

PUBLIC HEARING
STATE OF CALIFORNIA
HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH
PREVENTATIVE HEALTH AND HEALTH SERVICES BLOCK GRANT
ADVISORY COMMITTEE

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
KINGS RIVER CONFERENCE ROOM
1616 CAPITOL AVENUE, SUITE 74.463
SACRAMENTO, CALIFORNIA

MONDAY, SEPTEMBER 12, 2016

1:00 p.m.

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<p>2</p> <p>1 A P P E A R A N C E S</p> <p>2</p> <p>3 ADVISORY COMMITTEE MEMBERS:</p> <p>4 Christy Adams, RN, BSN, MPH (telephonically)</p> <p>5 Wes Alles, PhD, Director, Co-chair (telephonically)</p> <p>6 Paul Glassman, DDS, MA, MBA (telephonically)</p> <p>7 Rebekah Kharrazi, MPH, CPH</p> <p>8 Diana Cassady, PhD</p> <p>9 Caroline Peck, MD, Co-Chair</p> <p>10 Dan Spiess, EMS Administrator (telephonically)</p> <p>11 Samuel Stratton, MD, MPH (telephonically)</p> <p>12 Wilma Wooten, MD, MPH (telephonically)</p> <p>13 Nathan Wong, PhD (telephonically)</p> <p>14</p> <p>15 STAFF MEMBERS/PRESENTERS:</p> <p>16 Anita Butler, Block Grant Coordinator</p> <p>17 Karen L. Smith, CDPH Director</p> <p>18 Susan Fanelli, CDPH Assistant Director</p> <p>19 Brandon Nunes, Chief Deputy Director of Operations</p> <p>20 Claudia Crist, Chief Deputy of Policy Programs</p> <p>21</p> <p>22 ALSO PRESENT:</p> <p>23 Dan Smiley, EMSA</p> <p>24 Monica Morales, Fusion Center Deputy</p> <p>25</p>	<p>4</p> <p>1 who's professor and director of the UC Davis MPH program</p> <p>2 is unable to attend the meeting today, and so</p> <p>3 representing him and speaking on behalf of his program</p> <p>4 is Diana Cassidy. And so welcome both Diana and</p> <p>5 Rebekah.</p> <p>6 And now I'll ask that roll call of the committee</p> <p>7 members be taken.</p> <p>8 GRANT BLOCK COORDINATOR BUTLER: Thank you, Dr.</p> <p>9 Alles.</p> <p>10 Christy Adams?</p> <p>11 ADVISORY COMMITTEE MEMBER ADAMS: Here.</p> <p>12 GRANT BLOCK COORDINATOR BUTLER: Paul Glassman?</p> <p>13 ADVISORY COMMITTEE MEMBER GLASSMAN: Here.</p> <p>14 GRANT BLOCK COORDINATOR BUTLER: Rebekah</p> <p>15 Kharrazi?</p> <p>16 ADVISORY COMMITTEE MEMBER KHARRAZI: Here.</p> <p>17 GRANT BLOCK COORDINATOR BUTLER: Samuel</p> <p>18 Stratton?</p> <p>19 ADVISORY COMMITTEE MEMBER STRATTON: Here.</p> <p>20 GRANT BLOCK COORDINATOR BUTLER: Wilma Wooten?</p> <p>21 ADVISORY COMMITTEE MEMBER WOOTEN: (No</p> <p>22 response.)</p> <p>23 GRANT BLOCK COORDINATOR BUTLER: Nathan Wong?</p> <p>24 ADVISORY COMMITTEE MEMBER WONG: Here.</p> <p>25 GRANT BLOCK COORDINATOR BUTLER: Are there any</p>
<p>3</p> <p>1 P R O C E E D I N G S</p> <p>2 ---oOo---</p> <p>3 GRANT BLOCK COORDINATOR BUTLER: Welcome to the</p> <p>4 Preventive Health and Health Services Block Grant</p> <p>5 Advisory Committee Meeting.</p> <p>6 Is Dr. Wes Alles on the line?</p> <p>7 CO-CHAIRPERSON ALLES: I am.</p> <p>8 GRANT BLOCK COORDINATOR BUTLER: Hi, Dr. Alles.</p> <p>9 How are you today.</p> <p>10 CO-CHAIRPERSON ALLES: I'm fine. Thank you.</p> <p>11 And I hope everyone on the call is as well.</p> <p>12 GRANT BLOCK COORDINATOR BUTLER: Thank you. I</p> <p>13 will go ahead and turn it over to you.</p> <p>14 CO-CHAIRPERSON ALLES: Okay. Thank you. I want</p> <p>15 to begin even before roll call to just mention two</p> <p>16 things. You'll hear two names on the call as they go</p> <p>17 through the roll call -- I mean, that I want to alert</p> <p>18 you to. First thing is that Manal Aboelata has stepped</p> <p>19 down from her position on the advisory committee. But</p> <p>20 before doing that, she spoke with one of her colleagues,</p> <p>21 Rebekah Kharrazi at the Prevention Institute and talked</p> <p>22 with her about the committee. And Rebekah has agreed to</p> <p>23 replace Manal on the committee, and so you will hear her</p> <p>24 name during roll call.</p> <p>25 And the second thing is that Dr. Steven McCurdy,</p>	<p>5</p> <p>1 other advisory committee members on the line?</p> <p>2 Oh, Diana Cassady?</p> <p>3 ADVISORY COMMITTEE MEMBER CASSADY: Here.</p> <p>4 Sorry.</p> <p>5 GRANT BLOCK COORDINATOR BUTLER: Diana is</p> <p>6 joining us in person. I will turn it back over to you,</p> <p>7 Dr. Alles.</p> <p>8 CO-CHAIRPERSON ALLES: Okay. Thank you. I want</p> <p>9 to issue everybody a warm welcome and thank you for</p> <p>10 spending your afternoon with us today. The primary</p> <p>11 purpose of today's meeting is for us to have an</p> <p>12 opportunity to hear from Karen Smith, the director for</p> <p>13 the public health department, to provide the committee</p> <p>14 and members of the public who are joining us today, to</p> <p>15 share her vision with us. And this will give us an</p> <p>16 opportunity to listen and to -- we'll have an</p> <p>17 opportunity to ask questions and perhaps to provide some</p> <p>18 informed input.</p> <p>19 Our role really is to use our varied expertise</p> <p>20 the way we look at issues, to be constructive and</p> <p>21 informative to the Department of Public Health, and</p> <p>22 specifically, to Director Smith. And in order to be</p> <p>23 helpful, I think we need to listen, we need to question,</p> <p>24 and we need to advise. That's what we are being asked</p> <p>25 to do as committee members and certainly on the</p>

<p>6</p> <p>1 individual presentations that will be made, not only by 2 Karen, but by Susan Fanelli, who is the assistant 3 director; Brandon Nunes, who is the chief deputy 4 director of operations; and by Claudia Crist, chief 5 deputy of policy and programs.</p> <p>6 So with that -- oh, I need to say that our 7 committee is very transparent. We have a court reporter 8 at all of our committee meetings. The minutes are 9 derived from the notes that are taken by the court 10 reporter. We do invite the public to join in our 11 meetings. And I would guess that we have some members 12 of the public on the call today and perhaps in the room, 13 and there will be two opportunities for input from 14 members of the public.</p> <p>15 Also, information is available on the 16 department's website. I want to remind the committee 17 members that before speaking, I know it's hard, but 18 before speaking, so that the court reporter can get the 19 name accurate, if you would say your name. So just a 20 reminder, "I'm Nathan Wong and I have this to say," as 21 an example.</p> <p>22 So I want to just give Caroline a couple of 23 moments to also welcome you. And, Caroline, there may 24 be people in the room there that you would like to 25 introduce, and I'll leave that to you to recognize</p>	<p>8</p> <p>1 So I had a lot of ideas of the way that the 2 department could better work with local health 3 departments, you know, change some of its business 4 practices. I have to say that, quite obviously, there's 5 a lot more to the department than the work that we do 6 with health departments, but I remain firm in my belief 7 that the -- perhaps the most important interactions that 8 we have, most important stakeholders are the local 9 health departments, because they are boots on the ground 10 for public health. But I also believe really strongly 11 that the department and field of public health in 12 general is changing rapidly, particularly over the last 13 ten years, and the department needs to begin to change 14 to keep up. We will become rapidly anachronistic if we 15 don't.</p> <p>16 So I just want to kind of touch on some of the 17 reasons -- the reasons that I think that we need to 18 change, what some of the drivers of change are that are 19 happening in the world of public health these days.</p> <p>20 First and most obviously I'm sure to everyone on 21 the phone is the fact that we are no longer expected 22 just to provide, you know, safety net services and 23 immunizations, but rather, as we've learned more about 24 the ultimate determinants of health, we are expected now 25 to take into consideration, and where we can, intervene</p>
<p>7</p> <p>1 everybody who needs to be recognized.</p> <p>2 CO-CHAIRPERSON PECK: Thank you so much, 3 Dr. Alles.</p> <p>4 Well, I think I will just recognize our 5 directors office, our director, Dr. Karen Smith, we are 6 so glad to have her here as well her team, who will be 7 able to share a little bit about all the wonderful 8 initiatives and work they've been doing since -- since 9 starting with us a couple years ago.</p> <p>10 So with that, I'll just turn it over to 11 Dr. Smith.</p> <p>12 DIRECTOR SMITH: Well, thank you. Hello 13 everyone. Nice to meet you all, virtually and in 14 person.</p> <p>15 Yeah. So my name is Karen Smith. And what I 16 thought I would do is, there's a lot going on in the 17 department, so I thought would just kind of reflect on 18 we have kind of -- we have a -- we named an initiative 19 just to keep track of all the things we are doing, 20 basically. But when I first came to the department, one 21 of things that I was really -- I was a -- I've been a 22 client of the department -- or customer, I guess -- 23 before I came, for about 18 years, first as the deputy 24 health officer in Santa Clara County and then as a 25 health officer in Napa County for almost ten years.</p>	<p>9</p> <p>1 in things like poverty, homelessness, poor educational 2 attainment. All the social determinants of health that 3 we know are arguably the strongest determinants of your 4 ultimate health outcome, and that especially true in the 5 world of chronic diseases.</p> <p>6 The other than thing, though, is our population 7 is changing. We are growing. More people, more diverse 8 population, and actually -- and a population that's 9 become older and older. And all of those things lead to 10 the need to change, but they also reflect the fact that 11 change isn't going to stop happening. And similarly 12 with the department, I think that one of the most 13 important things that we need to do is to actually 14 become able to change, to evolve over time, and so 15 that's part of what we are doing.</p> <p>16 The other thing that has -- is really for me 17 personally really important is the increasing focus on 18 the community as the level at which intervention to 19 approve health, and in particular, upstream 20 determinants, is the place where that can be most 21 effectively done, and the need to engage those 22 communities and empower those communities. I'm going to 23 talk a little bit more about that later, but that's a 24 really important change as well.</p> <p>25 And I think it's obvious to everyone that</p>

