Preventive Health and Health Services Block Grant

Revision for Additional Funding for Federal Fiscal Year 2014

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Executive Summary

This is California's application for Preventive Health and Health Services Block Grant (PHHSBG) funds for federal fiscal year (FFY) 2014 (October 2013 through September 2014). The Federal Government administers PHHSBG funds in accordance with the Public Health Service Act, Sections 1901–1907, as amended in October 1992, and Section 1910(a), as amended in October 1996. These funds are distributed to the Emergency Medical Services Authority (EMSA) and the California Department of Public Health (CDPH), with CDPH serving as lead.

Background

In 1900, chronic diseases and injuries accounted for one-third of the deaths in the United States, and communicable diseases were the leading cause of death. Over the last century, chronic disease and injuries have gone from causing approximately one-third of all deaths to causing approximately two-thirds of all deaths, taking over from communicable diseases as the leading cause of death. The leading killers in California are heart disease, cancer, and stroke, to which hypertension, diabetes, and obesity are often precursors and are driven by common risk factors.

Traditionally, health promotion and prevention interventions (primary prevention), such as modifying sedentary lifestyles, improving nutrition, reducing the use of tobacco, and facilitating policy change to reduce the risk of these leading killers, have received less attention and funding than medical care to patients who have already been diagnosed with an illness. The impacts of the environment, including services such as transportation, housing, and education, have now been shown to play a significant role in the burden of chronic disease.

A recent initiative, the California Wellness Plan (CWP), has been developed by CDPH staff and external partners of the CDPH PHHSBG funded programs. These programs will be critical to the implementation of the CWP objectives, which is detailed in each funded program.

Within California, and indeed nationally, PHHSBG funds are used to address chronic diseases and injuries for which limited funds exist, given the magnitude of the health and fiscal burden or disease. These allotments address invaluable, strategic programs designed to effectively:

- Prevent deaths and disabilities from chronic diseases, such as cardiovascular disease and cancer, through public health interventions such as promoting healthy nutrition, physical activity, and environmental policy changes;
- Prevent deaths from cancer through risk-reduction programs;
- Prevent deaths and disabilities through injury prevention and policy change;
- Prevent deaths and disabilities by providing quality pre-hospital emergency medical care;

- Prevent dental caries by fluoridation of the community water supply;
- Improve public health infrastructure by supporting the development of the professional public health workforce;
- Address health equity using a health-in-all-policies approach;
- Ensure preparedness by effective health information exchange during urgent public health incidences via health alerting messaging;
- Address health disparities and prevent death and disability from human immunodeficiency virus (HIV) through early detection, treatment and partner services;
- Improve public health infrastructure by supporting local and tribal public health agency accreditation and quality improvement;
- Improve equity in health and well-being by implementing the California Wellness Plan, the statewide chronic disease prevention plan for California;
- Improve public health infrastructure by enhancing laboratory and epidemiology capacity to address Valley Fever and other Emerging Diseases;
- Improve public health infrastructure by enhancing Select Agent Laboratory Capacity and Biosafety; and,
- Prevent and reduce fetal and infant deaths and preterm births and promote health equity by developing a strategic communications plan to increase enrollment and retention in the local Black Infant Health (BIH) Programs.

EMSA uses PHHSGBG funds to promote the development and maintenance of Emergency Medical Services (EMS) systems in California.

Within EMS, PHHSBG funds eight programs that assist local EMS agencies (LEMSAs) in ensuring that the EMS systems:

- Are easily accessible and available to all persons needing emergency care;
- Include a comprehensive range of services;
- Provide high-quality care;
- Have an efficient and cost-effective management structure;
- Provide public education and information;
- Are responsive to local needs;
- Provide for the coordination of medical mutual aid at local, regional, state, and federal levels in the event of a disaster; and,
- Prevent deaths and disabilities by providing quality pre-hospital emergency medical care.

The Rape Prevention Set-Aside line item is specifically earmarked for primary prevention of sexual violence. In California, these funds are used for:
(1) implementation of comprehensive community-based primary prevention strategies (e.g., social norms change, bystander engagement, coalition building);
(2) implementation of *MyStrength Clubs*, an evidence-based program that takes young men, ages 14 to 18, through a multi-session curriculum to promote bystander

involvement, individual attitude and behavior change, and social climate change in local high schools; and, (3) dissemination of rape prevention information.

Within CDPH, PHHSBG now funds fifteen programs that address chronic disease and injuries, strengthen California's public health infrastructure and preparedness, and address health equity using a health-in-all-policies approach. Using PHHSBG funds as seed money, these programs have leveraged an additional $106.7 million over the past five years, greatly enhancing chronic disease and injury control efforts in this State.

The Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC), the federal agency responsible for the administration of the PHHSBG, requires a specified format for its electronic submission. In December 2012, CDC updated the Block Grant Management Information System (BGMIS) and replaced the *Healthy People 2010* (*HP 2010*) Objectives with the *Healthy People 2020* (*HP 2020*) Objectives.

In April 2009, CDC reviewed California's compliance with the statutory provisions of the PHHSBG. The resulting report indicated that California's PHHSBG is in compliance with the statutory provisions of the PHHSBG. They determined that California's public health programs seem to be appropriately and effectively applying the PHHSBG funds to bring about a positive public health impact. They also determined that the programs have been extremely successful in leveraging other funds due to the PHHSBG funding and its flexibility.

CDC asked that California's EMSA program provide to CDC a five-page report describing its major accomplishments since it first received PHHSBG funding. Furthermore, CDC found that CDPH appropriately completes its reporting requirements, including annual work plans, annual progress reports, and success stories. They also noted that the State's Block Grant Coordinator and other staff have been engaged in Block Grant activities at the national level and have provided constructive feedback to help in various national Block Grant activities.

Federal Preventive Health and Health Services Block Grant Awards and State Fiscal Year Budgets

The annual PHHSBG state fiscal year (SFY) budget is established by using two applicable FFY grant awards (i.e., 25 percent of the prior FFY award, ending September 30, coupled with 75 percent of the new FFY award, beginning October 1 of each year).

Since the inception of the PHHSBG in 1982, CDPH has pooled the prior year's unspent funds (Reserve) from programs. These pooled funds have been used to expand or establish new programs in years of fiscal largesse or to mitigate the effect of award reductions in leaner years. Since 1995, CDPH has been able to mitigate

federal reductions through the judicious use of the pooled prior year's unspent program funds.

However, by FFY 2003, the Reserve funds had been depleted, and it became necessary to reduce the program by $1.4 million. The PHHSBG Advisory Committee (AC) was integrally involved in recommending to the Director how the $1.4 million in CDPH program reductions should be made. CDPH finalized a difficult decision process and implemented the necessary reductions, choosing to reduce all CDPH programs by 20 percent. The decision reflected the preference of CDPH to retain all of the important chronic disease and injury control programs that are funded by the PHHSBG, albeit at a reduced level.

In FFY 2004, the award was reduced from $9,346,614 to $9,318,578.

In FFY 2005 the award was reduced to $8,377,629.

In FFY 2006, although the President's budget had initially eliminated the PHHSBG entirely, Congress reinstated it at the $100 million level (with a one percent rescission), resulting in a national appropriation of $99 million. California's share of this allocation was $6,820,205. Thus, the PHHSBG suffered an additional 20 percent reduction from the prior year. After consultation with the federally mandated AC, CDPH revised its program allocations, placed limitations on hiring and expenditures, eliminated seven CDPH programs altogether, and redirected three defunded staff to other programs. These programs were eliminated:

- Epidemiology and Health Promotion Section;
- Chronic Disease Epidemiology and Control Section;
- Medicine and Public Health Section;
- Health Incentive Program;
- Epidemiology and Program Evaluation Unit;
- Integrating Medicine and Public Health Program; and
- Continuing Professional Education Program (as part of the reductions in the allocation to the Program Development Section training programs).

The loss of these programs meant that the medical leadership for the Epidemiology and Health Promotion and Medicine and Public Health Sections had to be eliminated. Senior research scientists who provided direction to the Chronic Disease Epidemiology and Control Section and the Epidemiology and Program Evaluation Unit were lost, as was the chronic disease epidemiology capacity. The entire Integrating Medicine and Public Health Program was eliminated, as was a small amount of funding each local health department (LDH) received to help them meet the *HP 2010* Objectives. Funding for the provision of continuing education to public health medical, nursing, pharmacy, dental, health education, laboratory, and other public health staff also had to be eliminated. Thus, an economical source of

Continuing Medical Education credits no longer exists since the eliminated Continuing Professional Education Program provided this service.

Although the President's 2007 proposed budget again eliminated the PHHSBG entirely, both the Senate and House Appropriations Subcommittees reinstated funding for the PHHSBG at the 2006 level. As a result of this action, program funding remained stable.

When Congress finalized the federal budget for FFY 2008, the final allocation was $6,730,544 ($116,841 less than FFY 2007).

Due to rising costs, the reduction in the federal appropriation, and the continued need to draw on Reserve funds, it was necessary to eliminate two additional programs from the list of CDPH programs receiving PHHSBG funds. Therefore, in SFY 2008–09, the Skin Cancer Prevention Program, Worksite Wellness Program, and Cal EIS Program funding unfortunately had to be eliminated. The Cal EIS program was incorporated into the Preventive Medicine Residency Program.

In late FFY 2009 (June), CDC notified California that it would receive $295,675 in addition to its preliminary award of $6,730,544. Since this notice was received so late, California decided to carry over the $295,675 to FFY 2010. Therefore, California's preliminary budget for FFY 2010 was $7,247,975. In FFY 2009, Congress mandated that to receive PHHSBG funds, all states would be required to submit a Healthcare Associated Infections Plan by January 1, 2010. The Division of Communicable Disease Control was responsible for submitting this plan to CDC for California and did so on December 30, 2009.

Congress finalized the FFY 2011 budget in April 2011, and reduced CDC's FFY 2011 budget by $740 million. CDC finalized the California FFY 2011 PHHSBG allocation on June 13, 2011, a 23 percent reduction from the FFY 2010 allocation. To accommodate the mid-year FFY 2011 reductions, the PHHSBG administration allocated Reserve funds from prior years and did not need to make program budget reductions for SFY 2010–11.

The FFY 2012 budget was passed by Congress and signed by the President in December 2011. Congress funded the PHHSBG at the same level as FFY 2011; however CDC reduced the FFY 2012 California allocation by $414,355. Since the program spends the allocation based on the state fiscal year, the revised SFY 2011–12 PHHSBG budget was reduced to a total of $5,119,201. The final program allocations reflect this change. On June 6, 2012, CDC augmented California's award by $225,000. On August 31, 2012, CDC augmented California's award by $65,528. The final FFY 2012 allocation was $5,306,140. The augmentations received after June 30, 2012, were carried over and placed into the SFY 2012–13 allocations and distributed to the programs in SFY 2012–13.

CDPH PHHSBG program management worked hard to keep the programs going for SFY 2012–13 in spite of the lack of a federal budget. Thus, as a result of guidance from the Director's Office, all eight CDPH programs were nevertheless funded at the SFY 2011–12 levels through December 2012, using the FFY 2012 funds and Reserve funds for SFY 2012–13.

For FFY 2013, Congress issued two Continuing Resolutions (CRs). CDC began accepting FFY 2013 work plans once an updated version of the BGMIS was completed and made available to states. On April 23, 2013, CDC awarded California $4,736,764; on June 20, 2013, an additional $301,355 was awarded, for a total of $5,038,119.

In FFY 2014, the President again zeroed out the PHHSBG from the federal budget. However, Congress doubled the PHHSBG in FFY2014 at the national level, from $79M to $160M. CDC, which had originally notified California of a $4.7M preliminary allocation, revised the preliminary allocation to $9.7M in Spring 2014. The California Department of Public Health conducted a process for stakeholders to give input, including soliciting proposals from throughout the Department, an Advisory Committee meeting, a Public Hearing and a presentation to the Legislature Budget Committee. The Department added seven new programs and augmented two programs (California Active Communities and Office of Health Equity), and EMSA added one new program [STEMI (ST-segment Elevation Myocardial Infarction) and Stroke Systems]; EMSA previously discontinued the Personnel Standards Program.

Funding by State Fiscal Year

The table below outlines the fiscal history of the PHHSBG allocations for programs from FFY 2009 (SFY 2009–10) through preliminary FFY 2014 (SFY 2013–14) by state fiscal year (SFY), which is calculated by using two applicable federal fiscal year (FFY) grant awards (i.e., 25 percent of the prior FFY award beginning July 1 through September 30, coupled with 75 percent of the new FFY award, effective October 1 through June 30 of each year).

PHHSBG Allocations to CDPH and EMSA
SFY 2009–10 through SFY 2013–14

Award	SFY 2009–10	SFY 2010–11	SFY 2011–12	SFY 2012–13	SFY 2013–14
Total	*$7,247,979	**$5,756,783	***$5,119,201	****$5,097,004	*****$6,023,335
CDPH	4,492,969	3,449,135	3,000,362	2,984,825	3,066,336
EMSA	1,925,558	1,478,201	1,285,870	1,279,211	1,687,721
Rape Set-Aside	829,448	829,448	832,969	832,969	1,218,877

* In SFY 2009–10, California's initial award for FFY 2009 was $6,730,544. Toward the end of FFY 2009, California was awarded an additional $295,675. Because the notice of the additional funds was received so late in the state fiscal year, CDPH and EMSA carried over these funds to SFY 2009–2010. Therefore, the final grant award available for SFY 2009–10 consisted of 25 percent of the FFY 2009 preliminary award of $6,730,544, plus 75 percent of the preliminary FFY 2010 award of $7,026,219, plus $295,675 carried over from FFY 2009, for a total of $7,247,975.

** In SFY 2010–11, California's preliminary award for FFY 2010 was $7,026,219. Toward the end of the year, California's award was reduced by $72,247, resulting in a revised award of $6,953,972. Because the notification was received late in the budget year, the reduction was carried over into the following year.

Therefore, a reduction of $54,185 was taken from the SFY 2009–10 allocation, based on 75 percent of the difference between the preliminary and final awards issued for FFY 2010 [0.75(7,026,219–6,953,972)]. As a result, the final grant award was equal to $1,738,593, minus the $54,185 reduction, plus 75 percent of the preliminary FFY 2011 award of $6,953,972, for a total allocation for SFY 2010–11 of $6,899,787.

Congress finalized the FFY 2011 budget in April 2011 and reduced CDC's FY 2011 budget by $740 million. CDC finalized the California FFY 2011 PHHSBG allocation on June 13, 2011, a 23-percent reduction from the FFY 2010 allocation. To accommodate the mid-year FFY 2011 reductions, the PHHSBG administration allocated Reserve from prior years and did not need to make program budget reductions for SFY 2010–11.

*** In SFY 2011–12, the final grant amount available consisted of 25 percent of the FFY 2011 award of $5,429,967, plus 75 percent of the FFY 2012 allocation of $5,015,612, for a total of $5,119,201.

**** For SFY 2012–13, Preliminary Allocation memos were distributed for the first six months of SFY 2012–13 (through December 2012) but funded at the SFY 2011–12 levels. Funding consisted of 25 percent of the FFY 2012 draft final award of $5,015,612, plus 75 percent of the FFY 2013 award, including the funds received after June 2012. These funds included $225,000, plus $65,528 received late in the year, for a total of $5,097,004.

***** The SFY 2013–14 budget was built using 25 percent of the FFY 2013 allocation of $4,736,764 ($1,184,191), plus $301,355 (increase received on June 20, 2013). The FFY 2012 Reserve of $1,604,174, plus FFY 2013

Reserve of $2,933,615, were then added, for a total of $6,023,335.

Ordinarily, the SFY 2013–14 budgets would have included 75 percent of the anticipated FFY 2014 appropriation. California cannot depend on a PHHSBG Congressional appropriation for FFY 2014. Therefore, the FFY 2012 Reserve of $1,604,174 and FFY 2013 Reserve of $2,933,615 are being used to fund the preliminary SFY 2013–14 allocations for CDPH, EMSA, and Rape. The allocations for EMSA and Rape set-aside include reserve from prior years.

The California Preventive Health and Health Services Block Grant Advisory Committee

As established by the Public Health Services Act, Section 1905(d), the AC makes recommendations to the Director of CDPH regarding the development and implementation of the State Plan.

The AC recommends PHHSBG funding of programs committed to reducing the burden of the leading causes of death and disability by emphasizing effective prevention strategies. One responsibility of the AC is to recommend program priorities to the Director for the purpose of determining program allocations, particularly when federal allocations to states have been reduced. After a careful review of each of the programs, the AC has determined program priorities, with the understanding that, when necessary, funding reductions of programs would occur by reducing allocations of the lowest-priority programs.

At its meeting in August 2005, in response to the 25 percent FFY 2006 funding reduction, the AC recommended the reconfiguration of programs within the Division of Chronic Disease and Injury Control into primary and secondary prevention programs, the overall reduction of most programs by 25 percent, and the elimination of seven CDPH programs (see list above, pp. 5–6). (Programs having only one full-time-equivalent [FTE] position did not suffer the 25 percent reduction).

In January 2012, in anticipation of program reductions, the AC met to review program priorities. The Chief of the Center for Chronic Disease Prevention and Health Promotion addressed the AC at its meeting to give her vision of Chronic Disease and Injury Prevention Programs, so AC members could consider her vision in making its final recommendations.

The Chief of the Center for Chronic Disease Prevention and Health Promotion prepared her own list of priorities. Following is her prioritization:

1. Prevention 2010;
2. Community Water Fluoridation Initiative;
3. Safe and Active Communities Branch;
4. CA Project LEAN;
5. CA Heart Disease and Stroke Prevention Program;
6. CA Active Communities;
7. Preventive Medicine Residency/Cal-EIS;
8. Healthy Cities and Communities;
9. Office of Multicultural Health (Effective July 2013, this program became part of a new Office of Health Equity [OHE] in CDPH).

In March 2012, the after a careful review of the programs, the AC continued the work it started in January 2012, and updated its program priorities:

1. Prevention 2010 (Administrative Overhead);
2. California Community Fluoridation Initiative;
3. Preventive Medicine Residency Program/Cal-EIS;
4. Safe and Active Communities Branch;
5. California Project LEAN;
6. California Heart Disease and Stroke Prevention Program;
7. California Active Communities;
8. California Healthy Cities and Communities;
9. Office of Health Equity (previously the Office of Multicultural Health).

An Options Memo was finalized and sent to the Director's Office with three options, in anticipation of a final Congressional/CDC decision: (1) Proportional cuts to programs, (2) Reductions based on AC priorities, and (3) Reductions based on the Center Chief's prioritization. The Department Director's Office determined that the PHHSBG programs would not assume additional cuts for FFY 2012, and programs would continue with the same funding level as SFY 2011–12.

In FFY 2014, the Healthy Cities and Communities program was removed from the list of programs funded by California's PHHSBG funds. This program was implemented using contract employees. However, due to Government Code 19130, programs could not use contract employees in place of state employees. Therefore, during the July 10, 2013 AC teleconference, the $176,435 previously allocated for Healthy Cities and Communities was equally distributed to the three programs receiving the least amount of PHHSBG funding—California Community Water Fluoridation Program, the Office of Health Equity, and the Safe and Active Communities Branch.

As discussed previously, with the increase in FFY2014 California allocation, 7 new programs were funded and 2 programs were allowed increases by CDPH, and one new program was funded by EMSA. Fourteen of the sixteen existing programs were kept at the same funding levels.

Synopsis of the State Plan and Application

The content of the FFY 2014 (SFY 2013–14) State Plan consists of California's PHHSBG process, policies, and procedures, followed by a description of current programs funded with PHHSBG funds that coincide with the *HP 2020* Focus Areas.

A brief synopsis of the State Plan follows:

Chapter I, entitled "Administration, Grant Amounts, State Provisions, Grant Application," briefly describes the administration, funding, and CDC requirements of the Grant. In California, CDPH administers the Grant in cooperation with EMSA.

Chapter II, entitled "The California PHHSBG Advisory Committee and the Public Hearing Process," describes the AC and public hearing process, as required by the amended Public Health Service Act as implemented in California. Also described is a revised summary of the principles, as accepted by the AC on October 1, 2008. Review of the principles assures that programs appropriately address the Topic Areas in *HP 2020*.

Chapter III, entitled "Application of the Principles Accepted by the Advisory Committee to the 42 Healthy People 2020 Topic Areas," summarizes the basis for deciding which *HP 2020* Topic Areas receive California's PHHSBG funds.

Chapter IV, entitled "State Programs to Address Objectives within 16 Selected HP 2020 Topic Areas," links the *HP 2020* topic area to California's PHHSBG-funded program by name.

Chapter V, entitled "Programs, Health Objectives, and the Four Domains," includes, using the format required by CDC, a description of all programs funded by the PHHSBG, and specifically identifies which National Health Objective(s) and which CDC Domains the program addresses. In addition, State Health Objectives, Target Populations, and Objectives are included. At the end of each program description, a program profile summarizes how much money is allocated to each national health objective, and how many state staff members work on the program.

If you have any questions regarding the PHHSBG State Plan, please contact Anita Butler, Preventive Health and Health Services Block Grant Coordinator, or Caroline Peck, M.D., M.P.H., Chief, Chronic Disease Control Branch, at (916) 552-9900.

I. ADMINISTRATION, GRANT AMOUNTS, STATE PROVISIONS, GRANT APPLICATION

A. Administration of the Grant: Two Departments

CDPH is the lead Department for disease prevention in California. As such, CDPH is committed to reducing the occurrence of preventable diseases, disabilities, and premature death among California's citizens; closing the gaps in health status and access to care among the State's diverse population subgroups; and building and fostering strong partnerships for health with 61 local health departments (LDHs) and other public and private agencies, with community-based organizations, providers, consumers, educational and academic institutions, and other interested groups.

The goals of CDPH include:

- Achieve health equity and eliminate health disparities;
- Prepare for, respond to, and recover from emerging public health threats and emergencies;
- Improve quality and availability of data to inform public health decision-making;
- Promote quality of workforce and the workplace environment;
- Improve effectiveness of business functions.

EMSA was established in 1981 (Division 2.5 of the Health and Safety Code) with a general mandate to develop a statewide system of coordinated emergency medical services. Prior to 1980, the responsibility for emergency medical services and disaster medical preparedness was spread among a variety of state departments. It became clear, however, that a more unified approach to emergency and disaster medical services was needed. This legislation was the culmination of several years of effort by local administrators, health care providers, consumer groups, and legislators to establish a state lead agency and centralized resource to deal with emergency and disaster medical services.

B. Grant Amounts and Split-Funding

The Public Health Service Act, Title XIX, Part A, Sections 1901–1907, and Section 1904(A) reauthorized the PHHSBG Program through 2002.

The annual budget is established by split-funding each state fiscal year expenditure authority by using two applicable FFY grant awards (i.e., approximately 25 percent of the prior FFY award, ending September 30, coupled with approximately 75 percent of the new FFY award, effective October 1 of each year). In the event that not all funds are expended, CDPH has adopted the policy of maintaining these funds until such time that they are needed. However, due to small reductions in the federal award, these funds are diminishing, leaving fewer resources available for programs.

These funds have been used to mitigate the impact of cost-saving cuts, along with other measures, including, but not limited to, placing a freeze on CDPH grant-funded positions; placing a hold on awarding contracts resulting from a Request for Proposal; curtailing travel and operating expenses, and denying requests to rollover any prior year's unexpended funds.

C. Administrative and Programmatic Costs

During SFY 2013–14 administrative costs for programs funded by the PHHSBG are expected to be approximately 10 percent (the legislatively established limit).

CDPH definitions of administrative and programmatic costs are consistent with those contained in the State Administrative Manual, the Federal Office of Management and Budget Circular A-87, and the California Government Code.

Regarding "Examples of State-Level Administrative and Programmatic Activities," please see the adopted definitions summarized as follows:

1. Administrative costs are those costs incurred by state staff in providing the following non-programmatic administrative support services:
   a. Grants management and fiscal monitoring;
   b. Assistance in development of administrative costs guidelines and standards;
   c. Budgeting and accounting activities;
   d. Technical assistance to local contractors in program administration.

   Administrative costs include direct costs (salaries and benefits), plus any operating costs incurred in the provision of administrative support services and indirect costs (prorated overhead associated with administrative staff). For further discussion of direct and indirect costs, see section D below.

2. Programmatic Costs are those costs incurred by state staff involved in activities that utilize health professional expertise, including:
   a. Direct services to target population (usually statewide);
   b. Activities that assist in the implementation and maintenance of direct services;
   c. Activities that directly affect achievement of service-related objectives;
   d. Surveillance of health status indicators and development of programs for prevention and control of factors adversely affecting health.

   Programmatic costs include direct costs (salaries and benefits), plus any operating costs incurred in the provision of direct program services, and indirect costs (prorated overhead associated with programmatic direct service staff).

D. Direct and Indirect Costs

As noted in the section above, state-level administrative and programmatic costs may be either direct or indirect. The following definitions of direct and indirect costs are consistent with those contained in:

1. State Administrative Manual, Sections 8753–8755.1;
2. Federal OMB Circular A-87: "Principles for Determining Costs Applicable to Grants and Contracts with State, Local, and Federally Recognized Indian Tribal Governments";
3. California Government Code, Sections 11010, 11270, and 11256.

Direct costs can be specifically identified with a particular cost center. Direct costs include, but are not limited to, salaries, benefits, and operating expenses directly benefiting either administrative support services or programmatic services.

Indirect costs *cannot* be identified specifically with a particular cost center, and are incurred for the common benefit of more than one cost objective.

Indirect costs are based on a formula percentage rate of portions of direct costs. Indirect costs are also referred to as overhead costs. CDPH's proposed indirect cost rate for the State of California for SFY 2013–14 is 18.1 percent (of total personnel services, i.e., salaries and benefits).

Indirect costs attributable to state staff performing administrative support services are included under administrative costs, while indirect costs attributable to state staff performing direct program services are included in programmatic costs.

E. Due Dates

Electronic Grant Application [Block Grant Management Information System (BGMIS)]. By October 1 of each year, the electronic application is due to the Centers for Disease Control and Prevention (CDC) since this is the start of the Federal Fiscal Year. This due date is flexible and is dependent on when the Federal Budget is enacted, when CDC notifies states that their appropriations have been determined, and when BGMIS is ready to accept State Plans. Once the State Plan has been entered into BGMIS, a transmittal letter signed by the Governor or his designee, with necessary certifications, is included. Once BGMIS, which includes the State Plan, is submitted, CDC will pay states their allocations in quarterly installments.

Annual Progress Report (APR). By February 1 of each year, a separate document reports the progress in meeting program objectives. This APR is transmitted to CDC in a format required by federal guidelines outlined in BGMIS. The State will not receive outstanding payments until the APR is submitted.

II. THE CALIFORNIA PHHSBG ADVISORY COMMITTEE AND THE PUBLIC HEARING PROCESS

A. Advisory Committee

Under the Public Health Service Act, as amended in 1992, Caroline Peck, M.D., M.P.H., and Wesley Alles, Ph.D., serve as Co-Chairs of the PHHSBG Advisory Committee (AC). Dr. Alles began his term in May 2002; Dr. Peck began her term in April 2010.

As required by Section 1905(d) of the amended Public Health Service Act, the AC will meet twice this fiscal year by teleconference. The first meeting is scheduled for October, and the second will be held in Spring 2014.

The AC approved the principles listed in the summary below in SFY 2008–09, along with the recommendation that they continue to be used for the next five years, through SFY 2012–13. These criteria were used to establish priorities during the March 2012 AC teleconference.

Summary of the Principles for Allocation of California PHHSBG Funds, as Accepted by the AC:

- Emphasize primary and secondary prevention programs. (Primary prevention includes prevention of future injury among the injured population.)
- Fund each program for at least three years.
- Do not transfer monies out of the PHHSBG.
- Prioritize Year 2020 Priority Areas using the following criteria:
  - Condition severity;
  - Size of the problem/condition;
  - Overcoming population disparities in health status;
  - Community concern;
  - Cost of the condition;
  - Cost-effectiveness of interventions;
  - Concordance with Year 2020 Objectives;
  - Other resources available to address the condition;
  - Innovation in areas for which there are few proven interventions.
- Leverage other funds.
- Impact of terminating program*
  - Infrastructure vs. services;*
  - History/longevity of program;*
  - Reconfiguration/modification of program;*
- In future years, consider program performance. The needs of EMSA should be considered.

*Staff experience; Addition to previous Principles for Allocation of California PHHSBG funds.

B. The Public Hearing Process

Public notification procedures were conducted in accordance with Section 1905(d) of the Public Health Service Act, as revised in October 1992.

CDPH has a formal procedure to appropriately provide for public notification, review, and comment regarding the California PHHSBG application. Accordingly, the Department, upon preparation of its annual application to the Federal Government for PHHSBG funding, files a notice of general public interest with the State Office of Administrative Law. This notice is then published in the "California Regulatory Notice Register." The published notice indicates that the application is available for public inspection at a specified location in the Department's headquarters during specified business hours. The notice, in addition, provides procedures for the submission of written comments to the State from interested governmental agencies and interested members of the public.

The Department published appropriate notice for the FFY 2014 PHHSBG State Plan to provide for required public announcement, review, and comment pertaining to the State's application. A Public Hearing was held on April 14, 2014.

III. APPLICATION OF THE PRINCIPLES ACCEPTED BY THE ADVISORY COMMITTEE TO THE 42 *HEALTHY PEOPLE 2020* TOPIC AREAS

Chapter III contains the AC philosophy of not using PHHSBG to support programs currently receiving different federal, state, grant, or other foundation funds. The following is a list of *HP 2020* Topic Areas and whether PHHSBG funds are allocated for their purpose.

1. **Access to Health Services (Includes EMS)**
   EMS will continue to catalyze the placement and effective utilization of modern EMS systems in communities all over California. *EMS programs will continue receiving PHHSBG funds. California Cardiovascular Disease Prevention Program (CCDP) will continue receiving PHHSBG funds.*

2. **Adolescent Health**
   The Center for Family Health has programs that address adolescent health, including the Office of Family Planning. These programs receive funding from other sources. *PHHSBG funds are not allocated for adolescent health, except as needed for obesity prevention through nutrition education and physical activity promotion.*

3. **Arthritis, Osteoporosis, and Chronic Back Conditions**
   CDPH has a federally funded arthritis program in the Chronic Disease Control Branch. *No PHHSBG funds are allocated for arthritis.*

4. **Blood Disorders and Blood**
   California's public health system does not address issues relating to blood disorders and blood. *No PHHSBG funds are allocated for these issues.*

5. **Cancer**
   PHHSBG funds are not used to support cancer prevention or treatment programs. There is strong support for federally and state funded cancer control programs, particularly breast and cervical cancer, colorectal cancer, cancer registry, and comprehensive cancer control.

6. **Chronic Kidney Disease**
   CDPH does not have a program that addresses chronic kidney disease. *No PHHSBG funds are allocated for this issue.*

7. **Dementias, including Alzheimer's Disease**
   Through the General Fund, California supports ten Alzheimer's disease centers that provide clinical care for Alzheimer's patients. California also supports research for Alzheimer's Disease through a voluntary "tax check off" contribution. *No PHHSBG funds are allocated for Alzheimer's Disease.*

8. **Diabetes**
The California Diabetes Program receives categorical federal funding from CDC to support their prevention and control program. Cardiovascular disease prevention and tobacco control efforts also support diabetes prevention and control efforts. California's Tobacco Control, the California Center for Physical Activity, California Arthritis Prevention Program, and the California Heart Disease and Stroke Prevention Program will address the population with diabetes. *No PHHSBG funds are allocated for Diabetes.*

9. **Disability and Health**
California has a Department of Rehabilitation. *No PHHSBG funds are allocated for disability-related issues.*

10. **Early and Middle Childhood**
The Center for Family Health and the Title 5 Block Grant address issues of early and middle childhood. *No PHHSBG funds are allocated for public health issues of early and middle childhood, except for obesity prevention programs (Nutrition Education and Obesity Prevention Program [NEOPP] and the California Active Communities [CAC] Program).*

11. **Educational and Community Based Programs**
Educational and community-based programs, such as Healthy Cities and Communities*, need to receive continued support from the PHHSBG to ensure the overall well-being of Californians.*

12. **Environmental Health**
A substantial amount of funding, including a CDC Environmental Health Grant for asthma, supports other programs related to this *HP 2020* Focus Area. *There are no proposals to provide PHHSBG funds to environmental health issues.*

13. **Family Planning**
With a comprehensive program in place providing educational and clinical services, supplementing the program with more federal funds is unjustifiable. *No PHHSBG funding is allocated for this priority area.*

14. **Food Safety**
The activities already underway are primary and systems are in place, both in state and county health laboratories and epidemiologic surveillance programs, to detect outbreaks. *No PHHSBG funds are allocated for these programs.*

15. **Genomics**
CDPH does not address issues relating to genomics. *No PHHSBG funds are allocated for this topic area.*

16. Global Health

CDPH has a funded Office of Bi-national Border Health that includes a core program, focusing on emerging public health issues, informing and educating public health professionals, and assessing the health status of the United States/Mexico border region. There is an Early Warning Infectious Disease Surveillance System, and a U.S.-Mexico Border Health Commission. *No PHHSBG funds are used to address global health/border health issues.*

17. Health-Care–Associated Infections

In SFY 1993–94, CDPH established a Nosocomial Program to address the problem of nosocomial (hospital-acquired) infections. This program was supported with *Prevention 2000* grant funds. In SFY 1995–96, the *Prevention 2000* AC recommended an alternate funding source, which CDPH sought.

