10 We have program staff available to answer
11 specific questions from the Advisory Committee or the
12 public. Are there any questions? Hearing none, I'll
13 turn it over to you, Dr. Alles.

14 DR. ALLES: I have a question for the program on
15 HIV Care and Partner Services. In a way this might be
16 what Nathan, Wilma and Manal were talking about. So it's
17 funding three counties to replicate the programs in Los
18 Angeles and San Francisco. I wanted to know whether this
19 is a kind of demonstration project such that there will
20 be outcome measures that will determine whether this kind
21 of program ought to be implemented statewide then? Is
22 that the case or is it because these three counties have
23 higher than usual incidents and, therefore, they are
24 targeted?

25 MS. BROCKMAN: This is Kama Brockman with the

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1 Office of Aids. I'm the prevention surveillance
2 integration specialist, I guess, and you're right on all
3 counts. First of all, San Diego, Alameda and Orange
4 County represent the largest prevalence of people with
5 HIV after San Francisco and Los Angeles in the, I guess,
6 61 local health jurisdictions. Los Angeles and San
7 Francisco have had success with these projects because
8 they've been relatively focused on various geographic
9 areas in those counties. We wanted to see if we could
10 replicate those programs in these other counties, and
11 then once we know that we can do, that we will move this
12 project to other high and medium prevalence jurisdictions
13 outside of those five counties. So Riverside, San
14 Bernardino, other larger places, and high to medium
15 prevalence HIV programs.

16 DR. ALLES: So there would be metrics then that
17 would determine success?

18 MS. BROCKMAN: Yeah.

19 DR. ALLES: Go ahead.

20 MS. BROCKMAN: The metrics that we've
21 identified, I guess they don't show up in this
22 description, but are how many people have been re-linked
23 to care, how many people have identified partners and
24 then those partners have been notified and those partners
25 then get tested for HIV, so what is the prevalence of

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1 those partners that were tested. Typically you find, if
2 you are testing someone who has already been the partner
3 of someone who has been tested for HIV, the positivity of
4 those partners is higher than the general public HIV
5 positivity rate. So it's a way to target your resources
6 to people that you know have been -- that have been
7 engaged in high risk activity with someone who has HIV.

8 DR. ALLES: Just following up one more time,
9 these would be then the largest populated areas or among
10 the largest which would leave a lot of counties that are
11 more suburban -- I'm particularly interested in the more
12 rural counties, and I wonder if there's a plan that would
13 take what's known from the demonstration projects and
14 identify modifications that might need to be made that
15 could be done perhaps with the assistance of the county
16 public health director to speak for kind of a different
17 paradigm, or is it the case that the paradigm of size of
18 the population or population density is less important
19 than the products that were delivered or the programs
20 that were delivered in the largest counties.

21 MS. BROCKMAN: Well, it is somewhat of a paradox
22 that it's easier to keep track in the smaller counties, a
23 medium or lower prevalence county through the
24 surveillance program, who is in care and who is receiving
25 and who, say, has a new STD diagnosis because you just

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1 have fewer people in these larger counties. It's more
2 difficult to do that because you're just -- you just have
3 more people with HIV there. But we will be using what we
4 learn from these larger counties -- and this prevention
5 surveillance integration is an ongoing project of the
6 Office of Aids and so we're not just doing this project
7 in these three counties and waiting for the information
8 to come back from that before we're working with medium
9 or lower prevalence counties. We're working with them
10 all at the same time. We think the things we learn from
11 San Diego, Alameda and Orange and, obviously, Los Angeles
12 and San Francisco as well, will help make this kind of
13 case finding more robust for us and all the local health
14 jurisdictions.

15 DR. ALLES: Great response. I wonder for the
16 folks who raised the issue about targeting versus
17 statewide, would this fall within the construct or would
18 it violate the construct that you were raising earlier?
19 Wilma, do you want to start on that?

20 DR. WOOTEN: I'm sorry. What's the question
21 again?

22 DR. ALLES: The issue about targeting the
23 counties or targeting areas and part of it had to do with
24 geography versus statewide initiatives, the responses
25 that were given. My question is, are you comfortable, in

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1 essence, in the design of the program and the allocation
2 of the funds for the program based on the comments that
3 the three of them made?

4 DR. WOOTEN: Absolutely, for many reasons, and
5 it's probably obvious. But, yes, just from a nonbiased
6 standpoint, the rationale for that allocation makes
7 sense. And as you stated, once the demonstration
8 project, thinking about the HIV project, focused on those
9 three jurisdictions where the prevalence of HIV is
10 highest next behind Los Angeles and San Francisco, that
11 allocation makes sense to me with the understanding that
12 in future years there will be funding based on what's
13 learned from these projects that are disseminated or
14 allocated to other jurisdictions.