<p style="text-align: right;">10</p> <p>1 healthcare reform hasn't just impacted the health care 2 system, it's impacted public health pretty 3 substantially. As physicians and clinics and hospitals 4 are being told that they have to work more with the 5 community in which they are -- they exist, but also -- 6 and take more responsibility for the health of the 7 population, we find ourselves in a world where things 8 that were traditionally public health are now at, least 9 to some extent, being of interest as well to the health 10 care system. So taking advantage of that to allow us to 11 redirect some of our energy on things that are maybe 12 upstream in an opportunity, I think, not to be missed.</p> <p>13 And then, finally, we have up -- we have a lot 14 more data sources. We have a lot more information 15 available to us. We have big data is a -- is -- may 16 well be a game-changer, although, at this point, it's 17 not really accessible. It's kind of like seeing your 18 doctor. It's not just, is there a doctor? Is it -- are 19 there hours? Do they operate when you can get there? 20 Do they speak your language?</p> <p>21 Well, access to data is similar too. It's not 22 just, is it out there; do we have the skill sets and the 23 technology that we need, both the people and the tech, 24 to actually take advantage of that? There's tremendous 25 promise, but there's also some significant challenges.</p>	<p style="text-align: right;">12</p> <p>1 Public Health 2035 -- that's what we are calling it. 2 And I intentionally asked the department to look out 3 that far, because I wanted to be clear that we are 4 talking about creating a strategic plan, that we have a 5 really good strategic map, we have strategic plans for 6 many of the different areas that we work in. What I 7 wanted was to say, put all these amazing people's minds 8 who we have in the department looking at what is public 9 health, and in -- for us in particular, what is the 10 department -- what is the department going to have to 11 look like? What -- who's going to -- what kind of 12 people are we going to have to have working for us? 13 What tools are we going to have available? What kind of 14 work are we actually going to be doing that far into the 15 future? Because the trends I think are there. It's 16 really, can we envision what that looks like?</p> <p>17 And I will tell you, some of the key principles 18 that came out of that conversation have been being a 19 collaborative, transformative -- which speaks to the 20 need for us to change, but also be able to continuously 21 evolve -- and more transparent in the way that we work 22 and the work that we do and the outcomes that we have.</p> <p>23 And the focus also changes a little bit. For 24 one thing, I think that one of our -- one of our most 25 important missions is to really work to increase health</p>
<p style="text-align: right;">11</p> <p>1 And, certainly, the-- where the department is right now, 2 I think we are not taking maximal use of the data that's 3 there. Maybe -- but also speaking at the local level, I 4 think that some of the most exciting stuff is the 5 ability to map much more closely and in detail where 6 health problems are so that resources can be targeted, 7 rather than having to sort of put -- if you are going to 8 do an education campaign, trying to create something 9 that you can roll out to an entire diverse community is 10 very different and probably less effective than being 11 able to really target a communications campaign to a 12 neighborhood or two with in which you are already 13 working. And so there's a lot of opportunity, I think, 14 to be had with our limited categorical funding to 15 actually be able to be more effective. And I think we 16 have to.</p> <p>17 The other final thing I'll say about the drivers 18 of change isn't really a driver of change. It's one of 19 the biggest barriers. And that is that our funding 20 really is limited and it's very, very categorical. It's 21 very disease-specific, and -- which gets in the way of 22 finding new ways to do kind of broader, less specific 23 things like working on social determinants. But I think 24 it -- that challenge also has its opportunities.</p> <p>25 So that said, what we are trying to do with</p>	<p style="text-align: right;">13</p> <p>1 equity. And increasing health equity by its very nature 2 means working on those upstream determinants. So the 3 challenge for us is to figure out how do we do that? 4 Who do we partner with? What resources do we use? What 5 interventions work? It's kind of a brave new world, but 6 it's the single most important thing, I think, that we 7 have to do. The best way that we can do that is to work 8 on building healthy communities, and that's really at 9 the heart of what public health has always tried to do. 10 I think it's really incumbent upon us to figure out how 11 we start moving in that direction.</p> <p>12 For one thing, I think our services -- and I'm 13 not sure exactly what those will be in 2035, though I 14 have some ideas -- what I do know is that they need to 15 be data driven, they have to be focused on outcomes, and 16 we have to be able to articulate the values of those 17 services. They have to be collaborative.</p> <p>18 By its very nature, public health cannot -- and 19 governmental public health in particular -- simply can't 20 do this work by ourselves. We need to be able to bring 21 that leading edge science-based practice to bear in the 22 settings of communities that are empowered to really 23 decide what their priorities and then move toward 24 becoming healthier.</p> <p>25 And, ultimately, what we really want to do is</p>

<p>14</p> <p>1 decrease the dependence on the health care system. The 2 health care system is extremely expensive thing to do, 3 and it's expensive not just in cost but in human 4 suffering. The more we do our job well, the less people 5 need the health care system, and that's frankly good for 6 all of us.</p> <p>7 So I still -- our tools at the state level 8 certainly are going to continue to be public health 9 policy. I don't think that's going to change.</p> <p>10 Similarly, issuing guidelines and providing technical 11 assistance and also helping communities to find funding 12 opportunities to pay for some of the cutting-edge work 13 that we hope we'll be doing. So those are some of our 14 challenges.</p> <p>15 What we are doing is, we have several things 16 going on that are -- we think are really going to help. 17 One is really pertinent to this committee, which is, 18 we've landed on a particular approach to becoming a 19 change oriented organization. That essentially means 20 that what we are trying to do is not sort of up end 21 everything and do things differently from day one. What 22 we are trying to do is find those areas, those business 23 practices that we currently have that are amenable to 24 change, and changing them.</p> <p>25 So, for example, it may sound a little esoteric</p>	<p>16</p> <p>1 getting -- really getting our money's worth out of the 2 work that the Block Grant is turned to is really 3 important. And so we wanted to use those same kind of 4 approaches looking at collaborative work, focusing on 5 foundational public health issues. That's one thing I 6 didn't mention.</p> <p>7 We are really trying to be clear that we need 8 to -- we need to retain those basic public health 9 functions that no one else does. We still need to have 10 communicable disease control. We still need to have 11 chronic disease prevention and control. We have to do 12 environmental health. There are things this public 13 health does, there are capabilities that are 14 foundational, so we want to try to build those back 15 where we've lost ground, but also make sure that the 16 foundation is really strong before we start building 17 lots of new seemingly exciting opportunities on top of 18 that. So being strategic about how we use funding is 19 really at the heart of all of it.</p> <p>20 And then finally, I'll stop by saying, the other 21 thing that we are doing is trying to across -- not just 22 the department -- but across our agency and then with 23 other partners out in the community, create alignment 24 and shared goals. And we are using the Let's Get 25 Healthy California plan as an a set of shared priorities</p>
<p>15</p> <p>1 to those of you who don't work with the State, but the 2 process by which a department asks for money in the 3 system is called a budget change proposal. So we had a 4 process for developing budget change proposals that was 5 very programs-specific, so individual programs looked at 6 their program and said, we need X, Y, or Z, and those 7 things were written up in a particular form and thrown 8 on the table, and the executive team figured out, you 9 know, what to do.</p> <p>10 Instead of that, instead of doing that, what we 11 are currently doing, trying in particular to look at 12 collaboration and working differently, was to ask the 13 department to look across programs and more across 14 centers, to really look for opportunities to make -- 15 take advantage of the collaborative nature of the work 16 that we need to do, and really, rather than trying to 17 fix programs in small increments, look at doing things 18 differently, and really trying to push the envelope a 19 little bit. So that's an example.</p> <p>20 The other place that we've identified early on 21 was taking a look at how we are using what flexible 22 funding we do have. And I don't think it's comes as a 23 surprise to anybody on the advisory committee, but the 24 Block Grant is one of the few sources of flexible 25 funding that we have. And so knowing that we are</p>	<p>17</p> <p>1 that we can align around. It helps us to make sure that 2 we collectively, as I said, within our -- within our 3 agencies, but then also with our partners in the health 4 care system and throughout the local health departments, 5 say, we've all -- we have a set of priorities that have 6 been identified by people who work very hard to get 7 them. There are goals and there are indicators of 8 progress and so we are -- every single program of the 9 200-plus programs in the department is looking at Let's 10 Get Healthy California and figuring where in there what 11 they do works, what are they speaking to, where are they 12 moving the dialogue. And so that kind of alignment also 13 helps us when we are trying to articulate what public 14 health does. I don't think it will come as a surprise 15 to anybody who has worked with public health or in 16 public health. We have challenges getting people to 17 understand what we do and why it's important, and so 18 using a common language, I think, can really help with 19 that.</p> <p>20 This does not detract from the other plans that 21 we have. For example, the Portrait of Promise, 22 California's strategic plan for achieving health and 23 mental health equity, and the Wellness Plan are two 24 complement plans of this work over all. So we still 25 have our disease-specific strategic plans that we create</p>

<p>18</p> <p>1 with other partners, and we have, as we say, sort of 2 chronic disease overarching plans, health equity 3 overarching plans. But really they all roll up into -- 4 within the sort of umbrella of Let's Get Healthy. 5 So let me see if there's anything I've left out 6 in that much longer than I intended conversation about 7 public health 2035. Oh, yeah, there is. 8 So when we talked about where -- what we are 9 trying to create in this sort of brave new world of 10 public health, really starting to talk systems of 11 prevention, as opposed to just prevention, but really a 12 set of over -- of overlapping and mutually reinforcing 13 levels of prevention that will ultimately, we hope, 14 really drive down rates of in particular chronic 15 disease, but also many of the other challenges that we 16 have. 17 If you think about tobacco control, for example, 18 you can get a feel for the way that individual 19 interventions, community interventions, and high-level 20 policy interventions can really reinforce each other. 21 And so that -- working towards systems of prevention, 22 that's a language that we are taking on really 23 intentionally within the department to talk about, but 24 also using it in our communications externally. 25 And then with respect to empowering communities</p>	<p>20</p> <p>1 world, but savings, say, in the correctional facilities, 2 improved educational attainment, et cetera. So across 3 the entire society, what are the benefits that we gain 4 from this kind of collective focus on shared priorities 5 and improving health. 6 So those are some of the things that are 7 happening. It's very busy time, as you can imagine, but 8 we are really looking for this conversation with the 9 advisory committee about the Block Grant. We've had a 10 conversation now for a year with the department saying 11 that we are going to take a different approach to 12 looking at where the funding goes. That doesn't mean 13 that we are necessarily even going to change where the 14 funding goes. We are just going to start from the 15 beginning, look back at the intent of the funding, both 16 our -- the funder's intent, the CDC's intent, but also 17 what's best for the department and for the people of 18 California in our work there. 19 So with that, I'm going to turn it over to my 20 colleagues. Who's going first? Susan? 21 ASSISTANT DIRECTOR FANELLI: Yes. 22 DIRECTOR SMITH: Oh, so I didn't say, one of the 23 most important structural changes that we've made in the 24 department largely because of Public Health 2035 to have 25 created the Fusion Center, which is within Susan's</p>
<p>19</p> <p>1 to take ownership of their health and to really advocate 2 for their health, we are deeply involved in the 3 Accountable Communities for health work that's going on 4 in California. The California Accountable Communities 5 for Health Initiative, which is being funded by six of 6 our foundation partners, is about to launch and that -- 7 this model of bringing together communities, letting the 8 community -- giving the community the information it 9 needs to understand where health is coming from and what 10 their challenges are to helping letting them set the 11 priorities, sharing those priorities in a cross-sectoral 12 land and creating plans that address it from this 13 systematic point of view is, I think, a very promising 14 new practice, and we are really looking forward to 15 seeing how that rolls out over the next three years. 16 And it's a model that is getting a lot of attention 17 across the country, but in California, our model is a 18 little bit different than what, say, the CMS is taking 19 on with their Accountable Health Communities. 20 There, the goal really is the look for rapid 21 return on investment into the health care system in 22 California. The goal is more to see how -- what the 23 return is for a community as a whole to this kind of 24 collaborative collective impact work across sectors, so 25 taking account of not just savings in the health care</p>	<p>21</p> <p>1 scope, and so she's going to talk to you specifically 2 about that. 3 ASSISTANT DIRECTOR FANELLI: So a lot of what 4 I'll talk about will reference what Karen's been talking 5 about in Public Health 2035. Really, to make change, 6 takes the whole department, and I see the Fusion Center 7 as sort of a -- maybe a kick start to some of the 8 changes we want to make in terms of bringing people 9 together across our 200-plus programs with distinct and 10 categorical funding to look at the way that we do 11 business a little bit differently, where are the 12 opportunities to better collaborate, how do we sort 13 of -- people come to public health with all kinds of 14 backgrounds; some with a lot of knowledge about public 15 health, some with less knowledge. 16 So how do we teach those models and approaches 17 to public health; how do we look at things like systems 18 of prevention, social determinants of health, defining 19 return on investment a little differently than just 20 savings in the health care delivery system; how do we 21 build that culture of health and how we move the whole 22 department that direction; and then how do we understand 23 the State's role in public health and our partner's 24 role, either in local public health or in the 25 communities.</p>