The Nosocomial Infections Program is administered by the Center for Health Care Quality's Health Care Associated Infections Program. The Immunization Branch receives significant funding from CDC and is directed toward achieving a fully immunized childhood population, and the Tuberculosis Control Program receives a substantial amount of federal funds.

No PHHSBG funds are allocated for health-care associated infections, although a required State Plan was submitted to CDC in a timely manner.

18. Health Communications and Health Information Technology

CDPH has an Information Technology Services Division (ITSD) that addresses health information technology. Various programs have social marketing campaigns as part of their core program responsibilities. *No PHHSBG funds are specifically allocated for these topic areas.*

19. Health-Related Quality of Life and Well-Being

The CWP will begin to address these topic areas since the entire public health system and other public programs, when services are provided, help improve the quality of life and well-being of Californians. *PHHSBG funds are specifically allocated to California Wellness Plan Implementation (CWPI) for this topic area.*

20. Hearing and Other Sensory or Communication Disorders

The Center for Family Health has a newborn hearing screening program. *The PHHSBG does not allocate funds for these topic areas.*

21. Heart Disease and Stroke

Although progress is being made to lower the prevalence of some cardiovascular disease risk behaviors in California (e.g., cigarette smoking and to some extent high blood pressure), *PHHSBG resources continue to be needed to prevent and control the number-one cause of death in California.*

22. Human Immunodeficiency Virus

Federal funds support this priority area. PHHSBG funds are allocated to the Office of AIDS (OA) for this area.

23. Immunization and Infectious Diseases

The Center for Infectious Diseases receives substantial federal money for its immunization assistance efforts and to control infectious diseases. *No PHHSBG funds are allocated for these topic areas in California.*

24. Injury and Violence Prevention

Given the magnitude of health problems attributed to violence and abusive behavior, *PHHSBG will continue to support the Injury and Violence Prevention Program within the Safe and Active Communities Branch.*

CDPH will continue to focus on development of policy based on data analysis, and support of local programs to foster utilization of available primary prevention interventions. *PHHSBG funds will maintain and expand efforts in this area. The Partnerships for Injury Prevention and Public Education administered by EMSA will continue.*

Originally, funding supported centers to provide rape crisis intervention and follow-up services, but responsibility has expanded to include education aimed at middle- to high-school age girls and boys. Federal legislation amended the PHHSBG, moving the rape prevention and education funds to the National Center for Injury Prevention in October 1, 2001. *The Rape Set-Aside funds that support the Rape Prevention Resource Center continue to support this program.*

25. Lesbian, Gay, Bisexual, and Transgender Health

CDPH receives funding for these services through the Mental Health Services Act and is producing a comprehensive strategic plan to reduce disparities and provide recommendations on embedding cultural and linguistic competence into the public mental health system. This program is located in the Office of Health Equity. *No PHHSBG funds are allocated to this topic area.*

26. Maternal, Infant, and Child Health

PHHSBG funds are allocated to BIH for this program area. Other funding is also being directed toward the program objectives in this area.

27. Medical Product Safety

CDPH has a Section within the Food and Drug Branch that addresses medical device safety. It licenses approximately 1,200 medical device manufacturers and 1,800 home medical device retailers and is responsible for the investigation and control of unsafe medical devices. *No PHHSBG funds are allocated for this purpose.*

28. Mental Health and Mental Disorders

California now supports the Department of State Hospitals, which provides psychiatric care for mental health and mental disorders. Any PHHSBG contribution to address these sub-objectives would pale in comparison to the existing budgets of these tertiary (clinical) programs. *No PHHSBG funds are allocated to this subject area.*

29. Nutrition and Weight Status

The PHHSBG continues to further efforts in preventing chronic disease and obesity through the current nutrition intervention program, NEOPP.

30. Occupational Safety and Health

An independent agency devoted to occupational safety and health and an existing epidemiologic program within CDPH *will not receive PHHSBG funds.*

31. Older Adults

The California Department of Aging (DOA) primarily serves California's aging population. *No PHHSBG funds are provided to DOA.*

32. Oral Health

The PHHSBG continues to support California's effort to increase the number of Californians receiving fluoridated water. The PHHSBG AC has continuously ranked the Water Fluoridation Program as its highest priority program.

33. Physical Activity

PHHSBG funds are allocated for the purpose of preventing chronic disease through physical activity and fitness through California Active Communities (CAC) and Nutrition Education and Obesity Prevention Program (NEOPP).

34. Preparedness

The Office of Emergency Services is funded to respond to emergencies at all times to address statewide disasters such as earthquakes and floods. CDPH's Emergency Preparedness Office, primarily using federal funds, responds to the public health aspects of statewide disasters. *PHHSBG funds are allocated to the California Health Alert Network (CAHAN) for this issue.*

35. Public Health Infrastructure

PHHSBG funds have continuously funded the Preventive Medicine Residency and the California Epidemiologic Investigative Services (Cal-EIS) programs. These programs support the public health infrastructure by providing highly training public health physicians, statisticians, and epidemiologists (researchers). *PHHSBG funds will also be allocated to Infectious Disease Branch/Microbial Diseases Laboratory Branch (IDB/MDL) and the Office of Quality Performance and Accreditation (OQPA) to support laboratory capacity and public health accreditation efforts.*

36. Respiratory Diseases

CDPH's Center for Chronic Disease Prevention and Health Promotion includes an Occupational Disease Control program. Within this program is the Environmental Health Investigations Branch which addresses Asthma. *No PHHSBG funds are allocated for asthma at this time.*

37. Sexually Transmitted Diseases

These programs currently receive a substantial amount of federal funds. *No PHHSBG funds are allocated to address STDs.*

39. Sleep Health

Sleep health is not addressed by California's public health system. *No PHHSBG funds are allocated to this issue.*

40. Social Determinants of Health

The social determinants of health are important factors in health status, but CDPH does not have programs that specifically address these issues. *No PHHSBG funds are allocated for this purpose.*

41. Substance Abuse

The California Department of Health Care Services, Mental Health and Substance Abuse Disorders Services, addresses substance abuse. These programs receive a substantial amount of federal funds. *No PHHSBG are allocated for program objectives in this topic area.*

42. Tobacco Use

California's Tobacco Control Program has funding to combat tobacco-related diseases, which are a major public health problem. *No PHHSBG funds are allocated for this topic area.*

43. Vision

No PHHSBG funds are allocated for vision screening or other vision-related services.

IV. STATE PROGRAMS TO ADDRESS OBJECTIVES WITHIN 16 SELECTED *HP 2020* TOPIC AREAS

Summary of state programs addressing the *HP 2020* Topic Areas (TA)

***HP 2020* TA**	**Title**	**Program***
1	Access to Quality Health	EMS, CCDP
2	Adolescent Health	—
3	Arthritis, Osteoporosis, and Chronic Back Conditions	
4	Blood Disorders and Blood Safety	—
5	Cancer	—
6	Chronic Kidney Disease	—
7	Dementia including Alzheimer's Disease	
	Diabetes	—
8	Disability and Health	SACB
9	Early and Middle Childhood	—
10	Educational and Community Based Programs	CAC, NEOPP
11		
12	Environmental Health	OHE, CWF
13	Family Planning	—
14	Food Safety	—
15	Genomics	
	Global Health	—
16	Health Care Associated Infections	
17	Health Communications and Health	—
18	Information Technology	—
19	Health Related Quality of Life and Well-Being	CWPI
20	Hearing and Other Sensory or Communication Disorders	
21	Heart Disease and Stroke	CCDP
22	Human Immunodeficiency Virus	OA
23	Immunization and Infectious Diseases	
24	Injury and Violence Prevention	SACB, Rape
25	Lesbian, Gay, Bisexual, and Transgender Health	—
26	Maternal, Infant, and Child Health	BIH
27	Medical Product Safety	—
28	Mental Health and Mental Disorders	—

29	Nutrition and Weight Status	NEOPP
30	Occupational Safety and Health	
31	Older Adults	
32	Oral Health	CWF
33	Physical Activity	CAC, NEOPP
34	Preparedness	CAHAN
35	Public Health Infrastructure	IDB/MDL, MDL PMRP/Cal EIS, OPQA
36	Respiratory Disease	
37	Sexually Transmitted Diseases	
38	Sleep Health	
39	Social Determinants of Health	OHE
40	Substance Abuse	
41	Tobacco Use	
42	Vision	

* BIH: Black Infant Health Program
CAC: California Active Communities
CAHAN: California Health Alert Network
CWF: California Community Water Fluoridation Implementation Project
CCDP: California Cardiovascular Disease Prevention Program
EMS: Emergency Medical Services
IDB/MDL: Infectious Disease Branch/Microbial Diseases Laboratory Branch
MDL: Microbial Diseases Laboratory Branch
NEOPP: Nutrition Education and Obesity Prevention Branch
OA: Office of AIDS
OHE: Office of Health Equity
OPQA: Office of Quality Performance and Accreditation
PMRP/Cal EIS: Preventive Medicine Residency Program/California Epidemiological Investigative Service
Rape: Rape Set-Aside
SACB: Safe and Active Communities Branch

The State Plan is primarily made up of documents providing program information in alphabetical order, as requested by CDC.

V. PROGRAMS, THE FOUR CDC DOMAINS, IMPACT OBJECTIVES, AND ACTIVITIES

California Active Communities

State Program Strategy:

Goal: Decrease falls in California by promoting safe physical activity among older adults of all ethnicities and abilities.

Primary Strategic Partnerships: Project will involve a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:
- California Arthritis Program
- California Diabetes Program
- California Heart Disease and Stroke Program
- California Obesity Prevention Program
- California Project LEAN
- Environmental Health Investigation Branch
- Health in All Policies Program
- Network for a Healthy California

External:
- AARP
- Archstone Foundation
- California Department of Aging
- California State University System
- Fall Prevention Center for Excellence
- Local public health departments
- Public Health Institute
- Prevention Institute
- Stanford University
- University of California System
- University of Southern California

Role of PHHSBG Funds: For FFY 2014, PHHSBG funds will be used by the Safe and Active Communities Branch (SACB) to support statewide trainings and technical assistance to individuals from local government agencies and organizations to increase the number of community-based physical activity interventions. These interventions are aimed at reducing falls among older Californians by increasing their mobility through strength and balance activities. Funds will also be used to develop materials and conduct trainings to increase knowledge of universal design and older adult mobility issues among local public health and government staff, and produce a "Return on Investment Report" featuring evidence-based older adult fall prevention programs.

Evaluation Methodology: Data from the EpiCenter: California Injury Data Online will be used to evaluate changes in the death rate due to unintentional falls in older adults.

Process evaluation will focus on measuring the extent to which objectives are met (e.g., number of trainings conducted, number of participants). Impact evaluation will assess immediate and intermediate outcomes using multiple measures, including evaluations administered as part of the trainings to determine knowledge and skills improvement; number and nature of requests for technical assistance; and, reported uses of materials.

State Program Setting:
Community based organization, Local health department, State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manager II
State-Level: 25% Local: 0% Other: 75% Total: 100%
Health Program Specialist II
State-Level: 100% Local: 0% Other: 0% Total: 100%
Associate Government Program Analyst
State-Level: 100% Local: 0% Other: 0% Total: 100%
Research Scientist I
State-Level: 50% Local: 0% Other: 50% Total: 100%

Total Number of Positions Funded: 4
Total FTEs Funded: 2.75

National Health Objective: HO IVP-23 Deaths from Falls

State Health Objective(s):
Between 10/2013 and 09/2015, maintain California baseline death rate of 38.7/100,000 population aged 65 years and older due to unintentional falls.

Baseline:
38.7 deaths per 100,000 population aged 65 years and older were caused by unintentional falls in 2010.

Data Source:
EpiCenter: California Injury Data Online, CDPH-OVR-DSM

State Health Problem:

Health Burden:
California has more than 4.3 million adults over the age of 65, the largest older adult population in the nation. In California, falls cause 42 percent of the injury deaths and 70 percent of injury-related hospitalizations among seniors. In 2011, 1,638 Californians age 65 and older died from a fall and 74,529 were hospitalized. In addition, 174,758 people ages 65 and older were treated for falls in California's emergency departments.

Target Population:
Number: 4,382,250
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 65 years and older

Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 4,382,250
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: "EpiCenter" California Injury Data Online, CDPH-OVR-DSM

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: CDC has identified Tai Chi: Moving for Better Balance as an evidence-based intervention for falls prevention. CDC cites a study that compared the effectiveness of a 6-month program of Tai Chi classes with a program of stretching exercises. Participants in the Tai Chi classes had fewer falls and fewer fall injuries, and their risk of falling was decreased 55 percent. CDC also recognizes the Stepping On Program as an evidence-based multifaceted intervention for falls prevention, citing a study which found about a 30 percent reduction in fall rates compared with those who did not receive the intervention.

CDC's Guide to Community Preventive Services also recommends the following community-based interventions that are in line with this project's activities:
• Community-wide campaigns to promote physical activity.
• Individually-adapted health behavior change programs.
• Social support interventions in community settings.
• Community-scale urban design and land use policies and practices to increase physical activity.
• Creation of or enhanced access to places for physical activity combined with informational outreach activities.
• Street-scale urban design and land use policies and practices to increase physical activity.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $676,666
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $200,000

Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Document the cost effectiveness of older adult fall injury prevention interventions.
Between 10/2013 and 09/2015, SACB staff will develop **one** "Return on Investment Report" for older adult fall prevention programs, which includes information on the burden of falls in California, efficacy of evidence-based falls prevention programs, and a cost-benefit analysis.

Annual Activities:

1. Conduct cost-benefit analysis.
From 10/2013 through 09/2015, SACB staff will conduct a cost-benefit analysis based on (1) a review of existing data on the prevalence and cost burden of falls in California and (2) existing scientific literature on evidence-based falls prevention programs. This analysis will be translated into a "Return on Investment Report" that staff will publish and broadly disseminate to California stakeholders.

Objective 2:
Increase ability to implement Tai Chi: Moving for Better Balance (TCMBB) Program.
Between 10/2013 and 09/2015, SACB staff will train a minimum of **15** individuals so they will be able to deliver the TCMBB Program to older adults at risk for falls.

Annual Activities:

1. Fund local health department staff to participate in TCMBB Program trainings.
Between 10/2013 and 09/2015, SACB staff will conduct a selection process and provide funding for a minimum of **15** local health department staff to participate in TCMBB Program trainings.

2.Conduct TCMBB Program training activities.
Between 10/2013 and 09/2015, SACB staff will conduct and evaluate at least **one** two-day instructor training, conduct video-based fidelity checks for new instructors, and provide at least **four** post-training support webinars and at least **15** technical assistance consultations.

Objective 3:

Increase ability to implement the Stepping On Program.

Between 10/2013 and 09/2015, SACB staff will conduct at least **one** three-day leader training for a minimum of **ten** individuals so they will be able to deliver the Stepping On Program to older adults at moderate risk for falls.

Annual Activities:

1. Fund local health department staff to participate in Stepping On Program trainings.

Between 10/2013 and 09/2015, SACB staff will conduct a selection process and provide funding for a minimum of **10** local health department staff to participate in Stepping On Program training.

2. Conduct Stepping On Program trainings.

Between 10/2013 and 09/2015, SACB staff will conduct and evaluate training, conduct video-based fidelity checks for new leaders, and provide at least **four** post-training support webinars and **four to eight** technical assistance consultations.

Objective 4:

Promote universal design and older adult mobility in community planning.

Between 10/2013 and 09/2015, SACB staff will develop **one** training manual, **one** webinar presentation, and collateral materials on universal design and addressing older-adult mobility issues to be used in future trainings for local public health and government staff.

Annual Activities:

1. Develop training materials.

Between 10/2013 and 09/2015, SACB staff will convene an advisory group to provide guidance in the development of materials, review existing universal-design/older-adult mobility training materials, draft, field-test, and finalize materials, and develop a PowerPoint webinar presentation, to increase the ability to promote older adult mobility.

California Cardiovascular Disease Prevention Program

State Program Strategy:

Goal: The mission of the California Cardiovascular Disease Prevention (CCDP) Program is to reduce death and disability from heart disease and stroke, the first and third leading causes of death in California. Approximately 30 percent of all deaths in California are due to heart disease and stroke (CDPH, Death Records, 2010). The estimated annual direct and indirect medical cost of cardiovascular disease (CVD) in California exceeded $35 billion in 2010.

In 2013, California was awarded Centers for Disease Control and Prevention (CDC) funding (State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health) to support statewide implementation of cross-cutting approaches to promote health and prevent and control chronic diseases and their risk factors. The CCDP Program will align with this effort and with California Department of Public Health (CDPH) program efforts that promote and implement nutrition guidelines to address CVD prevention. In addition, the Program will align its efforts with the four CDC chronic disease prevention and health promotion domains which include: (1) Epidemiology and Surveillance, (2) Environmental approaches that promote health, (3) Health systems interventions, and (4) Community-clinical linkages strategies.

The CCDP Program will focus on heart disease and stroke prevention with an emphasis on hypertension, employing both primary and secondary prevention strategies in the fulfillment of objectives. Due to the strong association of excessive sodium consumption with elevated blood pressure levels and increased risk for heart attack and stroke, the CCDP Program will include the primary prevention strategy of reducing sodium intake. Excess dietary sodium consumption is associated with elevated blood pressure levels and increased risk for heart attack or stroke and Americans consume an average of 3,400 mg of sodium each day, far exceeding the current Dietary Guidelines for Americans recommendation of less than 2,300 mg per day (USDA, Agricultural Research Service, 2008). Estimates show that a reduction in dietary salt to 3 grams of sodium per day would reduce the annual number of new cases of coronary heart disease in California by 6,700 to 13,000; stroke by 4,100 to 8,100; and myocardial infarction by 3,400 to 6,400 annually (Bibbins-Domingo et al., 2010). State-level strategies for sodium reduction include increasing awareness through public education about the recommended daily sodium limit, and establishing a task force of stakeholders to inform sodium reduction efforts.

The CCDP Program's secondary prevention strategy involves utilizing team-based care to improve blood pressure control. The Community Preventive Services Task Force (Task Force) recommends team-based care to improve blood pressure control based on the findings from systematic reviews of studies published in peer-reviewed journals. The Task Force also recognized the limitations of their recommendation, and the need for additional evidence. The CCDP Program will conduct a formative assessment of the providers who are early adopters of team-based care for the

management of high blood pressure, with a goal of evaluating the successes and challenges of these team-based care practices including: (1) the necessary core elements, including team composition and roles; (2) populations best served (including setting); (3) patient satisfaction and health outcomes; and (4) methods of communication between team members (Guide to Community Preventive Services. Cardiovascular disease prevention and control: team-based care to improve blood pressure control, 2012).

The CCDP Program's key activities include: (1) identifying current interventions and best practices for team-based care to improve blood pressure control; (2) increasing awareness of the recommended daily sodium limit and the health benefits of lowering sodium consumption; (3) collaborating with key partners to implement evidence-based guidelines for reducing high blood pressure; and (4) assessing the cardiovascular health of Californians. Interventions will directly address *Healthy People* (HP) *2020* Objectives for heart disease, stroke, heart failure and their risk factors. These activities are consistent with the recommendations of the *California Heart Disease and Stroke Prevention and Treatment Master Plan, the California Wellness Plan, the Guide to Community Preventive Services, and the US 2010 Dietary Guidelines for Americans.*

This program is also responsible for implementing 38 objectives of the California Wellness Plan.

Primary Strategic Partnerships: The CCDP Program has developed collaborative partnerships with the following organizations:

Internal:
- Nutrition Education and Obesity Prevention Branch
- WISEWOMAN
- Tobacco Control Program

External:
- Survey Research Group
- Prevention First-Diabetes and Heart Disease Unit
- American Heart Association/ American Stroke Association
- California Conference of Local Health Officers
- California Health Interview Survey
- Million Hearts Campaign
- CA BRFSS
- University of California
- LA County Sodium Reduction Initiative

Script Your Future Campaign

Role of PHHSBG Funds: PHHSBG funds are used to support the CCDP Program, including operating expenses and activities. Since the Program's inception (formerly titled the California Heart Disease and Stroke Prevention Program), PHHSBG funds have been the program's primary source of support.

Evaluation Methodology: Program staff implementing annual activities (as described below) will evaluate progress/outcomes on an ongoing basis. Project activity evaluation will be based on a Logic Model, including process measures and short-, intermediate-, and long-term measures. Priority will be given to assessing outcome measures that reflect the required project activities that are critical to the project's success. Impact and evaluation measures will be used to assess intermediate- and long-term outcomes. These outcomes will include both qualitative and quantitative measures. Short-term outcomes will be assessed immediately following implementation of the intervention and will likely include more quantitative measures. The evaluation process will include an assessment of contextual factors that may impact implementation of proposed activities and their outcomes.

The planned evaluation activities include the following elements: (1) evaluation questions; (2) indicators/measures needed to answer the evaluation questions; (3) identified data sources; (4) identified data collection methods; (5) a time frame for the evaluation activities; (6) appropriate methodologies to analyze data; (7) outcomes communication (e.g., annual conference presentations, written reports); and (8) responsible staff lead(s). Results from the evaluation activities will be included in the annual progress report. Barriers/challenges/opportunities, and the methodologies used to address unanticipated change, will also be described in the annual progress report.

State Program Setting:
Community based organization, State health department, University or college

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Specialist II
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Title: Associate Governmental Program Analyst
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 2
Total FTEs Funded: 2.00

National Health Objective: HO HDS-2 Coronary Heart Disease Deaths

State Health Objective(s):

Between 10/2013 and 09/2015, Heart Disease: Reduce coronary heart disease deaths. (HDS-2)

Stroke: Reduce stroke deaths. (HDS-3)

Heart Failure: Reduce hospitalizations of older adults with heart failure as the principal diagnosis. (HDS-24)

Blood Pressure:
1. Reduce the proportion of persons in the population with hypertension. (HDS-5)
2. Increase the proportion of adults who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high. (HDS-4)

Blood Cholesterol:
1. Reduce the proportion of adults with high total blood cholesterol levels. (HDS-7)
2. Increase the proportion of adults who have had their blood cholesterol checked within the preceding five years. (HDS-6)

Sodium Reduction: Reduce consumption of sodium in the population aged 2 years and older (NWS-19)

Baseline:
Heart Disease: In 2010, the overall heart disease death rate was 120.8 per 100,000 population.

Stroke: In 2010, the overall stroke death rate was 38.1 per 100,000 population.

Heart Failure: In 2009, the hospitalization rate for congestive heart failure was 10.2 per 1,000 population.

Blood Pressure: (1) Data from 2011–2012 showed that 27.2 percent of adults reported a diagnosis of high blood pressure. (2) Data from 2011–2012 showed that 69.9 percent of Californians who had been given a diagnosis of high blood pressure by a clinician were taking medications to control high blood pressure.

Blood Cholesterol: (1) In 2005, 22.1 percent of Californians reported a diagnosis of high cholesterol. (2) In 2005, 85.7 percent of Californians had been screened for high cholesterol within the previous five years.

Data Source:
Compressed Mortality File 1999–2010 on CDC WONDER Online Database; 2005, 2009 and 2011–2012 California Health Interview Survey (CHIS)

State Health Problem:
Health Burden:
The **target population** for program interventions includes 28 million (2010) **California adults** aged 18 years and over, both genders, all racial and ethnic groups, and all geographic regions of the State.

Mortality: In 2010, overall rates of heart disease deaths were 120.8 per 100,000 population. In that same year, the stroke death rate was 38.1 per 100,000 population, and heart failure rates were 12.8 per 100,000 population.

Morbidity: In 2009, rates of hospitalization for heart disease were 15.8 discharges per 1,000 population. In that same year, stroke hospitalization rates were 5.7 per 1,000 population, and heart failure hospitalization rates were 10.2 per 100,000 population.

Risk: 2011–2012 data showed that 27.2 percent of Californians had been told by a clinician that they had high blood pressure, including 40 percent of African Americans and 39 percent of American Indian/Alaska Natives.

(The **target** and **disparate populations** are the **same**.)

Target Population:
Number: 28,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 28,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: California Department of Finance (2012)

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:

- Guide to Clinical Preventive Services (U.S. Preventive Services Task Force); American College of Cardiology and the American Heart Association (ACC/AHA);
- U.S. Dietary Guidelines for Americans; and Guide to Community Preventive Services. Cardiovascular Disease Prevention and Control: Team-based Care to Improve Blood Pressure Control.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective:	$509,768
Total Prior Year Funds Allocated to Health Objective:	$0
Funds Allocated to Disparate Populations:	$0
Funds to Local Entities:	$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Improve quality of care through implementation of Patient-Centered Medical Homes (PCMHs).

Between 10/2013 and 09/2015, CCDP Program staff, in collaboration with key partners, will increase the number of federally qualified health centers (FQHCs) that achieve National Committee for Quality Assurance (NCQA) certification as a Patient-centered Medical Home (PCMH) from 26 to 30.

Annual Activities:

1. Implement Patient-Centered Medical Homes (PCMHs).

Between 10/2013 and 09/2015, CCDP Program staff will identify current interventions for PCMHs in FQHCs. To achieve this objective, program staff will collaborate with key partners to assess the current capacity within FQHCs to implement PCMHs; identify sustainable, scalable, and replicable PCMHs models; and provide training and technical assistance to encourage FQHCs to incorporate PCMHs concepts within their health settings.

The success of this activity will be measured by the number of FQHCs that receive NCQA PCMH certification.

Objective 2:

Increase awareness of the importance of sodium reduction.

Between 10/2013 and 09/2015, CCDP Program staff will implement **one** sodium reduction strategic communication initiative that will target different sectors, such as worksites, hospitals, and schools.

Annual Activities:

1. Increase sodium reduction awareness.

Between 10/2013 and 09/2015, CCDP Program staff will increase awareness through education about the recommended daily sodium limit and the health benefits of lowering sodium consumption by:

- Coordinating with the CDPH/DHCS Wellness committee to add a question on sodium awareness/reduction to their employee survey.

- Coordinating with CDPH nutrition and tobacco control branches to add messages on hypertension and heart disease to their existing educational and/or media materials.
- Adding a sodium awareness education message to CDPH employee paystubs.
- Producing a fact sheet on sodium awareness/reduction for the CDPH website.

The success of this activity will be measured by the increase in public health education messages regarding the recommended daily sodium limit and the benefits of lowering sodium consumption.

Objective 3:
Maintain active partnerships.
Between 10/2013 and 09/2015, CCDP Program staff will maintain **five** active partnerships with key national, statewide, and local stakeholders/community partners to support policy, systems, and environmental change.

Annual Activities:

1. Collaborate with stakeholders.
Between 10/2013 and 09/2015, CCDP Program staff will demonstrate evidence of active partnerships with key national, statewide, and local stakeholders that support cardiovascular risk reduction, with an emphasis on high blood pressure (e.g., Million Hearts Campaign, Script Your Future, Right Care Initiative/QIO, Sodium). To reach this objective, program staff will:

- Participate in stakeholder meetings.
- Maintain memberships in national and statewide councils and advisory groups.
- Collaborate with partners to implement evidence-based guidelines and public health best practices.

The success of this activity will be measured by the number of active partnerships.

2. Establish sodium reduction task force.
Between 10/2013 and 09/2015, CCDP Program staff will establish one state-level sodium reduction taskforce within CDPH that will provide guidance on state-level efforts to increase awareness of association of sodium reduction and CVD prevention, and identify policies to support environmental change.

- Identify CDPH programs leads to participate in a sodium reduction task force.
- Participate in state and national sodium reduction initiative meetings, conferences, or committees.
- Coordinate with the Coordinated Chronic/Prevention First Advisory Group to identify state-level priorities related to sodium reduction.

The success of this activity will be measured by the established state-level sodium reduction task force.

Objective 4:
Respond to data requests.
Between 10/2013 and 09/2015, CCDP Program staff will provide responses to data requests to **at least ten** state and local agencies, and other stakeholders, as needed, to inform the planning processes for the prevention and treatment of heart disease, stroke, heart failure, and their risk factors.

Annual Activities:

1. Provide cardiovascular disease and sodium reduction data.
Between 10/2013 and 09/2015, CCDP Program staff will provide state and local agencies, and other stakeholders, with data and associated analyses, as required to inform the planning processes for the prevention and treatment of heart disease, stroke, heart failure, and their risk factors in the following ways:

- Respond to data requests from state and local agencies and other stakeholders.
- Disseminate reports/fact sheet electronically (CDPH Web site), and as requested.

The success of this activity will be measured by the number of contacts with state and local agencies, and other stakeholders.

Objective 5:
Update data reports.
Between 10/2013 and 09/2015, CCDP Program staff will update **one** data report documenting progress toward the HP 2020 goals for heart disease and stroke, and their risk factors. This will increase the capacity to measure and monitor the cardiovascular health status of Californians.

Annual Activities:

1. Promote California Wellness Plan objectives.
Between 10/2013 and 09/2015, CCDP Program staff will promote the California Wellness Plan objectives related to heart disease and stroke in the following ways:

- Develop and disseminate fact sheets.
- Disseminate fact sheets electronically (CDPH Web site).

The success of this activity will be measured by the completion of two fact sheets.

California Community Water Fluoridation Implementation Project

State Program Strategy:
Goal: The California Community Water Fluoridation Implementation Project (CWF) is committed to reducing the epidemic of dental decay in California's children by fluoridating California's public drinking water systems.

Community water fluoridation is the safest, most effective, and most economical public health intervention for reducing dental caries. At a cost of approximately $0.54 per person, per year, community water fluoridation in California could save millions of dollars allocated to the Denti-Cal program (California's Medicaid dental program), as well as prevent hundreds of thousands of sick days from school and lost days of work resulting from visits to the dentist or hospital emergency room.

The California Department of Public Health's (CDPH's) Oral Health Unit (OHU) is committed to reducing dental decay and tooth loss by continuing to provide leadership and facilitating collaboration and cooperation among public, private, and voluntary organizations. OHU also provides technical assistance, consultation, and public and professional education to local communities that are implementing and maintaining optimally fluoridated community water supplies.

In collaboration with the Drinking Water Program (DWP), OHU will establish a quality-assurance system to determine whether community water fluoridation systems actually maintain optimal levels of fluoride in drinking water.

With our partners, CDPH is striving to reach the *HP 2020 (Healthy People 2020)* goal of 79.6 percent of the population of California having access to fluoridated public drinking water. The current goal of OHU and the fluoridation project is to secure fluoridation for at least one additional community by 2020 and maintain fluoridation efforts for at least eight communities currently fluoridating.

This program is also responsible for implementing five objectives of the California Wellness Plan.

Primary Strategic Partnerships: OHU has fostered a number of collaborative relationships and strategic partnerships, both internally and externally, to achieve our goal.

Internal:
- Division of Drinking Water and Environmental Management

External:
- California Dental Association
- Fluoridation Advisory Council
- Delta Dental of California
- Centers for Disease Control and Prevention

Role of PHHSBG Funds: PHHSBG dollars support staff in the effort to expand water fluoridation in California and to maintain fluoridation of water systems or communities currently fluoridating. Personnel salaries are provided by PHHSBG.

Evaluation Methodology: The increase in the percentage of the population receiving fluoridated water from public water systems in California will be evaluated to determine if efforts to implement community water fluoridation are effective.

State Program Setting:
Community based organization, State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Specialist I
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded:	1.00
State FTEs:	1.00
Local FTEs:	0
Other FTEs:	0
Total FTEs Funded:	1.00

National Health Objective: HO OH-13 Community Water Fluoridation

State Health Objective(s):
Between 10/2013 and 09/2015, increase the proportion of the population in California served by community water systems with optimally fluoridated water from 58.8 to 64 percent.