15 DR. ALLES: Thank you. Manal.

16 MS. ABOELATA: This is Manal. To me, this
17 really highlights how it would be so helpful to say
18 something like, you know, the committee aims to have
19 statewide impact in cases -- and then maybe a subpoint on
20 geographic targeting -- in cases where, you know, for
21 whatever reasons the resources are limited, the need for
22 targeting because of phase approach based on prevalence
23 is needed, the expectation of the committee and where the
24 block grant is, that where appropriate there is a process
25 for learning and bringing to scale, I think that this

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1 makes sense and speaks to me about how we might refine
2 our criteria to begin to get at when we make a decision
3 for this reason where we're going with that.

4 DR. ALLES: Thank you. Nathan. Nathan may have
5 dropped off.

6 DR. WONG: I'm sorry. I forgot to take it off
7 of mute. I totally agree on the last two comments that
8 were made and certainly appropriate justification, all
9 those things need to be considered. I think in this case
10 it certainly makes a lot of sense.

11 DR. ALLES: So let me ask if there are other
12 questions or comments that you want to make either on
13 document five, which is the proposed allocations, or upon
14 the description that was presented by Anita.

15 DR. GLASSMAN: This is Paul Glassman. I'd like
16 to ask a couple questions about the community water
17 fluoridation.

18 DR. ALLES: Go ahead.

19 DR. GLASSMAN: The first one is, I'm a little
20 concerned about the funding going to Community Water
21 Fluoridation. The reason I'm asking it is I know that in
22 the governor's budgets they restored a long dormant
23 position of a State Dental Director. I'm wondering if
24 anyone there can assure me that this money that has been
25 used for Community Water Fluoridation is not going to go

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1 to -- some of it to support the position of State Dental
2 Director but going to go with the Community Water
3 Fluoridation Committee?

4 DR. PECK: This is Caroline. I'll respond.
5 This funding primarily supports Roseanna Jackson who will
6 continue to work on Community Water Fluoridation, and so
7 the intent is this money will remain for those
8 activities.

9 DR. GLASSMAN: Okay. The second question is a
10 little bit similar, slightly different version of it,
11 which is that I'm concerned about what's happening in
12 many states across the country where community water
13 fluoridation is under attack, the anti-fluoridationists
14 have changed tactics from trying to block new cities from
15 being fluoridated to going back to cities previously
16 fluoridated and trying to undo that. That seems to be
17 picking up steam in California. There have been
18 contracts that have been very useful for a long time in
19 helping to support local communities in providing
20 information and education and advice about dealing with
21 new implementation and also go back activities. I wonder
22 if I could also be assured that that contract will be
23 able to continue in a system which is -- the efforts are
24 getting more expensive and funding is flat.

25 DR. PECK: That may be problematic. As you

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1 know, the water fluoridation allocation was cut several
2 years back during the decreases and was never augmented.
3 So we are functioning at a lower level right now and the
4 UCSF contract has been very useful, and it's possible --
5 we do want to continue that, but it may not be possible.
6 Given that the Dental Director may be coming on or take
7 on some of those roles or release Roseanna to spend 100
8 percent of her time on fluoridation, we'll just have to
9 see what the budget is. But we will take that into
10 consideration that you feel strongly about it.

11 DR. GLASSMAN: Just to add, I think this is
12 something, I'm sure you're well aware but maybe for the
13 rest of the committee, I think that the description said
14 that California used to be near the bottom in water
15 fluoridation supply, but you could read that as saying
16 we're doing really well, but we're not doing well.

17 We've got a long way to go under a reduced
18 budget, a huge state. So I'm concerned that that
19 funding -- it seems great to not be losing funding, but
20 in a situation where we're doing so poorly and things are
21 getting more expensive and the attacks are sort of
22 picking up steam, I would urge the department to look for
23 ways to be able to augment the fluoridation activity.

24 DR. PECK: We'll throw our hat in the ring this
25 time next year. We'll convey what you're saying right

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1 now regarding this allocation, but definitely for the
2 next year's allocation we will put in for more money to
3 go with fluoridation. I think the real benefit I see
4 from this additional money from the state general fund is
5 that Roseanna right now has been doing everything,
6 including water fluoridation, and now she will be able to
7 focus 100 percent on that once our new staff comes on
8 board. It's a huge issue. We're only at 64 percent
9 right now. It's a big issue for California.

10 DR. GLASSMAN: And the bottom third of the
11 states across the country.

12 DR. PECK: Do you have a recommendation for
13 funding amounts you would want to bring back to our
14 Director's Office?