<p>22</p> <p>1 And so how do we align public health with health</p> <p>2 care with community-based organizations; and how does</p> <p>3 the work that we do across our 200 programs align the</p> <p>4 that effort.</p> <p>5 How do we strengthen those internal</p> <p>6 collaborations? A lot of work we've been doing in the</p> <p>7 Fusion Center first has to be internal before we look</p> <p>8 externally, although I'll give you some of the examples</p> <p>9 of the work that we are doing both internally and</p> <p>10 externally.</p> <p>11 How do we then look at -- I really think our</p> <p>12 biggest asset is our people and how do we make sure that</p> <p>13 they have the training and the background and the skills</p> <p>14 that we need to really move to that public health</p> <p>15 department of the future; and how do we maybe use the</p> <p>16 resources that we have and the talent that we have in</p> <p>17 one program across the department; and how do we find</p> <p>18 funding mechanisms to do that or use the funding sources</p> <p>19 that we have and understand that there's more</p> <p>20 flexibility in some of the funding than we might</p> <p>21 originally.</p> <p>22 And then how do we coordinate our efforts to</p> <p>23 include health equity in all of our programs.</p> <p>24 So the key functions. We tend to be the</p> <p>25 conveners and the bringing together of people from</p>	<p>24</p> <p>1 been doing?</p> <p>2 How do we start to really look at health</p> <p>3 economics and not health care economics but health</p> <p>4 economics? And there's not a lot of work done in that</p> <p>5 area, I have to say. We've checked with CDC. We</p> <p>6 thought they would have like this model or some way of</p> <p>7 looking at health -- public health economics or</p> <p>8 generally health economics. There's not a lot of work</p> <p>9 done there, so most of the models we have are actuarials</p> <p>10 or health care delivery system, but how do we start to</p> <p>11 really start to understand and evaluate programs in a</p> <p>12 different way, and what are all of those other maybe</p> <p>13 softer or more difficult to quantify benefits to some of</p> <p>14 the things that we are most interested in doing?</p> <p>15 And then how do we build that our internal</p> <p>16 knowledge or knowledge transfer? Because we know, as a</p> <p>17 state or as government, we are not going to be able to</p> <p>18 keep everybody forever. And so how do we, you know,</p> <p>19 understand that we may have people come and go but we</p> <p>20 have a process in place that knowledge transfer happens?</p> <p>21 Some examples of the work being doing by the</p> <p>22 Fusion Center, we are working to help implement the</p> <p>23 Public Health 2035 framework that Karen talked about,</p> <p>24 and really to start to get the ball rolling a little bit</p> <p>25 on those first steps, how do we start in the direction</p>
<p>23</p> <p>1 diverse sectors or diverse parts of our department when</p> <p>2 we have a new issue or issues that needs a little bit of</p> <p>3 a highlight or may need external partners to work with</p> <p>4 across either departments within our agency or</p> <p>5 foundations or others where the ability to research out</p> <p>6 independently program by program is difficult, versus</p> <p>7 bringing people together for more of a collective</p> <p>8 gathering of people and resources.</p> <p>9 How do we really build a -- one of things I'll</p> <p>10 say is, there more collaboration happening than I</p> <p>11 thought, and I think we tend to think we work in these</p> <p>12 silos and we don't collaborate, but what I will say, in</p> <p>13 the last year that I've been doing this job -- I've been</p> <p>14 with the department for 14 years, but in doing this job</p> <p>15 for the last just over a year, how -- what we do across</p> <p>16 the department is, by natural, collaborative largely.</p> <p>17 But how do we increase that? How do we make sure that</p> <p>18 we know everybody who's touching a certain population or</p> <p>19 a -- you know, in all of work we are doing and all of</p> <p>20 data that we may have on that particular subject, how do</p> <p>21 we start to bring that together across our programs?</p> <p>22 And then how do we promote that innovation and</p> <p>23 that not doing the same thing we've always done but</p> <p>24 looking for new and different ways and perhaps more</p> <p>25 collaborative ways for some of the work we've already</p>	<p>25</p> <p>1 towards that vision.</p> <p>2 We manage the Let's Get Healthy California goal</p> <p>3 teams, although they are led and made up of people</p> <p>4 across the department. And I think the only way to</p> <p>5 actually make that work is to be representative of the</p> <p>6 whole department. And we are trying our best to not</p> <p>7 only represent the program side, but the administrative</p> <p>8 side of the house as well, and recognizing the need</p> <p>9 that -- Let's Get Healthy, I think, is a good platform</p> <p>10 in the sense of the fixed-goal area, not necessarily</p> <p>11 just the metrics -- because the metrics are very much</p> <p>12 focused on chronic disease, which is great, but there's</p> <p>13 another part of the department and how do we see</p> <p>14 ourselves under the development umbrella as far as we</p> <p>15 improve the goal area.</p> <p>16 The Innovation Challenge. I don't know if any</p> <p>17 of you are familiar with it, but the Innovation</p> <p>18 Challenge is a way to collect from the community from</p> <p>19 local health departments. What are the things they are</p> <p>20 most proud of that they are moving the dial on public --</p> <p>21 the public's health, and many of those Innovation</p> <p>22 Challenges -- we got about 100 of them last year. We</p> <p>23 just reached out in our first effort, we were worried</p> <p>24 what we might get, but the innovations challenges -- or</p> <p>25 the innovations that came in were very cross-sector</p>

<p>26</p> <p>1 based. They were doing some amazing work at the local 2 level, and it gave them an opportunity to just share 3 that work. We are going to be releasing Innovation 4 Challenge 2.0 this week, and that will be much more 5 focused on social determinants on health, not just the 6 Let's Get Healthy goal areas. But now how do you tie it 7 to work being done to move -- to move the work upstream? 8 We designed the website, the 9 letsgethealthy.ca.gov website. If you haven't had a 10 chance to take a look at that, I think it's really 11 innovative in the way we are trying to have two-way 12 communications, not only with local health departments, 13 but boarder than that, and really look at, you know, to 14 make the changes we are trying to make, we really need 15 to reach out beyond public health into the health care 16 community and essential services; and how do we have a 17 platform to have that information come together. 18 Some of the emerging issues we worked on, opioid 19 overdose prevention, violence prevention, really taking 20 some issues that are of key focus right now, bringing 21 the necessary subject matter experts from across the 22 department together. Sometimes not only across the 23 department, but across government and the private 24 sector -- public and private sector to make a difference 25 Health care reform. Dana Moore, I know, is</p>	<p>28</p> <p>1 chart of our small but mighty team in the Fusion Center, 2 and some of the doted lines, you'll see that there are 3 six staff people. And I will say that some of is it 4 funded through the Block Grant. And so six staff people 5 who work on a variety of the projects that I've talked 6 about. And then you'll see some doted liens where we 7 are taking a more creative look at how do we buy portion 8 of people's time because they have really good skills 9 that we need, and rather than hiring people full-time, 10 how do we use the resources already in the department 11 and purchase some of their time or have them work in 12 time for long time and then purchase some of their time 13 if you can do it. 14 And then just a quick look at the Block Grant 15 funding that we have used in the past year of -- we are 16 just bringing on our econometric person, our health and 17 economics. You start down that path, and then we have 18 our Let's Get Healthy dashboard and website that I 19 talked about, and then staff that are supporting the 20 Accountable Communities for Health. 21 And there if there's any questions, I'll be 22 happy to take them. 23 CO-CHAIRPERSON ALLES: Susan, are you going to 24 remain available? 25 ASSISTANT DIRECTOR FANELLI: Sure.</p>
<p>27</p> <p>1 here. She's been working a lot on building that public 2 health and health care integration, more collaboration 3 with our sister department and the medical program, 4 really trying to understand their world, because I think 5 we come at it a thinking, oh, we should just make all 6 these teams. But the only way we are going to make real 7 teams is to understand the world in which our partners 8 live and how we come to the table with them to make 9 change. 10 Accountable Communities for Health, which I 11 won't talk a lot about because we mentioned that in 12 terms of what the future may look like for that model. 13 But that's only to say, what does that evaluation 14 component look like, and how do we use that evaluation 15 methodology to not only look at the Accountable 16 Communities for Health, the six pilot projects that are 17 happening, but as a model for future projects and future 18 work. 19 And then the California Reducing Disparities 20 Project has an equal evaluation component. And so how 21 do we bring those together to really understand what are 22 those things we need to be looking at to evaluate our 23 programs? 24 Looking at econometrics, we are building that 25 better model, and looking at staff. I gave you an org</p>	<p>29</p> <p>1 CO-CHAIRPERSON ALLES: I think it would be 2 better if we had the other two presentations and then 3 what I'll do is ask for questions specifically to Karen 4 and then to you and, you know, on down the line so that 5 we don't get into a conversation as questions about all 6 four areas at the same time. 7 ASSISTANT DIRECTOR FANELLI: Sounds great. 8 CO-CHAIRPERSON PECK: This is Caroline. If I 9 would just interject. For those who are listening by 10 webinar, can you please put yourselves on mute, because 11 sometimes the typing gets in the way. 12 Now we'll turn it over to Brandon 13 CHIEF DEPUTY DIRECTOR NUNES: My name is Brandon 14 Nunes. I'm the chief deputy director for operations 15 here at the department. 16 I've been asked to provide a little bit of a 17 funding history and kind of project history of the Block 18 Grant itself. So we'll get into that right now. 19 A little bit of a road map as far as where we'll 20 go in this presentation. Talk a little bit about the 21 recent history of the Block Grant, some of the federal 22 changes that happen organizationally within the CDC and 23 where the grant now sits basically, and then a little 24 bit on the funding history. 25 It's been an -- it was the declining funding</p>

<p>30</p> <p>1 source for a lot of years until, I think, FFY '14, so 2 we'll kind of show how that's changed over time and 3 specifically what California's allocation has been. 4 We'll get a little bit into the federal award 5 process and timeline because, of course, we are, you 6 know, restricted to when the federal budget passes as 7 far as when the note is provided to us and when we can 8 actually start spending the money that the feds provide, 9 and so we'll get a little bit into that time frame and 10 what we are expecting to occur in FFY '17. And then 11 we'll give you a little bit about where we sit with the 12 2016 award, as well as a very high level overview of 13 which areas of the department have been funded by the 14 Block Grant. My colleague called Claudia Crist will get 15 into a little more of the details. I'll just provide a 16 high level overview of where it's gone. 17 So a little bit on the history. In federal 18 fiscal year 2014, there were some changes to Block 19 Grant, both from a funding perspective and 20 organizationally. The Block Grant doubled in size that 21 particular year. It had been declining pretty steadily 22 since 2002. And 2013 was its lowest point at about 23 75 million at the federal level. That doubled in size 24 to about 140 million in 2014. And this really just 25 brings us back to about where the funding was maybe at</p>	<p>32</p> <p>1 federal fiscal year 2016. And while we don't have a 2 budget in place yet, we are still anticipating we'll be 3 right around that 10.5 million mark for FFY '17. 4 So the Block Grant is provided to us on an 5 annual basis. Thankfully, because of the way the 6 federal budget rolls out, we do have two years to spend 7 that funding, and we'll go into a little bit about how 8 that process works. As I mentioned there in the slide, 9 only -- we only actually have one year to spend that 10 funds, and it's mainly because of the way that the 11 federal budget comes in. It's typically the budget is 12 past late, which delays our allocation being received. 13 The Block Grant, once CDC actually gets the 14 Block Grant appropriation, the preliminary award that as 15 they go through their allocation and determine what each 16 state will get, the timing on that typical varies and 17 can be part of the process of delaying when we get our 18 award. 19 And but typically for us, the notice of grant 20 award isn't provided until about nine months after the 21 federal budget is actually passed, so hence why we 22 really only have one year to spend the funds. 23 Based on that timeline, what we are anticipating 24 for 2017 is to get the preliminary award from the CDC 25 actually in sometime in the spring of 2017. Shortly</p>
<p>31</p> <p>1 the 2002 levels. 2 Organizationally, the Block Grant used to be a 3 separate line item within the federal budget, and now 4 since '14, it's now a part of the prevention and public 5 health fund, which is now a portfolio of about 16 6 different federal grants and programs totally about 7 950 million, of which the 160 million that we get out of 8 the Block Grant is one of those allocation out of that 9 portfolio of projects in the fund 10 From the organizational perspective, the 11 responsibility for the grant also changed. It was 12 within the center for chronic disease within the CDC, 13 and now it's within the Office for State, Tribal, Local, 14 and Territorial Support, which is now an office that 15 reports directly to the CDC's director, so a little bit 16 more visibility there at the federal level. 17 So I mentioned this a little bit. I talked 18 about the federal allocations that have occurred. This 19 is how the recent funding history, this represents 20 California's allocation from the Block Grant. So you'll 21 see that low point there and FFY '13 where we had our 22 lowest point in a decade of 5 million dollars that went 23 to California. And, again, in 2014, it doubled in size, 24 and we've been remaining around that 10.5 million 25 allocation since '14, and that's also what we got in</p>	<p>33</p> <p>1 after that or while in August roughly of 2017, we are 2 anticipating actually getting the actually grant award 3 notice after we submit our state plan. And the thing 4 that makes obviously 2017 a little bit unique is that it 5 is an election year, and that could cause further delays 6 to when the federal budget passes. But based on where 7 we've seen, you know, the budget go historically, these 8 are the time frames that we're work under right now, and 9 we will adjust those exceptions accordingly as things 10 occur. 11 Regarding the California award, as Dr. Smith 12 mentioned in her remarks, it is truly one of the few 13 flexible funding sources that we have. Even -- we are a 14 department that has about 4 percent general funds 15 associated with all the rest come from very specific 16 federal -- restrictive federal funds or state funding 17 sources, and even our general fund has certain 18 restrictions on it, that it has to go to certainly 19 things. So the Block Grant is very unique to us in the 20 sense that it does represent a flexible funding source. 21 Historically, the Block Grant funding did go to 22 fund chronic disease prevention. That did change as we 23 kind of laid out how the funding occurred or came in for 24 us. '14 being that year that it doubled. That was also 25 the first year that we actually started to fund program</p>