Baseline:
58.8 percent (2008) of Californians had access to fluoridated drinking water.

Data Source:
Centers for Disease Control and Prevention (CDC), 2008

State Health Problem:
Health Burden:
Tooth decay (dental caries) affects 50 percent of all school-aged children and 96 percent of adults aged 18 or older. Tooth decay is five times more common in children than asthma. According to the 2004–2005 *California Smile Survey,* 54 percent of the kindergartners and 71 percent of third-grade children screened had a history of tooth decay. Twenty-eight percent of kindergartners and third graders had untreated tooth decay. Twenty-two percent of children needed non-urgent dental care and an

additional four percent needed urgent dental care because of pain or infection. Seventeen percent of kindergartners and 5.5 percent of third graders had never been to a dentist, putting them at greater risk of having untreated tooth decay. In addition, low-income, high-risk children rarely have dental insurance, and children of color are more likely to be from low-income families.

The **target population** includes all Californians. Although adults benefit from community water fluoridation, most benefits are noticed by children in the tooth-forming years, up to the age of 16 years (**disparate population**). An additional benefit to the senior population is gained because fluoridated water reduces the occurrence of root caries in seniors by as much as 40 percent.

Target Population:
Number: 37,966,471
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 9,295,040
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: California Department of Finance, 2012

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

- MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
- Other:
  - "Surgeon General's Report on Oral Health in 2002"
  - The California "Smile Survey"

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $151,905
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Domain #1: Policy, Systems, and Environmental Change
Objective 1:
Provide leadership and coordination.
Between 10/2013 and 09/2015, CWF staff will provide ongoing leadership and coordination with **a minimum of four** public, private, and voluntary organizations throughout the State to promote community water fluoridation and maximize resources.

Annual Activities:

1. Coordinate and collaborate.
Between 10/2013 and 09/2015, CWF staff will meet with the Fluoridation Advisory Council at least quarterly to strengthen collaboration and identify challenges, strategies, and resources for fluoridation.

2. Track fluoridated water systems.
Between 10/2013 and 09/2015, CWF staff, in collaboration with DWP, will track public water systems that are fluoridating to provide information to the public and identify and address noncompliant water systems.

3. Identify funding resources.
Between 10/2013 and 09/2015, CWF staff will identify at least one funding resource to share with communities interested in implementing or maintaining community water fluoridation.

Objective 2:
Provide technical assistance and training on community water fluoridation.
Between 10/2013 and 09/2015, CWF staff will provide consultation and technical assistance to **at least four** local communities to increase or maintain the percent of the population receiving community water fluoridation.

Annual Activities:

1. Provide technical assistance.

Between 10/2013 and 09/2015, CWF staff will provide technical assistance to at least four local communities interested in implementing or maintaining fluoridation, and to at least one state program regarding the public health benefits, safety, and efficacy of community water fluoridation.

2. Provide information and education.

Between 10/2013 and 09/2015, CWF staff will provide information and education regarding the benefits of community water fluoridation to local water purveyors, community leaders, policymakers, and interested community members in one to two communities to facilitate the implementation of water fluoridation.

3. Conduct webinar.

Between 10/2013 and 9/2014, CWF staff will conduct one webinar on community water fluoridation to a minimum of 30 representatives from local health departments, water engineers, operators, dental health professionals, and other interested individuals or partners to increase awareness of the science, benefits, and efficacy of community water fluoridation.

4. Promote CDC water fluoridation course.

Between 10/2013 and 09/2015, CWF staff, in collaboration with CDC and the DWP, will identify and recruit 5–10 water engineers and/or operators to attend **one** basic water fluoridation course.

Emergency Medical Dispatch Program/EMS Communications

State Program Strategy:

Goal 1: The California Emergency Medical Dispatch (EMD) Program will improve statewide training standards and provide uniformity through guidelines. This goal will be achieved by assessing established statewide EMS training standards that encourage the use of medical pre-arrival instructions by dispatchers at Public Safety Answering Points (PSAPs). This goal will also be accomplished working in conjunction with the California 9-1-1 Emergency Communications Office staff who have technical and fiscal oversight of the PSAPS. The guidelines and a template have been provided to the local EMS agencies (LEMSAs).

Goal 2: Encourage PSAPs that use EMD guidelines to strive to reach minimum national dispatcher certification standards for the dispatchers and dispatch center accreditation standards for dispatch centers. This represents a common goal of improving public care and maximizing the efficiency of 9-1-1 systems.

Primary Strategic Partnerships: The Emergency Medical Services Authority (EMSA) established an EMD Advisory Committee composed of stakeholders from public safety and technical groups and fostered a number of collaborative relationships and strategic partnerships, both statewide and nationally, to develop the EMD guidelines. That group will be reestablished as necessary to assess the progress of EMD in the State. Furthermore, EMSA routinely works with the LEMSAs throughout the State on EMS dispatch issues.

Internal:

- California Technology Agency/ 9-1-1 Emergency Communications Office
- California Emergency Management Agency
- EMS Commission
- California Highway Patrol
- California Department of Forestry and Fire Protection

External:

- California State Association of Counties
- California Fire Chiefs Association
- California Ambulance Association
- California Chapter of Emergency Numbers Association
- International Municipal Signal Association
- Northern Association of Public Safety Communication Officers
- Local EMS Agencies

Role of PHHSBG Funds: PHHSBG dollars support efforts to improve the capability of local medical dispatch. Funded positions serve to coordinate state and local agencies that work to implement statewide standardized program guidelines for emergency medical dispatch. Positions will also improve interoperability communications among EMS agencies and public safety responders.

Evaluation Methodology:

- Conduct surveys to determine the number of PSAPs that utilize EMD protocols, are currently EMD accredited, and utilize quality improvement (QI) processes.
- Assess survey data to evaluate whether EMD Programs have been established and to evaluate QI processes for the medical dispatch program and EMS communications.
- Conduct ongoing review of updated and new data from the LEMSAs for inclusion in the *State Communications Resource Manual.*

State Program Setting:
Local health department; Other: Counties

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manager II
State-Level: 16% Local: 0% Other: 84% Total: 100%
Position Title: Staff Services Manager I
State-Level: 16% Local: 0% Other: 84% Total: 100%
Position Title: Legal Typist
State-Level: 16% Local: 0% Other: 84% Total: 100%

Total Number of Positions Funded: 3
Total FTEs Funded: 3.00

National Health Objective: HO AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):
Between 10/2013 and 09/2015,

- Collaborate with LEMSAs in the development of EMD Program services in the majority of PSAPs within California.
- Coordinate with LEMSAs to provide resources for PSAPs to achieve a high standard of excellence at the dispatcher level, through certification, and at the communication center level, through an accreditation process.
- Coordinate with LEMSAs in the implementation of a continuous QI process for EMD programs.
- Work in conjunction with California 9-1-1 Emergency Communications Office to assist PSAPs with accreditation process.

Baseline:

- *EMSA established voluntary guidelines for EMD training and scope of practice that were approved by the EMS Commission. The intent is to encourage PSAPs to utilize pre-arrival emergency care instructions and uniform EMD protocols.*
- *A statewide communications feasibility study found California's EMS communications system to be fragmented. EMS agencies previously did not communicate with each other and restricted communications with on-scene public safety personnel. Furthermore, medical personnel at nearby hospitals had limited, if any, radio communications capabilities to the scene of an incident.*

Data Source:
U.S. Department of Transportation; Office of Traffic Safety, 2001

State Health Problem:
Health Burden:

- Without up-to-date dispatch guidelines, public safety agencies throughout the State have been following inconsistent EMD training standards and protocols.
  A caller dialing 9-1-1 in one part of the State could receive potentially life-saving pre-arrival medical instructions, such as CPR instructions, from the dispatch agency, while in another area, dispatchers may not be trained or equipped to provide such instructions.
- Without an updated communications resource manual, data necessary for radio interoperability is unavailable or not readily accessible to field personnel. This is particularly problematic in disaster situations, where personnel may be dispatched from other areas.

The **target population** and the **disparate populations** are the same: the 37,966,471 residents of California.

Target Population:
Number: 37,966,471
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 37,966,471
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: California Department of Finance, 2012

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:

- Statewide EMD guidelines were established in 2003, based on evidence from the U.S. Department of Transportation and the Office of Traffic Safety. These guidelines were developed by the California EMD Advisory Committee and approved by the EMS Commission.
- A feasibility study was conducted of the State's EMS communications system. In response to the feasibility study's findings, a State Communications Plan was developed, including an operational manual that needs to be continually updated.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $50,869
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Assist LEMSAs in upgrading EMS communications.
Between 10/2013 and 09/2015, EMSA staff will provide guidelines for improving communications systems to **32** LEMSAs and EMS participants (law enforcement, fire, ambulance, hospital).

Annual Activity:
Improve EMS communications.
Between 10/2013 and 09/2015, EMSA staff will:

- Assisting LEMSAs in improving EMS communications by providing access to data contained in the *EMS Operations and Communications Resource Manual.*
- Assessing emerging technologies in mobile data applications and information sharing between PSAPs, ambulances, hospitals, and EMS agencies.
- Soliciting interest from EMS agencies for participation in communication projects.

Objective 2:
Improve radio communication.
Between 10/2013 and 09/2015, EMSA staff will provide evaluations of improvements to radio communications interoperability functions to **12** state public safety agencies.

Annual Activity:
Attend quarterly meetings.
Between 10/2013 and 09/2015, EMSA staff will attend quarterly public safety committee meetings and other ongoing technical workgroup meetings to participate in planning an integrated public safety communications system for state agencies that coordinate with local agencies.

EMS for Children

State Program Strategy:

Goal 1: The California Emergency Medical Services for Children (EMSC) program is committed to continuing its efforts to fully institutionalize EMSC in California's Emergency Medical Services (EMS) system. This process incorporates statewide compliance with national EMSC performance measures and the development of a statewide EMS data collection system.

By integrating EMSC into the state EMS system, the EMS Authority (EMSA) will:

- Improve the availability of online and offline pediatric medical direction: A statewide survey was conducted in 2013 and baseline data acquired. Based on the responses received from the survey, California still needs to meet the EMSC federal program target of 80% for the 2010 survey process. Since the survey, the EMSC Coordinator has worked with the local EMSC Coordinators by helping them understand the survey process and by analyzing system gaps in meeting this performance measure.
- Ensure a complete inventory of essential pediatric equipment and supplies are on EMS response vehicles: A statewide survey was conducted in 2013 and baseline data acquired. Based on the responses received from the survey, California still needs to meet the EMSC federal program target of 80% for the 2010 survey process. Since the 2013 survey, the new national 2009 revised pediatric equipment list was e-mailed to all Local EMS Agencies (LEMSAs). The EMSC Coordinator has worked closely with the local EMSC Coordinators to develop steps or processes for each LEMSA to use and improve county/region results for the 2013 survey process.
- Integrate EMSC priorities into existing local/state EMS policy: By meeting the national EMSC performance measures, California is moving closer to integrating EMSC into existing local/state policy. Ultimately it is the EMSC program goal to integrate EMSC into state regulations.
- Provide pediatric continuing education for prehospital personnel: The EMSC program puts on a yearly pediatric educational conference for prehospital personnel. Continuing Education credit units are available for nurses, paramedics, and EMTs. The 16th annual conference held in 2013 had the highest attendance since we started having the EMSC conferences. We anticipate the 2014 conference to be even larger.

Goal 2: Improve utilization of California's pediatric data system to develop prehospital quality improvement (QI) indicators: The QI indicators have been tested in part by three LEMSAs utilizing local data systems. These indicators will be tested and reports will be generated at the State level as the California EMS Information System (CEMSIS) is populated with EMS and Trauma Center data from the local level.

Goal 3: Integrate family-centered care for children into California's EMS system: It is the EMSC program goal to develop a comprehensive model for the integration of family-centered care for children into California's EMS system. The guidelines will be a framework for LEMSAs, hospitals, and EMS providers in placing the patient and those

persons who are most important to the patient at the center of all health care interactions.

A family-centered approach to emergency care nurtures strong bonds between children and their families and uses those relationships to assist in providing quality care and promoting children's overall health and safety. This approach recognizes the expertise and range of experiences families bring to the health care system.

As consumers of emergency services, families can:

- Assist in and/or improve direct patient care;
- Design and evaluate programs and systems;
- Provide input on organizational governance;
- Support public policy and fundraising activities; and
- Raise public awareness about specific issues

Primary Strategic Partnerships: EMSA has established a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- California Health and Human Services Agency
- California Children Services
- Programs within the California Department of Public Health (CDPH)
- Commission on EMS
- Office of Traffic Safety
- Department of Social Services

External:

- EMSC Technical Advisory Committee
- EMSC Coordinators Group
- National EMSC Data Analysis Center (NEDARC)
- American Academy of Pediatrics
- American College of Emergency Physicians
- Human Resources Services Administration
- Maternal and Child Health Bureau
- Emergency Nurses Association
- EMS Agency Administrators Association
- EMS Medical Directors Association

Role of PHHSBG Funds: Block Grant dollars support the EMSC Coordinator position at EMSA. The EMSC Coordinator position continues program efforts by working with LEMSAs to develop and improve EMSC throughout California. Block Grant funds pay for 50% of the EMSC Coordinator position.

Evaluation Methodology: Surveillance data collected will be used to evaluate progress toward the overall goal of institutionalizing EMSC in California's EMS system. NEDARC assists California in surveying LEMSAs on compliance with national EMSC performance measures and subsequent data analysis. The EMSC Coordinators Group works with EMSA to develop and evaluate LEMSA compliance strategies.

Until the development of CEMSIS, the State was unable to collect standardized EMS/EMSC data to determine how to improve training and response. Pediatric-specific indicators have been developed for use with the new EMS System and Quality Improvement Model Program Guidelines and Regulations for EMS providers, base hospitals, Trauma Centers, and LEMSAs.

State Program Setting:
Community based organization, State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manager II
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Staff Services Manager I
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Legal Typist
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Associate Governmental Program Analyst
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 4
Total FTEs Funded: 4.00

National Health Objective: HO AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):
Between 10/2013 and 09/2015, provide technical assistance to at least five LEMSAs to explore ways of fully institutionalizing EMSC into their EMS system.

Baseline:
100% of LEMSAs have implemented all or part of the EMSC program (based on 31 LEMSAs).

Data Source:
Emergency Medical Services Agency

State Health Problem:
Health Burden:
Children have unique problems and needs associated with acute injury and illness, suffer from different types of injuries and illnesses than adults, and react differently to acute injury or illness and shock. As a result, children require different types of diagnostic procedures, medication, and support techniques. To ensure that California's children are adequately served, EMSC must be integrated into the overall EMS system.

Coordination and implementation of EMSC statewide has not been a simple task due to the complexity of the California EMS system, which is composed of 31 single-county or multi-county EMS systems overseen by EMSA. To address this problem, a comprehensive model for an integrated pediatric emergency and critical care continuum was developed in 1994. Since 1994, the 31 LEMSAs have implemented some, if not all, components of EMSC. The most frequently mentioned barrier to fully implementing EMSC is lack of cooperation among hospitals, coupled with the lack of authority of the LEMSA to perform site visits at hospitals or enforce any requirements for pediatric education for hospital personnel.

EMSA continues to strive toward 100% institutionalization of EMSC at the LEMSA level. The State has come a long way in promoting the EMSC model, as demonstrated by the fact that all 31 LEMSAs have implemented portions of EMSC into their EMS systems. The pediatric **target population** includes all California **children below 19 years of age** regardless of their race or socioeconomic background. The pediatric population of California is 29 percent of the State's population, per the July 1, 2007, Census Bureau estimates. The **target** and **disparate populations** are the **same**.

Target Population:
Number: 10,488,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 10,488,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Statewide Assessment of Emergency Medical Services for Children in California, 2005

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other:

- The Future of Emergency Care: Emergency Care for Children: Key Findings and Recommendations (Institute of Medicine of the National Academies, June 2006);
- Statewide Assessment of Emergency Medical Services for Children in California, 2005;
- American Academy of Pediatrics: Policy Statement—Equipment for Ambulances, 2009

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $82,762
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Provide technical assistance and direct activities.

Between 10/2013 and 09/2015, the state EMS for Children Program Manager will provide technical and administrative assistance to **13** committees: three statewide EMS for Children Committees and ten EMS for Children subcommittees to help plan and address EMS issues and accomplish select EMSC objectives.

Annual Activity:

Provide support to EMSC Committee.

Between 10/2013 and 09/2015, EMSA staff will, in order to provide information and skills necessary to accomplish EMSC objectives:

- Plan and sponsor November 2013 Northern California EMS for Children Prehospital Educational Forum.
- Conduct surveys – Compliance with national standard of off-line and on-line medical direction and compliance with national standard for essential pediatric equipment and supplies on EMS transport vehicles.
- Provide technical assistance to EMSC subcommittee to develop a toolkit for integration of family-centered care for children into California's EMS system.
- Set up and monitor monthly conference calls and biannual meetings of the state EMS for Children TAC and quarterly meetings of the local EMS for Children Coordinators Group.
- Attend federal EMSC grantee meetings.

EMS Partnership for Injury Prevention and Public Education

State Program Strategy:
Goal: The California Emergency Medical Services Authority (EMSA) is committed to ensuring that the role of emergency medical services (EMS) is recognized in state prevention and public education initiatives, programs, and policies.

EMSA provides technical assistance and program resources to facilitate local EMS participation in prevention and public education activities and to ensure greater public understanding of and access to the 9-1-1 system (including appropriate use). EMSA participates in statewide prevention and public education committees and task forces to ensure that EMS is recognized as a key partner in these activities and provides expertise in policy and program development for the EMS community.

EMSA recognizes that paramedics, emergency medical technicians (EMTs), first responders, and other prehospital emergency personnel are important resources for promoting and advancing injury prevention education and will continue to support training and community activities in this critical area.

EMSA's Strategic Plan and Mission Statement, the EMS Vision Process, the NHTSA Evaluation of California EMS, the Centers for Disease Control and Prevention, and the National Association of Emergency Medical Technicians have identified injury prevention and public education as valuable components of EMS and have identified several prevention and public education goals and unmet needs that EMSA is committed to. In addition, the federal Department of Transportation (DOT) paramedic and EMT training curriculums (the minimum standards for California's training programs) include recommendations for classroom hours in injury prevention, public education, employee wellness, and other related areas.

Primary Strategic Partnerships: EMSA has fostered a number of internal and external collaborative relationships and strategic partnerships, *as a co-lead, in California's Strategic Highway Safety Plan (SHSP), Challenge Area 15 (CA 15), whose goal is to improve post-crash survivability. Challenge Area teams are tasked with proposing and carrying out Safety Action Needs Plans (SNAPs) that will improve traffic safety in California. The SHSP Plan is maintained through a collaborative process that involves a wide range of safety stakeholders including many staff representing the Office of Traffic Safety. Currently, CA 15 is developing actions related to the safe removal of collisions related to traffic incident management (Steer It Clear Campaign), and the update of the 2015 DMV Driver Handbook.*

Internal:

- California Business, Transportation, and Housing Agency (BTH)
- California Children's Services (CCS)
- California Department of Alcoholic Beverage Control
- California Department of Corrections and Rehabilitation (CDCR)
- California Department of Motor Vehicles (DMV)
- California Department of Public Health (CDPH)
- California Department of Transportation (Caltrans)
- California Strategic Highway Safety Plan (SHSP)
- California Emergency Management Agency
- California Highway Patrol (CHP)
- California Office of Traffic Safety (OTS)
- California State Office of Rural Health (CalSORH)
- EMS Commission
- Health and Human Services Agency (HHS)
- Office of Statewide Health Planning and Development (OSHPD)

External:

- American College of Surgeons (ACS)
- American Trauma Society (ATS)
- Association of Air Medical Services (AAMS)
- California Ambulance Association (CAA)
- California Chapter of the American College of Emergency Physicians (CAL/ACEP)
- California Fire Chiefs (Cal-Chiefs)
- California Hospital Association (CHA)
- California Peace Officers' Association
- California Rural Indian Health Board (CRIHB)
- Centers of Disease Control and Prevention (CDC)
- Critical Illness and Trauma Foundation (CIT)
- Emergency Nurses Association (ENA)
- EMS Administrators Association of California (EMSAAC)
- EMS Medical Directors Association of California (EMDAC)
- Intermountain Injury Control Research Center (IICRC)
- National Highway Transportation Safety Association (NHTSA)
- National Trauma Data Bank (NTDB)
- Statewide Coalition on Traffic Safety (SCOTS)
- Society of Trauma Nurses (STN)
- Trauma Managers Association of California (TMAC)
- U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA)
- U.S. Department of Transportation, Federal Highway Administration (FHWA)
- Western Trauma Association (WTA)

Role of PHHSBG Funds: Block Grant dollars support the efforts of EMSA to participate in statewide prevention and public education activities. These funds pay for a percentage of personnel costs and associated operating expenses related to these activities.

Evaluation Methodology: Inclusion of an EMS role in statewide prevention and public education initiatives, programs, and policies will be used to evaluate the success of the overall program goal of ensuring the recognition of EMS as a vital partner in prevention and public education activities.

State Program Setting:
Community based organization, Medical or clinical site, State health department, University or college

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manger II
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Staff Services Manager I
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Legal Typist
State-Level: 12% Local: 0% Other: 88% Total: 100%

Total Number of Positions Funded: 3
Total FTEs Funded: 3.00

National Health Objective: HO AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):
Between 10/2013 and 09/2015, provide technical assistance to at least five of the State's 33 Local EMS Agencies (LEMSAs) regarding prevention of injuries along with appropriate access and utilization of EMS and other health care services in their counties/regions.

Baseline:
Baseline: *Traumatic injury is the primary cause of death for people ages 1 through 44, regardless of gender, race, or economic status. Injuries, both unintentional and those caused by acts of violence, are among the top ten killers for Americans of all ages. The cost of all traumatic injury in the United States is estimated at more than $224 billion each year. These costs include direct medical care, rehabilitation, lost wages, and lost productivity. The Federal Government pays about $12.6 billion each year in injury-related medical costs and about $18.4 billion in death and disability benefits. Insurance companies and other private sources pay about $161 billion.*

Data Source:
Trauma Managers Association of California

State Health Problem:
Health Burden:
CDPH's Epidemiology and Prevention for Injury Control (EPIC) data reports that in 2009 there were 16,888 injury deaths in California (spread across all ages) killed as a result of all types of injuries (target population). The highest concentration of deaths (10,352) fell into the 25–64 years of age category (disparate population). Nonfatal California injuries in 2009 that resulted in hospitalization were reported at 254,055. The highest concentration of nonfatal injuries (128,700) fell into the 45–84 years of age category (disparate population). Falls account for the high incidence in this category.

Because motor vehicle collisions are one of the most common causes of traumatic injury, a trip to work, a ball game, or even a vacation can become a life-altering event, resulting in lost productivity, lost quality of life, lifelong pain or disability, or even death.

Although injury deaths rank higher than serious illnesses such as heart disease, cancer, and diabetes for much of California's population, strategies for reducing the numbers of preventable injuries are often not stressed among some sectors of the public health community. This includes EMS. Whatever the cause of the injury or its outcome, an EMS responder would likely be dispatched to care for the injured victim and to transport the victim to a hospital or other facility, or to pronounce the victim dead. EMTs and paramedics have long been first on the scene of traumatic injuries, and have long witnessed firsthand the need for reducing preventable injuries whenever possible.

EMS providers in California are making a concerted effort to collect comprehensive injury data from patient care reports to develop effective injury prevention programs. They have also applied for funding to implement programs in their communities. Involvement in injury prevention and public education activities among EMTs and paramedics and their employers is steadily growing and has recently become an accepted part of their training and scope of practice. This is due in large part to an increased awareness of the value and logic, and cost-effectiveness, of using EMS personnel as a first-line defense in curbing needless traumatic injury, as well as greater public recognition of those who have made a difference.

Even with this greater appreciation for the importance of EMS involvement in prevention and public education activities, resources directed toward facilitating this process, including funding, training, employer support, and access to data and other tools, have been limited and often inadequate. Some assistance in this area has come through PHHSBG funding, which EMSA has used to provide local assistance grants to over one-third of California's LEMSAs for developing, implementing, evaluating, and sharing innovative prevention and education programs. Many of these programs are still active.

Target Population:
Number: 36,961,664
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 18,763,417
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau demographic data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:

- In 2002, the American Trauma Society, supported by the U.S. Department of Transportation, National Highway Traffic Safety Administration, issued "Trauma System Agenda for the Future." This report noted that: "Trauma systems, when fully implemented throughout the United States, will enhance community health through an organized system of injury prevention, acute care, and rehabilitation that is fully integrated with the public health system in a community."
- The American College of Surgeons report, "Resources for Optimal Care of the Injured Patient: 2006," supports:
- Primary prevention strategies to prevent the occurrence of the injury itself (e.g., legislation to limit sale of alcohol to teenagers).
- Secondary prevention measures to seek to limit energy transfer to the individual, thus minimizing the severity of the injury (e.g., implementation of a bicycle helmet use campaign).
- Tertiary prevention to target improving outcome following injury (e.g., institution of triage to trauma centers).

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $56,103
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Attend quarterly meetings.
Between 10/2013 and 09/2015, EMSA staff will provide input on implementation objectives for injury prevention and public education strategies to **four** state, local, and federal public health and transportation safety groups.

Annual Activity:
Serve on EMS Committee.
Between 10/2013 and 09/2015, EMSA staff will serve as EMS representative of prevention/public education committees, to provide input on implementation objectives.

- *State Strategic Highway Safety Plan Steering Committee.* This committee develops, per federal requirements, priority needs and strategies for improving California highway safety and to reduce deaths and injuries on all roadways from all causes. Participate in a minimum of four meetings by 06/30/2014.
- *Challenge Area 15.* A working group developed from the *Strategic Highway Safety Plan (SHSP),* whose goal is to improve post-crash survivability. EMSA staff co-leads this group. Convene a minimum of two meetings by 6/30/2014.
- *Regional Trauma Coordinating Committees.* EMSA will promote injury prevention activities within each of the five regions. Attend meetings or participate in conference calls for a minimum of two meetings/calls per region by 06/30/2014.
- *State Trauma Summit.* Direct the California State Trauma Summit III to provide preventive information to participants by 06/30/2013.
- *TMAC (Trauma Managers Association of California) Injury Prevention Subcommittee.* Attend (or participate in conference calls) a minimum of two meetings by 06/30/2014.
- *EMS for Children (EMSC) Coordinators Group*. A subgroup of the EMSC Technical Advisory Committee. This group develops statewide guidelines for EMSC, including prevention and public education, and is the lead in coordinating the annual EMSC Workshop, which sponsors at least one prevention-related presentation. Attend a minimum of two meetings and or conference calls by 06/30/2014.

Objective 2:
Offer continuing education credits.
Between 10/2013 and 09/2015, EMSA staff will implement **two** state supported education workshops to provide continuing education to EMS constituents and their members.

Annual Activity:
Provide continuing education.
Between 10/2013 and 09/2015, EMSA staff will offer EMS continuing education credits for all workshops that provide training related to prevention and/or public education activities.

EMS Poison Control System

State Program Strategy:

Goal: The Emergency Medical Services Authority (EMSA) is committed to protecting the health of Californians by providing immediate, uninterrupted, high-quality emergency telephone advice for poison exposures. The California Poison Control System (CPCS) is accessible to all people and serves as the primary resource for poison education, prevention, and treatment in California.

EMSA is dedicated to preventing unnecessary trips to the emergency department by improving use of emergency services resources. Each year, poison center call data is analyzed to determine how to improve telephone services and reduce the burden for emergency departments. EMSA has contracted with the University of California, San Francisco (UCSF) to provide administrative services for CPCS. CPCS incorporates four poison centers, all managed by the program director at the UCSF School of Pharmacy.

CPCS incorporates four poison centers, all managed by the program director at the UCSF School of Pharmacy. The Governor's fiscal year (FY) 2012–13 budget provided $2.95 million to CPCS, and the Managed Risk Medical Insurance Board matched the $2.95 million provided by EMSA, for a total of $8.4 million. In addition, $800,000 from Supplemental Medi-Cal funding is being provided. EMSA continues to assist in the acquisition of stable funding for the provision of poison control services. EMSA will continue to use Preventive Health and Health Services Block Grant (PHHSBG) funds for staffing to monitor and evaluate the Poison Control System.

Primary Strategic Partnerships: EMSA has fostered collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- California Health and Human Services Agency
- California Department of Health Care Services
- California Emergency Preparedness Office
- EMS Commission
- Department of Finance

External:

- American Association of Poison Control Centers
- Health Resources and Services Administration
- University of California (San Francisco, San Diego, Davis)
- Children's Hospital, Central California
- Emergency medical community organizations
- Centers for Disease Control and Prevention
- Office of Emergency Services

Role of PHHSBG Funds:

- A portion of Block Grant dollars supports efforts of poison control educators to increase poison awareness and promote poison prevention.
- Other Block Grant funds support staffing at EMSA to monitor and evaluate the Poison Control System according to California regulations.

Evaluation Methodology:

- Quarterly progress reports are required to evaluate and monitor CPCS operations and compliance with state standards for poison control services. These reports include information on:
  - CPCS operations;
  - Local community involvement;
  - Quality improvement;
  - Clinical and triage protocols;
  - Public information;
  - Prevention education; and
  - Call and poisoning statistical reports.
  - Sites are visited by EMSA staff periodically to provide additional monitoring activities.

State Program Setting:

Community based organization, Home, Medical or clinical site, University or college

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manager II
State-Level: 12% Local: 0% Other: 82% Total: 94%

Position Title: Staff Services Manager I
State-Level: 12% Local: 0% Other: 88% Total: 100%

Position Title: Health Program Specialist I
State-Level: 30% Local: 0% Other: 20% Total: 50%

Position Title: Legal Typist
State-Level: 12% Local: 0% Other: 88% Total: 100%

Total Number of Positions Funded: 4
Total FTEs Funded: 3.44

National Health Objective: HO IVP-9 Poisoning Deaths

State Health Objective(s):

Between 10/2013 and 09/2015, Reduce poison-related morbidity and mortality by assuring that CPCS maintains quality improvement and by accessing performance through submission of quarterly progress reports and site visits.

Baseline:
CPCS received 314,541 poison exposure calls, according to the CPCS 2011/12 "Poison Control Call Statistic Report." About 1646,506 of these calls were managed at home, and 49 percent of poison exposure calls involved children aged five years and under.

Data Source:
California Poison Control System

State Health Problem:
Health Burden:
Poisonings are a significant health problem in California. Annually, there are more than 300,000 poison exposure calls to CPCS. About 80 percent of all calls come from residences, and more than half of these calls involve children aged five years and under. Poison centers reduce health care expenditures by reducing the number of calls to ambulance dispatch centers and by preventing unnecessary ambulance transports and emergency department visits. More than 164,000 emergency room and physician office visits were averted in 2010 because of immediate service available from CPCS. When poisonings are not treated immediately, it may ultimately cost more for treatment in an emergency department or intensive care unit. Poison control centers provide a proven prevention service that reduces deaths and disabilities.

The **target population** and the **disparate populations** are the same: the 37.67 8,563 residents of California, plus an unknown number of visitors to the State.

Target Population:
Number: 38,487,889
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 38,487,889
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state

Target and Disparate Data Sources: The Institute of Medicine's "Forging a Poison Prevention and Control System"

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other: The Institute of Medicine's "Forging a Poison Prevention and Control System"

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $80,293
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Maintain oversight.
Between 10/2013 and 09/2015, EMSA staff will provide oversight to **two** poison control centers that provide emergency telephone advice by an expert workforce 24 hours a day.

Annual Activity
Provide technical assistance.
Between 10/2013 and 09/2015 EMSA staff will:

- Collecting and reviewing poison control c*all center and Poisoning Statistic Reports.*
- Monitoring contract compliance.
- Providing ongoing technical assistance.

EMS Prehospital Data & Information Services and Quality Improvement Program

State Program Strategy:
Goal: Develop the capacity of the EMS Authority (EMSA) to collect and analyze patient-level data from emergency medical service systems in California.

Without state-level data collection activities, EMSA is unable to comply with federal, state, and constituent requests for information concerning the State's emergency medical services (EMS). Data collection is critically needed to establish the value of EMS and facilitate system oversight. Information and data analysis, when timely and accessible, empower EMS leaders to make informed decisions, invest state resources in programs that improve patient outcomes, and maximize the value returned by state and federal tax dollars.