15 DR. GLASSMAN: I think you'd have to ask at the
16 staff level. I assume Roseanna is the person most
17 closely tied to the amount of a lot of the activities to
18 be sustained. I'm concerned about the issue getting more
19 complicated and California is behind, and I'm concerned
20 flat funding is not going to be adequate to do anything.
21 So I don't have a specific number, no.

22 DR. PECK: That's fine. I'll talk with
23 Roseanna. We'll come up with a number. Thanks,
24 Dr. Glassman.

25 DR. ALLES: Thank you very much. To your first

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1 question about taking money out of the block grant and
2 the possibility or potential of sending that to the new
3 position that's funded out of general fund, that actually
4 would violate one of the principles that we've had, which
5 is that the money should be directed towards programs
6 that are within the block grant. So I'm happy that you
7 asked the question and I'm especially happy that the
8 answer came back the way it did.

9 DR. GLASSMAN: Thank you.

10 DR. ALLES: Are there other questions or
11 comments you want to make about any of the programs that
12 were described to us? Let me then -- we have two action
13 items. One is the selection criteria and one is the
14 anticipated funding. I think I need to do those
15 separately.

16 Let's go back to the selection criteria. Is
17 there any more comment on the selection criteria from the
18 committee? Is there any comment from the public related
19 to the selection criteria? Then I would entertain a
20 motion and a second to accept the recommendations about
21 the selection criteria from the three sources that were
22 designated. May I have a motion.

23 DR. WOOTEN: So moved.

24 DR. WONG: I'll second it. This is Nathan.

25 DR. ALLES: All in favor of the approval of the

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1 motion to accept the selection criteria indicate by
2 saying aye. Any opposed? Any abstain?
3 The second item then for action is the
4 anticipated funding. This is the conversation that we
5 just had, and I'd like to get a motion and a second to
6 approve the anticipated funding amounts and say that I'd
7 like it particularly noted about the fluoridation program
8 so that that's clear. And part of my bringing that back
9 up is the notion that Dr. Glassman presented that it does
10 give the impression that we're doing much better now and
11 that's not the case, so we kind of want to reflect that.

12 Can I get a motion to approve the recommended allocation?

13 DR. WOOTEN: Wilma Wooten, San Diego, so moved.

14 I have to get off after this vote.

15 MS. ADAMS: Christy Adams. I second.

16 DR. ALLES: All in favor please indicate by
17 saying aye. Any opposition? Any abstain? I also should
18 ask if there's public comment on either of these two
19 matters. I asked earlier, but I said I would come back
20 to it.

21 The final agenda item is Advisory Committee
22 recommendations to CDPH. Does any member of the
23 Committee want to make a comment to the department?
24 Okay. Is there a public comment? Hearing none, then I
25 will take a motion and a second -- let me just ask,

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1 Caroline, is there something you were hoping to come back
2 to or something you wanted to say to the committee?

3 DR. PECK: No. Thank you very much for joining
4 us and thank you to all the program staff that joined us
5 today ready to answer questions. We appreciate you all
6 continuing to be a part of this and helping guide the
7 department as we make decisions about how to allocate the
8 funds. So thank you and thank you, Dr. Alles.

9 DR. ALLES: You're welcome. I'll take a motion
10 and second to adjourn.

11 DR. WONG: I move that we adjourn.

12 MS. ADAMS: Christy Adams, and I'll second that.

13 DR. ALLES: All in favor, aye? Anybody opposed?
14 Abstention? Thank you all very much. Nice to reconnect
15 with all of you and we'll be back together again.

16 When is our next one scheduled, Anita? Maybe
17 not specifically. Is it next year this time or something
18 in the meantime?

19 MS. BUTLER: We'll have something in the
20 meantime. We'll be meeting again sometime in May, and at
21 that time we'll be talking about approving the state
22 plan.

23 DR. ALLES: Okay. Great. Thank you very much.

24 (Proceedings concluded at 3:25 p.m.)

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1 REPORTER'S CERTIFICATE

2
3 STATE OF CALIFORNIA)
4 COUNTY OF SACRAMENTO) ss.

5

6

7 I, PHYLLIS MANK, CSR, hereby certify that I was
8 duly appointed and qualified to take the foregoing
9 matter;

10 That acting as such reporter, I took down in
11 stenotype notes the testimony given and proceedings had;

12 That I thereafter transcribed said shorthand
13 notes into typewritten longhand, the above and foregoing
14 pages being a full, true and correct transcription of the
15 testimony given and proceedings had.

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PHYLLIS MANK, CSR No. 5093

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