<p>34</p> <p>1 areas outside the Center For Chronic Disease within our 2 department, and we I'll get to it on the last slide, 3 kind of where the funding goes to now. But it was in 4 that year that the Block Grant doubled for us that we 5 started to expand beyond the Center for Chronic Disease. 6 So, again, in 2016 we received an award of 10.5 7 million after the 800,000 set aside for rape prevention 8 activities and the 9 percent that's allocated for 9 administration. The feds allow us 10 percent but I 10 think we usually spend around the nine percent mark. 11 The remaining funding is split between the 12 Department of Public Health and the Emergency Medical 13 Services Authority, roughly 70-30. And back in -- I 14 think way back in the days when these were separate 15 categorical funding sources, this is kind of how -- 16 before it was all rolled up into Block Grant, I think it 17 was in '81, but this is how those separate funding 18 sources actually played out. So about 70 percent came 19 to Public Health and about 30 went to Emergency Medical 20 Services Authority. So we've maintain that funding 21 split, if you will, for this award since that time. 22 And finally based on that 70-30 split, this is 23 how the 2016 grant currently split out. There are 19 24 different programs within Public Health that receive 25 funding from the Block Grant. About half of our</p>	<p>36</p> <p>1 my colleagues. 2 So if you were to go to the CDC website right 3 now, you would see, under the title where they highlight 4 projects for each state, that a lot of them tend to be 5 in the area of chronic disease and chronic disease 6 prevention. And so I would be amiss if I didn't just 7 underscore that chronic disease, as we all know, is 8 still very much an issue nationwide and worldwide and in 9 the state of California. Leading cause of preventable 10 deaths, and according to the CDC, 7 out of 10 deaths are 11 attributed to chronic disease. As far as on a national 12 level, it is 86 percent of the nation's health care cost 13 every year. 14 And, obviously, health inequities in chronic 15 disease are dependent on place as well as social 16 determinants of health. And we know that successful 17 public health interventions can reduce the burden on 18 individuals in the health care systems as it relates to 19 chronic disease. 20 All states, territories, and tribes are funded 21 by the Block Grant and can keep the Block Grant flexible 22 to address emerging health issues, sometimes gaps as 23 well; decrease premature death and disabilities focusing 24 on leading preventable risk factors, focusing on health 25 equity; and eliminating health disparities by addressing</p>
<p>35</p> <p>1 6 million, about 3 million of it or so, 3.1 million, 2 goes to Center for Chronic Disease and the rest split 3 between these four areas -- environmental health, 4 infectious disease, emergency preparedness -- and these 5 are the things that Susan mentioned in the directors 6 office and Fusion Center. And then the remaining 30 7 percent goes to fund nine different programs within 8 EMSA. 9 So that's a very kind of high-level overview of 10 the funding history and where we sit current with the 11 Block Grant, and I'm happy to pass it over to my 12 colleague Claudia Crist to continue on. 13 CHIEF DEPUTY CRIST: Well, I get to cover with 14 you, and I know that most of if not all of the Advisory 15 Committee members are familiar with the actual projects 16 that we set out to do fiscal year '15-'16, including all 17 the objectives and many of the projects underneath. I 18 know that you have access to the detail of that, but I 19 wanted to highlight a few areas for a couple of reasons. 20 One of them is, I wanted to share with you CDC's 21 feedback from a site visit they did of us earlier this 22 year to look at how we administer the Block Grant, as 23 well as just some examples of all the breadth of 24 programs and areas that the funding has been used to 25 kind of underscore the messages that have been shared by</p>	<p>37</p> <p>1 social determinants of health; support local programs, 2 achieve healthy communities; and establish data and 3 surveillance systems. 4 And that said, in -- California does have, as 5 you know, the autonomy to decide on the funding 6 priorities, take into consideration our particular 7 needs, address core public health issues, as mentioned 8 by Dr. Smith and my colleagues here as well, and we -- 9 just to underscore, the funding priorities do have to 10 align with 1 of the 1200 or so Healthy People 2020 11 Objectives. 12 So going to the CDC -- so the Office of State, 13 Tribal, Local, and Territorial Support, OSTLTS, as they 14 lovely call themselves, not just us, but they actually 15 came for a site visit in May of this year, took a look 16 at everything that we do as it relates to Block Grant. 17 Anything from how we handle the money, accounting, 18 controls, programs, and making sure that the money is 19 actually being used as allowed and by the Block Grant 20 and further criteria. 21 So on a high level, the feedback back from the 22 CDC was that California exceeds the goals and objectives 23 for the Block Grant, that we deliver high-level work, 24 including the state projects and evaluations. They felt 25 we had very robust stakeholder engagement as well. They</p>

<p>38</p> <p>1 said that, per the review, we've used the funds in a 2 flexible and creative -- in creative ways and in ways 3 that allow pivoting and budgets and priorities changed 4 and that are critical to the existence of programs. 5 And lastly, they shared that we have very solid 6 internal fiscal controls, and that's very good to know. 7 They did make a recommendation that we did need to 8 perform an annual audit, and we have been monitoring the 9 program but we haven't done an annual audit in the way 10 that they are asking us to do now. And so moving 11 forward, we already have plans to implement that, and so 12 we should be fine there. 13 So those findings really great. Kudos by the 14 CDC, and it was a pleasure meeting with the folks there. 15 And I hope that you are happy with that feedback as 16 well. 17 So currently, we are using the Block Grant funds 18 in alignment with the Advisory Committee principles for 19 the allocation. We support state-level public health 20 infrastructure that include essential services and core 21 functions. We have filled and we do fill gaps in public 22 health foundational areas and capabilities, and we 23 address the emerging issues. 24 So this now goes to again -- these are not my 25 favorite projects. These are just projects -- well,</p>	<p>40</p> <p>1 how -- the funding has supported public health. We've 2 been able to enhance laboratory capacity to identify 3 human fungal pathogens, and specifically to valley 4 fever, we've been able to provide a lot of assistance 5 because of the Block Grant funding developed real-time 6 PCR assay reference laboratory services that are able to 7 determine the exact etiologic agent of valley fever for 8 our local public health agencies, and have looked at 9 over 100 isolates so far. 10 Also, sequencing types of etiologic agents have 11 been performed, and that leads to the development of 12 genotyping tools for valley fever outbreak 13 investigations, and so far -- and over 30 cell samples 14 have isolated five strains. So overall, that is 15 certainly an issue that is very near and dear to 16 California as well some of our surrounding states. 17 As far as public health accreditation, we've 18 provided technical assistance to 55 local public health 19 agencies, arranged Accreditation Readiness Conference, 20 and convened two trainings specific to tribal public 21 health accreditation as well. 22 Workforce development. As you know, this is 23 key. This is a very, very big topic guess for us at the 24 State department and for public health in general, so 25 wanted to highlight that one. And that would be,</p>
<p>39</p> <p>1 they are all my favorite, but these are areas that I 2 wanted to highlight that tie into several of the areas 3 that have just been mentioned, and really underscore the 4 breadth of how the funding is being used. 5 So starting with Accountable Communities for 6 Health that you've heard about now, we've prepared 7 comparative analysis and a crosswalk for the initiative, 8 and also a crosswalk and analysis of the federal 9 Accountable Health Communities grant, and three of the 10 Medi-Cal 1115 waiver projects, which include the Whole 11 Person Care Pilot, the Dental Transformation Initiative, 12 and then PRIME, which is the Public Hospital Redesign 13 and Incentives in Medi-Cal. 14 Also, you heard already about the -- how your 15 funding has supported Let's Get Healthy and a lot of 16 work through the Fusion Center. And then as it relates 17 to the California Wellness Plan and chronic disease, 18 specifically, there are several objectives that were 19 outlined in the plan and that we've been able to really 20 provide work for. Publishing various fact sheets and 21 tools and information, held two trainings on economic 22 evaluation using decision-making tools and methods, and 23 facilitated a CalPERS insurance coverage of the 24 Nationality Diabetics Prevention Program. 25 Again, kind of scanning across the breadth of</p>	<p>41</p> <p>1 through the preventive medicine residency program have 2 been able, with the Block Grant funding, train 3 residents. And also to let you know that of the 111 4 graduates overall, 66 percent are actually working in 5 public -- California Public Health agencies, institutes, 6 community clinics, or university, which is tremendous. 7 And also, we currently have three health offices that 8 are actually graduates from that program. 9 And the California Epidemiologic Investigation 10 Service or Cal EIS program, with the funding, we've 11 trained 13 fellows. And those who are not particular 12 with it, this is the program that takes fellows for one 13 or two years and take what I understand to be graduated 14 but green epidemiologist, and really partners them with 15 an -- and provides them with hands-on experience working 16 with a preceptor at local or state health departments. 17 So those were just some of the highlights. You 18 can see the full extent of everything, but I thought it 19 did a great job of just outlining some of the breadth 20 that it provides and want to leave you with something 21 that the CDC shared with us as they exited their -- on 22 their site visit, and that is really that they have been 23 really tasked with focusing on the evaluation of -- and 24 so they are working on the evaluation framework. And as 25 the CDC mentioned, the value of the public -- of the</p>