EMSA seeks to develop its state data system by collecting information on EMS calls, pre-hospital EMS patient encounters, and hospital encounters for patients who have experienced medical emergencies. Currently, EMSA collects EMS call and pre-hospital patient information through the California EMS Information System (CEMSIS) data system known as CEMSIS-EMS, and injured patient care data from hospitals is collected by CEMSIS–Trauma, the state trauma registry.

Ultimately, the goal of EMSA is to add specialized hospital data sets to its system and unite components under a single data warehouse. This would provide a comprehensive electronic picture of California's EMS system operations statewide, fostering analyses on patient cohorts and public health systems alike.

EMSA participates, as a co-lead, in California's Strategic Highway Safety Plan (SHSP), Challenge Area 15 (CA 15), whose goal is to improve post-crash survivability. Challenge Area teams are tasked with proposing and carrying out Safety Action Needs Plans (SNAPs) that will improve traffic safety in California. The SHSP Plan is maintained through a collaborative process that involves a wide range of safety stakeholders including many staff representing the Office of Traffic Safety. Currently, CA 15 is developing actions related to the safe removal of collisions related to traffic incident management (Steer It Clear Campaign), and the update of the 2015 DMV Driver Handbook.

Primary Strategic Partnerships: EMSA has fostered a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- Office of Statewide Health Planning and Development
- California Office of Traffic Safety
- California Highway Patrol
- California Department of Public Health
- EMS Commission
- California Health and Human Services Agency

External:

- California Fire Chiefs Association
- California Ambulance Association
- EMS Administrators Association
- EMS Medical Directors Association
- California Hospital Association
- Trauma Managers Association
- National EMS Data Analysis Resource Center
- NEMSIS Technical Assistance Center
- National Trauma Data Bank (American College of Surgeons)
- California Healthcare Foundation

Role of PHHSBG Funds: PHHSBG dollars support efforts to improve the collection of data related to EMS calls, pre-hospital patient care, and inpatient care at specialty hospitals across the State. The funds are applied to operating expenses and program personnel costs.

Evaluation Methodology: Data from CEMSIS will be used to evaluate the delivery of EMS throughout the State. EMSA staff will collect, collate, and distribute data that will be used for EMS system improvements, operational oversight, and statewide policy development.

Quality Improvement Program

Goal: Implement a State Quality Improvement (QI) Program in accordance with California Code of Regulations (CCR) Title 22, Chapter 12, and the Model Quality Improvement Guidelines. State EMS System QI indicators used to evaluate the effectiveness of EMS were developed by EMS constituent groups via the EMS Data Committee and are reflected in the QI Program Guidelines referenced in CCR Title 22, Chapter 12. With the development of CEMSIS–EMS, data will be obtained from Local EMS Agencies (LEMSAs), allowing for the use of the approved QI indicators. With use, new indicators will be developed, and existing indicators may require some revision in collaboration with EMS constituent groups.

Each LEMSA is responsible for approving EMS provider agency, Base Hospital, and Trauma Center QI Plans. Each LEMSA is also responsible for developing a local system QI Plan that must be approved by EMSA.

Primary Strategic Partnerships: EMSA has fostered a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- Office of Statewide Health Planning and Development
- California Office of Traffic Safety
- California Highway Patrol
- California Department of Public Health
- EMS Commission
- California Health and Human Services Agency

External:

- California Fire Chiefs Association
- California Ambulance Association
- EMS Administrators Association
- EMS Medical Directors Association
- National EMS Data Analysis Resource Center
- California Healthcare Foundation

Role of PHHSBG Funds: PHHSBG dollars support efforts to develop a state QI Program and carry out QI activities. The dollars pay for operating expenses and program personnel costs.

Evaluation Methodology: Statewide QI activities, including review and revision of state QI indicators, will provide evidence-based information for EMSA and statewide EMS stakeholders to improve the delivery of EMS care throughout California.

State Program Setting:
Community based organization, State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manger II
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Health Program Manger I
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Legal Typist
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Staff Services Analyst
State-Level: 50% Local: 0% Other: 50% Total: 100%

Total Number of Positions Funded: 4
Total FTEs Funded: 4.00

National Health Objective: HO AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):
Between 10/2013 and 09/2015, maintain EMS information systems and facilitate compliance with national data standards such as those published by NEMSIS and NTDB.

Baseline:
Each of the 33 LEMSAs has a system for collecting and evaluating patient care data; however baseline measures to describe the nature of these systems do not exist. For example:

- *The completeness, accuracy, and scalability of local data systems are not well understood.*
- *The percentage of EMS patient encounters in California that are reported electronically has yet to be calculated.*
- *The availability of key data management resources at the local level has not been studied quantitatively.*

Forty-eight of California's 58 counties (83 percent) currently participate in the State's electronic data program to some degree, although the degree to which they participate remains undetermined.

Of the ten remaining counties, five are actively working with EMSA to begin state data program participation, and five had no known plans to participate, as of July 2012.

Data Source:
EMS Systems Division at California EMS Authority, July 2012

<u>State Health Problem</u>:
Health Burden:
California does not have an enforceable mandate for the electronic collection of patient care information by local agencies. Also, there is no enforceable mandate for local agencies to submit that information to EMSA. Therefore, participation and engagement in data-related activities by local stakeholders is voluntary.

EMSA works with stakeholders and software vendors to develop state data standards, adopt national data standards, and encourage local participation in CEMSIS. Although data reflecting these incidents may exist at the EMS provider, Trauma Center, or LEMSA level, statewide data is not captured centrally (**disparate population**).

The **target** and **disparate** populations are the **same**.

The challenge that remains is extracting the information from CEMSIS and converting it into the national format. NEMSIS support staff works with EMSA staff to create the procedures that will load CEMSIS data into the NEMSIS format and allow for transmission of state data to the national data warehouse. As of July 2012, these procedures are undergoing final testing, and the first official NEMSIS data file from California is expected to be completed in Summer 2013. This important milestone for EMSA will lay the foundation for developing California's long-term NEMSIS participation strategy

California also contributes trauma center inpatient data to NTDB; however the NTDB prefers to receive that data directly from trauma centers rather than from state data

systems. EMSA supports national and state trauma data initiatives by maintaining trauma data standards that are compliant with NTDB. NTDB communicates directly with the transmitting trauma center to ensure quality data. A communication link between EMSA and NTDB remains open for possible state-level participation in the future.

One of five recommendations for EMS information systems in *EMS Agenda for the Future* (NHTSA 2010) is specific to cost: EMS must develop and refine information systems that describe the entire EMS event such that patient outcomes and cost-effectiveness issues can be determined. Data lacking in this area include the cost and value of EMS and Trauma systems. National and state EMS/Trauma databases could be used to facilitate cost–benefit analyses.

Target Population:
Number: 36,966,471
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 36,966,471
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: 2009 California Department of Finance demographic data

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other: American College of Surgeons (ACS) has been addressing the need for a strong national trauma care system through the development of NTDB.

The goals and objectives of NTDB are to:
- Improve the quality of patient care;

- Provide an established information system for evaluation of injury care and preparedness;
- Develop better injury scoring and outcome measures;
- Provide a rich source of data for clinical benchmarking, process improvement, and patient safety.

Evidence-Based Guidelines: Trauma:
Since 1989, the American College of Surgeons (ACS) has been addressing the need for a strong national trauma care system through the development of the National Trauma Data Bank (NTDB). The NTDB has been designed by a collaborative group of ACS Committee on Trauma members, emergency medical organizations, governmental agencies, trauma registry vendors, and other interested parties.

The goal of the NTDB is to inform the medical community, the public, and decision makers about a wide variety of issues that characterize the current state of care for injured persons in our country. The information contained in the data bank has implications in many areas, including epidemiology, injury control, research, education, acute care, and resource allocation. The goals and objectives of the NTDB are to:
- Improve the quality of patient care;
- Provide an established information system for evaluation of injury care and preparedness;
- Develop better injury scoring and outcome measures;
- Provide a rich source of data for clinical benchmarking, process improvement, and patient safety.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $290,804
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Increase local agency participation in state-level EMS Quality Improvement Program.
Between 10/2013 and 09/2015, EMSA staff, to assess system effectiveness and/or performance, will increase the number of submitted and approved Local Quality Improvement Plans from one to **three**.

Annual Activity:

Provide outreach and assistance.

Between 10/2013 and 09/2015, EMSA staff will increase local agency effectiveness and performance by:

- Providing outreach and assistance to 33 Local EMS Agencies.
- Increasing transparency and standardization of the EMS Plan review process by using customary processes in the evaluation of at least three Quality Improvement Plans.

EMS STEMI and Stroke Systems

State Program Strategy:
Goal: By 2014, develop the California STEMI System (ST–segment Elevation Myocardial Infarction) and Stroke System Regulations and submit to the Office of Administrative Law (OAL) to begin the regulatory approval process.

The Emergency Medical Services Authority (EMSA) has the statutory authority to set standards for STEMI and Stroke systems through the development of California State Regulations. This project involves expert guidance in the development of specific language that will regulate the establishment of STEMI and Stroke systems throughout the State of California. Regulations created by EMSA will have a direct public benefit by improving the care of patients suffering from life-threatening acute heart attacks and strokes. As described by law within Section 2.5 of the California Health and Safety Code, specialty care systems, including hospital designations, can be regulated by EMSA. Local communities, through the professional work and decision-making authorities of their Local EMS Agencies (LEMSAs), may implement these regulations.

An acute heart attack occurs when there is a disruption or blockage in a blood vessel and reduction in oxygenated blood flow. The most severe form of a heart attack is called an ST-segment Elevation Myocardial Infarction (STEMI). This term refers to a specific pattern that is observed on an electrocardiogram (EKG). STEMIs occur when there is complete occlusion of a blood vessel resulting in a lack of blood flow to the heart muscle. Within minutes, irreversible tissue damage occurs. Approximately 30 percent of heart attacks in the United States are classified as STEMIs. This project will develop important expert guidance, in the form of proposed regulatory language, for the development and implementation of STEMI care systems in California.

Stroke is the third leading cause of death in California and the leading cause of long-term disability. A stroke occurs when blood flow to a part of the brain is interrupted because a blood vessel in the brain is blocked or bursts. The sudden death of some brain cells is due to a lack of oxygen when the blood flow to the brain is impaired by blockage (ischemic) or rupture (hemorrhagic) of an artery to the brain. Stroke is also called a cerebrovascular accident, or CVA. Ischemic strokes are caused by the blockage of a blood vessel and hemorrhagic strokes are caused by bleeding in the brain. Stroke, sometimes called a “brain attack,” is injury to the brain, spinal cord, or retina caused by reduction in oxygenated blood flow. Recent advances in stroke care, including the introduction of time-sensitive therapies, have emphasized the critical need for optimal stroke treatment pathways.

This project will develop important expert guidance, in the form of proposed regulatory language, for the development and implementation of stroke care systems in California.

These regulations will consider the current, state-of-the-art standards of care as recognized by the American Heart and Stroke Association and American College of Cardiology, as well as the California Department of Public Health, Heart Disease and

Stroke Prevention Program. The regulations will provide direction to LEMSAs for the development, implementation, and ongoing review of the effectiveness of these specialty care systems. These systems include the oversight of patient care in both the pre-hospital and in-hospital environments.

The key areas to be addressed within the regulatory recommendations are: pre-hospital EMS policies, hospital designation criteria, data collection, quality improvement processes, and time-critical intervention. The overall goal of this project is to reduce morbidity and mortality from acute cardiac and stroke disease through regulations focused on improving the delivery of emergency medical care in local communities. EMSA utilizes recognized STEMI and Stroke experts throughout the State on the STEMI and Stroke System task forces to develop regulations for local and regional STEMI and Stroke systems. In addition to the development of regulations, implementing a State Registry for STEMI and Stroke will be explored.

Primary Strategic Partnerships: The program has established a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- California Department of Public Health
- California Emergency Management Agency
- California Highway Patrol
- California Office of Traffic Safety
- California State Office of Rural Health
- Commission on EMS
- California Health and Human Services Agency
- Office of Statewide Health Planning and Development
- California Heart Disease and Stroke Prevention Program

External

- American Heart Association
- American College of Cardiology
- California Hospital Association
- California Ambulance Association
- EMS Providers
- Local EMS Agencies
- California Chapter of the American College of Emergency Physicians
- California Fire Chiefs
- Emergency Nurses Association
- EMS Administrators Association of California
- EMS Medical Directors Association of California
- National Highway Transportation Safety Association
- U.S. Department of Health and Human Services, Health Resources and Services Administration
- California Stroke Registry

Role of PHHSBG Funds: Block Grant dollars support EMSA's efforts to establish STEMI and Stroke Systems with strong state leadership. The funding provides for a State Specialty Care System Specialist and supporting staff.

Evaluation Methodology: As the regulations are drafted, task force members discuss key issues with the organizations they represent and bring back to the group any

recommended revisions. The pre-public comment period with the EMS Administrators Association of California (EMSAAC) and the EMS Medical Directors Association of California (EMDAC) provides comments from the key stakeholders in STEMI and Stroke System development. All comments are taken into consideration as the draft regulations are revised. Status of the project is provided to EMSAAC and EMDAC on a quarterly basis, allowing for discussion and recommendations. In addition, project status is provided to the Commission on EMS on a quarterly basis, allowing for EMS constituent feedback on the process. In the next fiscal year, EMSA will create an Advisory Committee for STEMI and Stroke programs that will include internal and external stakeholders to provide guidance to these systems. EMSA will use the collected data to evaluate progress toward the goal of institutionalizing the STEMI and Stroke programs in California's EMS system.

State Program Setting:
Local health department, Medical or clinical site, State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manager II
State-Level: 10% Local: 0% Other: 0% Total: 10%
Position Title: Health Program Specialist II
State-Level: 85% Local: 0% Other: 15% Total: 100%
Position Title: Staff Services Manager I
State-Level: 15% Local: 0% Other: 85% Total: 100%
Position Title: Legal Typist
State-Level: 10% Local: 0% Other: 90% Total: 100%

Total Number of Positions Funded: 4
Total FTEs Funded: 3.10

National Health Objective: HO AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):
Between 10/2013 and 09/2015, establish STEMI and Stroke System Regulations.

Baseline:
The State is comprised of 58 counties divided into 33 LEMSAs (26 single-county, seven multi-county agencies). LEMSAs plan, implement, and manage local STEMI and Stroke systems based on state guidelines, but they are not mandated to have a plan. Of the 58 counties, 43 have a STEMI System and 26 have a Stroke System for their EMS region.

Data Source:
CEMSIS; NEMSIS

State Health Problem:

Health Burden:

Heart disease is the leading cause of death and long-term disability in adults. The chance of stroke is doubled each decade after the age of 55, and three-quarters of all heart attacks occur in people over 65. In California, heart disease accounts for approximately 47,000 deaths each year, 134 deaths per 100,000 population. In the past, six percent of Californians reported a diagnosis of heart disease. The annual cost of coronary heart disease in California is approximately $20 billion. Stroke is the third leading cause of death in California and a leading cause of long-term disability.

Multiple organizations (U.S. Department of Health and Human Services, California Department of Public Health, California EMS Authority, American Heart and Stroke Association, American College of Cardiology, National Institute of Neurological Disorders and Stroke, and American College of Emergency Physicians), have created a workgroup whose mission is to reduce heart attack and stroke morbidity and mortality in California by:

- Establishing strategies for the development of a statewide system of STEMI and Stroke care for adults over age 18, including: (1) recommendations for pre-hospital patient assessment and destination hospital determination for eligible STEMI and Stroke patients; (2) criteria for the designation of STEMI and Stroke Receiving Centers; (3) criteria for the designation of STEMI and Stroke Referral Facilities; (4) criteria for transfer of STEMI and Stroke patients; and (5) continuity of care through linkages between medical facilities.
- Providing guidance as STEMI and Stroke systems of care are implemented in California.
- Promoting recovery from STEMI and Stroke, including access to rehabilitation services.
- Promoting secondary prevention of STEMI and Stroke, including smoking cessation and other risk-reduction strategies.

EMSA will standardize these systems through the STEMI and Stroke regulations.

Target Population:

Number: 28,683,239
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 28,683,239
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: 2012 U.S. Census estimate. This report utilized federal data when possible. The State of California needs to collect data on STEMI and Stroke to evaluate these systems and improve the quality of car

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:

- "A Statewide Plan for California, Recommendations for the Establishment of an Optimal System of Acute Stroke Care for Adults," Stroke Systems Work Group, 2009. Co-sponsored by American Heart Association/American Stroke Association, and California Department of Public Health.
- "A Statewide Plan for California, Recommendations for the Early Management of Adults with ST-Elevation Myocardial Infarction (STEMI)," Stroke Systems Work Group, 2010. Co-sponsored by American Heart Association/American Stroke Association, and California Department of Public Health.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $146,106
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Facilitate two specialty care task force groups.
Between 10/2013 and 09/2015, EMSA staff will provide facilitation for **two** multidiscipline taskforces for the development of STEMI and Stroke System regulations.

Annual Activity:
Develop specialty care regulations.
Between 10/2013 and 09/2015, EMSA staff will help develop STEMI and Stroke System regulations by:

- Recruiting Specialty Care taskforce members.
- Facilitating 6–12 regulation development meetings to ensure appropriate taskforce membership.
- Providing drafts of specialty care system regulations (STEMI & Stroke) to EMSAAC, EMDAC, and OAL, for pre-public comment, revising regulations based on comments received, and then preparing one final draft for public comment.

EMS Systems Planning and Development

State Program Strategy:

Goal: This program provides statewide coordination of planning, development, and implementation of local Emergency Medical Service (EMS) systems. The EMS system is committed to ensuring quality patient care by administering an effective statewide system of coordinated emergency care, injury prevention, and disaster medical response. Thirty-three local Emergency Medical Services agencies (LEMSAs) are made up of six multi-county EMS systems composed of 30 counties, one regional agency composed of two counties and 26 single-county agencies that administer all local EMS systems. Multi-county agencies are usually small and rural; single-county agencies are usually larger and more urban. Statewide coordination includes the following:

- Assessment of EMS systems to coordinate EMS activity based on community needs and the effective and efficient delivery of emergency services.
- Provision of technical assistance to local and state agencies developing or implementing components of an EMS system.
- Development and maintenance of standards and guidelines for the development of EMS systems throughout the State.
- Review and approval of local EMS plans, which must comply with the minimum standards set by the EMS Authority (EMSA).
- Provision of PHHSBG funds to develop and improve rural EMS systems. These funds have been used for the development of rural multi-county EMS systems over the past 15 years.

Primary Strategic Partnerships: EMSA has fostered a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- California Health and Human Services Agency
- EMS Commission
- Department of Finance
- California State Office of Rural Health

External:

- Emergency Medical Directors Association
- LEMSAs
- Emergency medical Administrators Association
- Local area hospitals
- Ambulance companies
- Nurse associations
- Paramedic associations
- EMT associations
- First responders
- Fire departments

Role of PHHSBG Funds: PHHSBG dollars pay for 50 percent of the EMS System Program Analyst position. This position provides oversight of the LEMSAs, which includes monitoring the regional agencies and their performance according the *EMS System Standards and Guidelines.*

Evaluation Methodology: EMSA provides management of the State's EMS System by maintaining oversight of the LEMSAs. The LEMSAs are required to submit an annual EMS Plan. In addition, multi-county agencies submit quarterly progress reports. The LEMSAs are held to standards designated by statewide guidelines covering the eight components of EMS service. The local plans are used to evaluate progress toward the goal of statewide coordination, including planning, development, and implementation of local EMS systems.

State Program Setting:
Community based organization, Other: Various EMS Associations

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manager II
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Health Program Manager I
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Staff Services Analyst
State-Level: 50% Local: 0% Other: 50% Total: 100%
Position Title: Legal Typist
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Health Program Specialist I
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 5
Total FTEs Funded: 5.00

National Health Objective: HO AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):
Between 10/2013 and 09/2015, provide statewide coordination for the planning, development, and implementation of LEMSAs.

Baseline:
There are 33 LEMSAs serving California's residents. This includes six multi-county agencies that cover over two-thirds of the State's geography.

Data Source:
- Institute of Medicine;
- American College of Emergency Physicians;
- National Association of EMS Officials

State Health Problem:
Health Burden:
California's emergency care continues to be fragmented; emergency departments (EDs) and trauma centers are not effectively coordinated, resulting in unmanaged patient flow. Training and certification of emergency medical technicians (EMTs) does not consistently conform to national and state standards, resulting in various levels of trained and qualified personnel working the front lines of EMS. Multi-county agencies are often served by multiple 9-1-1 call centers, and often EMS providers operate on different radio frequencies; therefore they do not effectively communicate with each other. Many EDs are overcrowded, and the diversion system is controversial.

Critical care specialists are often unavailable to provide emergency and trauma care; the emergency care system is not fully prepared to handle a major disaster; and not all EDs are equipped to handle pediatric care. Many deficiencies exist in EMS systems, making it critical to have LEMSAs that work to improve coordination of the system to maximize the resources available to the public.

The **target population** is the number of persons that may require 9-1-1 emergency calls for medical care annually. The **disparate population** is the number of persons making 9-1-1 calls in rural counties. Six multi-county agencies cover over two-thirds of the State's geography. These agencies provide service to 30 of the State's 58 counties, with a total resident population of 5,604,678 and an annual tourist population of 42,066,000.

Target Population:
Number: 37,966,471
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 5,604,678
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural
Primarily Low Income: No
Location: Specific Counties
Target and Disparate Data Sources: EMS plans and California Department of Finance 2012 state population estimate

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:
- Division 2.5 of the California Health and Safety Code, and operational standards and guidelines created by a committee of EMS professionals and authorized by the EMSA Commissioners.
- The Institute of Medicine's annual reports, beginning with "Crossing the Quality Chasm" (2001); "Future of Emergency Care: Dissemination Workshop Summaries" (May 2007), and ending in the latest (March 2010) workshop summary report, "Regionalizing Emergency Care Workshop Summary."
- Research provided through the American College of Emergency Physicians; and papers produced by the National Association of EMS Officials.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $329,318
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Facilitate regulation development.
Between 10/2013 and 09/2015, EMSA staff will provide facilitation to **one** multi-disciplinary task force of EMS constituents to assist with the development of regulations

related to the coordination of ambulance zones, transportation, and EMS service providers.

Annual Activity

Develop regulations.

Between 10/2013 and 09/2015, EMSA staff will:

- Develop regulations to provide clarification of statutes on exclusivity of ambulance zones and EMS provider agency administration requirements.
- Review and provide technical assistance to LEMSAs with ambulance zone and exclusive operating area issues.

Objective 2:

Improve EMS reporting standards in rural environments.

Between 10/2013 and 09/2015, EMSA staff will update six regional EMS plan reporting formats that will improve the development of rural multi-county EMS.

Annual Activity

Work collaboratively with LEMSAs.

Between 10/2013 and 09/2015, EMSA staff will provide information on updating regional plans by:

- Conferring with regional LEMSA administrators regarding changes in the reporting requirements.
- Revising the policy for the Multi-County Fund.

Objective 3:

Monitor and provide assistance.

Between 10/2013 and 09/2015, EMSA staff will evaluate **33** LEMSAs to ensure that they have submitted current EMS System Plan updates to EMSA for approval.

Annual Activity:

Update EMS System Plans.

Between 10/2013 and 09/2015, EMSA staff will facilitate plan update submissions by:

- Requesting EMS System Plan updates from the LEMSAs that have not provided current EMS Plan updates.
- Providing technical assistance to LEMSAs in compiling their EMS Plan updates.
- Contacting LEMSAs to request any needed clarification to complete review of their EMS Plans.
- Distributing correspondence to all LEMSAs that submitted EMS Plan updates before June 30, 2014, regarding the status of their EMS Plan approval.

Objective 4:

Provide information.

Between 10/2013 and 09/2015, EMSA staff will provide the most current EMS statutes and regulations, and both EMSA and non-EMSA materials relating to EMS, on an ongoing basis, to **33** LEMSAs to ensure submitted EMS Plans are written in accordance with current laws and regulations.

Annual Activity

Update EMSA website.

Between 10/2013 and 09/2015, EMSA staff will update EMSA website to ensure information and links are current for statutes, regulations, publications, LEMSAs, and other EMS-related information.

Objective 5:

Revise 1993 EMS Standards and Guidelines to reflect current EMS Standards.

Between 10/2013 and 09/2015, EMSA staff will update **one** document, the *EMS System Standards and Guidelines,* that outlines the planning and implementation guidelines for EMS systems and identifies the eight EMS components utilized within the LEMSAs.

Annual Activity:

Revise guidelines.

Between 10/2013 and 09/2015, EMSA staff will revise the *EMS System Standards and Guidelines* document and present the final draft to the State Commission on EMS.

EMS Trauma Care Systems

State Program Strategy:
Goal: By 2014, begin implementation of the State Trauma System in accordance with the new State Trauma Plan to be approved by the Commission on Emergency Medical Services (EMS).

The Emergency Medical Services Authority (EMSA) sets standards for trauma systems and trauma centers and reviews and approves local trauma care system plans and annual trauma system status updates. Additionally, EMSA provides technical assistance to EMS agencies to develop, implement, and maintain trauma care systems. Regulations encourage local EMS agencies (LEMSAs) to develop and implement trauma systems, designate trauma centers (including pediatric trauma centers), and to standardize trauma patient care statewide.

EMSA staff uses *Prevention 2020* funds to provide technical assistance to LEMSAs in the establishment of new and/or revised local trauma care systems. In addition, staff assists the five trauma regions in establishing a regional approach to trauma care, including triage, re-triage, and performance improvement. The State Trauma Plan provides an inclusive approach to quality trauma care throughout the State:

- Trauma System Leadership
- System Development Operations
- Trauma System Finance
- EMS System
- Prehospital
- Transportation
- Communications
- Definitive Care Facilities
- Information Systems
- System Evaluation and Performance Improvement
- Education, Training, and Research
- Injury Prevention
- Emergency/Disaster Preparedness

EMSA utilizes recognized trauma experts through the State Trauma Advisory Committee and various task forces to provide assistance to EMSA and LEMSAs with trauma-related issues. Projects may include implementing the State Trauma System based on the new State Trauma Plan, improving the statewide trauma registry, quality improvement activities, triage and destination criteria standards, and guidance to ensure timely access to trauma care.

EMSA participates, as a co-lead, in California's Strategic Highway Safety Plan (SHSP), Challenge Area 15 (CA 15), whose goal is to improve post-crash survivability. Challenge Area teams are tasked with proposing and carrying out Safety Action Needs Plans (SNAPs) that will improve traffic safety in California. The SHSP Plan is maintained through a collaborative process that involves a wide range of safety stakeholders including many staff representing the Office of Traffic Safety. Currently, CA 15 is developing actions related to the safe removal of collisions related to traffic incident management (Steer It Clear Campaign), and the update of the 2015 DMV Driver Handbook.

The Central Coast, North Coast, and Eastern Sierra regions have limited access to Trauma Centers. When access is available, transport times can be lengthy. Air transport times may be up to three hours from the time of injury. When a trauma patient arrives at a non-trauma center and needs secondary transfer to a Trauma Center, the average time spent in the non-trauma center is four to six hours. The four to six hours does not include the time to transport the critically injured patient to a Trauma Center.

In response to the *2006 California Statewide Trauma Planning: Assessment and Future Direction* document, a precursor to the State Trauma Plan, five Regional Trauma Coordinating Committees (RTCCs) were created to work toward a State Trauma System. To provide the necessary tool to evaluate this process, CEMSIS was implemented. Due to increased constituent participation, a gap analysis, and trauma regionalization funded in part with PHHSBG Funds, California has increased its total Trauma Centers to 74; 15 of which are pediatric Trauma Centers. Some of the recently designated Trauma Centers are in rural, previously uncovered areas. EMSA continues to work with its local partners to increase the number of Trauma Centers in the underserved areas of the State.

Primary Strategic Partnerships: EMSA has fostered a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- California Business, Transportation, and Housing Agency
- California Children's Services
- California Department of Alcoholic Beverage Control
- California Department of Corrections and Rehabilitation
- California Department of Motor Vehicles
- California Department of Public Health
- California Department of Transportation (CalTrans)
- California Strategic Highway Safety Plan
- California Emergency Management Agency
- California Highway Patrol
- California Office of Traffic Safety
- California State Office of Rural Health
- Commission on EMS
- California Health and Human Services Agency
- Office of Statewide Health Planning and Development

External:

- American College of Surgeons
- American Trauma Society
- Association of Air Medical Services
- California Ambulance Association
- California Chapter of the American College of Emergency Physicians
- California Fire Chiefs (Cal-Chiefs)
- California Hospital Association
- California Peace Officers' Association
- California Rural Indian Health Board
- Centers of Disease Control and Prevention
- Critical Illness and Trauma Foundation
- Emergency Nurses Association
- EMS Administrators Association of California
- EMS Medical Directors Association of California
- Intermountain Injury Control Research Center
- National Highway Transportation Safety Association
- National Trauma Data Bank
- Statewide Coalition on Traffic Safety
- Society of Trauma Nurses
- Trauma Managers Association of California
- U.S. Department of Health and Human Services, Health Resources and Services Administration
- U.S. Department of Transportation, Federal Highway Administration
- Western Trauma Association

Role of PHHSBG Funds: PHHSBG dollars support EMSA's efforts to establish a State Trauma System with strong state leadership. The funding provides for a full-time State Trauma Coordinator position and support staff.

Evaluation Methodology:

- Evaluation of the State Trauma System will be ongoing as goals/objectives from the State Trauma Plan are realized.
- The management of a State Trauma Registry component of the California EMS Information System (CEMSIS) maintaining National Trauma Data Standards (NTDS) and National EMS Information System (NEMSIS) compliance. The information will provide the necessary data to evaluate the system and develop statewide policies as needed to support statutes and regulations.
- Program status is provided to the EMS Administrators Association of California (EMSAAC) and the EMS Medical Directors Association of California (EMDAC) on a quarterly basis allowing for discussion and recommendations.
- Program development status is provided to the Commission on EMS on a quarterly basis allowing for EMS constituent feedback on the process.

State Program Setting:

Community based organization, Medical or clinical site, State health department, University or college

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manager II
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Staff Services Manager I
State-Level: 12% Local: 0% Other: 88% Total: 100%
Position Title: Health Program Manager II (Retired Annuitant)
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Title: Legal Typist
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 4
Total FTEs Funded: 4.00

National Health Objective: HO AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):

Between 10/2013 and 09/2015, initiate implementation of the State Trauma System in accordance with *California Statewide Trauma Planning: Assessment and Future Direction, to be approved by the Commission on EMS.*

Baseline:
The State is comprised of 58 counties divided into 32 LEMSAs (25 single-county, seven multi-county agencies). LEMSAs plan, implement, and manage local trauma systems based on state regulations, but they are not mandated to have a plan. Of the 34 LEMSAs, 33 have approved trauma plans for their EMS county/region. Yolo County recently became a single-county LEMSA and is currently working on its trauma plan. LEMSAs are in varying stages of plan implementation. Although the majority of LEMSAS have trauma care plans, only 25 LEMSAS (34 counties) have designated trauma centers.

Data Source:
- California Statewide Trauma Planning: Assessment and Future Direction
- National Trauma Data Bank
- United States Census Bureau State and County QuickFacts
- EMSA Trauma Center Patient Destination Study 2010

State Health Problem:
Health Burden:
In the United States and California, the leading cause of death and permanent disability among people aged of 1 to 44 years is traumatic illness and injury; additionally, less-traumatic injuries have an even greater mortality rate in the elderly. Recent data indicates the largest expanding group of trauma patients is baby-boomer motorcyclists. As a result, trauma impacts **all age groups (target population).**

Multiple organizations (U.S. Department of Health and Human Services, American

College of Surgeons, Eastern Association for the Surgery of Trauma, American College of Emergency Physicians, and American Academy of Pediatrics) have sponsored studies that reiterate the necessity of transporting trauma patients to an appropriate facility within a 60-minute window known as —the golden hour. After the golden hour is eclipsed, positive outcomes decline rapidly.

As described in the CDC's January 23, 2009, issue of Morbidity and Mortality Weekly Report, trauma care systems are developed so that systems are in place to correctly identify trauma
patients (trauma triage criteria), rapidly transport to an appropriate facility (destination policies), survey trauma centers (trauma center designation), and provide regional quality improvement. In California, LEMSAs individually develop and implement trauma care systems based on state regulations, including regional variances based on available resources. EMSA monitors LEMSA plans on a yearly basis.