<p>42</p> <p>1 Block Grant is the opportunity to innovate, address 2 emerging issues, plug gaps in some issues, build 3 partnerships, integrate across systems, implement 4 evidence-based practice, increase reach, build public 5 health infrastructure, and be what they -- what we call 6 a "force multiplier." 7 So that said, there will be more details, but 8 they are definitely working on a very solid evaluation, 9 framework, and more information on that to come. 10 Thank you. 11 CO-CHAIRPERSON ALLES: Well, that was a lot of 12 dense information in a short period of time. Thank you 13 for the preparation that you put into the presentations. 14 And it's clear to me that there's a lot of alignment 15 within each of the four presentations. It seems that 16 there has been a lot of conversation and planning to 17 bring focus to this idea of Public Health 2035, 18 recognizing some of the social determinants and looking 19 at the importance of collaboration, flexible of funding, 20 and so forth that the -- were the kinds of things that 21 were repeated. 22 And I think this brings us then to the time 23 where I would like to open it up to the advisory 24 committee to ask questions, and I would like the begin, 25 first of all, with individuals who have questions that</p>	<p>44</p> <p>1 balanced with the need to maybe continue some 2 foundational activities that are at the core of public 3 health. So just your thoughts about that balancing act 4 would be helpful. 5 DIRECTOR SMITH: Sure. So one of the -- again, 6 this is Karen Smith. So one strategy it a fairly broad 7 strategy is looking at where we can build capacity to 8 serve multiple purposes. So a really good example of 9 that is epidemiology. So right now, the way we are 10 structured, and the way we function, we have 11 epidemiologists in the Center for Infectious Diseases. 12 We have epidemiologists in almost every single one of 13 the branches within Infection Diseases, and they focus 14 on their particular programs or branches. So if you 15 were a tuberculosis epidemiologist, you do tuberculosis. 16 And we have, as it turns out, epidemiologists in almost 17 every single one of our centers, if not every single one 18 of our centers, but they tend to say pretty focus in the 19 area they are working. 20 So one of the things -- and this is true 21 actually across, I would say, pretty much all the 22 technical skills sets. And so we have begun to bring 23 them together, which as I realize is a shocking concept, 24 and have it at what is called an epiform. So everyone 25 still has their primary affiliation that is the work</p>
<p>43</p> <p>1 you would like to ask Karen Smith. And let's focus on 2 the presentation that she made, which was the vision of 3 Public Health 2035, and then we'll move to Susan and 4 then to Brandon and then to Claudia. 5 So I would entertain, again -- I would entertain 6 anybody kind of jumping in, but remember to say your 7 name first so that the court reporter can get this 8 accurate. 9 ADVISORY COMMITTEE MEMBER GLASSMAN: This is 10 Paul Glassman. I'll jump in if that's okay. 11 CO-CHAIRPERSON ALLES: Absolutely. 12 ADVISORY COMMITTEE MEMBER GLASSMAN: So 13 Dr. Smith, first of all, thank you for that. I loved 14 your presentation. I thought that many of the things 15 you said in terms of the vision of the department and 16 the focus on much bigger picture and introducing focus. 17 I think that -- that one of things I mentioned that 18 other people might be thinking and I am as well is, 19 maybe could be characterized as a balancing act, which 20 would be necessary going forward. You mentioned making 21 sure that the foundational public health functions still 22 remain and use the vaccinations as an example. And I'm 23 just wondering your thoughts about how that balancing 24 act between looking at crosscutting measures, more 25 focusing on communities and sort of determinants will be</p>	<p>45</p> <p>1 that they do, but they have the opportunity to talk to 2 each other. And that has already elicited some really 3 sort of novel approaches to doing things. And their 4 skill sets are, while they are all epidemiologist, they 5 are different and one -- you mentioned working with 6 community, so building community epidemiology expertise 7 is actually really important, because we need to know 8 how to really maximize the use, both the pros and cons 9 of things like geocoding, using geocoded data to map 10 where resources are going or where problems are -- has 11 potential, great potential in my opinion, but it also 12 has some challenges, and it can be misinterpreted. And 13 I've personally seen some stunning examples of that. 14 Completely unintended consequences. 15 So instead of us having to now create a program 16 of a decision around community-based epidemiology, what 17 we can do is the next time we are hiring an 18 epidemiologist in any program, we can actively look for 19 skill sets that enhance our capacity to where we don't 20 currently have it. 21 The other approach is that we are looking really 22 hard at how to grade funding. It's a challenge for us 23 because most of the department doesn't currently have 24 systems to track -- to do essentially -- those of you 25 who've ever worked in IT, know what project costing is,</p>

<p style="text-align: right;">46</p> <p>1 so you divide your day up by how much of it you spent on 2 a given project and it's actually coded to those 3 sources. At my previous employer, we did that in 4 15-minute segments, and it sounds onerous. The truth is 5 it's not. And it's tremendously powerful in 6 demonstrating -- you can take multiple funding streams 7 and bring them together to support an individual or a 8 project and yet be 100 percent able to document the 9 accountability to each funding stream. And that's very 10 important to me.</p> <p>11 One of the pieces I didn't talk about but is 12 right up front in our work right now is, we are working 13 really hard at improving our business processes, because 14 I'm of the opinion that, unless we are a really high 15 performing business entity, we can't do any of our real 16 work. So our back office functions have to be really -- 17 they have to be impeccable.</p> <p>18 So we are trying really hard. We are spending a 19 lot of resources addressing all audit findings in those 20 areas, that kind of stuff, so that when we do something 21 new, those organizations that are funding us will know 22 that they can trust the information they are getting 23 back and that their funding is in fact being used in the 24 way they intended it to be used.</p> <p>25 So it's finding those kinds of opportunities.</p>	<p style="text-align: right;">48</p> <p>1 the case in California in whatever forms I can for the 2 need to support basic communicable disease control. And 3 part of it -- part of where you get an extra bang for 4 that is that if you fund an epidemiologist, you can -- 5 yes, they do your -- your STD control or your TB 6 control, but if you are smart, you are going to get one 7 who either is really to train or already has skills. 8 Those same mapping skills that you use to map an 9 outbreak can be used to map a lot of other community 10 health issues. And so I love epidemiologist in case you 11 can't tell, partly because they -- it is such an 12 incredibly valuable yet flexible skill set. And so 13 it -- that's a kind of an oblique answer to your 14 question, but we are not -- I don't think that there's 15 ever going to be a magical new source of funding and -- 16 for public health. We are just not that sexy and we are 17 just not that good at articulating what we do.</p> <p>18 Also, I have to say, for all I've spent -- too 19 many years to actually mention on a public call -- you 20 know, whining about how health care gets all the money 21 and we don't, if I was sitting in the seat of somebody 22 who has to vote, am I going to provide care to all those 23 people who have diabetes or am I going to instead direct 24 it toward, you know, active living and healthy foods, 25 you can get that it's a challenge. And so what we have</p>
<p style="text-align: right;">47</p> <p>1 The other thing is that of all the -- I'm an infectious 2 disease physician by background, and I actually started 3 my career doing communicable disease control before I 4 went to medical school. So, you know, I love a good 5 outbreak as much as anybody else. It is probably the 6 one area where we are likely to get funding; however, 7 even that is at risk.</p> <p>8 So throughout the recession, one of the areas 9 that we lost a lot of capacity across California was in 10 communicable disease control, and in particular, those 11 diseases that don't have a specific funding source. So 12 tuberculosis has a specific funding source. 13 Immunization, preventable diseases, vaccine preventable 14 disease have has funding source, but things like STD 15 control -- sexually transmitted diseases, no funding 16 source. Guess what happened to the capacity. It 17 vanished. And what is happening now is we are seeing, 18 with about the delay you would predict, around five 19 years, a dramatic increase in rates.</p> <p>20 So what we have to be able to do is be really 21 good at articulating what it takes and what it takes in 22 the absence of something like Zika or Ebola to keep the 23 communicable diseases from reoccurring -- and I'm 24 actually on sort of a two-mirror -- one of my personal 25 missions is I'm on a two-year time course to really make</p>	<p style="text-align: right;">49</p> <p>1 to do is make the case that you can take a tiny sliver 2 off of that and get a whole lot of prevention out of it. 3 And none of that is new, but we are trying to do it in 4 way that says, look, we are open to, you know, sort of 5 having conversations about ways of doing business 6 differently in public health as well.</p> <p>7 CO-CHAIRPERSON ALLES: Dr. Glassman, did you 8 want to have a follow-up question to that?</p> <p>9 ADVISORY COMMITTEE MEMBER GLASSMAN: No. Thank 10 you. That was a great answer. And as she said, it was 11 extensive compared to the question, but I didn't expect 12 an exact detailed answer but I just really wanted to put 13 on the table the point of the balancing act. And I 14 think that you've given some great examples of way that 15 things can be levered, so no, I appreciate the answer.</p> <p>16 ADVISORY COMMITTEE MEMBER KHARRAZI: Rebekah 17 Kharrazi. Thank you so much for the presentation. It's 18 really great to see -- to see the department moving this 19 direction, and obviously a lot of it is aligned with 20 what Prevention Institute works on every day.</p> <p>21 DIRECTOR SMITH: Thank you for the systems of 22 prevention, by the way. I should have given them 23 credit. It's on my slide. I promise.</p> <p>24 ADVISORY COMMITTEE MEMBER KHARRAZI: It's 25 wonderful to hear you say it is.</p>

<p>50</p> <p>1 (Conference call momentarily disconnected.)</p> <p>2 GRANT BLOCK COORDINATOR BUTLER: This is Anita</p> <p>3 again. We lost contact, but we are back now.</p> <p>4 CO-CHAIRPERSON ALLES: Okay. Very good.</p> <p>5 So Rebekah, you were asking a question.</p> <p>6 ADVISORY COMMITTEE MEMBER KHARRAZI: Yeah. This</p> <p>7 is Rebekah Kharrazi again. I was just thanking Dr.</p> <p>8 Smith for a great presentation and to see the department</p> <p>9 moving in this direction towards upstream social</p> <p>10 determinants of health initiatives, and so thank you for</p> <p>11 that.</p> <p>12 My question actually builds nicely off of</p> <p>13 Paul's. And I'm interested in your thoughts on, you</p> <p>14 know, we are envisioning 2035. This Block Grant may not</p> <p>15 be here in 2035. What does it look like to try to move</p> <p>16 all that we are doing within the Block Grant into the</p> <p>17 functioning that, you know -- that the department gets</p> <p>18 already from the State, from the federal government,</p> <p>19 if -- should it go away?</p> <p>20 At the same time, should it continue, how are we</p> <p>21 starting, you know, what efforts are being made to move</p> <p>22 those infrastructure needs more and more away from the</p> <p>23 Block Grant.</p> <p>24 And then also a third piece would be taking the</p> <p>25 sort of innovative efforts under the Block Grant and</p>	<p>52</p> <p>1 believer in the power of policy to affect change. So I</p> <p>2 that role is always going to be there.</p> <p>3 Similarly, I think -- so we will be better able</p> <p>4 to do what we do when we have better data systems. So</p> <p>5 that's another area that we are really moving to</p> <p>6 improvement. If we have to spend less human hours</p> <p>7 generating the kind of analyses that we currently have</p> <p>8 to grab from multiple databases and it take months of</p> <p>9 many people's work, that is another way of getting cost</p> <p>10 savings.</p> <p>11 So I don't think the way that we currently do</p> <p>12 public health is necessarily sustainable. If we don't</p> <p>13 get better at prevention, nothing in health or health</p> <p>14 care is sustainable. So -- but I actually am very</p> <p>15 optimistic about the power of the models that are</p> <p>16 currently coming out to do that. I don't think like --</p> <p>17 the Block Grant is -- the Block Grant is an incredibly</p> <p>18 important source of funneling because it's one of the</p> <p>19 few that allows for innovation. I think there are ways</p> <p>20 to gain from innovation in any of the areas in the</p> <p>21 department.</p> <p>22 I actually had a conversation with Judy Monroe,</p> <p>23 who is the director of OSTLTS, which is where the Block</p> <p>24 Grant is currently located, about the move that</p> <p>25 occurred. That was done explicitly to recognize that</p>
<p>51</p> <p>1 starting to make them into more infrastructure.</p> <p>2 DIRECTOR SMITH: Well, thank you. I'll see if I</p> <p>3 can --</p> <p>4 ADVISORY COMMITTEE MEMBER KHARRAZI: Sorry.</p> <p>5 That was a lot.</p> <p>6 DIRECTOR SMITH: No, no. It's okay. It's</p> <p>7 actually a really interesting question. So I'll go</p> <p>8 really broad. Ultimate first. Ultimately, I don't</p> <p>9 think governmental public health is going to be doing</p> <p>10 most of this work. I mean, if we do our job right, the</p> <p>11 only way that we can make sustainable changes in</p> <p>12 health is this culture of health is when we empower</p> <p>13 communities to really take it on, like own it, and then</p> <p>14 we provide the technical assistance and that sort of</p> <p>15 thing.</p> <p>16 So I would hope that we won't be the only</p> <p>17 entities doing it. In fact, and this is heresy, I</p> <p>18 realize, to a lot of people, but I see a smaller more</p> <p>19 focused governmental public health role, where one of</p> <p>20 the things that we can do that almost no one else can</p> <p>21 do -- well, one in California, obviously, is bring in</p> <p>22 money from the federal government, but state level</p> <p>23 policy will also have two piece, the advocates external</p> <p>24 to the government, but then it needs to have the</p> <p>25 internal to the government as well. And I'm a big</p>	<p>53</p> <p>1 while chronic disease has always been in the forefront</p> <p>2 with this particular, but also with innovating, because</p> <p>3 quite frankly, there was never an infrastructure. There</p> <p>4 didn't need to be one until we started living the way we</p> <p>5 currently do.</p> <p>6 There was a recognition that all of the areas of</p> <p>7 public health really do have a need to innovate. And so</p> <p>8 it wasn't because someone else got tired of, you know,</p> <p>9 kind of handling the Block Grant. It moved because</p> <p>10 that, and in particular, because that -- the whole</p> <p>11 function of that program as its name, indicates is to</p> <p>12 support state and local governments. And that's a</p> <p>13 recognition on CDC's part that they're are less able to</p> <p>14 do innovation and cutting-edge work. And the closer you</p> <p>15 get to community, The more able you are -- you are to do</p> <p>16 that. And for me, it's been about one of our key</p> <p>17 principles is facilitating the work of local health</p> <p>18 departments, getting out of their way, making the</p> <p>19 funding as flexible as possible.</p> <p>20 So I have dreams of more of the Block Grant</p> <p>21 being used wherever it is going to get the biggest bang</p> <p>22 for the buck. I'm also cautiously optimistic about</p> <p>23 being able to make our case for core -- well, I should</p> <p>24 use -- the better terminology is foundational public</p> <p>25 health capabilities and activities. Because now that we</p>

<p>54</p> <p>1 are not in the throes of a recession, I think people 2 have begun to come back around to the fact that we 3 actually really do need things like environmental 4 health. They -- the issues of climate change and 5 sustainability, the people outside the field of public 6 health are now drawing the connections.</p> <p>7 So I think that twenty years is going to show a 8 pretty big change, unless of course there's a big 9 economic meltdown, in which case, we'll go back to the 10 way we were. Unfortunately, that's -- so I don't really 11 have an answer except to say that I hope to see the 12 Block Grant doing what it's intended to do, which is 13 stimulating innovation and different ways of doing 14 things, not just filling holes. And you can ask around, 15 I've said that inside the department as well.</p> <p>16 ADVISORY COMMITTEE MEMBER WOOTEN: Karen, great 17 presentation by everyone. This is Wilma in San Diego.</p> <p>18 DIRECTOR SMITH: Hi, Wilma.</p> <p>19 ADVISORY COMMITTEE MEMBER WOOTEN: Hi. I wanted 20 to ask and get your thoughts on how you feel the 21 prevention block grants can support public health 22 accreditation, particularly for those very small and 23 smaller jurisdictions.</p> <p>24 DIRECTOR SMITH: So I'm -- I think accreditation 25 can be incredibly valuable to a health department. We</p>	<p>56</p> <p>1 looking forward to the recommendations of the advisory 2 committee, and then that will all -- those will go along 3 with kind of our overarch in guiding principles, not 4 just for Block Grant, to the rest of the department as 5 well, so that we can feel like we are actually 6 reflecting the will of the people, if you will. The 7 will of those people who you all, who are -- have 8 charged to think seriously about where the Block Grant 9 can do California the most good, and us internally in 10 the department in where both our program people who are 11 much closer to the strengths and challenges of the 12 individual programs than certainly I am.</p> <p>13 ADVISORY COMMITTEE MEMBER WOOTEN: Great. Thank 14 you.</p> <p>15 CO-CHAIRPERSON ALLES: Do we have another 16 committee member that would like to ask Karen a 17 question?</p> <p>18 Karen, I'd like to ask you one. Do you have a 19 timeline for when you -- when you will begin the 20 processes that are necessary, and then what would be 21 your expectation for a timeline in terms of when you 22 would begin to see some of the results of the different 23 orientation and process that support that?</p> <p>24 DIRECTOR SMITH: I'm assuming you are talking of 25 -- the phone disconnected again.</p>
<p>55</p> <p>1 were, as you know when I was in Napa, going through 2 accreditation. And I can tell you from walking into 3 this department, it did -- it had some tremendous 4 benefits. I don't want to -- I think that if 5 accreditation at the local level can really make a huge 6 difference in some of the -- in particular for me, it 7 was that the areas that are benefited most were those 8 business practices areas again. You know, what is it? 9 11 and 12, or 10, 11, and 12?</p> <p>10 ADVISORY COMMITTEE MEMBER WOOTEN: 11 and 12, 11 yes. Administrative and governmental -- the governance.</p> <p>12 DIRECTOR SMITH: Right. As tedious as they are, 13 and they are -- not the areas, but the actually doing 14 those things -- they are critical to your ability to do 15 anything else. And so I think -- and it also makes 16 you -- we are governmental public health. We have 17 responsibility to be good fiscal stewards. It's the 18 public's money we are spending after all.</p> <p>19 So I'm supportive of accreditation. I don't 20 want to go too far out in saying what I think should 21 happen in the Block Grant, because I'm committed to that 22 being a collaborative process.</p> <p>23 ADVISORY COMMITTEE MEMBER WOOTEN: Totally, 24 yeah.</p> <p>25 DIRECTOR SMITH: That's why we are really</p>	<p>57</p> <p>1 (Conference call momentarily disconnected.)</p> <p>2 DIRECTOR SMITH: It's Karen Smith. My big feet 3 apparently touched the wrong wire.</p> <p>4 CO-CHAIRPERSON ALLES: Are you okay?</p> <p>5 DIRECTOR SMITH: No. I'm fine. It was just a 6 telephone wire, but what were we talking about? Oh, 7 yeah, processes, etc.</p> <p>8 So we've actually already started. We have 9 changed, as I said, the way we make decisions about 10 funding. We've -- we are in -- you are living and 11 breathing the change to how we allocated the funding for 12 -- the process by which the funding for the Block Grant 13 will be allocated. We have already -- we've increased 14 resources in several key administrative divisions to 15 help with our focus on really becoming much more 16 administratively adept. The Fusion Center now exists, 17 and it is incredibly active in working on some really 18 significant work. There are several multi departmental 19 and cross-sectoral initiatives that are being 20 undertaken. So there are a lot of changes. They are 21 not necessarily visible from the outside at this point, 22 but the fact that we now have a process whereby when 23 a -- an issue comes to the floor as violence did during 24 the spring and summer, we actually have a process -- a 25 standard process by which we were -- we will evaluate</p>

<p>58</p> <p>1 that issue both from the perspective of what are we 2 already doing, but also, are there gaps in what we are 3 doing, should we be putting more energy or resources 4 toward this issue? If so, what does that look like? 5 And which was not something that was in place before, 6 and it worked extremely well when -- in addressing the 7 questions and the challenges that people put forth to us 8 in terms of violence prevention as a public health 9 issue.</p> <p>10 And so you probably get a better answer from 11 people who are actually in the department of about 12 whether or not it feels different in the department. 13 I -- I can tell you because I'm -- I pay very close 14 attention, a lot of moving pieces are happening. One 15 thing we are going to be doing and Claudia is taking the 16 lead on this, and this is indicative of -- and I'll 17 mention just briefly another -- one thing -- so we have 18 many, many registries. We have cancer registries. We 19 have immunization registries, and they are scattered all 20 about the department and they function in different 21 ways. None of them are -- with the exception of vital 22 records, actually reside in our Center for Statistics 23 and Informatics.</p> <p>24 So -- so we are going to bring all the 25 registries together this week -- next week. Sometime in</p>	<p>60</p> <p>1 So for me, that's a really important piece. 2 It's especially important because you don't come from 3 the world of chronic disease, so we don't take anything 4 about the way that the -- this department is approaching 5 chronic disease for granted, because I don't have a 6 perfect vision in mind. So that conversation first and 7 foremost will be with the Center for Chronic Disease, 8 the people who live and breathe in that center, to talk 9 about it.</p> <p>10 We don't have a director yet, and that's a big 11 challenge, but we are waiting for the right person. And 12 I think that our chances are better when we have a 13 better sense and can articulate where we want the center 14 to go. Because I want to bring in somebody who's 15 looking to the future, who really wants to join with all 16 the incredibly smart and capable people that we have in 17 this center and really move it forward. But I don't 18 know what forward looks like yet. So that's -- so 19 that's the kind of -- we are also looking at 20 laboratories.</p> <p>21 I threw a challenge down to the California 22 Association of Public Health Laboratory Directors to 23 come back and tell me what the public health laboratory 24 system in California should look like 20 years from now. 25 They are going to answer me back next month, actually.</p>
<p>59</p> <p>1 September, and just talk about what do you do, what 2 things do you have in common, are -- is the structure as 3 it currently -- I'm a big believer that structure and 4 function are interdependent. So when you look at 5 functions, if there are challenges with the function, 6 one of the things that you have to look at besides 7 resources is structure, and really just take a deep look 8 at that.</p> <p>9 On the radar is taking on for me chronic 10 disease. We have a center for chronic disease, but I'm 11 still challenged when people say to me, what's 12 California's approach to chronic disease, or what are 13 you doing about chronic disease. I don't have a, you 14 know, I could sit down and have a 30-minute conversation 15 with somebody over coffee, but the 3-minute elevator 16 speech kind of eludes me. And I don't mean that 17 flippantly. I think that what it feels to me as an 18 outsider is missing a coherent, explainable, and 19 therefore supportable approach to chronic disease as 20 opposed to the, we have to give more money to diabetes, 21 we have to give more money to Alzheimer's. All of these 22 things I agree with, but we don't have that more money. 23 So the question becomes, are we doing it right? Are we 24 doing the right things? Are we doing enough of each 25 thing? Is the structure the way it ought to be?</p>	<p>61</p> <p>1 And so we are going to do the same thing with 2 all of our various and assorted laboratories. So it's a 3 systematic but not necessarily kind of entirely 4 longitudinal approach.</p> <p>5 CO-CHAIRPERSON ALLES: And I'd like to do a 6 follow-up on that. And the issues that I'd like to 7 raise are metrics that demonstrate income as rates or 8 percents or whole numbers. And for so many years, those 9 metrics being the determination of success and 10 recognizing that a change, as you've described, it in 11 the beginning will take a lot more conversation to get 12 to the collaboration, a lot more adjusting of what a 13 lab -- what the lab system should look like, and that 14 while the transformation is happening, it could happen 15 that the traditional metrics will suffer from that. And 16 I think you've already given an example of that, was the 17 issue of the violence and then I think you also 18 referenced rape as another issue.</p> <p>19 So public health people are really good people, 20 and my guess is they will sign on on this, with this, 21 and they will think of it as an exciting journey of 22 something that is an improvement to what we've had since 23 we've begun public health.</p> <p>24 Do you think that you'll be able to make the 25 case -- not you personally -- but do you think the case</p>