As described in the CDC's January 23, 2009, issue of *Morbidity and Mortality Weekly Report,* trauma care systems are developed so that systems are in place to correctly identify trauma patients (trauma triage criteria), rapidly transport to an appropriate facility (destination policies), survey trauma centers (trauma center designation), and provide regional quality improvement. In California, LEMSAs individually develop and implement trauma care systems based on state regulations, including regional variances based on available resources. EMSA monitors LEMSA plans on a yearly basis through submitted Trauma System Status Updates.

The disparate counties are clearly identified by the **disparate population**. There are also vast differences in resources and geography within California and locally driven EMS systems, resulting in compartmentalized trauma care systems within county borders. Pediatrics, burns, and rehabilitation are some of the specialties that suffer when LEMSAs fail to have transparent borders. RTCCs attempt to blur the county borders by creating regional systems of care.

Vassar et al. (2003), *Fractures in Access to and Assessment of Trauma Systems*, reported that only 59 percent of the trauma patients in California's non-rural areas arrived at a trauma center; despite the fact that 83 percent of this population had access to a trauma center. Additionally 30 percent of all trauma deaths occurred in non-trauma centers.

Another recent California study, by Hsia et al. (2010), *Disparities in Trauma Center Access Despite Increasing Utilization*, states, Admissions to trauma centers for all categories of injury severity are increasing. There remains, however, a large disparity in trauma center care, depending on geographical distance and availability
of a trauma center within counties and/or areas. The article concludes with a recommendation to examine areas covered by trauma centers to enhance regionalized approaches to improve care.

The above research unveils additional under-reported disparate populations within the

target population. Caution should be taken when identifying a disparate population solely on coverage. More research is needed to better identify disparate populations. Data in California has been elusive due to the lack of a statewide trauma/EMS data repository. The implementation CEMSIS will close the data gap.

This Block Grant provides the only funding for EMSA resources devoted to trauma care in California. Without the grant, there would be no resources available to ensure appropriate trauma care for citizens and visitors in the State.

Data Collection:
This report utilized federal data when possible. The State of California has begun collecting trauma and EMS data with increased participation over time.

Target Population:
Number: 36,961,664
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 3,743,850
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Specific Counties
Target and Disparate Data Sources: Target and Disparate Population Data: California Statewide Trauma Planning: Assessment and Future Direction, National Trauma Data Bank, United States Census Bureau State and County Quick Facts, and E

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:

- American College of Surgeons (ACS), Committee on Trauma, "Optimal Hospital Resources Care of the Injured Patient" 1976. Provides guidelines for resources necessary for optimal trauma care; latest revision 2006.
- "Reducing the Burden of Injury" (Institute of Medicine, 1999), called on Congress to support a greater national commitment to, and support of, trauma care systems at federal, state, and local levels.
- In 2002, the American Trauma Society (ATS) supported by the U.S. Department of Transportation, National Highway Traffic Safety Administration, issued Trauma System Agenda for the Future. The ATS vision statement reiterated previous documents by stating, “Trauma systems, when fully implemented throughout the U.S., will enhance community health through an organized system of injury prevention, acute care and rehabilitation that is fully integrated with the public health system in a community.”
- • U. S. Dept. of Health and Human Services, Health Resources and Services Administration, "Model Trauma System Planning and Evaluation" (2006): Guide to statewide trauma system development promotes collaboration between systems and stresses need for trauma system development in underserved (usually rural) areas.
- In 2008, the ACS published the Regional Trauma Systems: Optimal Elements, Integration and Assessment System Consultation guide. The systems guide emphasized the need for a regional approach to trauma, with benchmarks derived from a trauma registry.
- Dr. A. Brent Eastman, Chair, Board of Regents, American College of Surgeons, Scudder Orator (Keynote Speech for American College of Surgeons 95th Clinical Congress, 2009): evolution of trauma systems across the U.S.; focus on California’s recent regionalization through the use of LEMSAs; challenged states to determine gaps in care and build systems to fortify these gaps through regionalization.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $135,452
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Conduct workshops.
Between 10/2013 and 09/2015, EMSA staff will conduct **three** national educational workshops for continuing education and to gain system and clinical knowledge from experts and constituents.

Annual Activity:
Review event content.
Between 10/2013 and 09/2015, EMSA staff will review available content for the following events:

- *Western States Trauma Managers Meeting.* EMSA will electronically review available content and participate via conference call (if available) in the Western States Trauma Managers Meeting to gain current trauma practice applied to trauma systems.
- *American College of Surgeon (ACS) Scientific Clinical Congress.* EMSA will review electronically available content from this ACS Clinical Congress to glean better understanding of nationally recognized injury prevention models, site verification changes, regional trauma activities, and trauma system perspectives.
- *Society of Trauma Nurses annual meeting.* EMSA will review electronically available content to gain current knowledge on trauma system and trauma patient care issues.

Objective 2:
Coordinate committee meetings.
Between 10/2013 and 09/2015, EMSA staff will conduct **four** State Trauma Advisory Committee meetings and/or conference calls and ensure appropriate Committee membership to discuss trauma-related activities, policy development, guidelines and regulations, and State Trauma System development.

Annual Activity:
Attend quarterly meetings.
Between 10/2013 and 09/2015, EMSA staff will:

- Review committee membership to ensure adequate representation of internal and external EMS partners.
- Coordinate four quarterly meetings and/or conference calls with the State Trauma Advisory Committee.

Objective 3:
Coordinate State Trauma Summit.
Between 10/2013 and 09/2015, EMSA staff will implement **one** State Trauma Summit to develop strategies through consensus for implementation of working groups to improve care for the critically injured patient on a statewide level.

Annual Activity:
Host Trauma Summit.
Between 10/2013 and 09/2015, EMSA, in partnership with UC San Diego (UCSD) Medical Center Trauma Service, will host State Trauma Summit V in February 2014. Summit staff work will include agenda development, liaison with UCSD for Summit logistics, speaker selection with topic development, moderator responsibilities and group facilitation, mailings, and post-Summit evaluations review.

Objective 4:
Increase compliance with Trauma Plan by 75 percent.
Between 10/2013 and 09/2015, EMSA staff will provide technical assistance to **33** LEMSAs to increase the submission and approval of local Trauma System plans and to have current local Trauma System Status Updates in place.

Annual Activity
Assist with Trauma Plan updates.
Between 10/2013 and 09/2015, EMSA staff will:

- Ensure that 29–33 LEMSAs have current approved local Trauma System Status Updates on file.
- Provide assistance to Yolo County in developing a trauma plan.

Objective 5:
Initiate implementation of the State Trauma Plan.
Between 10/2013 and 09/2015, EMSA staff will identify **one** State Trauma Plan to obtain approval by the Commission on EMS, by working with administrative staff and the State Trauma Advisory Committee.

Annual Activity:
Revise State Trauma Plan.
Between 10/2013 and 09/2015, EMSA staff will:

- Revise the State Trauma Plan.
- Monitor pre-public comment period with EMSAAC and EMDAC.
- Compile all comments and develop a revised State Trauma Plan.
- Work on a minimum of two objectives from the State Trauma Plan that are approved by EMSA administration.

Objective 6:
Support Regional Trauma Coordination Systems of Care.
Between 10/2013 and 09/2015, EMSA staff will provide collaboration to **five** regional trauma coordination committees to evaluate local trauma system plans within its geographic area and provide recommendations for State Trauma System development and improvement with funding needs summarized for those purposes.

Annual Activity:
Plan Outreach to RTCCs.
Between 10/2013 and 09/2015, EMSA staff will provide technical assistance to the five RTCCs on regional activities, policy development, and data collection to support and evaluate trauma care within each region.

Objective 7:
Update EMSA Trauma website.
Between 10/2013 and 09/2015, provide and submit **four** updates that will allow access to current trauma care resources to EMS Systems Content Manager to update and/or revise website content for the Trauma Program in order to have access to current trauma care resources.

Annual Activity:
Update EMSA Trauma website.
Between 10/2013 and 09/2015, EMSA staff will provide continuous access to the most current trauma information on the EMSA website.

California Nutrition Education and Obesity Prevention Branch

State Program Strategy:

Goal: The mission of the Nutrition Education and Obesity Prevention Branch (NEOPB) is to increase healthy eating and physical activity to reduce the prevalence of obesity and chronic diseases such as heart disease, cancer, stroke, osteoporosis, and diabetes. NEOPB works with state and local physical activity and nutrition leaders, and key school and community organizations, to conduct programs in communities throughout California.

This program is also responsible for implementing 38 objectives of the CWP.

Primary Strategic Partnerships: NEOPB has fostered a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:
- California Obesity Prevention Program
- Network for a Healthy California
- Safe and Active Communities Branch
- Health in All Policies taskforce
- Chronic Disease Control Branch
- DHCS/CDPH Worksite Wellness Program
- Obesity Prevention Group
- Network's Worksite Wellness team
- Maternal and Adolescent Health Branch
- Healthier U (CDPH Wellness Program)

External:
- The California Endowment
- The Strategic Alliance for Healthy Food and Physical Activity Environments
- The Prevention Institute
- California Action for Healthy Kids
- California Parent Teacher Association
- California Department of Education
- Kaiser Permanente
- Partnership for the Public's Health
- California Food Policy Advocates California Center for Public Health Advocacy
- University of California, Berkeley
- University of California, Davis

California local health departments
- CA Women Infants and Children Association
- California Breastfeeding Coalition

Role of PHHSBG Funds: PHHSBG funds provide foundational support for NEOPB's

state infrastructure in the following ways:

1. PHHSBG funds the core of the Local School Wellness Policy efforts that aim to increase healthy food and physical activity options for California youth by:
   - Using policy strategies to create support for healthy eating and physical activity in schools and communities.
   - Training youth, parents, and other school stakeholders to identify and implement policy and environmental solutions.
   - Educating youth to eat more healthfully and engage in physical activity.
   - Coordinating state and local efforts that promote youth nutrition and physical activity.
   - Supporting work around youth/teen fruit and vegetable consumption.

These efforts focus on meeting the needs of low-income youth. Students, particularly in low-income communities, are faced with an abundance of unhealthy food choices, a proliferation of advertisements promoting these foods, and poor access to healthy foods and physical activity opportunities. PHHSBG funds support NEOPB's infrastructure that allows staff to work with community stakeholders to implement obesity prevention policy-level solutions.

2. PHHSBG provides funds to support state staff positions that provide leadership, oversight, and administrative support for obesity prevention projects and programs.

3. PHHSBG funds allow NEOPB to provide state- and local-level coordination and leadership. NEOPB provides training, technical assistance, and resources to state and local organizations/agencies. The trainings and technical assistance cover such topics as developing and implementing policy solutions; advancing obesity prevention and wellness in schools and community settings; and engaging key stakeholders. NEOPB heads the planning committee for the biennial Childhood Obesity Conference, the largest such conference in the nation.

Evaluation Methodology: NEOPB projects will be evaluated using quantitative and/or qualitative research methods, as appropriate.

State Program Setting:
Community based organization, schools or school district, State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Specialist II
State-Level: 48% Local: 0% Other: 52% Total: 100%
Position Title: Health Program Specialist I
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Title: Health Education Consultant III
State-Level: 53% Local: 0% Other: 47% Total: 100%
Position Title: Public Health Nutrition Consultant III
State-Level: 15% Local: 0% Other: 85% Total: 100%
Position Title: Health Program Manager II
State-Level: 25% Local: 0% Other: 75% Total: 100%
Position Title: Research Scientist II
State-Level: 30% Local: 0% Other: 70% Total: 100%

Total Number of Positions Funded: 6
Total FTEs Funded: 6.00

National Health Objective: HO NWS-10 Obesity in Children and Adolescents

State Health Objective(s):
Between 10/2013 and 09/2015,
1. Decrease the incidence of overweight or obesity in children and adolescents to the *HP 2020* goal of ten percent.
2. Increase the proportion of children and adolescents aged 5 to 19 years whose intake of meals and snacks at school contributes proportionally to good overall dietary quality.

Baseline:
- *Over 40 percent of low-income, school-aged youth in California are overweight or obese.*
- *In California 15.1 percent of children 10–17 years old are obese.*

According to data regarding school-aged children from the "National Health and Nutrition Examination Survey, 1999–2004", the issues of greatest concern are related to excessive consumption of discretionary calories from solid fats and added sugars, excessive intakes of saturated fat and sodium; and inadequate consumption of specific types of nutrient-dense foods such as fruits and vegetables, legumes, and whole grains.

Data Source:
USDA

State Health Problem:

Health Burden:

Obesity represents a public health challenge of equal magnitude to that of tobacco. According to federal data, the prevalence of overweight children in the U.S. increased from 6.5 percent to 19.6 percent among 6- to 11-year-olds between 1976–1980 and 2007–2008, and among 12- to 19-year-olds from 5 percent to 18.1 percent during the same time period. Overweight children and youth are developing serious health problems now and are facing worse health problems in the future. According to a study from CDC, poor diet and physical inactivity together may soon become the leading preventable cause of death among Americans. The percentage of deaths attributed to poor diet and physical inactivity increased 17 percent from 1990 to 2000 and is expected to surpass tobacco as the leading attributable cause of death in the near future. The Surgeon General states that an unhealthy diet and low levels of physical activity increase children's risk of developing chronic health problems, including type 2 diabetes, high blood pressure, asthma, and heart disease.

In California, obesity affects 24.7 percent of adults, and 15.1 percent of children 10–17 years old. Communities of color are disproportionately affected by obesity. Hispanic and African-American communities experience higher rates of obesity, and low-income communities suffer from both social and health inequities. California is the most ethnically diverse state in the nation (over 60 percent of the population of nearly 38 million is non-White), resulting in a population especially vulnerable to the consequences of higher rates of obesity. Although obesity rates in California have leveled in recent years, they remain alarmingly high. Over the past 30 years, obesity rates have tripled among children and adolescents and have remained high. More than 40 percent of low-income California children and teens are overweight. It is estimated that between 40 and 80 percent of overweight children will become overweight adults. California ranks number three in the nation for obesity in young, low-income children. Given the current high prevalence of overweight among California children and teens, the *Healthy People 2020* target of ten percent overweight is unattainable but remains a goal for the State's continued efforts.

Obesity significantly increases the risk for developing type 2 diabetes and its related complications. Overweight and obesity among adolescents has led to an increased prevalence of early-onset type 2 diabetes, putting this population at risk for diabetes-related complications at a much earlier age. Doctors are seeing a significant rise in obesity-attributed chronic diseases among children. Obese children are more than twice as likely to have type 2 diabetes as children of normal weight. Based on this trend, experts project that one of three children born in 2000—and half of all children from ethnic/racially diverse populations—will develop type 2 diabetes in his/her lifetime. The California Diabetes Program reports that more than two million Californians have diabetes, and this number will double to four million by 2020.

At least 40,000 deaths each year in California are attributable to poor nutrition and lack of physical activity. Fueled by environmental forces and individual choices that lead to

unhealthy eating and physical inactivity among Californians, obesity threatens to surpass tobacco as the leading cause of preventable death.

The **target population** includes all children aged 5–19 years, regardless of race or socioeconomic background. This definition recognizes that all children will benefit from obesity-prevention efforts, although it is important to recognize that in California, American Indian, Hispanic, African-American, and Pacific-Islander children are more likely than White children to meet the criterion for obesity (**disparate population**).

Target Population:
Number: 6,220,993
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 3,118,053
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
Age: Under 1 year, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: DHCS 2008; CDPH Burden Report 2013; DHHS 2001; BRFSS 2010; CDE 2011–12

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:

- In collaboration with public and private organizations, schools can play a critical role in reshaping social and physical environments. They can also provide resources, tools, and practical strategies to help students adopt healthy lifestyles (Make a Difference at Your School! CDC Resources Can Help You Implement Strategies to Prevent Obesity Among Children and Adolescents, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. January 2008).
- Recent studies link physical activity to improved academic performance, classroom behavior, and school attendance among children and youth (The importance of physical activity and physical education in the prediction of academic achievement, Journal of Sports Behavior 31(4)368–388. Dec. 2008.).

- The Institute of Medicine developed guiding principles for nutrition standards for food in schools in "Nutrition Standards for Foods in Schools: Leading the Way toward Healthier Youth." These recommendations outline specific guidelines for kindergarten through grade-12 students and acknowledge that implementation of school food standards will require clear policies; technical and financial support; a monitoring, enforcement, and evaluation program; and new food and beverage products (Institute of Medicine 2007);
- Parent engagement guidance: Center on School, Family, and Community Partnerships (Johns Hopkins); parent engagement in school governance leads to improved academic outcomes and school quality.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $568,269
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $15,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Activate partnerships.
By 09/2015, NEOPB staff will develop **a minimum of 30** partnerships to facilitate state- and local-level coordination of obesity prevention efforts in California.

Annual Activities:

1. Work with external partners.
Between 10/2013 and 09/2015, NEOPB staff will work with external partners through the Childhood Obesity Conference Planning Committee, which shapes the content of the Childhood Obesity Conference and includes representation by over 30 external partners.

2. Work with internal partners.
Between 10/2013 and 09/2015, NEOPB staff will convene CDPH's Obesity Prevention Group, which includes representation by such programs as Prevention First, Health in all Policies, Comprehensive Cancer Control Program, Maternal, Child and Adolescent Health Division, and Children's Medical Services.

Objective 2:
Increase capacity.
By 09/2015, NEOPB staff will develop and provide educational opportunities, resources and technical assistance to **a minimum of 25** partners on evidence-based and evidence-informed strategies to support the advancement of nutrition education and obesity prevention policy, systems and environmental changes across the state.

Annual Activities:

1. Convene Childhood Obesity Conference.
Between 10/2013 and 09/2015, NEOPB staff will serve in a leadership role for the Childhood Obesity Conference by convening the conference Executive Committee, which is responsible for implementing all aspects of the Childhood Obesity Conference.

2. Provide resources and training.
Between 10/2013 and 09/2015, NEOPB staff will develop and/or provide training and resources for a minimum of 30 internal and external partners on various obesity-prevention topics, including school wellness, breastfeeding, and peer-led nutrition education.

Objective 3:
Support interventions.
By 09/2015, NEOPB staff, in conjunction with community partners, will implement **a minimum of two** obesity prevention interventions to improve the health of Californians, particularly children and youth, in an effort to reduce the prevalence of obesity and chronic diseases.

Annual Activities:

1. Promote breastfeeding.
Between 10/2013 and 09/2015, NEOPB staff will provide training and/or technical assistance to community partners who seek to develop breastfeeding friendly clinics throughout the State.

2. Advance School Wellness.
Between 10/2013 and 09/2015, NEOPB staff will support California Local School Wellness Policy Collaborative interventions, including California's Smarter Lunchrooms Movement, and the dissemination of California's new competitive food and beverage standards that combine existing California law with the new federal Smart Snacks in School standards.

California Office of Health Equity

State Program Strategy:

***Goal*:** The Office of Health Equity (OHE) will establish an advisory committee to advance the goals of OHE and to actively participate in decision making. The advisory committee will be composed of representatives from applicable state agencies and departments, community-based organizations, and other entities working to advance physical and mental health equity for vulnerable communities.

Goal: OHE will perform various duties related to reducing physical and mental health disparities for unserved and underrepresented groups in California.

The OHE was established for the purposes of aligning state resources, decision making, and programs to accomplish all of the following:

1. Achieve the highest level of physical and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities. Communities from diverse racial, ethnic, LGBTQ, and multicultural groups.
2. Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote physical and mental health.
3. Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent physical and mental health care and services.
4. Improve the health status of all populations and places, with a priority on eliminating physical and mental health disparities and inequities.

Primary Strategic Partnerships: OHE has fostered a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- California Department of Public Health, Division of Chronic Disease and Injury Control
- California Department of Public Health, California Tobacco Control Program (CTCP)

External:

- OHE Advisory Committee
- California Department of Health Care Services
- Office of Statewide Health Planning and Development
- Department of Health and Human Services (DHHS), Office of Minority Health
- University of California, San Francisco, Center on Social Disparities in Health
- University of California, Davis, Health System, Center for Reducing Health Disparities
- California Pan Ethnic Health Network
- The African American Health Institute of San Bernardino County
- Pacific Clinics

- Equality California Institute
- Mental Health America of Northern California
- Native American Health Center
- Mental Health Association in California/Racial Ethnic Mental Health Disparities Coalition

Role of PHHSBG Funds: For FFY 2014 (SFY 2013–14) the PHHSBG OHE allocation will be used to: (1) provide technical assistance to state and local agencies and departments with regard to building organizational capacity, staff training, and facilitating communication to develop strategies to reduce health and mental disparities; (2) provide information and assistance within and across state departments that improve the effectiveness of public health and mental health services to vulnerable communities and that address community environments to promote health; and (3) provide consultation and assistance to public and private entities that are attempting to create innovative responses to improve the physical and mental health status of vulnerable communities.

Evaluation Methodology:
OHE will utilize existing and new data from California Department of Public Health (CDPH) vital statistics files on selected health outcome (mortality) indicators for monitoring state outcomes and progress as the primary qualitative method in evaluating progress of OHE. Other evaluation methods will be used if appropriate.

State Program Setting:
Community based organization, State health department, University or college

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Associate Governmental Program Analyst
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1
Total FTEs Funded: 1.00

National Health Objective: HO ECBP-11 Culturally Appropriate Community Health Programs

State Health Objective(s):
Between 10/2013 and 09/2015, increase the proportion of local health departments (LHDs) that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs.

Baseline:
Data not available

Data Source:
Data not available.

State Health Problem:
Health Burden:
In 2010, the California population was 37,253,956. Of that total, 50.3 percent are female and 49.7 percent are male. The majority of this population (42.4 percent) was comprised of **target and disparate** subpopulations (i.e., non-Whites), including Hispanics/Latinos (14.0 million; 37.6 percent); Asians (4.9 million; 13.0 percent); Blacks/African Americans (2.3 million; 6.2 percent); American Indians/Alaska Natives (208,833; 0.6 percent); Native Hawaiian and other Pacific Islanders (144,386; 0.4 percent); and Multiracial (1,815,384; 4.9 percent). In comparison, the White population was 21.5 million (57.6 percent).

A significant proportion of immigrants to the United States end up settling in the western region. California is a leading western state for immigration with 27.0 percent (Population Survey Data, 2010) of its population being foreign born.

The California Current Population Survey (2010) showed the following: Whites reported the highest *excellent* health (37.0 percent), followed by Hispanics (34.5 percent), Blacks (28.3 percent), Asians (27.8 percent), Hawaiian/ Pacific Islanders (27.6 percent), and American Indians (24.5 percent). At the other extreme, American Indians reported the highest *poor* health (11.13 percent), followed by Asians (3.6 percent), Blacks (3.6 percent), White (3.4 percent), and Hispanics (2.7 percent). Concurrently, Hispanics reported the highest percentage of persons not covered by health insurance (30.8 percent), followed by Blacks (17.8 percent), Asians (16.7 percent), and Whites (11.5 percent).

Vital Statistics figures from CDPH show that the ten leading causes of death in 2009 were: heart disease, cancer (malignant neoplasms), cerebrovascular diseases, chronic lower respiratory diseases, accidents, Alzheimer's disease, diabetes mellitus, homicide, chronic liver diseases, and intentional self-harm assault. In the following disease areas, morbidity and mortality data show a disparate effect on California's racial and ethnic groups:

Heart Disease: In 2009, African Americans had a significantly higher heart disease (HD) death rate at 251 compared to all other racial or ethnic groups. African American males had a higher mortality rate at 302.5 compared to African American females at 209. The HD death rate for Whites/Other/Unknown was 177.1 in 2009, with males having the highest mortality rate at 224.4 compared to females at 139.9. Asians reported the lowest rate in 2009 at 98.6, followed by Hispanics at 121, with both of these groups meeting and exceeding the *HP 2010* objective for Heart Disease (*HP 2010* Target = 162 per 100,000 population).

Cancer (Malignant Neoplasm: African Americans continue to experience significantly higher cancer death rates than any other racial or ethnic population in the state at 221.8 per 100,000 in 2009. African American males had a higher mortality rate at 271.7, compared to African American females at 190.2. Cancer death rates for White/Other/Unknown were 168.8 in 2009. The *HP 2010* target for both Hispanics and Asians is being achieved as of 2009 at 114.9 and 112 respectively (*HP 2010* Target = 158.6 per 100,000 population).

Cerebrovascular Diseases: Mortality data in 2009 show that African Americans had the highest cerebrovascular disease (stroke) death rates across racial and ethnic groups in California at 57.3, are not meeting the *HP 2010* target. All other groups met and exceeded the Cerebrovascular Disease death rate in 2009 with Whites at 37.1 followed by Asians at 34.1, and Hispanics at 31.8 (*HP 2010* Target = 48 per 100,000 population).

Chronic Lower Respiratory Diseases: California's White population had the highest mortality rate for chronic lower respiratory diseases (CLRD) in 2009 at 45.8 followed by African Americans at 41.8, more than double that of Hispanics at 17.8 and Asians at 16.4. However, the *HP 2010* target for CLRD as of 2009 is being met by all groups (*HP 2010* Target = 62.3 per 100,000 population).

Diabetes Mellitus: Across race and ethnic groups in 2009, African Americans had the highest diabetes-related death rate. However, all groups were below the *HP 2010* target rate in 2009 with African Americans at 41.7, Hispanics at 26.9, Asians at 15.9, and Whites at 15.6 (*HP 2010* Target = 46.0 per 100,000 population).

Homicides: The homicide mortality rate for African Americans in 2009 was nearly eight times more than the *HP 2010* target at 21.9, followed by Hispanics at 6.5 (*HP 2010* Target = 2.8 per 100,000 population)[3].

Risk Factors and Behaviors: Most of the above-stated causes of death resulted from unhealthy behaviors that people engage in, leading to mortality and/or poor quality of life from the above-described diseases.

According to data from the California Health Interview Survey (CHIS) in 2009, of all racial/ethnic populations in California, African Americans had the highest percentage of people with three of the six risk factors (poor nutrition, no physical activity, and obesity) that lead to the chronic diseases discussed above.

The prevalence of another risk factor—high blood pressure—is very high among Native Americans (47.8 percent) and African American (36.4 percent).

Smoking, which is a risk factor for CLRD, cancer, heart disease, and stroke, is most prevalent among American Indians/Alaska Natives (22.9 percent), followed by Multiracial populations (18.6 percent).

California's changing demographic profile underscores the increasing need for culturally and linguistically competent health programs, materials, and other resources. Furthermore, there is a growing need for training in cultural competency and other related areas for state public health personnel. CDPH is committed to improving access to services in this changing health care environment by system-wide organizational changes that effectively address and eliminate cultural and linguistic barriers.

Target Population:
Number: 15,800,022
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 15,800,022
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: California Population Projections, California Department of Finance, 2010; U.S. Census Bureau, 2010

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:
- DHHS Office of Minority Health CLAS Standards
- Agency for Healthcare Research and Quality—National Healthcare Quality Report, 2009, and National Healthcare Disparities Report, 2009
- DHHS Action Plan to Reduce Racial and Ethnic Health Disparities
- DHHS Office of Minority National Stakeholder Strategy for Achieving Health Equity

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $332,897
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1
Develop policies for improving the health status of Californians.
Between 10/2013 and 09/2015, OHE staff will develop **at least two** new policies, initiatives, data, reports, public forums, and other tools to improve the overall health status of all Californians.

Annual Activity

1. **Develop collaborative partnerships**:
Between 10/2013 and 09/2015, OHE staff will participate in a collaborative effort among DHCS-based organizations and other entities to develop data analyses and strategic plan highlighting physical and mental health disparities, social determinants of health, and recommendations on how to achieve health equity.

The projected outcomes and products from these joint efforts will include:
- Creating California-specific *HP 2020* objectives that address disparities among the State's diverse populations; and
- Institutionalizing the reduction of racial and ethnic health disparities in CDPH, Department of Health Care Services (DHCS), and other organizations.

Objective 2
Develop relationships with stakeholders and other institutions.
Between 10/2013 and 09/2015, OHE staff will conduct **at least 25** meet & greets focused on representatives of vulnerable communities, including diverse racial, ethnic, cultural, and LGBTQ communities; women's health and mental health advocates; physical and mental health providers; community-based organizations and advocates; and state and local health departments, to inform policy making, support funding opportunities, and advise and assist OHE program development and implementation.

Annual Activity

1. **Engage community.**
Between 10/2013 and 09/2015, OHE staff will work collaboratively on developing policy, locating funding sources, and program planning and implementation with:
- local public, mental, or behavioral health departments; local service providers; and community-based organizations, among other entities addressing key health

determinants, including, but not limited to, housing, transportation, planning, education, parks, and economic development;

- advisory bodies and stakeholders to provide a platform to identify and address the complexities of physical and mental health inequities and disparities and the need to develop and implement multiple, interrelated, and multi-sectorial strategies.

Objective 3

Expand linkages in the field of public health and mental health.

Between 10/2013 and 09/2015, OHE staff will develop **at least five** working relationships with interdepartmental decision makers, local and statewide providers, advocacy organizations, and leaders in the field of physical, public, and mental health to develop solutions to ongoing disparities and ways to embed culturally and linguistically appropriate services to improve access and positive physical and mental health outcomes.

Annual Activity

1. **Develop collaborative partnerships.**

   Between 10/2013 and 09/2015, OHE staff will actively participate in interdepartmental and external meetings to expand working relationships that will foster integration of culturally and linguistically appropriate services that will improve access and positive health outcomes.

California Preventive Medicine Residency Program

State Program Strategy:

Goal: The California Department of Public Health (CDPH) will continue to support public health professional training through the Preventive Medicine Residency Program (PMRP) and the California Epidemiologic Investigation Service Fellowship Program (Cal EIS).

Aligns with CDPH Strategic Plan Extension Report Goal #4: Promote Quality of the Workforce and the Workplace Environment, and the CDPH Strategic Map Priority Objective: Retain and Recruit a Skilled, Diverse, and Empowered Workforce.

PMRP, established in 1980, produces physician leaders in preventive medicine, population health, public health administration, and epidemiology. PMRP is accredited by the Accreditation Council for Graduate Medical Education (ACGME) to provide training for physicians seeking Board Certification in the medical specialty of General Preventive Medicine/Public Health (GPM/PH). After completing an internship at an outside accredited institution during Post-Graduate Year (PGY)-1 and obtaining a California medical license, Preventive Medicine Residents enter the CDPH GPM/PH Residency. PGY-2 Residents complete coursework and receive a Masters of Public Health (MPH) degree at one of the Council for Education in Public Health accredited universities in California. The PGY-2 training year provides the Residents with requisite exposure to epidemiology, biostatistics, social and behavioral aspects of public health, environmental health, health services administration, clinical preventive services, and risk communication.

PGY-3 Residents work under supervision in a local and/or state health department program. During the PGY-3 year, Residents work on assigned projects under the supervision of a preceptor, both independently and as a member of a team, to meet American College of Preventive Medicine (ACPM) and ACGME competencies. Residents are trained in population health, state and local public health practice, emergency preparedness, infectious disease prevention and control, chronic disease prevention and health promotion, family health, health care quality improvement, environmental health, health informatics, and social determinants of health. California is in dire need of physicians well trained in population and public health to competently address current and future public health and health care challenges.

Of the 109 CDPH PMRP graduates since 1980 who are currently practicing, over half are working in federal, state, or local public health departments. Sixty-eight percent of graduates have remained in California; 67 percent of those are working in California's local or state public health agencies, public health institutes, community clinics representing underserved populations, or at academic institutions conducting research related to Preventive Medicine. This includes four current Local Health Officers and one Assistant Local Health Officer. An additional 35 percent of graduates work in clinical

medicine, 24 percent of whom either work in or direct a community clinic. Of the graduates in the last 10 years, 12 percent are African American, 12 percent are Asian, 8 percent are Latino, and 4 percent are Middle Eastern. These diverse physicians testify to the success of this program in training residents who are committed to public-sector public health and California's disadvantaged and underserved communities.

The Cal EIS Fellowship, established in 1989, has a similar structure to PMRP in which post-MPH trainees' gain real-world experience in the practice of epidemiology and public health. Cal EIS Fellows enter the Fellowship after completing an MPH, DVPM, PhD, or DrPH, and work under supervision on surveillance, epidemiology, and/or evaluation projects in a local or state health department program for 1–2 years. The Council of State and Territorial Epidemiologists (CSTE) competencies are the framework for the Fellowship, in order to provide qualified epidemiologists for California local and state public health agencies. The location of Cal EIS within CDPH provides an ideal environment for training epidemiologists to subsequently work in California. A total of 124 Cal EIS Fellows have completed the program; of which 75 percent work in public health agencies, 61 percent work in California public health, and 18 percent entered graduate or medical school.