<p style="text-align: right;">62</p> <p>1 will be made about the change in the paradigm before 2 people -- it's going to take time to be able to get new 3 metrics and in sync that those new metrics are even more 4 important.</p> <p>5 I guess the question I'm asking is how 6 optimistic are you that the public, whoever -- whatever 7 that contingency -- is will give you the time to get 8 there?</p> <p>9 DIRECTOR SMITH: Well, so the issue of -- let me 10 break that apart a little bit. The issue of performance 11 appearing to deteriorate as you makes change, that's one 12 of the reasons we are making evolutionary change and not 13 revolutionary change. I want to keep my job. So I -- I 14 want to -- so we are -- that's -- and that's the other 15 reason why we are focusing on business practices, 16 because frankly, if you live in this particular world 17 where we are, everybody is really happy if you just get 18 your audits fixed. And so if we can do that while at 19 the same time actually providing better service to our 20 customers, and realize that the -- at the State level, 21 the customer isn't really the general public. It is in 22 terms of, you know, the ultimate effective policy and a 23 lot of our communications because do a huge amount of 24 public communication, and that's one of the areas where 25 we've increased resources. But it's local health</p>	<p style="text-align: right;">64</p> <p>1 don't look at necessary -- we don't tend to quantify the 2 very real differences that we can make when we do 3 collaboration well. And there actually are ways to 4 measure that. We just haven't taken advantage of 5 though -- that.</p> <p>6 And I am no expert. Let me just put that out 7 there, but I have colleagues who are, and who are like, 8 well, of course you can measure the value -- and for me, 9 what I'm trying to communicate is the value of what we 10 do, which is different than impact. Impact implies 11 numbers, and this is especially true when talking to the 12 general public or to legislatures. They want to know 13 why they should be paying for your service, and they 14 don't want to know why in terms of there will be 15 fourteen, you know, less syphilis case this is year. 16 They want to know what's the value to them. And it's a 17 different way of talking about what we do from the very 18 strict science base, so we do have a challenge with 19 people pulling in different directions.</p> <p>20 I'm a scientist I go way back. In case you 21 haven't noticed, I do have a little bit of an 22 epidemiology, but I started in microbiology, so that's a 23 very -- we do numbers, by God, and, you know, life 24 cycles and hard science.</p> <p>25 But on the other hand, the work that -- of</p>
<p style="text-align: right;">63</p> <p>1 departments and communities that with work with in our 2 stakeholder groups.</p> <p>3 I think it's possible that if we don't message 4 things well, some advocacy groups will feel like they 5 are somehow being left out if they hear of other 6 advocacy groups that -- where the issue comes -- sounds 7 like it's coming to the floor.</p> <p>8 You know, I'm pretty optimistic, though, because 9 the other thing is the Accountable Communities for 10 Health is a really interesting intervention, not just 11 because I think it will make real sustainable change, 12 but because you have to measure it differently. The 13 whole field of public health that this focused on did 14 your disease rates go down, if you are in governmental 15 public health, that's a lose-lose situation, because 16 nothing that you do is ever going to make that rate of 17 tuberculosis go down. You always are extrapolating to 18 affect.</p> <p>19 However, what we failed to do in public health 20 and I think we really need to do is learn from the arena 21 of social services not government -- but social science. 22 We look at numbers of disease, you know, numbers of 23 individuals, case rates, morbidity rates, et cetera, 24 things that, as governmental public health, you have 25 very little ability to actually affect. But what we</p>	<p style="text-align: right;">65</p> <p>1 addressing issues like poverty and some of the more 2 subtle mental health issues, addiction, you can't 3 measure those in the same way and you can't measure a 4 community's satisfaction with your services in the same 5 way.</p> <p>6 So some of the challenge, I think, is to change 7 the way we talk about -- not to stop, you know, giving 8 the funders the data that they need, not to stop, God 9 forbid, tracking disease rates and that sort of thing. 10 That's always going to be core to what we do. But to 11 add to the conversation information, as opposed to data, 12 that's actually persuasive to the people that I 13 personally think need to understand what we do and why 14 they should care, and that's the general public as well 15 as the people that have the power to fund what do.</p> <p>16 CHIEF DEPUTY CRIST: Could I add to that?</p> <p>17 DIRECTOR SMITH: Please someone else talk.</p> <p>18 CHIEF DEPUTY CRIST: I think it was Dr. Alles 19 that asked the question. This is Claudia. One thing I 20 wanted to add to that is, I'm looking at -- not the 21 microphone, so I hope you can hear me -- is I come from 22 health care and I have a 26-plus-year health care 23 background, anything from bedside care to enroll in 24 urban settings and international settings, but mainly in 25 California and as well as administration, and just</p>

<p>66</p> <p>1 trying to -- on a business end as well. And one of 2 my -- so I'm going to tie this into why that is 3 important because you asked a very good question about 4 measurements. And one of the other things we need to do 5 as part of this is to really connect with the world of 6 health care and health care needs to connect with public 7 health. And I can tell you by now having spent about 8 five minutes on the public health side, and I'm learning 9 every day from an amazing array of colleagues and 10 experts here, but also having spent a lot time on the 11 health care side, that neither side understands each 12 other still. We talk about having the come close to 13 each other, but I speak a little bit of both now and my 14 personal mission is to try to help facilitate bringing 15 those two worlds together.</p> <p>16 And I tell you that on the health care side, the 17 measurements are very, very, very, very, very different 18 of what we measure in public health. And what we need 19 to measure in the future, so that -- I wanted to just 20 underscore what you said, and I wanted to add to that by 21 saying and it's even more complex because now we have 22 the figure out how to connect a couple of worlds that 23 really have very different ways of measuring success and 24 at different focus for very good reasons.</p> <p>25 So thank you for that great question and</p>	<p>68</p> <p>1 it.</p> <p>2 CHIEF DEPUTY CRIST: This is Claudia. Maybe 3 having it be kind of one after the other, Susan and 4 Brandon and me, maybe if you wanted to open a question 5 for either of us and then we can answer and I can defer 6 to my colleagues to answer my questions too. Just 7 kidding.</p> <p>8 CO-CHAIRPERSON ALLES: Okay. So somebody on the 9 committee jump on in.</p> <p>10 ADVISORY COMMITTEE MEMBER GLASSMAN: So this is 11 Paul Glassman again. So when I introduced myself 12 before, I didn't point out on the member list that I'm a 13 dentist and the oral health representative on the 14 committee. I work at the University of Pacific School 15 of Dentistry.</p> <p>16 So first of all, Dr. Smith Smith, when you were 17 saying earlier that want to start moving away from 18 filing holes, I assumed you were talk about dentist.</p> <p>19 DIRECTOR SMITH: You should see, I have so many 20 cavities I practically have more metal in my mouth than 21 anything else. I love a good dentist.</p> <p>22 ADVISORY COMMITTEE MEMBER GLASSMAN: The 23 question I wanted to ask is a little bit broader than -- 24 related to, I think, Claudia said a few minutes ago 25 about the differing roles between Department of Health</p>
<p>67</p> <p>1 challenge.</p> <p>2 CO-CHAIRPERSON ALLES: Thank you. And I think 3 one of the other paradigms shifts that's is occurring at 4 the same time was -- I think you mentioned that -- 5 Karen -- was the issue of changing from a mindset 6 related to disease to a mindset related to health. And 7 doing the measurement that would demonstrate that we 8 were becoming a healthier nation. And through that, you 9 talked about structure and function, that by thinking in 10 those ways about becoming healthier instead of becoming 11 sicker, that will resonate with a lot of constituencies, 12 and that will be exciting to communities as stakeholders 13 and even for individuals as for medicine scientist to 14 become engage in the work of public health.</p> <p>15 So I want to just do a time check here. We 16 have -- you had indicated on hour and a half and 17 possibly you may -- one or all four of you may have made 18 some other plans or have other appointments. Can you 19 let me know if you want like to continue with questions 20 and whether you would entertain questions for other 21 speakers.</p> <p>22 DIRECTOR SMITH: Please. Everybody is nodding 23 that they can stay for a little while, so I don't want 24 to hog the airwaves, so -- besides, I have to write down 25 what you just said a minute ago because I really liked</p>	<p>69</p> <p>1 Care Services and Department of Public Health and around 2 the topic that you were bringing up around metrics. And 3 so even the opposite end on the spectrum, you are 4 talking about trying to enhance or thinking about 5 metrics to look more at bigger social determinant type 6 of issues. But even if you are looking at very specific 7 sort of data driven metrics, from my perspective, and I 8 talked to number of other people who have similar kinds 9 of experiences, it is extraordinarily difficult to get 10 data from the Department of Health Care Services that 11 would help to measure the outcomes of public health 12 programs even though that data does reside in databases 13 in the Department of Health Care Services.</p> <p>14 I know the oral health program in the Department 15 of Public Health has just done some extraordinary work 16 and negotiations in trying to set up some way to query 17 the Department of Health Care Services database to give 18 up some of that information, but to me it's a ripe 19 opportunity to departmental cooperation that would help 20 to enhance stability of public health programs to have 21 some data that's already there and be able to get at it 22 to be able to demonstrate value and some of the 23 interventions that are taking place.</p> <p>24 CHIEF DEPUTY CRIST: Thank you, Dr. Glassman. 25 This is Claudia. I'd like to take the first crack at</p>

<p>70</p> <p>1 this since -- that's also the teeth, isn't it? Sorry --</p> <p>2 since Dr. Jay Kumar, our state dental officer, is --</p> <p>3 resides within the department here, and specifically</p> <p>4 within this Center for Chronic Disease prevention and</p> <p>5 health promotion. And I'm very pleased to share that</p> <p>6 not only have we been able to negotiate, but he is, in</p> <p>7 part, funded by DHCS.</p> <p>8 We together own and take both ownership, even</p> <p>9 though we own him much more so, and we -- in Dr. Jay's</p> <p>10 work and -- Dr. Kumar's work, and he provides</p> <p>11 consultation to DHCS, but also we have an interagency</p> <p>12 agreement that we can take advantage of in helping to</p> <p>13 share data so it should be -- and there's a fairly new</p> <p>14 elements to it agency wide. We've come to the</p> <p>15 conclusion that we need to be able to do a better job</p> <p>16 and easier share data with each. So that is fairly new</p> <p>17 and so it's made easier from that perspective, but also</p> <p>18 Dr. Kumar has great connections with DHCS, specifying</p> <p>19 Renee Mollow, who is over the dental side over on the</p> <p>20 DHCS side, but also with the team as a whole. And with</p> <p>21 them being part of and participating very actively in</p> <p>22 the advisory committee that he had convened to look at</p> <p>23 creating the oral health plan as well that is in the</p> <p>24 process of being finalized.</p> <p>25 So I acknowledge what you are saying. You are</p>	<p>72</p> <p>1 information between the two departments. That way you</p> <p>2 don't have to start from the beginning with the</p> <p>3 data-sharing agreement. You can start, at least, you</p> <p>4 know, three, four steps down the path, and kind of, you</p> <p>5 know, make that process a little faster and a little</p> <p>6 more efficient, standardize among all our departments of</p> <p>7 the agency.</p> <p>8 CHIEF DEPUTY CRIST: And I do realize coming</p> <p>9 from a private sector, to me, when I first came, was</p> <p>10 like what, you can't just send an e-mail, but it is a</p> <p>11 little bit more complicated than that. And also to</p> <p>12 protect the information of the individuals which makes</p> <p>13 sense. I think it's a lot easier now.</p> <p>14 CO-CHAIRPERSON ALLES: Another question? Well,</p> <p>15 let me ask -- try it a different way.</p> <p>16 Susan, you've heard a couple of the questions</p> <p>17 and you probably were thinking about how you might</p> <p>18 answer some of the questions that were asked of Karen.</p> <p>19 Was there anything that came up that you said -- you</p> <p>20 said to yourself, I wish I had a chance to just comment</p> <p>21 on that question related to the Fusion program?</p> <p>22 ASSISTANT DIRECTOR FANELLI: I think it, for me,</p> <p>23 stems down to how we use the resources that we have and</p> <p>24 how we look at the vast resources that we do have in the</p> <p>25 department and become more creative about how we use</p>
<p>71</p> <p>1 absolutely correct. Sometimes is a lot harder than it</p> <p>2 seems to be, not just specific to DHCS, but in general</p> <p>3 to get data out of our systems, and we feel we have a</p> <p>4 good partnership there now. So I'm hoping this will be</p> <p>5 a much better path forward.</p> <p>6 ADVISORY COMMITTEE MEMBER GLASSMAN: Great.</p> <p>7 Thank you.</p> <p>8 ASSISTANT DIRECTOR FANELLI: I was going to add</p> <p>9 that our information person here Jim Green from our</p> <p>10 health and statistics group is meeting with a health --</p> <p>11 with the data person from Medi-Cal and really looking at</p> <p>12 requests for data and how do we streamline them, how do</p> <p>13 we put them together better so that we understand and</p> <p>14 make the request for data easier. Because if you don't</p> <p>15 know the Medi-Cal system and what you can and can't get</p> <p>16 from the system, we spend a lot of time trying to fix</p> <p>17 those data requests. And I think more we can bring the</p> <p>18 two sides together and, you know, streamline that</p> <p>19 process, we're working on that.</p> <p>20 CHIEF DEPUTY DIRECTOR NUNES: This is Brandon.</p> <p>21 That's one of the things that our agency has identified</p> <p>22 as an issue in trying to make it a little bit easier.</p> <p>23 They've recently finalized a data-sharing agreement</p> <p>24 among all the 13 or 14 departments that are under our</p> <p>25 agency that where it will ease with the sharing of</p>	<p>73</p> <p>1 those resources. And so the way that we are going to</p> <p>2 make changes is not by great new dollars, but taking</p> <p>3 advantage of opportunities like the Block Grant to use</p> <p>4 them for the innovation pieces, to use them to really</p> <p>5 look at how do we do business a little differently, how</p> <p>6 do we -- and the braided funding. I think that's the</p> <p>7 other opportunity.</p> <p>8 We are doing a project on how do we get dollars</p> <p>9 out the door, and so how do we look at our local</p> <p>10 partners and say, we spent a lot of time and effort just</p> <p>11 getting dollars out the door, and trying to get the --</p> <p>12 all the information back that we need for that. If we</p> <p>13 could find a better and easier way to get dollars out</p> <p>14 the door with less restriction, understanding dollars</p> <p>15 have to be used according to what's allowable and what's</p> <p>16 not allowable, but if we could come up with easier ways</p> <p>17 like allocations or grants versus cooperative agreements</p> <p>18 versus different types of contract vehicles.</p> <p>19 The more we can do to free up our time to do the</p> <p>20 program work, the better off we are all going to be, and</p> <p>21 so how do we look at that a little differently? And I</p> <p>22 that's really in terms of how do with get there with</p> <p>23 what we have. It's really being more creative with the</p> <p>24 resources we have.</p> <p>25 CO-CHAIRPERSON ALLES: Thank you. And Karen, a</p>