Program activities include:

- Monitoring of trainee activities through on-site visits, review of competency charts, monthly reports, and evaluations;
- Coordinating bimonthly seminars for the trainees; these seminars are case based and problem solving, and cover the major topic areas of public health;
- Conducting training in essential public health topics and skills, such as program leadership and administration, grant writing and review, health policy, quality improvement, public health law, communication, surveillance and evaluation, clinical and community preventive services;
- Sponsoring trainees' attendance at professional and community conferences.

Primary Strategic Partnerships: The Programs have fostered a number of collaborative relationships and strategic partnerships, both internally and externally. These are the collaborations for 2014:

Internal:

- Safe and Active Communities Branch
- Public Health Veterinary Section
- Chronic Disease Control Branch
- Immunization Branch
- Infant Botulism Branch
- Environmental Health Investigations Branch

External:

- University of California, Davis, School of Medicine, Department of Public Health Sciences
- University of California, Berkeley, School of Public Health

- University of California, Los Angeles, School of Public Health
- University of California, San Francisco, Preventive Medicine Residency Program
- Department of Health Care Services
- Sacramento County Division of Public Health
- County of Los Angeles Department of Public Health
- Contra Costa County Department of Public Health
- Office of Statewide Health Planning and Research
- Alameda County Department of Public Health
- California Conference of Local Health Officers

Role of PHHSBG Funds: The funding also supports salaries for Program staff, who recruit, place, and monitor the Residents/Fellows; leverage state and local funding for trainee stipends; and assure continued accreditation of the Residency Program, including program revision to meet new accreditation requirements. The staff funded by PHHSBG includes a Program Coordinator and support staff. In addition, the funding supports the stipends of trainees placed in either a local or state health department program.

Evaluation Methodology:

- Program goals and objectives, which are in line with national organization requirements and state health objectives, are monitored and evaluated yearly. Controls such as program policies and procedures, annual report submission, and fiscal and program oversight are already in place.
- Trainees track their knowledge and skill levels via periodic ACPM/ACGME or CSTE competency assessment; program staff evaluates trainee performance via review of the competency charts, monthly reports, preceptor evaluations, seminar and conference participation, performance on in-service exams, and semiannual site visits.

State Program Setting:

Community based organization, Local health department, State health department, University or college

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Associate Government Program Analyst
State-Level: 100% Local: 0% Other: 0% Total: 100%

Position Title: Health Program Specialist I
State-Level: 65% Local: 0% Other: 35% Total: 100%

Position Title: Office Technician
State-Level: 70% Local: 0% Other: 30% Total: 100%

Total Number of Positions Funded: 3
Total FTEs Funded: 3.00

National Health Objective: HO PHI-1 Competencies for Public Health Professionals

State Health Objective(s):
Between 10/2013 and 09/2015, CDPH will recruit, place, monitor, teach, and graduate at least 10 trainees who, over the course of their training period, achieve moderate or high competency in specific Preventive Medicine or Epidemiology competencies developed by national organizations, by working in local or state health department programs.

Baseline:
Six graduates who have achieved moderate to high competency in specific competencies developed by national organizations, by working in local or state health department programs.

Data Source:
Competency charts, monthly activity reports, preceptor evaluations, and program staffs' evaluations of trainee performance.

State Health Problem:
Health Burden:
To maintain a skilled professional workforce, there is a requirement within public health to train the next generation to direct its programs. This arises from two realities and concerns:

- As older public health leaders retire, there is a need to replace them with well-trained professionals;
- New leaders offer novel perspectives and insights into methods of meeting the challenges of public health.

The **target** and **disparate populations** are the same: 37,966,471 (Department of Finance 2012).

The Programs are critical to ensure a steady supply of well-trained public health physicians and epidemiologists to assume leadership positions in public health agencies in California. California needs trained experts who are ready to respond to public health emergencies that result in deaths, such as H1N1, West Nile Virus, *Escherichia coli* O157:H7, heat waves, floods, wildfires, as well as the insidious but equally alarming rise of chronic diseases that are decreasing the productivity and life expectancy of Californians.

Target Population:
Number: 37,966,471
Infrastructure Groups: State and Local Health Departments, Community Based Organizations, Health Care Systems, Research and Educational Institutions

Disparate Population:

Number: 37,966,471
Infrastructure Groups: State and Local Health Departments, Community Based Organizations, Health Care Systems, Research and Educational Institutions

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:

- The Institute of Medicine addresses the public health workforce in "Training Physicians for Public Health Careers" (June 2007): "…despite the achievements of public health, there is a growing shortage of public health workers, including a critical shortage of public health physicians, and many public health workers are inadequately prepared to face today's public health challenges."
- The Association of State and Territorial Health Officials states in "Workforce Development Policy" (September 2004) that the strength of the public health infrastructure depends on the adequate supply and training of competent governmental public health professionals.
- The National Association of City and County Health Officers surveyed a subset of LHDs in "The Local Health Department Workforce" (May 2010) to determine the rising need of educated and capable public health professionals to fill positions on the front lines of increasing national health concerns.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $429,871
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1: Increase the public health workforce.
Between 10/2013 and 09/2015, PMRP staff will increase the number of trainees who have satisfactorily completed the CDPH GPM/PH Residency or Cal EIS Fellowship from **109 residents and 121 fellows to** 110 residents and 130 fellows, an increase of **at least ten graduates**. The program will recruit and select highly qualified candidates for placement at the State or local health departments. Funds will be leveraged from placement sites to fund stipends and trainees will be provided with epidemiologic and public health training under the mentorship of experienced and knowledgeable Preceptors. Satisfactory completion is determined by progress made on achieving the core competencies for the respective trainees' discipline.

Annual Activities:

1. Train the trainees.

Between 10/2013 and 09/2015, PMRP staff will train **at least ten** trainees to achieve Accreditation Council for Graduate Medical Education/American College of Preventive Medicine or Council of State and Territorial Epidemiologist competencies and therefore satisfactorily complete either Program.

2. Recruit applicants.

Between 10/2013 and 09/2015, PMRP staff will recruit and interview **at least 30** applicants for the Programs. State and national recruitment efforts include distributing information on PMRP and Cal-EIS to Schools of Public Health, Residency Programs, and Local Health Departments and posting on various websites, such as FREIDA Online, Electronic Residency Application Service (ERAS), Public Health Employment Connection, UC Berkeley, Public Health Jobs, California Public Health Association (CPHAN). Top candidates from this pool will be selected for interviews.

3. Present public health/preventive medicine seminars.

Between 10/2013 and 09/2015, PMRP staff will conduct **at least 16** public health/preventive medicine (PM) seminars for residents and fellows. Program will plan and coordinate PM seminars bimonthly on various topics that meet ACGME/ACPM and CSTE competencies.

4. Leverage funds.

Between 10/2013 and 09/2015, PMRP staff will leverage **at least $172,000** for trainee stipends. PMRP staff will leverage funds via outreach to Local Health Departments and State programs that can allocate monies for trainee stipends. Trainees will be assigned and placed at these various sites and obtain training under experienced preceptors.

Rape Prevention Program

State Program Strategy:

Goal: To implement evidence-informed primary prevention strategies aimed at stopping first-time perpetration and victimization of rape.

The Safe and Active Communities (SAC) Branch's Violence Prevention Unit administers the Rape Prevention and Education (RPE) Program with funding from the Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. California's RPE Program funds all 63 rape crisis centers in the state through a noncompetitive Request for Application (RFA) process to implement community-based primary prevention education and training activities consistent with CDC guidelines. It also sponsors a statewide social norms campaign called *MyStrength* for young men ages 14 to 18 to promote the message "My Strength is Not for Hurting" (www.mystrength.org). *MyStrength* Clubs are being implemented in California high schools to promote bystander involvement, individual attitude and behavior change, and social climate change. Evaluation efforts show that *MyStrength* Clubs help create social environments that promote positive male behaviors that contribute to preventing sexual violence.

This program is also responsible for implementing one objective of the California Wellness Plan.

Primary Strategic Partnerships: The CDPH/RPE Program has fostered a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:
- CDPH Office of Health Equity
- CDPH Maternal, Child, and Adolescent Health

External:
- California Coalition Against Sexual Assault
- California Office of Emergency Services
- California Partnership to End Domestic Violence
- California Department of Education
- California Commission on the Status of Women

Role of PHHSBG Funds: For FFY 2014 (SFY 2013–14) the PHHSBG Rape Set-Aside allocation will be used to: (1) support RPE Program local contractors implementing community-based rape prevention programs; (2) fund rape crisis centers to implement *MyStrength* Clubs; and, (3) increase dissemination of rape prevention information.

Evaluation Methodology:
- Data from the Behavioral Risk Factor Surveillance System (BRFSS) will be used to evaluate progress toward ending sexual violence.

- CDPH will conduct online surveys among local rape crisis centers and use results and other sources of information (e.g., scopes of work) to assess and monitor progress.

State Program Setting:
Community based organization, State health department, Other: Other State Departments - Education, Mental Health, Social Services

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds: None

Total Number of Positions Funded:	0
Total FTEs Funded:	0

National Health Objective: HO IVP-40 Sexual Violence (Rape Prevention)

State Health Objective(s):
Between 10/2013 and 09/2015, reduce by one percent the rate of rape in California, as measured by BRFSS.

Baseline:
In 2011, the incidence of rape among women age 18 and over in California was 120 per 100,000.

Data Source:
California BRFSS, 2011

State Health Problem:

Health Burden:
Rape victims often have long-term emotional and health consequences as a result of this "adverse experience," such as chronic diseases, emotional and functional disabilities, harmful behaviors, and intimate relationship difficulties (MMWR, CDC, 2008). All women in California are potential victims of sexual violence. However, rates for African-American women are higher. The lifetime rate of rape was 20 percent for African-American women, 16 percent for White women, 12 percent for Hispanic women, and 10 percent for Asian/Other women (BRFSS California data, 2010, 2011),. Females were more often the victims of rape; the lifetime rate for females was 14 percent versus 3 percent for males.

The **target population** includes females, regardless of race/ethnicity, age, socioeconomic condition, or geographic location. The **disparate population** includes African-American females.

Target Population:
Number: 15,948,134
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 951,008
Ethnicity: Non-Hispanic
Race: African American or Black
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: 2011: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010–2060. Sacramento, California, January 2013.

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Other:
- Preventing Intimate Partner and Sexual Violence: Program Activities Guide, CDC; • Creating Safe Environments: Violence Prevention Strategies and Programs, Prevention Institute, June 2006;
- “Interventions to Prevent Sexual Violence," by Paul A. Schewe, in Handbook of Injury and Violence Prevention, Centers for Disease Control and Prevention, 2006;
- Sexual Violence Prevention, the Prevention Researcher, 2007; and,
- The Prevention of Sexual Violence: A Practitioner’s Sourcebook, Kaufman, 2010

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $832,969
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Increase use of evidence-informed rape prevention strategies.
Between 10/2013 and 09/2015, RPE Program staff will increase the number of local rape crisis centers (RPE Program contractors) in California that implement evidence-informed prevention strategies in their communities from 31 to **63**.

Annual Activities:

1. Increase knowledge and skills of service providers.
Between 10/2013 and 09/2015, RPE Program staff will identify the educational needs of rape crisis center prevention staff and facilitate activities to enhance their knowledge and skills to implement evidence-informed rape prevention strategies.

2. Fund *MyStrength* Clubs.
Between 10/2013 and 09/2015, RPE Program staff will fund **six** RPE Program local contractors (rape crisis centers) to implement *MyStrength* Clubs in their communities.

Objective 2:
Increase dissemination of rape prevention information.
Between 10/2013 and 09/2015, RPE Program staff will disseminate **one** report on the results of a statewide survey on sexual violence.

Annual Activities:

1. Report on rape prevention survey results.
Between 10/2013 and 09/2015, RPE Program staff will fund the inclusion of sexual violence questions on **one** statewide survey and prepare a report on the results.

Safe and Active Communities Branch

State Program Strategy:

Goal: **Prevent injuries and reduce their consequences**. To support and strengthen injury prevention as a critical public health function at the state and local levels.

The Safe and Active Communities Branch (SAC Branch) will use PHHSBG support to strengthen its efforts to ensure that Californians have safe places to live, work, play, and fully participate in community life without injury. Because data-driven policies and interventions are critical to these efforts, the Branch will continue to focus on enhancing its web-based data query system, EpiCenter: California Injury Data Online (http://epicenter.cdph.ca.gov).

SAC Branch will also provide training and technical assistance to state and local colleagues to help them make the best possible use of the EpiCenter injury and violence death, hospital and ED data as a catalyst for injury and violence prevention and community change. For example, as we update and improve the functionalities available on EpiCenter, such as our Traumatic Brain Injury, California Electronic Violent Death Reporting (Cal-EVDRS), Crash Medical Outcomes Data, and Alcohol and Other Drugs Health Consequences query systems, we will disseminate information and provide training opportunities on how to use these data for policy and program activities to reduce unintentional injuries (i.e., motor vehicle crashes, poisoning, falls, suffocation, and burns), and violence (i.e., homicides, suicide, child maltreatment, and violence against women).

These innovative and user-friendly data systems will continue to help support primary prevention policies and programs, strengthen our partnerships with state and local agencies, and expand our reach and impact.

Finally, PHHSBG support will allow us to conduct outreach to recruit, train, and maintain Coroner/Medical Examiner participation in Cal-EVDRS, and to provide technical assistance to county child death review teams (CDRTs) and other partners to expand their potential for reporting high-quality data and using it to drive local child maltreatment prevention work. We also continue to make these data available in user-friendly formats to the full injury and violence field.

This program will include both an epidemiologic and a programmatic focus:

- SAC Branch will conduct periodic stand-alone webinars (or participate in other complementary sessions being conducted by the Branch) with local health departments and other prevention partners to demonstrate EpiCenter's many functions, highlighting trends and/or emerging data and suggesting evidence-based interventions that could address these findings.
- Wherever feasible, the data discussion will include social and physical factors/circumstances that have the potential to reduce injury: e.g., modifications of the environment; improvements in product safety, legislation and enforcement;

education and behavior change; and technology and engineering.

- Concomitant with the webinars, a subset of local partners will be offered technical assistance sessions to delve further into community-level injury and violence data, and once local issues are identified, linked to program development guidance materials and referred to potential funding sources (e.g., training on the use of logic models and empowerment based evaluation strategies use).
- SAC Branch will produce quarterly briefs (e.g., two- to four-page fact sheets) that capture data on specific injury topics covered during the webinars, other issues of interest raised by injury constituents, or brief analyses to explore special topics more fully (e.g., alcohol involvement among people in motor vehicle collisions, violent deaths among veterans, fatal child maltreatment).
- Emphasis will be placed on ensuring our state injury prevention staff have the epidemiologic support to inform their practice and programming through joint efforts to develop data-related materials and messages tied to current prevention-program activities (e.g., motor vehicle car seats/booster; bicycle and pedestrian safety; teen-dating violence).

Expected outcomes will vary, because health departments and local partners vary in their opportunities to take on different issues of local importance. For example:

- Educating and mobilizing public health department staff is a key first step. Examples include: preparing injury data to support fruitful programs such as traffic calming, infant safe sleeping, senior falls prevention, bicycle helmet use, prevention of underage/excessive alcohol use and prescription drug misuse, teen-dating violence prevention, and suicide-risk identification.
- Helping local partners assemble information on injury patterns, trends, consequences, and on effective prevention practices that can be used to engage communities in empowerment evaluation and successfully bid for grants.
- Helping the small, overworked staffs of local health departments make the best use of data already available from EpiCenter and CDRTs.

By investing in the provision of scientific data and technical assistance to maximize its utility, this project will help to support development of data informed, and evidence-based policies and practices to reduce the injury burden in California.

This program is also responsible for addressing 15 objectives of the California Wellness Plan.

Primary Strategic Partnerships: This project strengthens many collaborative partnerships, including:

Internal

- State and Local Injury Control staff
- CDPH's Chronic Disease Prevention, Maternal, Adolescent, and Child Health, and Environmental Health Programs
- Center for Gerontology (arthritis, senior pedestrians)

- Network for a Healthy California (i.e., CX3 [Communities of Excellence in Nutrition, Physical Activity, and Obesity Prevention])
- California Breathing (childhood asthma)
- Adolescent and Family Life (healthy teen relationships)
- Early Childhood Home Visiting (safe at home)
- Sudden Unexpected Infant Death Program and State SIDS Council (safe sleep)
- Health in All Policies Task Force

External
- Local public health departments
- Local public safety advocates, e.g., educators, fire and police depts.
- County child death review teams
- Local Sheriff/Coroners/ Medical Examiners
- Archstone Foundation
- California Wellness Foundation
- Injury Prevention Research Center, University of California, San Francisco
- Public Health Institute
- Safe Transportation Research and Education Center, UC Berkeley
- California Departments of Alcohol and Drug Programs, Aging, Transportation, Developmental Services, Mental Health, and Social Services
- California Office of Traffic Safety,
- Emergency Medical Services Authority
- Office of Statewide Health Planning and Development
- Local Government Commission
- Emergency Nurses Association
- California Chapter of the American Academy of Pediatrics
- California Public Health Association
- Association of California Life and Casualty Insurance Companies
- Safe Kids
- California Walks
- Drowning Prevention Network
- California Partnership to End Domestic Violence
- California Coalition Against Sexual Assault
- Prevent Child Abuse California

Role of PHHSBG Funds: For FFY 2014 (SFY 2014–14), PHHSBG funds will be used to: (1) help support data enhancements of EpiCenter; (2) conduct two to three web-based trainings, including the development of content and collateral materials; (3) provide at least 25 individualized follow-up technical assistance sessions, including outreach to Coroner/Medical Examiners and CDRTs; and (4) develop at least two injury data/program briefs tailored to the perceived needs of California's injury constituency.

Evaluation Methodology: A process evaluation will focus on benchmarks on the extent to which objectives are met (e.g., enhancements to EpiCenter, number of webinars conducted with number of participants, and number of injury briefs created and their distribution patterns). The EpiCenter website also has a built-in evaluation function that

asks users to document their uses and provide us with any public/online reports developed based on EpiCenter data.

Impact evaluation will assess immediate and intermediate outcomes using multiple measures, including evaluations administered as part of the webinars to determine knowledge and skills improvement; number and pattern of EpiCenter web site hits; number and nature of requests for technical assistance; reported uses of EpiCenter data; and the results of a brief survey questionnaire to discern how the injury briefs are being used to foster policy and program development. Although there are multiple factors influencing statewide injury rates, injury numbers and rates will also be tracked.

State Program Setting:
Community based organizations; Local health departments, Universities or colleges; Other: Foundation-based collaboratives

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Health Program Manager II
State-Level: 20% Local: 0% Other: 80% Total: 100%
Position Title: Research Scientist Supervisor 1
State-Level: 20% Local: 80% Other: 0% Total: 100%
Position Title: Research Scientist II
State-Level: 50% Local: 0% Other: 50% Total: 100%

Total Number of Positions Funded: 3
Total FTEs Funded: 3.00

National Health Objective: HO IVP-11 Unintentional Injury Deaths

State Health Objective(s):

Between 10/2013 and 09/2015, SAC Branch will improve the availability of data on the leading causes of injury death and disability by upgrading the data and functionality of EpiCenter and its web-based interactive data query system, and increasing its use. This will include updating the overall injury data to the most recent year available, updating the special linked data sources for the Crash Medical Outcomes Data (CMOD) and the California Electronic Violent Death Reporting System (Cal-EVDRS), adding death data to the Alcohol and Other Drug Health Consequences query systems, and enhancing the functionalities of each of these query systems.

SAC Branch will produce injury-specific fact sheets and analyses (e.g., bicycle helmets, car seat, alcohol involved traffic collisions, fatal child maltreatment numbers based on CDRT data) to translate data into meaningful and practical information for policy and program development. In addition it will continue to conduct outreach and provide

technical assistance to its constituents through webinars and training on improving data quality and using the EpiCenter website to improve state and local prevention-program and policy activities.

Baseline:

- *Injury and Violence Prevention Objectives 1, 2, and 3 from Healthy People 2020. Baseline age adjusted rates: deaths = 59.2; hospitalizations = 617.6; emergency department treatments = 8,370.4.*
- *California crude injury rates in 2011: deaths = 44.1; hospitalizations = 674.7; emergency department treatments = 6,072.*

Data Source:

- *Actual Causes of Death in the United States, 2000*, Mokdad AH, Marks JS, Stroup DF; Gerberding JL, JAMA. 2004;291(10):1238–1245;
- EpiCenter: California Injury Data Online, http://epicenter.cdph.ca.gov, accessed July 1, 2014.

State Health Problem:

Health Burden:

Injuries and violence rank as some of our most pressing public health problems, yet they remain under-recognized. Injuries are the leading cause of death for persons from the first year of life to middle age and the fourth-leading cause of death among persons of all ages, regardless of sex, race/ethnicity, or socioeconomic status. Each year in California, injuries cause more than 16,800 deaths, over 253,000 nonfatal hospitalizations, and more than 2,152,000 emergency department visits. The impact of injuries on public health is so great that health care reform will need to address injury prevention as a priority to help control costs and avoid waste of medical resources. Efforts to raise California's lagging life expectancy likewise cannot succeed without better injury and violence control.

Critical to all efforts to reduce injuries is access to sound, detailed information. By developing and expanding SAC Branch's data holdings and providing them in user-friendly formats for access and analysis online, information is made available to policy makers and others at all levels. Conducting webinars on EpiCenter data and functions for existing and potential new users, preparing and disseminating data briefs to showcase injury priority areas and emerging issues, and providing associated technical assistance on improving data quality and access will help to strengthen the capacity of injury-prevention colleagues in applying this knowledge to practice.

Target Population: The overall target and disparate populations are the same—Californians across the life span. However, injury patterns differ by age, gender, and race/ethnicity (e.g., suffocation among infants, fall-related hip fractures among persons over age 80, homicides among young people of color).

Target Population:
Number: 38,118,386
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 38,118,386
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: California Department of Finance demographic data; EpiCenter California Injury Data Online 2013

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $172,333
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1: Produce and disseminate injury briefs and reports.
Between 10/2013 and 09/2015, SAC Branch staff will publish at least two injury briefs that translate data into useful program and policy information and disseminate these findings to local, state, and national public health communities.

Annual Activities:

1. Produce and disseminate local and state injury related briefs and reports.
Between 10/2013 and 09/2015, SAC Branch staff will identify at least two injury topics, conduct data analyses, publish two injury briefs, and disseminate to local, state, and national public health communities.

2. Promote injury-prevention and intervention strategies.
Between 10/2013 and 09/2015, SAC Branch staff will contract for expert econometric analyses to produce a cost–benefit report for at least one injury area (e.g., senior falls); monitor, review, approve, and disseminate at least one cost–benefit injury report to local, state, and national public health professionals, policy makers, and the broader public.

Objective 2: Reduce mortality and morbidity by assuring a competent health care workforce.
Between 10/2013 and 09/2015, SAC Branch staff will provide direct data translation services and group and individualized technical assistance and training to increase competency in collecting, accessing, analyzing, reporting, and using data to prevent injuries among Californians to at least 35 public health professionals

Annual Activities:

1. Prepare injury and violence data.
Between 10/2013 and 09/2015, SAC Branch staff will prepare the most current fatal, nonfatal hospitalized, and emergency department injury data (e.g., drowning, falls, homicide, motor vehicle traffic, suicides, and suffocations), update our EpiCenter data website to include these data sources, and maintain and refine our predefined and custom query systems to allow user-friendly 24/7 online access to California injury data. This will include updating three sets of data on the EpiCenter web-based query system with 2011 California injury data for:

- deaths (approx. 16,200 annually),
- nonfatal hospitalizations (approx. 256,000 annually), and
- nonfatal emergency departments treatments/transfers (approx. 2,220,000 annually).

2. Provide technical assistance on use of EpiCenter.
Between 10/2013 and 09/2015, SAC Branch staff will provide technical assistance and training (TAT) to at least 25 state and local health departments (including SACB program staff), injury prevention professionals, policy makers, academicians, program advocates, and others to increase their capacity to access and utilize injury data via EpiCenter. Staff will use a variety of approaches to provide TAT, including one-on-one in person or phone consultations, teleconferences, webinars, and formal presentations.

3. Provide technical assistance and training to local Child Death Review Teams (CDRTs).
Between 10/2013 and 09/2015, SAC Branch staff will provide technical assistance and training to at least 10 CDRTs on data collection and management, team functioning, and/or taking findings to action (e.g., preparing data reports, improving the quality of written recommendations, implementing and tracking injury prevention activities).

4. Disseminate child maltreatment data.
Between 10/2013 and 09/2015, SAC Branch staff will complete and disseminate results from a Fatal Child Maltreatment Reconciliation Audit based on local CDRT reviews.

5. Track usage of the EpiCenter.
Between 10/2013 and 09/2015, SAC Branch staff will track the usage of EpiCenter to capture feedback (e.g., EpiCenter user logs, survey feedback, frequently asked questions, requests for more specialized table development, lessons learned) and use these to refine and update EpiCenter design and improve technical assistance processes.

California Health Alert Network (CAHAN)

State Program Strategy:
Goal: The California Health Alert Network, or CAHAN, is the official alerting and notification system for State and local public health departments to share information about urgent public health incidents. The alerts allow for information sharing with and between federal, State, and local public health, environmental health, and emergency medical services agencies; healthcare stakeholders; and other public health and medical partners. CAHAN enables quick and informed action to all hazards through health alert messaging; improves dissemination of public health information; and ensures the availability of a round-the-clock alerting and notification system for California.

CAHAN is operated on behalf of the State of California by the California Department of Public Health (CDPH) Emergency Preparedness Office (EPO). PHHSBG funding is requested to cover a significant portion of the CAHAN information system contract for 2014-15.

Primary Strategic Partnerships:

Internal:
California Department of Public Health Centers and Programs

External:
US Centers for Disease Control and Prevention
US Department of Health and Human Services, Region IX
Baja California, Mexico, and the States of Arizona, Nevada, and Oregon
California Rural Indian Health Board
California Consortium of Urban Indian Health
California Governor's Office of Emergency Services
California Health and Human Services Agency
California Emergency Medical Services Authority
California Department of Health Care Services
California Department of Rehabilitation
California Department of Social Services
California Office of Statewide Health Planning and Development
California City and County Public Health and Environmental Health Departments
California Local Emergency Medical Services Agencies
California Conference of Local Health Officers
County Health Executives Association of California
California Hospital Association
California Association of Health Facilities
California Primary Care Association and Clinic Consortia

Evaluation Methodology: CAHAN program staff will use industry-standard quantitative and qualitative research/analysis methods for all initiatives supported by PHHSBG funds.

Program Setting:

- [x] Business, corporation or industry
- [ ] Child care center
- [x] Community based organization
- [x] Community health center
- [ ] Faith based organization
- [ ] Home
- [x] Local health department
- [x] Medical or clinical site
- [ ] Parks or playgrounds
- [ ] Rape crisis center
- [x] Schools or school district
- [x] Senior residence or center
- [x] State health department
- [x] Tribal nation or area
- [ ] University or college
- [ ] Work site
- [x] Other

FTEs

Position Title	FTE Name	% State	% Local	% Other	% Total
N/A					

National Health Objective:

- **PREP-1:** (Developmental) Reduce the time necessary to issue official information to the public about a public health emergency
- **PREP-2:** Reduce the time necessary to activate designated personnel in response to a public health emergency

State Health Objective:

Maintain the alert and notification system for local, state and federal emergency response (the California Health Alert Network, or CAHAN).

The proposed funds would cover approximately 55% of the CAHAN information system contract for 2014-15. This will allow CDPH to do the following:

1. Sustain CAHAN program services:
   a. Round-the-clock availability of CAHAN to promote situational awareness and provide a common operational picture between Federal, State, regional, local, tribal, and other partners
   b. Capability for program participants to share information in a timely and effective manner using security rules, contact preferences, and organizational permissions

   c. Integration with medical countermeasure plans and program operations throughout California
   d. Integration with local public information plans and program operations throughout California
2. Sustain CAHAN program activities:
   a. Periodic notification drills and exercises to promote system familiarity and improve response time
   b. Ongoing policy and best-practice development to improve effectiveness of program operations
   c. Ongoing directory analysis and data collection to refine California's public health and medical information-sharing system (i.e. essential network constituents and elements of information)

CDPH's ability to maintain these program services and activities is dependent upon the continued availability of the CAHAN information system. This cannot be achieved without PHHSBG funds due to substantial reductions in the CAHAN program's other funding sources.

Between 07/2014 and 06/2015,
1. Maintain the CAHAN web application with a minimum of 99.9% availability during the measurement period.
2. Analyze the effectiveness of existing CAHAN directory structures and alerting practices.
3. Investigate the average time required for CDPH to disseminate information received from Federal and other State partners through CAHAN.
4. Decrease average time to respond for State-level staff notifications by at least 10 percent over the measurement period.
5. Increase California-area tribal organization responsiveness by at least 5 percent over the measurement period.

Baseline:
- *There are currently 35,000 CAHAN users, which include all acute care hospitals in California as well as 40% of clinics and skilled nursing facilities.*
- *CDPH has maintained at least 99.9% availability of the CAHAN web application during previous measurement periods.*
- *Local County Health Departments tested systems and trained staff during 2012-2013 on information sharing plans and equipment, including CAHAN. This included 18 full-scale emergency response exercise, 72 drills, 36 functional exercises, and 43 tabletop exercises.*
- *In one unannounced public health emergency response staff assembly drill at the State level (December 18, 2012), 46 staff present (of 55 total) responded within 1 hour of the CAHAN notification.*
- *For an announced public health emergency response staff assembly drill at the State level (December 12, 2012), 41staff present (of 55 total) responded within 6 minutes of the CAHAN notification*
- *As of February 2014, the response rate to tribal CAHAN drills is 55.7%.*

It is challenging to estimate a baseline for all alert and notification activities given the complexity and diversity of the types of CAHAN alerts. There is a potential to develop baselines for different types of notifications and activities. These baselines can then be applied in future years and used as a measurement of improvement.

Data sources:

- CDC Public Health Emergency Preparedness Cooperative Agreement End-Of-Year Progress Report FY 2012
- CAHAN vendor service level agreement and system availability reports, 2008–present
- CAHAN Program Survey Series, 2012–2013
- CDPH/EPO Duty Officer Incident Logs for Federal alert events
- CAHAN Alert History Logs
- CAHAN Tribal Health Drill initiative, 2012–present

State Health Problem:

California's disasters often have public health and medical impact. Many organizations, both public and private, must work together to form a public health and medical system that is able to successfully respond to the public health and medical consequences of disasters.

The complexity of California's threats, hazards, incidents, and risks has led to increased interaction between many public health, environmental health, and medical functions. This interaction has driven the need for a coordinated system that articulates common procedures across all functional components of public health and medical emergency operations.

CAHAN is the State of California's official information-sharing program for public health and medical emergency preparedness and response. It is a critical component of California's overall public health and medical system. The program maintains a round-the-clock web-based accessible application for alert and notification, health alert distribution; dissemination of treatment and prevention guidelines; and, provides a platform for coordination of disease investigation efforts, preparedness planning, and other initiatives that strengthen state and local preparedness. CDPH's success during public health and medical responses oftentimes depends on information shared through CAHAN.

Furthermore, an active HAN program is a stipulation of public health accreditation as well as a recommended practice by many national standards. By supporting CAHAN, PHHSBG funds will ensure the continued preparedness benefits the program provides to the citizens of California.

Preparedness is a new objective within the Healthy People 2020 Initiative. The goal of Preparedness is to improve capability and capacity across the United States to prevent, prepare for, respond to, and recover from public health emergencies and other disasters

with public health impacts. The United States is at risk from large-scale health impacts including disease outbreaks, natural disasters, and terrorist attacks. The public health, health care, and emergency response systems must be prepared to mitigate the morbidity and mortality associated with these threats.

The Healthy People 2020 Preparedness objectives are based on the National Health Security Strategy promulgated by the US Department of Health and Human Services. Two of the main goals within the security strategy are to ensure situational awareness and to ensure timely and effective communications, which are reflected in the proposed State Health Objectives.

Health Burden:
The target population includes California citizens, border jurisdictions, and federal partners. These are the ultimate recipients of CAHAN's preparedness outcomes. There are over 36,000 actual program participants from among the Primary Strategic Partnerships enumerated above. It is the expectation of CDPH that CAHAN participants use the system to enhance local preparedness systems and services for their respective constituents.

Target Population:	Number	38,332,521	Low Income:	N/A
	Ethnicity	Hispanic or Latino Non-Hispanic or Latino		
	Race	African American or Black American Indian or Alaskan Native Asian Native Hawaiian or Other Pacific Islander White Other		
	Ages	Under 1 year 4–11 years 12–19 years 20–24 years 25–34 years 35–49 years 50–64 years 65 years and older		
	Gender	Female Male	*Geography:*	Rural Urban
Population with Disparate Need	Number	N/A	Low Income:	N/A
	Ethnicity	N/A		
	Race	N/A		
	Ages	N/A		
	Gender	N/A	*Geography:*	N/A
	Location	N/A		
Data Source(s)	"California QuickFacts from the U.S. Census Bureau." Population, 2013 estimate. Obtained 6 May 2014, http://quickfacts.census.gov/qfd/states/06000.html.			

Evidence Based Guidelines/Best Practices:
Other:

- Public Health Preparedness Capabilities: National Standards for State and Local Planning (2011)
- Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness (2011)
- "Health Alert Network (HAN): CDC Program Descriptions and Best Practices" (2012)
- Public Health Information Network (PHIN) Requirements v. 2.0 (2007)
- PHIN Communications and Alerting (PCA) Guide v. 1.3 (2010)
- U.S. Department of Health & Human Services Public Health System, Finance, and Quality Program (http://www.hhs.gov/ash/initiatives/quality/index.html)
- Model Practices Database (National Association of County and City Health Officials)
- National Institutes of Standards and Technology (NIST) Special Publication 800-53 Rev. 4, "Security and Privacy Controls for Federal Information Systems and Organizations" (2013)

Block Grant Role:
Role of PHHSBG Funds:

- ☐ 100%: Total source of funding
- ☐ 75–99%: Primary source of funding
- ☑ 50–74%: Significant source of funding
- ☐ 10–49%: Partial source of funding
- ☐ Less than 10%: Minimal source of funding

Description (Optional):
Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Funds allocated and block grant role in addressing this Health Objective:

Category	Budgeted	Available	Allocated to this Health Objective
*1. Annual basic current year	$500,000		
2. Sex offense current year (Health Objective)	0		
3. Total current year	$500,000		
*4. Annual basic prior year	$0		
5. Sex offense prior year (Health Objective)	0		
6. Total prior year	$0		
7. Total current + prior year	$500,000		
*8. Current year funds allocated to disparate population	0		
*9. Current year funds to local entities for this health objective			
*10. Block $'s vs. other state health department	Significant source of funding (54%)		

OBJECTIVES – ANNUAL ACTIVITIES

Objective 1:
Maintain CAHAN Information System.
Between 07/2014 and 06/2015, CAHAN program staff, in partnership with the CAHAN vendor, will maintain CAHAN information system availability for a minimum of 99.9 percent of the budget period, measured in real time.

Annual Activities:

1. **Collect feedback** from program administrators.
2. **Mine the CAHAN alert database.**
3. **Score directory structures** according to effectiveness.

Objective 2:
Analyze Effectiveness of CAHAN Directory Structures.
Between 07/2014 and 06/2015, CAHAN program staff will identify directory structures that have less than a 50% effectiveness rating per program administrator feedback and quantitative analysis of CAHAN alert records.

Annual Activities:

1. **Collect feedback** from program administrators.
2. **Mine the CAHAN alert database.**
3. **Score directory structures** according to effectiveness.

Objective 3:
Investigate average time to disseminate information.
Between 07/2014 and 06/2015, CAHAN program staff will establish a credible baseline for the average time required for CDPH to disseminate information received from Federal and other State partners through CAHAN to California-area stakeholders.

Annual Activities:

1. **Track processing time** for all externally originating information events that require dissemination through CAHAN.
2. **Document workflow/processing issues** as they arise.
3. **Calculate baseline** of average processing time and corroborate using CDPH/EPO Duty Officer Incident Logs.

Objective 4:

Decrease average time to respond for state-level staff notifications.

Between 07/2014 and 06/2015, CDPH staff will decrease the average time to respond for State-level staff notifications requiring immediate report by at least 10 percent.

Annual Activities:

1. **Conduct at least four staff notification drills** to core State-level responders.
2. **Calculate baselines** of average response time and report time.
3. **Investigate strategies** to improve average response and report times from baseline.
4. **Implement and test** at least one strategy.

Objective 5:

Increase California-Area Tribal Organization Responsiveness to CAHAN Alerts

By 06/2015, CAHAN program staff will increase California-area tribal organization responsiveness to CAHAN alert notifications by at least 5 percent through partnership with the California Department of Health Care Services (DHCS) Indian Health Program (IHP) and other tribal partners enumerated in Primary Strategic Partnerships above.

Annual Activities:

1. **Conduct at least two unannounced CAHAN drills** to CAHAN participants from tribal organizations.
2. **Support IHP outreach and educational initiatives** with supplemental information about CAHAN's role in emergency preparedness.
3. **Liaise between IHP and CAHAN program administrators** to build partnerships between jurisdictional CAHAN programs and tribal organizations.

Re-engagement in HIV Care and Partner Services Using HIV Surveillance Data

Program Strategy:

Goal: The Office of AIDS (OA) is responsible for meeting the goals of the President's National HIV/AIDS Strategy in California. These goals are to: (1) reduce the number of people who become infected with HIV; (2) increase access to care and improve health outcomes for people living with HIV; and (3) reduce HIV-related health disparities.

Primary Strategic Partnerships:

Internal:

- Sexually Transmitted Disease (STD) Control Branch, Division of Communicable Disease Control

External:

- County of San Diego, Public Health Services, HIV, STD and Hepatitis Branch
- Alameda County Public Health Department, Division of Communicable Disease Control and Prevention, Office of AIDS Administration
- Orange County Health Care Agency, HIV Planning and Coordination

Evaluation Methodology

The Re-engagement in HIV Care and Partner Services Using HIV Surveillance Data Program will be evaluated by using HIV surveillance data in the funded counties to determine the current proportion of people living with HIV not in health care and its change over the funding period. The increase in those newly identified as HIV-positive by partner services will be measured by the Local Evaluation Online (LEO) database managed by OA Prevention Research and Evaluation Branch and STD surveillance data available from the STD Control Branch.

Program Setting: (check all that apply)

- ☐ Business, corporation or industry
- ☐ Child care center
- ☐ Community based organization
- ☐ Community health center
- ☐ Faith based organization
- ☐ Home
- ☑ Local health department
- ☑ Medical or clinical site
- ☐ Parks or playgrounds
- ☐ Rape crisis center
- ☐ Schools or school district
- ☐ Senior residence or center
- ☑ State health department
- ☐ Tribal nation or area
- ☐ University or college
- ☐ Work site
- ☐ Other

FTEs

Position Title	FTE Name	% State	% Local	% Other	% Total
Surveillance Outreach	Analyst III			100%	100%
Surveillance Outreach	Analyst III			100%	100%
Surveillance Outreach	Analyst III			100%	100%

FTE Summary

# of Positions	State FTEs	Local FTEs	Other FTEs	Total FTEs
3			3	3

National Health Objective:

- **HIV-1** (Developmental) Reduce new HIV diagnoses among adolescents and adults
- **HIV-10** (Developmental) Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards

State Health Objective:

OA's objectives are in line with the President's National HIV/AIDS Strategy (NHAS) that used 2010 as its baseline and will evaluate progress in 2015. OA's outcome goals for California are to 1) reduce the number of new HIV infections by 25 percent, 2) increase the proportion of newly diagnosed patients linked to clinical care within three months of HIV diagnosis from 65 to 85 percent; 3) increase the proportion of PLWH/A who are in continuous care to from 74 to 80 percent; and 4) increase the proportion of HIV-diagnosed gay and bisexual men, African Americans and Latinos with undetectable viral load by 20 percent in each category.

Data source: OA HIV Surveillance Case Registry

State Health Problem:

Health Burden:

California ranks second in the nation for cumulative AIDS cases, and as of the end of 2010, approximately 130,000 Californians were living with HIV. While deaths from HIV have declined, the rate of new infections has remained stable as the epidemic continues among populations heavily impacted by health disparities such as African Americans, Latinos, and men who have sex with men (MSM), especially young MSM of color. In 2012 the CDC released The Continuum of HIV Care, an analysis of the number of people nationwide that are infected with HIV, know their HIV status, are linked to HIV care, remain engaged in HIV care and achieve viral suppression. HIV suppression is the appropriate endpoint because when a person with HIV is virally suppressed s/he is 96 percent less likely to transmit HIV to their sex or needle-sharing partners. California has produced its own continuum of care. As of December 31, 2010, 130,000 people were living with HIV in California and of those, 82 percent know their HIV status, 50 percent are linked to care, 37 percent are retained in care and 36 percent achieved viral

suppression. California's viral suppression rate is higher than the national average of 25 percent, but needs to be significantly higher to decrease new HIV infections is California. African Americans and younger people are least likely to be retained in care or achieve viral suppression.

Target Population:
Number: 25,322
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 13 to 65 and older
Gender: Female and Male
Geography: Both
Primarily Low Income: No

Disparate Population:
Number: 13,652
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
Age: 13 to 65 and older.
Gender: Female and Male
Geography: Both
Primarily Low Income: Yes
Location: Alameda, Orange and San Diego Counties
Target and Disparate Data Sources: HIV Surveillance Data

Evidence Based Guidelines/Best Practices:

- ☐ Best Practices Initiative (U.S. Department of Health and Human Service)
- ☐ Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
- ☐ Guide to Community Preventive Services (Task Force on Community Preventive Services)
- ☑ MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
- ☐ Model Practices Database (National Association of County and City Health Officials)
- ☐ National Guideline Clearinghouse (Agency for Healthcare Research and Quality)
- ☐ Promising Practices Network (RAND Corporation)
- ☑ Other (identify):

The Centers for Disease Control and Prevention (CDC) recommends using HIV surveillance data[1] to re-engage people in HIV care, treatment, and partner services[2].

Block Grant Role:
Role of PHHSBG Funds:

- [x] 100%: Total source of funding
- [ ] 75–99%: Primary source of funding
- [ ] 50–74%: Significant source of funding
- [ ] 10–49%: Partial source of funding
- [ ] Less than 10%: Minimal source of funding

Funds:

Category	Budgeted	Available	Allocated to this Health Objective
*1. Annual basic current year	$500,000	$500,000	$500,000
2. Sex offense current year (Health Objective)			
3. Total current year			
*4. Annual basic prior year			
5. Sex offense prior year (Health Objective)			
6. Total prior year			
7. Total current + prior year			
*8. Current year funds allocated to disparate population			
*9. Current year funds to local entities for this health objective			
*10. Block $'s vs. other state health department			

[1] Sweeney, P., et al. (2013). "Shifting the paradigm: using HIV surveillance data as a foundation for improving HIV care and preventing HIV infection." Milbank Q **91**(3): 558-603.

[2] Centers for Disease Control and Prevention. Recommendations for partner services programs for HIV infection, syphilis, gonorrhea, and chlamydial infection. *MMWR*2008;57(RR-9):1-63. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm. Accessed June 13, 2012.

OBJECTIVES – ANNUAL ACTIVITIES

Objective 1

Increase number of people in HIV care.

By 9/2015, the proportion of people with HIV who are classified as out-of-care for a 12-month period will be decreased by 3 percent compared to the 2013 baseline year. (2016 = 10 percent; 2017 = 15 percent.)

Annual Activities:

1. Hire and train three field outreach workers for linkage to /re-engagement in care.
2. Using surveillance data, develop a monthly line list of PLWH who are out of care in each county.
3. Develop and implement work plan for each county's Surveillance outreach worker.

Objective 2

Increase number of people newly identified as HIV positive by partner services.

By 9/2015, the number of people newly identified with HIV through partner services will increase by 100% from 7 (baseline year 2013 to 14. (2016 = 200%(21); 2017 = 300% (28))

Annual Activities:

1. Hire and train three field outreach workers for partner services elicitation and notification activities.
2. Develop and implement work plan for each county's Surveillance outreach worker.

Office of Quality Performance and Accreditation (OQPA)

Program Strategy:
***Goal*:** OQPA's mission is to facilitate and support the California Department of Public Health (CDPH) as a quality performing organization, which includes providing leadership and coordination of the department's efforts to achieve and maintain National Public Health Accreditation which is administered by the Public Health Accreditation Board (PHAB). OQPA provides technical assistance to local health departments (LHDs) and Tribal health partners to foster accreditation readiness and the implementation of local quality performance and improvement activities.

Primary Strategic Partnerships: OQPA maintains a number of collaborative relationships and strategic partnerships, including:

Internal:
- California Conference of Local Health Officers (CCLHO)
- Center for Chronic Disease Prevention and Health Promotion
- Center for Environmental Health
- Center for Family Health
- Center for Health Care Quality
- Center for Health Statistics and Informatics
- Center for Infectious Diseases
- Emergency Preparedness Office
- Healthier U – Wellness Program
- Office of Health Equity
- Office of Public Affairs
- Office of the State Laboratory Director

External
- Association of State and Territorial Health Officers (ASHTO)
- California Conference of Local Health Data Managers
- California Endowment
- California Gaining Ground Coalition (CGGC)
- California Public Health Association-North
- California Public Health Practice-Based Research Network
- California Rural Indian Health Board
- Center for Disease and Control and Prevention
- City of Long Beach Department of Health and Human Services
- County Health Executives Association of California (CHEAC)
- County of San Diego Health and Human Services Agency
- Health Career Connection
- Health Officers Association of California
- Institute for Population Health Improvement (IPHI)
- National Public Health Institute

- Public Health Accreditation Board (PHAB)
- Public Health Institute
- Robert Wood Johnson Foundation
- The Health Care Connection
- University of California Berkeley School of Public Health
- University of California Center Sacramento
- University of California, Davis
- University of California Los Angeles

Evaluation Methodology: OQPA projects will be evaluated using quantitative and qualitative research methods.

Program Setting:

- ☐ Business, corporation or industry
- ☐ Child care center
- ☐ Community based organization
- ☐ Community health center
- ☐ Faith based organization
- ☐ Home
- ☑ Local health department
- ☐ Medical or clinical site
- ☐ Parks or playgrounds
- ☐ Rape crisis center
- ☐ Schools or school district
- ☐ Senior residence or center
- ☑ State health department
- ☑ Tribal nation or area
- ☐ University or college
- ☐ Work site
- ☐ Other

FTEs
Position Title: Health Program Specialist I
State-Level 100% Local 0% Other 0% Total: 100%
Position Title: Staff Services Analyst
State-Level 100% Local 0% Other 0% Total: 100%

Total Number of Positions Funded: 2
Total FTEs Funded: 2.00

<u>*National Health Objective</u>:
HO PHI-14, PHI-15, PHI-16, PHI-17 Public Health Infrastructure - Accreditation and Quality Improvement (QI).

State Health Objective(s):
Between 10/2014 and 9/2015

1. Increase the percentage of local and tribal public health agencies that have developed a quality improvement (QI) plan by 10%.
2. Increase the percentage of local and tribal public health agencies that submitted a Statement of Intent (SOI) to apply for national public health accreditation by 10%.
3. Increase the percentage of local and tribal public health agencies that have submitted an application (e.g. prerequisites) to PHAB by 10%.

Baseline:

- *In 2011, CDPH conducted a local health department (LHD) performance management and QI survey. Results showed that approximately 50% of LHDs had started basic QI activities, 25% had established a department-wide QI approach and only 8% had started building a performance management system.*
- *In 2013, CHEAC surveyed its members on their level of accreditation readiness. Of the 57 LHDs that responded only 5% had submitted a SOI. Between 5-14% of the 57 LHDs have completed one or all of the three prerequisites necessary to submit an application to PHAB.*
- *Currently there is no baseline assessment on the level of tribal accreditation readiness. However, the California Gaining Ground Coalition, funded by the National Network of Public Health Institute, will be conducting a baseline assessment of tribal accreditation readiness and QI efforts in 2014.*

Data source:

- CDPH
- CHEAC
- California Gaining Ground Coalition

Role of PHHSBG Funds: PHHSBG funds will be utilized to facilitate CDPH provision of technical assistance to local and tribal public health agencies on accreditation and QI planning activities by:

- Establishing two state-level positions to provide technical assistance to local and tribal public health agencies for accreditation readiness and QI activities.
- Assist in the development and deployment in the annual accreditation readiness and QI assessment of local and tribal public health agencies.
- Assist in the development of accreditation and QI tool kits that are based on the needs assessment and made available on the California Performance Improvement (CalPIM) website.
- Develop and facilitate trainings tailored to the level of local and tribal public health agencies readiness as identified by the assessment.

State Health Problem:
There are 61 legally designated LHDs in California, one from each of the 58 counties and three cities of Berkeley, Long Beach and Pasadena. Additionally, there are 32 Tribal health departments, which are tribally-controlled and serve the109 federally recognized tribes.

Local and tribal public health agencies are in various stages of accreditation readiness and implementation of quality performance and improvement systems. Over the past few years local health departments have become increasingly more interested in national voluntary public health accreditation. As such, extensive and focused training and technical assistance regarding the accreditation process, including development of work plans, evidence collection, Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), strategic planning, and quality performance and improvement systems is needed. Many local and tribal public health agencies don't have the in-house technical expertise and/or resources to facilitate, lead, direct or coordinate the QI and accreditation readiness activities.

Preparing for accreditation and developing quality performance and improvement systems is very complex and requires extensive coaching and technical assistance services. To address these emerging needs, the California Department of Public Health (CDPH) and CHEAC created the CalPIM network The network is intended to facilitate consistent communication with the local and tribal public health agencies on accreditation, QI, and quality performance related activities. The CalPIM network includes a CDPH housed website containing a repository of accreditation and quality performance information. The network conducts quarterly webinars on a variety of quality performance activities such as public health workforce development process. During the webinars, CDPH and other health department professionals share lessons learned and innovative solutions they have implemented regarding accreditation and quality performance. The CalPIM network, in itself, is insufficient to holistically address the accreditation and quality performance needs of the local and tribal public health agencies.

Evidence-Based Guidelines/Best Practices

- Other – Association of State and Territorial Health Officers (ASTHO) Accreditation Coordinators Learning Community serves as a peer network of state health agency accreditation coordinators who want to enhance their knowledge of the PHAB Accreditation process and exchange accreditation related resources.
- Other – Michigan QI Handbook was developed to provide a resource for all health departments wanting to begin or advance implementation of QI activities. The guidebook provides a starting point for LHDs to implement QI based on methods, tools, and techniques that are used in public health settings.
- Other – The National Association of County and City Health Officials (NACCHO) provides Mobilizing for Action through Planning and Partnerships (MAPP)- related tools and materials online for community health assessments.

Role of PHHSBG Funds: (choose one)

- ☑ 100%: Total source of funding
- ☐ 75–99%: Primary source of funding
- ☐ 50–74%: Significant source of funding
- ☐ 10–49%: Partial source of funding
- ☐ Less than 10%: Minimal source of funding

Description (Optional): OQPA will use PHHSBG funds to establish a mechanism to provide technical assistance to local and tribal public health agencies regarding accreditation and QI activities.

Funds:
Total Current Year Funds Allocated to Health Initiative: $0
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total Source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Objective 1:
Increasing capacity.
By 8/2014, OQPA will hire two additional state personnel to provide technical assistance to local and tribal public health agencies regarding accreditation and QI activities.

Objective 2:
Needs assessment.
By 9/2014, OQPA staff will collaborate with the California Gaining Ground Coalition with the development and deployment of a local and tribal public health agencies assessment of accreditation and QI activities readiness.

Objective 3:
Supporting interventions.
By 9/2015, OQPA staff will post on the CalPIM website accreditation and QI tool kits that were developed to address identified needs.

Objective 4:
Increasing capacity.
By 9/2015, OQPA staff will assist in the development of one training that is tailored to the local and tribal public health agencies accreditation and QI readiness as identified in the survey.

California Wellness Plan Implementation (CWPI)

State Program Strategy:

Goal: Building on the priorities recommended by the Let's Get Healthy California Task Force, the California Wellness Plan's Five Goals are "Equity in Health and Wellbeing" (overarching), 1 Healthy Communities, 2 Optimal Health Systems Linked with Community Prevention, 3 Accessible and Usable Health Information, and 4 Prevention Sustainability and Capacity. This was followed by the Advancing Prevention in the 21st Century: Commitment to Action 2014 (P21) Meeting in which priorities for the first two years were determined with statewide partners. California Wellness Plan Implementation will expand the capacity and expertise of the California Department of Public Health (CDPH) to effectively monitor and publish reports on chronic disease and injury and the California Wellness Plan (CWP) objectives and P21 strategies and activities, and to promote health, continue coordination and communication for collective impact among internal and external partners, and explore prevention sustainability opportunities. The Plan is available online at http://www.cdph.ca.gov/programs/cdcb/Documents/CDPH-CAWellnessPlan2014%20(Agency%20Approved).FINAL.2-27-14(Protected).pdf.

Primary Strategic Partnerships: CWPI has fostered chronic disease prevention and health equity collaborative relationships and strategic partnerships with stakeholders both internally and externally.

Internal

- Health and Human Services Agency
- CalSIM
  - 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 Public Affairs
Office of Quality Performance and Accreditation

External

Active Living Research
Afterschool Alliance
AHEAD Advocates for Health
Alzheimer's Association of California
American Cancer Society
American Heart Association
American Lung Association in California
Arthritis Foundation, Pacific Region
Asian American Network for Cancer Awareness
Bay Area Regional Health Inequities Initiative (BARHII)
Blue Shield of California Foundation
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 Convergence Coordinating Office
California Dental Association
California Department of Aging
California Department of Education
California Department of Finance
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

California Department of Housing and Community
California Department of Managed Health Care
California Department of Motor Vehicles
California Department of Parks and Recreation
California Department of Transportation
California Diabetes Coalition
California Dialogue on Cancer
California Emergency Medical Services Authority
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 Quality Collaborative
California Radiological Society
California Research Bureau
California Rural Indian Health Board
California Rural Legal Assistance
California School-Based Health Alliance
California School Health Centers Association
California State Association of Counties
California State University, Sacramento, College of Continuing Education

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 Plan
Contra Costa Health Services
Coordinated Student Support and Adult Education Division, California Department of Education
Covered California
Dairy Council of California
Del Norte County Department of Health and Human Services
DentaQuest Foundation
Diabetes Coalition of California
Elk Grove Unified School District
Federal Reserve Bank of San Francisco
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 Education Council
Health Officers Association of California
Health Services Advisory Group
Hospital Association of San Diego and Imperial County
Hospital Quality Institute
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
Latino Coalition for a Healthy California
Lifelong Medical Care
LIFT Levántate
Local Government Commission

Los Angeles County Department of Public Health
Los Angeles County Community and Senior Services
Medical Board of California
Metropolitan Transportation Commission
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 Research Institute
Partners in Advocacy (American Congress of Obstetricians and Gynecologists)
Partnership for the Public's Health
Pinnacle Trading
PolicyLink
Prevention Institute
Public Authority
Public Health Alliance of Southern California
Public Health Institute, CA4Health
Pump Handle Group
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
SEIU-UHW
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
Transform
Trust for America's Health
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, Merced
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
Vision y Compromiso
WALKSacramento
YMCA

Role of PHHSBG Funds: PHHSBG funds support state-level monitoring, communication, policy and coordination capacity, including health economic analysis, continued facilitated meetings with partners, analysis of survey results, and preparing and disseminating reports to advance chronic disease prevention (primary, secondary and tertiary) in order to improve population health.

Evaluation Methodology: CWPI plans to evaluate the progress of reaching California Wellness Plan goals with process evaluation [input and feedback from partners and stakeholders via in-person meetings, online surveys, calls and emails] and performance evaluation [by monitoring selected CWP objectives in collaboration with state partners].

Program Setting: (check all that apply)

- [x] Business, corporation or industry
- [ ] Rape crisis center
- [ ] Child care center
- [x] Schools or school district
- [x] Community based organization
- [x] Senior residence or center
- [x] Community health center
- [x] State health department
- [x] Faith based organization
- [x] Tribal nation or area

- [ ] Home
- [x] Local health department
- [x] Medical or clinical site
- [x] Parks or playgrounds
- [x] University or college
- [x] Work site
- [ ] Other

FTEs

Position Title	FTE Name	% State	% Local	% Other	% Total
Public Health Medical Officer IIIS	Jessica Nunez de Ybarra	100%			100%
Health Economist	TBD	100%			100%

FTE Summary

# of Positions	State FTEs	Local FTEs	Other FTEs	Total FTEs
2	2			2

***National Healthy People (HP) 2020 Health Objective: Health-Related Quality of Life and Well-Being-1 Increase the proportion of adults who Self-Report Good or Better Physical Health**

State Health Objectives	Data Sources
Between 10/2013 and 9/2015	
1. By 2022, increase the percentage of adults who report their overall health status to be good, very good, or excellent from baseline of 82 to 85 percent	*Behavioral Risk Factor Surveillance System, CDC*
2. By 2020, increase the percentage of 24–64 year old adults in good or better health from baseline of 81 to 85 percent	*Behavioral Risk Factor Surveillance System, CDC*
3. By 2020, increase the percentage of adults 65 years and older in good or better health from baseline of 76 percent to 78 percent	*Behavioral Risk Factor Surveillance System, CDC*
4. By 2020, decrease percentage of adults in fair or poor health from baseline of 21 to 18 percent for African Americans, and from baseline of 28 to 25 percent for Hispanics	*Behavioral Risk Factor Surveillance System, CDC*

Baselines:

1. *Per the BRFSS, CDC in 2012, 82 percent of adults reported their overall health status to be good, very good, or excellent.*

2. *Per the BRFSS, CDC in 2012, 81 percent of 24-64 year old adults reported to be in good or better health*
3. *Per the BRFSS, CDC in 2012, 76 percent of adults 65 years and older reported to be in good or better health*
4. *Per the BRFSS, CDC in 2012, 21 percent of African American adults and 28 percent of Hispanic adults reported to be in fair or poor health*

State Health Problem

Health Burden:

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.

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.

Moreover, the California Behavioral Risk Factor Survey (BRFS) has consistently shown that a majority of California adults have experienced at least one Adverse Childhood Experience (ACE) and that these early childhood traumas are associated with early social, emotional and cognitive impairment, risky and unhealthy behaviors, poor mental health, and multiple chronic diseases. In fact ACEs display a "dose response" pattern in terms of health impacts, i.e., as the number of childhood traumas increase so too does the likelihood of negative health impacts across the life span.

The ACEs module of questions developed by the Centers for Disease Control and Prevention (CDC) has been placed on the 2008, 2009, 2011, and 2013 California BRFS questionnaire in order to monitor the ongoing trends in exposure to early trauma and the magnitude of their impacts. This module serves as an important benchmark for how well our public health efforts are working. California's Let's Get Healthy Task Force, convened by the California Health and Human Services Agency recognized the critical role of ACEs in compromising health over the life span in its Final Report issued December 2012. The recent California Wellness Plan also includes ACEs as an important indicator as part of its roadmap for improving health and decreasing health disparities. It is anticipated that CWPI will integrate this trauma-informed perspective in order to focus efforts on preventing and mitigating these early childhood traumas and creating the conditions necessary to ensure our children have safe, stable and nurturing

relationships and environments that allow their bodies and brains to develop to their fullest. This will give children the best start and enable them to reach their full potential in life.

Target Population:	Number	38,451,604	Low Income:	No
	Ethnicity	Hispanic or Latino Non-Hispanic or Latino		
	Race	African American or Black American Indian or Alaskan Native Asian Native Hawaiian or Other Pacific Islander White Other		
	Ages	Under 1 year 4–11 years 12–19 years 20–24 years 25–34 years 35–49 years 50–64 years 65 years and older		
	Gender	Female Male	*Geography:*	Rural and Urban
Population with Disparate Need	Number	5,864,876	Low Income:	Yes – below poverty level
	Ethnicity	Hispanic or Latino Non-Hispanic or Latino		
	Race	African American or Black American Indian or Alaskan Native Asian Native Hawaiian or Other Pacific Islander White Other		
	Ages	Under 1 year 4–11 years 12–19 years 20–24 years 25–34 years 35–49 years 50–64 years 65 years and older		
	Gender	Female Male	*Geography:*	Rural and Urban
	Location	Entire state		
Data Source(s)	1) Target: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender 2010-2060. Sacramento, California, January 2013. 2) Disparate Population: Persons below poverty level, 2008-2012, CA 15.3% of 2010 CA population - U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits Last Revised: Thursday, 27-Mar-2014 09:53:56 EDT online at http://quickfacts.census.gov/qfd/states/06000.html			

Evidence Based Guidelines/Best Practices: (choose one or more)

- ☐ Best Practices Initiative (U.S. Department of Health and Human Service)
- ☑ Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
- ☑ Guide to Community Preventive Services (Task Force on Community Preventive Services)
- ☑ MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
- ☐ Model Practices Database (National Association of County and City Health Officials)
- ☐ National Guideline Clearinghouse (Agency for Healthcare Research and Quality)
- ☐ Promising Practices Network (RAND Corporation)
- ☑ Other (identify): American Academy of Pediatrics, Policy Statement: Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health http://pediatrics.aappublications.org/content/129/1/e224.full.pdf

Role of PHHSBG Funds:

- ☑ 100%: Total source of funding
- ☐ 75–99%: Primary source of funding
- ☐ 50–74%: Significant source of funding
- ☐ 10–49%: Partial source of funding
- ☐ Less than 10%: Minimal source of funding

Funds:

Category	Budgeted	Available	Allocated to this Health Objective
*1. Annual basic current year	$0		
2. Sex offense current year (Health Objective)			
3. Total current year	$600,000	$600,000	$600,000
*4. Annual basic prior year	$0		
5. Sex offense prior year (Health Objective)			
6. Total prior year	$0		
7. Total current + prior year	$600,000	$600,000	$600,000
*8. Current year funds allocated to disparate population	$0		
*9. Current year funds to local entities for this health objective	$0		
*10. Block $'s vs. other state health department	100% - Total Source of Funding		

IMPACT OBJECTIVES – ANNUAL ACTIVITIES:

Objective 1: Monitor California Wellness Plan implementation.
By 9/2015, in support of all CDC Domains (1 Policy, Systems, and Environmental Change, 2 Health Care Systems Change, 3 Clinical–Community Linkages and 4 Surveillance and Epidemiology), Dr. Nunez de Ybarra will lead CWP implementation efforts by collecting internal and external stakeholder and partner experiences and best practices in order to demonstrate implementation, as well as track CWP objectives and publish 1 annual report on progress.

Annual Activities:

1. **Identify CWP implementation priority activities.**
   By 9/2015, continue to engage with partners and stakeholders to determine activities.
2. **Develop CWP progress report.**
   By 9/2015, publish first California Wellness Plan progress report with a focus on CDPH and Partner supported strategies/action steps and commitments and any changes in CWP short-term, intermediate and long-term objectives.

Objective 2: Activate partnerships.
By 9/2015, in support of all CDC Domains, Dr. Nunez de Ybarra will hold 4 stakeholder meetings, develop one communication method with statewide partners for CWPI, and attend 6 Partner/Stakeholder meetings to promote California Wellness Plan Implementation and to assist in the definition and clarification of partnership roles and activities.

Annual Activities

1. **Convene stakeholders.**
   By 9/2015, convene Stakeholders through multiple forums (in person meetings, online surveys, webinars, calls) and encourage collective impact through shared priority activities ensuring partner input to optimize and improve population health.
2. **Maintain communications.**
   By 9/2015, develop mechanisms for communication (e.g., list serve, website, newsletter) of CWP implementation activity progress and opportunities by internal and external partners. Develop communications mechanism of choice, including website.
3. **Participate in six coalitions and partner conferences and meetings.**
   By 9/2015, maintain participation in Partner activities and provide guidance and clarification on role of stakeholders in California Wellness Plan implementation.

Objective 3: Measure economic burden of chronic disease.
By 9/2015, in support of Domain 4, Dr. Nunez will hire one health economist to begin to communicate county-level cost estimates of chronic disease to stakeholders and partners in 3 forums, and to set economic analysis priorities and perform analyses with completion of one needs assessment report.

Annual Activities

1. **Distribute "Economic Burden of Chronic Disease."**
   By 9/2015, promote and distribute Economic Burden of Chronic Disease, California 2014 report.
2. **Maintain Stakeholder Advisory Group**
   By 9/2015, convene Advisory Group to review Report and suggest methods for optimizing use of report by stakeholders and partners and to suggest future report improvements and revisions.
3. **Develop CDPH health economic analysis capacity.**
   By 9/2015, hire health economist in CDPH (state or contract) and perform needs assessment to determine priority analyses to guide statewide health policy.

Objective 4: Analyze impact of adverse childhood experiences.
By 9/2015, in support of Domain 4 (Surveillance and Epidemiology), CWPI will partially fund the Adverse Childhood Experiences (ACEs) module of 11 questions developed by CDC for the upcoming 2015 California Behavioral Risk Factor Survey questionnaire for future analysis.

Annual Activities

1. **Fund the ACEs module of questions.**
   By 9/2015, CWPI will partially fund the ACEs module of questions for the CDPH Safe and Active Communities Branch to analyze and report the results to stakeholders and partners.

Infectious Diseases Branch and Microbial Diseases Laboratory Branch

State Program Strategy:

Goal 1: Microbial Diseases Laboratory (MDL) is an important component of California's public health infrastructure with 34 local laboratories and a large number of academic and referral medical facilities. MDL's mission is to provide reference, diagnostic and applied research activities for the detection, epidemiologic investigation, control and prevention of bacterial, mycobacterial, fungal and parasitic diseases in humans, food, water and other environmental sources.

Goal 2: The Infectious Diseases Branch (IDB) protects the health of Californians from general infectious diseases through the surveillance, investigation, control, and prevention of general communicable diseases and outbreaks and by assisting local public health departments in these activities. Diseases monitored by IDB include foodborne, waterborne, vectorborne, zoonotic, and emerging infectious diseases.

Primary Strategic Partnerships:

Internal

- Center for Chronic Disease Prevention and Health Promotion, Division of Environmental and Occupational Disease Control, Occupational Health Branch.

External

- 34 Local Public Health Laboratories in California
- Referral hospitals for valley fever –
    - Kern Medical Center,
    - UC Davis Medical Center,
    - UCSF-Fresno Medical Center,
    - UC San Diego Medical Center,
    - UCLA Medical Center,
    - Santa Clara Valley Medical Center,
    - Stanford University Medical Center
- Local public health departments especially those in endemic counties
    - Fresno
    - Kings
    - Kern
    - Madera
    - San Luis Obispo
    - Tulare
- University of California (UC) San Francisco
- UC Davis

Role of PHHSBG Funds

PHHSBG funds provide foundational support for MDL's and IDB's state infrastructure in the following ways:

1. Two laboratory positions will be established in MDL to build laboratory capacity in the diagnosis of fungal infections such as Valley Fever. The specialist laboratorians will partner with local public health laboratories and disease control programs for identification, characterization and genotyping of Coccidioides species, the causal agents of coccidiodomycosis (Valley Fever).
2. One epidemiologist position will enhance IDB epidemiology capacity by providing leadership in conducting investigations of Valley Fever outbreaks as well as assisting local public health departments in the surveillance, prevention and control of Valley Fever. The PHHSBG support for an epidemiologist will also provide the opportunity to conduct community assessments of Valley Fever awareness and develop exposure reduction measures.

Evaluation Methodology: Laboratory activities will be evaluated using appropriate quantitative outcome measures. Epidemiologic activities will be evaluated by qualitative descriptions of outbreak investigations and community assessment activities.

Program Setting:

- ☐ Business, corporation or industry
- ☐ Child care center
- ☑ Community based organization
- ☐ Community health center
- ☐ Faith based organization
- ☐ Home
- ☑ Local health department
- ☐ Medical or clinical site
- ☐ Parks or playgrounds
- ☐ Rape crisis center
- ☐ Schools or school district
- ☐ Senior residence or center
- ☑ State health department
- ☐ Tribal nation or area
- ☐ University or college
- ☐ Work site
- ☐ Other

FTEs (Full Time Equivalents)

Position Title	% State
Research Scientist II	100%
Research Scientist II	100%
Research Scientist III Epidemiology / Biostatistics	100%

Total Number of Positions Funded: 3
Total FTEs Funded: 3

National Healthy People (HP) 2020 Health Objectives:
PHI-11 Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services to support essential public health services.

PHI 13.3 Increase the proportion of State public health agencies that provide or assure comprehensive epidemiology services to support essential public health services.

State Health Objectives
Between 10/2014 and 09/2015

1. Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services to support disease prevention, control and surveillance to the HP 2020 goal of 97%.
2. Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services that support specialized and reference testing to the HP 2020 goal of 86%.
3. Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services in support of public health related research to the HP 2020 goal of 32%.
4. Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services that support policy development to the HP 2020 goal of 74%.
5. Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services that foster partnership and communication to the HP 2020 goal of 67%.
6. By 10/2014 hire a dedicated epidemiologist to lead and assist local jurisdictions in investigating outbreaks of Valley Fever.
7. Assess the level of Valley Fever awareness and research practices that may reduce exposure in the endemic counties in California (Fresno, Kings, Kern, Madera, San Luis Obispo, and Tulare).

Baseline:
Since 2000, there has been a five-fold increase in the reported cases of coccidioidomycosis in California, with more than 4,000 cases reported in 2012. The capacity for diagnosis of mycotic diseases in California is woefully inadequate.

Data source: CDC, California Department of Public Health (CDPH), California Association of Public Health Laboratory Directors (CAPHLD)

State Health Problem:
Health Burden:
The most important of the mycotic diseases affecting Californians is Coccidioidomycosis or Valley Fever. The origin of the disease is found in two soil fungi *Coccidioides immitis* and *C. posadasii*. The disease is endemic in the state especially in the Central Valley. In

2012 there were 4,049 reported Valley Fever cases representing a 67% increase from 2009. The highest rates (200 cases per 100,000 population) are found in Kern and Kings Counties in the Central Valley. Although many Valley Fever infections are mild or not apparent, severe illness such as meningitis or disseminated disease may cause long-term disability and require lifelong treatment. From 2000 through 2011 there were more than 25,000 hospitalizations within California and a 8% of patients (1,220) hospitalized for Valley Fever died during an initial or subsequent hospitalization. During that time, the total charges for all coccidioidomycosis-associated hospitalizations in California was $2.2 billion, in comparison to the average annual total of $186 million.

California has a strong public health infrastructure with 34 local laboratories, the state laboratory (MDL), and a large number of academic and referral medical facilities. However, mycotic diagnostic capacity is inadequate in all laboratories, including MDL which currently offers a single test (GenProbe® for *Coccidioides* species). Although coccidioidomycosis is a reportable disease in California, the laboratories are not required to report. As a result, the true burden of coccidiodomycosis in California remains undetermined and likely underestimated.

The **target population** includes minorities in the endemic areas as they are at higher risk for valley fever. All age groups and both sexes are at high risk for this infection.

Target Population
Number: 3,523,483
Low Income
Ethnicity: Hispanic, Non-Hispanic
Race: African American, Asian, White and Other
Ages: 4– 65 years and older
Gender: Female and Male
Geography: Rural and Urban

Disparate Population
Number: 1,018,130
Ethnicity: Hispanic, Non-Hispanic
Race: African American, White and Other
Ages: 4– 65 years and older
Gender: Female and Male
Location: Specific Counties (name all) Fresno, Kern, Kings, Tulare, Merced, Madera, Fresno, San Luis Obispo,

Evidence Based Guidelines/Best Practices:
Other:

- Expert guidelines from the American Society for Microbiology and the Infectious Diseases Society of America for the utilization of microbiology and molecular biology tests for the identification of *Coccidioides* species
- Scientific publications from CDC and the University of California, Berkeley on the utility of whole genome sequence typing for investigations of *Coccidioides* species outbreaks

Role of PHHSBG Funds: (choose one)

- ☐ 100%: Total source of funding
- ☑ 75–99%: Primary source of funding
- ☐ 50–74%: Significant source of funding
- ☐ 10–49%: Partial source of funding
- ☐ Less than 10%: Minimal source of funding

Funds:

Category	Budgeted	Available	Allocated to this Health Objective
*1. Annual basic current year	0	0	0
2. Sex offense current year (Health Objective)	0	0	0
3. Total current year	$426,000	$426,000	$426,000
*4. Annual basic prior year	0	0	0
5. Sex offense prior year (Health Objective)	0	0	0
6. Total prior year	0	0	0
7. Total current + prior year	$426,000	$426,000	$426,000
*8. Current year funds allocated to disparate population	0	0	0
*9. Current year funds to local entities for this health objective	0		
*10. Block $'s vs. other state health department	100% - Total Source of Funding		

IMPACT OBJECTIVES – ANNUAL ACTIVITIES:

Objective 1:
Establish mycotic diagnostics.
Between 10/2014 and 09/2015, MDL staff will establish reference services for the isolation of pathogenic fungi from clinical specimens and identification of *Coccidioides* species isolates submitted to the state and local public health laboratories. Five-

hundred clinical specimens will be tested between 2014 -2015. This activity will ensure that California patients receive accurate and rapid confirmation for Valley Fever infection allowing for rapid treatment and averting more extensive hospitalization costs.

Annual Activities:

1. **Provide comprehensive laboratory services.**
   Between 10/2014 and 09/2015, MDL staff will complete licensing requirements for a comprehensive mycology laboratory and process 500 specimens and isolates for reference testing.
2. **Foster partnership.**
   Between 10/2014 and 09/2015, MDL staff will reach out to 34 local public health laboratories and academic centers involved with Valley Fever testing. The staff will conduct six conference calls, two webinars and two mailings to engage and educate laboratorians on the utilization of the specialized tests.

Objective 2:

Develop and conduct rapid molecular testing.

Between 10/2014 and 09/2015, MDL staff will validate real-time PCR assays for the differentiation of the two species of *Coccidioides (immitis* and *posadasii)*. During 2014 - 2015, one-hundred isolates of *Coccidioides* species will be tested by rapid molecular test. This activity will ensure better clinical management of coccidioidomycosis patients.

Annual Activities:

1. **Provide specialized and reference testing.**
   Between 12/2014 and 09/2015, MDL staff will introduce a one-tube molecular assay for same day confirmation and differentiation of 100 *Coccidioides* isolates from MDL and partner laboratories.
2. **Support public health related research.**
   Between 12/2014 and 09/2015, MDL staff will carry-out the development and validation of one real-time PCR assay for further improvement of published methods.

Objective 3:

Increase capacity.

Between 11/2014 and 09/2015, MDL staff will validate multi-locus sequence typing (MLST) and whole genome sequence (WGS) typing of *Coccidiodes* species. Twenty-five isolates of *Coccidioides* species from suspected outbreaks will be genotyped in 2014–2015. The genotyping results will enhance surveillance activities aimed at disease control and prevention.

Annual activities:

1. **Support disease prevention, control, and surveillance**
   Between 11/2014 and 09/2015, MDL staff standardize genotyping methods and provide real-time data for 25 isolates obtained from outbreak investigations being conducted by Infectious Disease Branch.
2. **Support policy development**
   Between 11/2014 and 09/2015, MDL staff will collaborate with Infectious Disease Branch to finalize guidelines for utilization of *Coccidioides* species genotyping data during an outbreak investigation.

3. **Support public health related research**
   Between 11/2014 and 09/2015, MDL staff will use 25 *Coccidioides* species outbreak isolates to compare MLST and WGS for their efficacy in determining relatedness among outbreak strains.

Objective 4:
Develop epidemiologic capacity.
By 10/2014 hire a full-time epidemiologist dedicated to Valley Fever. Through 9/2015 the IDB epidemiologist will provide support to local jurisdictions for Valley Fever surveillance and outbreak investigations. The position will function as a lead for CDPH IDB Valley Fever epidemiology activities and will coordinate with laboratory staff to investigate cases and outbreaks of Valley Fever in California.

Annual Activities:

1. Lead and assist local jurisdictions in conducting Valley Fever outbreak investigations (based upon recent past, up to two outbreaks of Valley Fever are anticipated per year).
2. Prioritize and oversee surveillance and investigations to study the epidemiology, disease burden, risk factors, and efficacy of prevention measures for Valley Fever in California.
3. Lead and coordinate translating Valley Fever data and findings into policies and practices to decrease the Valley Fever risk and disease burden in California.
4. Develop annual plans and benchmarks to address Valley Fever in California, and write annual progress report.

Objective 5:
Outreach and Collaborative Activities
Coordinate with health educators in local health jurisdictions and other local partners to assess and improve awareness of Valley Fever. In collaboration with local, state and federal partners to raise awareness of Valley Fever among targeted high-risk populations and the medical community. Coordinate with partners on outreach activities and potential prevention measures.

Annual Activities:

1. By March 2015 coordinate with health educator and local partners to identify outreach activities targeting high risk populations and raise awareness of Valley Fever.
2. By May 2015 identify and convene partners to conduct a community health assessment for Valley Fever.
3. By August 2015 draft a qualitative and quantitative community assessment plan for Valley Fever.
4. In collaboration with partners, develop a strategy for improving awareness of Valley Fever and incorporating prevention measures in schools, worksites and the general community.
5. In collaboration with partners, develop strategies for improving awareness of Valley Fever among clinicians in California and identify potential objective measures to assess improvements in early diagnosis.

Microbial Diseases Laboratory Branch

State Program Strategy:

Goal:

Microbial Diseases Laboratory (MDL) is an important component of the California's public health infrastructure with 34 local laboratories, and a large number of academic and referral medical facilities. MDL's mission is to provide reference, diagnostic and applied research activities for the detection, epidemiologic investigation, control and prevention of bacterial, mycobacterial, fungal and parasitic diseases in humans, food, water and other environmental sources. MDL is an integral component of California's infrastructure for emergency response against threats of bio-weapons or 'Select Agents'. The laboratory is the only public health repository of high-priority bio-threats agents ('Tier 1').

Primary Strategic Partnerships:

Internal

California Department of Public Health,
- Emergency Preparedness Office
- Center for Infectious Diseases
  - Division of Communicable Disease Control
    - Communicable Diseases Emergency Response Program
    - Infant Botulism Treatment and Prevention Program

External

- 14 California Laboratory Response Network (B) (LRN-B) Reference Laboratories
- Federal, state and local law enforcement agencies,
- Emergency responders
- US Postal Service

Role of PHHSBG Funds

PHHSBG funds provide foundational support for MDL's infrastructure. The funding will be used to hire one Associate Industrial Hygienist which will strengthen lab capacity to comply with Select Agent Tier 1 regulations. The Associate Industrial Hygienist will foster partnerships with state and local public health programs and laboratories and law enforcement to respond to all events triggered by suspect bio-threat agents.

Evaluation Methodology:

MDL project will be evaluated using appropriate quantitative and outcome measures.

State Program Setting:

- ☐ Business, corporation or industry
- ☐ Child care center
- ☐ Community based organization
- ☐ Community health center
- ☐ Faith based organization
- ☐ Home
- ☐ Local health department
- ☐ Medical or clinical site
- ☐ Parks or playgrounds
- ☐ Rape crisis center
- ☐ Schools or school district
- ☐ Senior residence or center
- ☑ State health department
- ☐ Tribal nation or area
- ☐ University or college
- ☐ Work site
- ☐ Other

FTEs

Position Title	FTE Name	% State	% Local	% Other	% Total
Associate Industrial Hygienist		100			100

FTE Summary

# of Positions	State FTEs	Local FTEs	Other FTEs	Total FTEs
1	1			1

National Health Objective: PHI-11 Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services to support essential public health services.

State Health Objective

Between 10/2014 and 09/2015, Increase the proportion of Tribal and State public health agencies that provide or assure comprehensive laboratory services in support of emergency response to the HP 2020 goal of 67% MDL to serve as reference diagnostic facility for the state and local public health programs, and as partner with local public health laboratories for advanced diagnostics of all suspected Select Agents including Tier 1 Agents (*Bacillus anthracis*, *Burkholderia mallei*, *Burkholderia pseudomallei*, Botulinum neurotoxins, Botulinum neurotoxin producing species of *Clostridium*, and *Francisella tularensis*).

Baseline:

The final rules on the Possession, Use, and Transfer of Select Agents and Toxins were published on October 5, 2012 in the Federal Register. Health and Human Services

Administration, Centers for Disease Control and Prevention designated those select agents and toxins that present the greatest risk of deliberate misuse; the most significant potential for mass casualties or devastating effects to the economy, critical infrastructure or public confidence as ``Tier 1" agents. The Federal Register established new security requirements for entities possessing Tier 1 agents, including the requirement to conduct pre-access assessments and on-going monitoring of personnel with access to Tier 1 agents and toxins and made revisions to the regulations to clarify regulatory language concerning security, training, biosafety, and incident response. CDPH MDL is the only public health facility in California with Tier 1 status for handling, processing, and storage of these Select Agents (Bacillus anthracis, Burkholderia mallei, Burkholderia pseudomallei, Botulinum neurotoxins, Botulinum neurotoxin producing species of Clostridium, and Francisella tularensis). MDL urgently needs additional resources to comply with recently enacted enhanced regulatory requirements.

Data source: Comprehensive Laboratory Services Survey (CLSS), Association of Public Health Laboratories (APHL), National Select Agent Registry (http://www.selectagents.gov/Regulations.html).

State Health Problem:

Health Burden: A cooperative effort to screen and confirm potential agents of bioterrorism (bio-threat or 'Select Agents') has been facilitated by considerable federal investment in the infrastructure and staffing following the September 11, 2001 terrorist attacks and the unrelated release of anthrax-laced letters. The funding received from CDC, Public Health Emergency Preparedness (PHEP) Cooperative Agreement supported a number of public health laboratories across California (LRN-B Reference Laboratory Network-Biologicals). CDC licenses the testing facilities under rigorous regulations for handling of bio-threat agents. CDPH has a high-level Select Agent program, which is able to serve as a reference laboratory for local public health labs and to perform critical activities enabling the state to quickly detect, characterize, and communicate regarding confirmed infections with bio-threat agents. Sustaining these resources at CDPH reduces the time needed to begin the response to an intentional act or other type of exposure to one of these agents.

The recently enacted requirements were added to the Code of Federal Regulations (42 CFR Part 73, 9 CFR Part 121, and 7 CFR Part 331) governing high level laboratories handling bio-threat agents such as the causes of botulism, plague and anthrax. A new category (Tier 1) was created with stringent requirements for certain activities related to these agents. MDL is the only California public health laboratory with Tier 1 status. No other California public health laboratories will be pursuing this status in the near future due to their inability to meet increasingly stringent federal guidelines. CDC estimates that only 20 out of 49 public health laboratories in the nation will obtain Tier 1 status. The MDL Tier 1 license ensures that there is a public health laboratory in the state which retains the full critical laboratory infrastructure to handle and store bio-threat agents. MDL urgently needs an Associate Industrial Hygienist to serve as a subject matter expert, provide technical guidance for compliance with Select Agent Tier 1

regulations, develop and monitor biosafety standard operating procedures, organize training and continuing education of laboratory staff in safe and secure work practices and coordinate incidence response to accidental release of exposure to infectious pathogens.

The **target and disparate populations** include Californians in all age groups and both sexes.

Target Population
Number: 38,340,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American, American Indian, Asian, Native Hawaiian, White and Other
Ages: Under 1 year – 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Location: Entire state of California

Evidence Based Guidelines/Best Practices:
Other:

- Comprehensive Laboratory Services Survey (CLSS), Association of Public Health Laboratories (APHL)

Role of PHHSBG Funds: (choose one)

- [x] 100%: Total source of funding
- [ ] 75–99%: Primary source of funding
- [ ] 50–74%: Significant source of funding
- [ ] 10–49%: Partial source of funding
- [ ] Less than 10%: Minimal source of funding

Funds:

Category	Budgeted	Available	Allocated to this Health Objective
*1. Annual basic current year	0	0	0
2. Sex offense current year (Health Objective)	0	0	0
3. Total current year	$165,000	$165,000	$165,000
*4. Annual basic prior year	0	0	0
5. Sex offense prior year (Health Objective)	0	0	0
6. Total prior year	0	0	0
7. Total current + prior year	$165,000	$165,000	$165,000
*8. Current year funds allocated to disparate population	0	0	0
*9. Current year funds to local entities for this health objective	0		
*10. Block $'s vs. other state health department	100% - Total Source of Funding		

IMPACT OBJECTIVES – ANNUAL ACTIVITIES

Objective 1:

Biosafety and biosecurity policies

Between 10/2014 and 09/2015, the MDL Associate Industrial Hygienist will assume full responsibilities as Alternate Responsible Official (ARO) for the Select Agent Tier 1 program and serve as lead contact for the CDC Select Agent Program. MDL policies will be finalized and streamlined for compliance with Tier 1 requirements. Staff security clearances via Department of Justice (DOJ), monitoring, intrusion prevention, inspections and drills will become operational to ensure a secure and safe work environment for processing and storage of Select Agents and suspect materials.

Annual Activities:

1. **Compliance review**
   Between 10/2014 and 09/2015, MDL Associate Industrial Hygienist will complete a review of laboratories procedures and inventory for their adequacy to meet compliance requirements. Branch Chief, Section Chiefs and other Subject Matter Experts will be advised of updates and areas of further improvement.
2. **Facility review**
   Between 10/2014 and 09/2015, the MDL Associate Industrial Hygienist will complete physical inspections of laboratories and equipment to ensure they are up to compliance standards. An efficient process will be established for coordination with Facilities Management Services and other offices not directly working with Tier 1 clearances.

Objective 2:
Biosafety and biosecurity practices
Between 10/2014 and 09/2015, the MDL Associate Industrial Hygienist will complete detailed procedures binders to prescribe handling, processing, storage and shipment of Select Agents. All personnel policies will be updated. An annual training exercise for Select Agent qualified individuals will be completed.

Annual Activities:

1. Provide annual training
Between 12/2014 and 09/2015, the MDL Associate Industrial Hygienist will provide annual training in biosafety and security to approximately 12 staff members.

2. Respond to mock and real security incidents
Between 12/2014 and 09/2015, the Associate Industrial Hygienist will perform a mock security incident exercise to test the level of preparedness and obtain hands-on experience for real breach events.

Objective 3:
Biosafety and biosecurity outreach
Between 11/2014 and 09/2015, MDL Associate Industrial Hygienist will undertake extensive outreach activities with internal and external partners to establish and refine emergency communication channels.

Annual Activities:

1. EPO and CDER
Between 10/2014 and 09/2015, the MDL Associate Industrial Hygienist will establish close contacts with the relevant parties in the internal EPO and CDER offices to ensure coordination and communication in response to a bio-threat event. An annual tabletop exercise will be completed to test the level of preparedness and intra-office communications.

2. Other LRN-B Labs
Between 10/2014 and 09/2015, the MDL Associate Industrial Hygienist will reach out to 14 California LRN-B laboratories. Two webinars and two mailings will be undertaken to engage other laboratories in performance of MDL Tier 1 duties and sharing of resources.

3. Law enforcement, emergency responders, USPS
Between 11/2014 and 09/2015, MDL Associate Industrial Hygienist will mail out a state of preparedness document to the appropriate contacts in local and state police, FBI, local and state fire and US Postal Service. An annual onsite ‘meet and greet’ event will be completed to familiarize all principals likely to be involved in responding to an actual bio-threat event.

Black Infant Health Program

State Program Strategy: Within a culturally affirming environment and honoring the unique history of African American women, the Black Infant Health (BIH) Program uses a group-based approach with complementary client-centered case management to help women develop life skills, learn strategies for reducing stress, and build social support. BIH clients participate in weekly group sessions designed to help them access their own strengths and set health-promoting goals for themselves and their babies.

Goals: The goals of BIH are to improve African American infant and maternal health and to decrease Black-White health disparities and social inequities for women and infants.

Primary Strategic Partnerships: BIH has cultivated a number of collaborative relationships and strategic partnerships, both internally and externally.

Internal:

- Maternal and Adolescent Health Division
    - Sudden Infant Death Syndrome (SIDS) Program
    - Women Infants and Children (WIC) Program
    - CA Home Visiting Program (CHVP)
    - Adolescent Family Health Program (AFLP)
    - Comprehensive Perinatal Services Program (CPSP)
    - CA Tobacco Control Program
    - Injury Prevention
    - Infant Health
    - Preconception Health
    - Oral Health Program
    - Information and Education (I&E) Program
    - Breastfeeding Program

External

- First 5
- University of California, San Francisco
- CA Department of Education
- CA Department of Health Care Services
    - Child Health and Disability Prevention (CHDP) Program
    - Immunization Branch
- California Local Health Departments
- CA Department of Social Services
- Covered California
- Medi-Cal

Evaluation Methodology: The ultimate goal of the BIH program is to improve African-American infant and maternal health in California and decrease black-white disparities. Both qualitative and quantitative data will be collected during each phase of the

implementation to document whether stated program goals are being met and whether aspects of the program require modification. The outcome evaluation, to be conducted subsequent to the process evaluation and determination of model fidelity, will focus on the effectiveness of the new BIH program model in reducing infant mortality and adverse birth outcomes as well as on key intermediate *health and health-related outcomes* that are (a) strongly associated with birth outcomes and/or other important measures of maternal and infant health, (b) could be influenced by the intervention in the relevant time frame, and (c) can be reasonably measured within the context of the program's resource constraints. The evaluation methodology for BIH is intended to meet requirements of utility, feasibility, propriety, and accuracy developed by the Joint Committee on Educational Evaluation in 1994 and operationalized for public health programs by the Centers for Disease Control and Prevention.

State Program Setting:

- ☐ Business, corporation or industry
- ☐ Child care center
- ☑ Community based organization
- ☐ Community health center
- ☐ Faith based organization
- ☐ Home
- ☑ Local health department
- ☐ Medical or clinical site
- ☐ Parks or playgrounds
- ☐ Rape crisis center
- ☐ Schools or school district
- ☐ Senior residence or center
- ☑ State health department
- ☐ Tribal nation or area
- ☐ University or college
- ☐ Work site
- ☐ Other

FTEs

Full Time Equivalents positions that are funded with PHHS Block Grant funds: None

***National Healthy People (HP) 2020 Health Objective:**

National HP 2020 Health Objectives consistent with long-term BIH program goals:

- MICH-1 Reduce the rate of fetal and infant deaths
- MICH-8 Reduce low birth weight (LBW) and very low birth weight (VLBW)
- MICH-9 Reduce preterm births

State Health Objective

Key state objectives, as defined in the California Wellness Plan, consistent with long-term BIH program impact objectives include:

- 2.9.1L: By 2020, decrease the percentage of live singleton births weighing less than 1500 grams
- 2.9.3L: By 2020, decrease the ratio of black to white infant mortality rate

Key intermediate BIH health objectives, strongly associated with the long-term outcomes stated above include the following:

- Increased levels of mastery, self-esteem, and resiliency as measured on the Pearlin's Self-Efficacy Scale, Rosenberg Scale, and Smith's Brief Resiliency Scale respectively.
- Increased levels of practical and emotional social support
- Healthier eating, during or after pregnancy
- Greater physical activity, during or after pregnancy
- Low/no postpartum relapse in tobacco use

During the early implementation phase, the measurable goals we are concerned with are those that move site programs toward model fidelity, the degree to which the intervention is implemented in comparison with the program design. BIH model fidelity is measured in terms of adherence to program standards, exposure to the intervention (AKA "dose"), quality of program delivery, participant engagement, and program differentiation.

Between 10/2014 and 9/2015, the BIH Program Objectives:

- Proportion of participants who enroll before their 3rd trimester will increase by 20%
- Proportion of women referred into BIH from medical providers, social service providers, and community-based organizations who attend at least one group session will increase by 15%
- Proportion of participating women who complete the group series will increase by 15%

State Health Objective baselines:

Baselines are based on the BIH participant data, collected for participants enrolled since January 2012:

- *Proportion of participants who enroll before their 3rd trimester: 52%*
- *Proportion of women referred into BIH from medical providers, social service providers, and community-based organizations who attend at least one group session: 54%*
- *Proportion of participating women who complete the group series: 51%*

Data source: Participant intake and assessment data obtained from the MCAH BIH Management Information System (MIS)

State Health Problem:

Health Burden

In California and in the United States, African American women persistently face a disproportionately high risk of delivering their babies too early (before 37 weeks of gestation) and too small (weighing less than 2500 grams). In California, African American babies are more than twice as likely as White babies to die before their first birthdays.

Birth outcomes are known to be influenced by the mother's health before she becomes pregnant. However, the reasons for these health disparities are complex and cannot be fully explained by differences in underlying medical conditions or behaviors like smoking. In fact, many experts believe that aspects of social disadvantage—including poverty, lack of social support, and racial discrimination—are important contributors to the increased risks of poor maternal and infant outcomes among African Americans. Current scientific understanding suggests that experiencing these kinds of stressful conditions—not only during pregnancy, but throughout life—can have dramatic adverse effects on a woman's own health and that of her baby.

In 2012, the statewide IMR was 4.5 deaths for every 1,000 live births, lower than the rate of 4.8 in 2011. While the African American Infant Mortality Rate decreased from 10.5 infant deaths per 1,000 live births in 2011 to 9.8 in 2012, racial/ethnic disparities in infant mortality persist. African American infant deaths occurred 2.6 times more frequently than White infant deaths in 2012. The White Infant Mortality Rate decreased from 4.1 infant deaths per 1,000 live births in 2011 to 3.8 in 2012.

Target Population:	Number		Low Income:	yes
	Ethnicity	Non-Hispanic		
	Race	African American or Black		
	Ages	18 years and older		
	Gender	Female	*Geography:*	Urban
Population with Disparate Need	Number		Low Income:	yes
	Ethnicity	Non-Hispanic		
	Race	African American or Black		
	Ages	18 years and older		
	Gender	Female	*Geography:*	Urban
	Location	BIH is located in 15 local health jurisdictions which represents over 90% of African-American births in California. The community messaging toolkit will benefit all BIH sites and be pilot tested in two or three sites to be determined.		
Data Source(s)	Participant information collected in the BIH MIS			

Evidence Based Guidelines/Best Practices: (choose one or more)

- ☐ Best Practices Initiative (U.S. Department of Health and Human Service)
- ☐ Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
- ☑ Guide to Community Preventive Services (Task Force on Community Preventive Services)
- ☐ MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
- ☐ Model Practices Database (National Association of County and City Health Officials)
- ☐ National Guideline Clearinghouse (Agency for Healthcare Research and Quality)
- ☐ Promising Practices Network (RAND Corporation)
- ☐ Other (identify):

Role of PHHSBG Funds:

- ☑ 100%: Total source of funding
- ☐ 75–99%: Primary source of funding
- ☐ 50–74%: Significant source of funding
- ☐ 10–49%: Partial source of funding
- ☐ Less than 10%: Minimal source of funding

Funds:

Category	Budgeted	Available	Allocated to this Health Objective
*1. Annual basic current year	$300,000		$300,000
2. Sex offense current year (Health Objective)			$0
3. Total current year			$300,000
*4. Annual basic prior year			$0
5. Sex offense prior year (Health Objective)			$0
6. Total prior year			$0
7. Total current + prior year			$0
*8. Current year funds allocated to disparate population			
*9. Current year funds to local entities for this health objective	$300,000		
*10. Block $'s vs. other state health department			

IMPACT OBJECTIVES – ANNUAL ACTIVITIES

Impact Objective: Clinical-Community Linkages.
Between 10/2014 and 9/2015, a community messaging toolkit will be developed and disseminated through a community stakeholder engagement process:

- Develop locally tested community messaging that fosters agreement between potential participants' expectations of BIH program services and the services BIH provides.
- Develop a standardized set of tested communication tools that can be used by Local Health Jurisdictions for all stakeholder audiences and in different communication platforms that clearly articulate the BIH program theory, activities, and short and long-term goals.
- Identify a primary set of tested, standard messages that can be used to educate local stakeholders about BIH program goals, activities, and expected outcomes through all communication channels.
- Develop written documentation that explains the rationale for shifting to the current model and the current model's program goals, intervention, and short-and long term outcomes that can be communicated in a standardized manner to state-level stakeholder organizations.

Annual Activities:
Activity #1: **Evaluate lists.**
Between July 1, 2014, and June 30, 2015, BIH staff will evaluate and refine the list of key stakeholders and audience groups at the local and state levels

Prior to the beginning of the grant cycle, through a participatory approach, State BIH program staff will work with local BIH leadership to begin the stakeholder analysis and identification of key audiences.

PHHS funds will then be used to secure subject matter expertise in the community engagement and development of effective communication strategies. The consulting subject matter expert will complete the following activities:

Activity #2:
Identify key messages.
Between July 1, 2014, and June 30, 2015, BIH staff will, with the participation of key stakeholders, identify key, audience-specific messages that align with the BIH program goals, activities, services, and expected outcomes.

Activity #3:
Create evaluation tools.
Between July 1, 2014, and June 30, 2015, BIH staff will create an outreach plan and messaging metrics that can be used to evaluate the effectiveness of messaging with local and state level stakeholder groups.

Activity # 4:
Develop documentation.
Develop written documentation that details the community engagement process; key stakeholders; and results of pilot testing for successful and unsuccessful messaging strategies.