<p>74</p> <p>1 little further down on the agenda, there's a little 2 bullet point called "future use of funding." Do you 3 have additional things that you would like to say 4 relative to that?</p> <p>5 DIRECTOR SMITH: No. I'm really interested in 6 hearing what the advisory committee comes up with and -- 7 no, I think it's going to be really interesting. I 8 mean -- yeah. Can't wait.</p> <p>9 CO-CHAIRPERSON ALLES: Okay. All right. One 10 more time for advisory committee members. Particularly, 11 I was thinking about EMSA. We haven't talked too 12 much -- we haven't talked at all really about EMSA, so 13 would somebody like to ask a question in that regard to 14 CDPH, the health side and the accident prevention and 15 the --</p> <p>16 ASSISTANT DIRECTOR FANELLI: We do have Dan 17 Smiley here from the Emergency Medical services 18 Authority.</p> <p>19 CHIEF DEPUTY CRIST: EMSA is here.</p> <p>20 CO-CHAIRPERSON ALLES: Say that again.</p> <p>21 DIRECTOR SMITH: Dan Smiley from EMSA is here.</p> <p>22 ASSISTANT DIRECTOR FANELLI: Do you want to say 23 a few words, Dan?</p> <p>24 MR. SMILEY: I wasn't planning on saying a few 25 words, but if you have question, happy to do that. Can</p>	<p>76</p> <p>1 it, and I think, you know, we try to quantify what we do 2 in terms of coordination of the infrastructure because 3 we know that we, with a small State staff, are not going 4 to be able to directly impact the health care, but what 5 we can do is make sure that all of the work that's being 6 done collaboratively across the State is well 7 coordinated to have an overall viewpoint.</p> <p>8 As we move forward with metrics, one of our 9 major priorities on EMS side is really to take a look at 10 the data and the metrics, but to also recognize that 11 health information technology and health information 12 exchange can serve as a sustainable direction for us to 13 bring in multiple sources of information, whether it's 14 from health care financing or public health or EMS, and 15 understand that all of this information, when we have 16 good individual patient identifiers and demographic 17 information, if we are able to do matching, that we'll 18 be able to, in a sustainable way, be able to pull those 19 informations up from various registries. All with the 20 ultimate goal aligned with the presidential Precision 21 Medicine Initiative.</p> <p>22 I think we can then begin to get those metrics 23 in a way that we ultimately again 15 or 20 years down 24 the road when health information technology is fully -- 25 well, I shouldn't say fully mature -- but more mature</p>
<p>75</p> <p>1 I steal your chair?</p> <p>2 ASSISTANT DIRECTOR FANELLI: Yes, you absolutely 3 can.</p> <p>4 MR. SMILEY: Okay, thanks. You know, EMSA is, 5 you know, for many years been pleased to be part of the 6 Block Grant program, and I think from the emergency 7 perspective, we had a element to this that is certainly 8 unlike much of the traditional public health programs. 9 And I think one of the benefits and one of the things 10 that we've seen from EMS and having our nine different 11 programs available is that we see our role as kind of a 12 systems integrator. As Dr. Smith said earlier, there's 13 certainly an element of the public health Block Grant 14 that serves as a force multiplier to create unit of 15 effort. And much of what we do in Emergency Medical 16 Services, like so many -- like so much of public health, 17 is we try to coordinate multiple autonomous 18 organizations that are functionally independent. And I 19 think our role and where we come across best is when we 20 are able to empower and enable our local EMS agencies, 21 our private and public EMS providers, hospitals, all to 22 work in a collaborative way to achieve some of those 23 metrics.</p> <p>24 And as it relates to metrics, we also struggle 25 with what's a metric, are we able to do anything with</p>	<p>77</p> <p>1 that we can then begin to harvest that important health 2 information. And I think those are some of the things 3 we are looking at from EMS perspective in terms of 4 integrating with other public health activities to 5 reduce morbidity and mortality in the pre health care 6 setting.</p> <p>7 CO-CHAIRPERSON ALLES: You know, for somebody 8 who wasn't planning to talk, you did pretty good. Thank 9 you very much.</p> <p>10 Does any of the committee members want to ask a 11 question about EMS?</p> <p>12 ADVISORY COMMITTEE MEMBER CASSADY: This is 13 Diana Cassidy. I don't have a question, but I want to 14 make a comment about workforce development whenever that 15 is appropriate.</p> <p>16 CO-CHAIRPERSON ALLES: I think it's now Diana.</p> <p>17 ADVISORY COMMITTEE MEMBER CASSADY: Terrific.</p> <p>18 So like Steve McCurdy, I teach in the MPH program at UCD 19 and can speak directly to the value that the funding for 20 the Cal EIS program had made to not just UCD graduates 21 but graduates all across the state, as well as the 22 Preventive Medicine Residency program. So I want to 23 applaud the spirit of innovation that I think you 24 addressed, Dr. Smith Smith, in your -- in your opening 25 remarks, and to say that I think these students, these</p>

<p>78</p> <p>1 young graduates, really can make a tremendous 2 contribution to the direction in which you are turning 3 the department. And so, you know, even as funds are 4 short or limited, I encourage you to continue to invest 5 in these programs.</p> <p>6 DIRECTOR SMITH: In fact, we are actually 7 centralizing our internship program, which is called 8 internship, but it's really all of that -- students, 9 interns, residents, et cetera, because we value it so 10 much. And, honestly, when you don't have a lot of 11 funding and you want energetic people, that's a great -- 12 that's a great source. And they bring so much 13 enthusiasm into the workplace. And in fact my -- one of 14 my dearest friends is Cal EIS who is now a health 15 officer and the first epidemiologist I ever hired as a 16 local health office was also Cal EIS fellow, so I also 17 value the program tremendously.</p> <p>18 CO-CHAIRPERSON ALLES: Okay. Another committee 19 member questions?</p> <p>20 ADVISORY COMMITTEE MEMBER KHARRAZI: Rebekah 21 Kharrazi again. Maybe Susan would be the right person 22 for this. I'm really interested in the work that's 23 going on with health economics and bridging in 24 economists into this world, because as you pointed out 25 in your presentation, very much underdeveloped and new</p>	<p>80</p> <p>1 academic institutions that we are working with that have 2 given us at least starting place. But I will say that 3 health economists are hard to come by. Health care 4 economist are hard to come by. They sort of describe to 5 when I was look for a health economist this meeting once 6 a year in San Francisco where all the students coming 7 out with a master's degree in economics get together and 8 they write them checks on the spot to go work for health 9 care. You know, very hard to complete in government 10 with that. And so we have worked with a few folks who 11 we've brought on to do some training, but we'll be 12 looking at developing modes with our epidemiologist with 13 some of our folks and looking at social services as 14 well. So a lot of work to be done.</p> <p>15 ADVISORY COMMITTEE MEMBER KHARRAZI: Thank you.</p> <p>16 ASSISTANT DIRECTOR FANELLI: I wanted to take a 17 minute to introduce Monica Morales who is the deputy for 18 the Fusion Center and brought on board -- you've been 19 here about.</p> <p>20 MS. MORALES: Two months. I've made it.</p> <p>21 DIRECTOR SMITH: She's on old hand now.</p> <p>22 CO-CHAIRPERSON ALLES: Thank you.</p> <p>23 DIRECTOR SMITH: I'm going to have to excuse 24 myself. I have another meeting, but it's really been a 25 pleasure to talk with you all. Thank you for the -- for</p>
<p>79</p> <p>1 for public health really. So I'm curious -- I haven't 2 heard too much about what that person's meant to be 3 working on, but I'm curious how it's going to touch some 4 of these concepts of highlighting values of moving 5 upstream, and so make you can speak that a little bit.</p> <p>6 ASSISTANT DIRECTOR FANELLI: Sure. So we 7 brought on someone who I would say is not necessarily an 8 economist as much as has an epidemiology background and 9 data background and is first looking at what are we 10 doing in evaluation of our programs today. So looking 11 at starting with some of the chronic disease programs, 12 what are they looking at and are there some parameters 13 that we could build upon that sort of lead to that 14 evaluation structure. And we are trying very hard to 15 take it to the next level, which is, how do you get to 16 that return on investment in a formula that really, you 17 know, has some science to it to say, how do we value all 18 relationship building, how do we value these softer 19 kinds of things. And so first we are starting with a 20 scan of what we are doing already in the department. We 21 are looking at models that are out there. ASTHO has a 22 model, and there's a few models that are trying to take 23 the return on investment into public health, not so much 24 into health care delivery.</p> <p>25 We are working with CDC. We have a couple of</p>	<p>81</p> <p>1 listening, and look forward to hearing what you all come 2 up with.</p> <p>3 CO-CHAIRPERSON ALLES: We're going to move into 4 the area of discussion now on the funding criteria that 5 we came up with and advisory group and so somebody will 6 pass along that information to you, the conversation 7 that we have.</p> <p>8 So, one of the agenda items, and it was 9 Document 7, that you received, presents the advisory 10 committee's recommendations for funding, the way in 11 which funding is determined by us as we make our 12 recommendation. And I want to go through just some of 13 them to give both the people who are in the department 14 but who probably know what these are, but also the 15 public and a better understanding of the way we've -- 16 the issues that we looked at to concrete our priority.</p> <p>17 So one was the size of the problem, how many 18 people are involved. Second was the severity of the 19 condition. Third was equity and health status. Fourth 20 was community concern. Fifth was programs that engage 21 community at the local level. Sixth was cost of the 22 condition. Seven was cost effectiveness of 23 interventions that were being implemented. Concordance 24 with the healthy people objectives. Other resources 25 that are available, that is if there are other resources</p>

<p style="text-align: right;">82</p> <p>1 such as Prop 99 for smoking, and perhaps our money 2 wouldn't be able to add very much to the work that was 3 already being done on that initiate because of the money 4 they had. The ability to leverage funds, that is to be 5 for programs to find other groups, organizations, to 6 collaborate with in terms of bringing more funds in. 7 And performance programs metrics. 8 Now, those have served us pretty well for, I 9 don't know, I guess the last 15 years. We've brought 10 this up every several years. We brought it up again 11 this year. And in that conversation, many of these seem 12 to be useful. I would say that there were several of 13 them, perhaps only several of them, that in a new 14 paradigm would already be accounted for. 15 So, for instance, equity would be a good example 16 of that, and community concern would be another example 17 of that. It's clear that -- it's clear to me anyway, 18 that the committee ought to take a look at the ASTHO 19 recommendations. I think that there are probably -- 20 there's probably more consistency with what Karen and 21 the other speakers presented with their funding 22 priorities. And of course the California Department of 23 Public Health has even had to make some changes in the 24 way that they are thinking about how priorities should 25 be adjusted in order to accommodate a plan that was</p>	<p style="text-align: right;">84</p> <p>1 us determine the priority for the funding source. So 2 the information provided is really good at thinking for 3 the future, but I don't think it changes our criteria, 4 unless we add a criteria -- actually, do we have a 5 criteria focused on evidence-based? That might be a way 6 to link to some of the factors that Karen spoke about. 7 CO-CHAIRPERSON ALLES: That's a good 8 observation, Wilma. Thank you. 9 ADVISORY COMMITTEE MEMBER WOOTEN: Do we -- I 10 didn't recall. 11 CO-CHAIRPERSON ALLES: We do not. 12 ADVISORY COMMITTEE MEMBER WOOTEN: So that might 13 be another criteria to add in. 14 CO-CHAIRPERSON ALLES: We do have something 15 that's close to that. It's called proven interventions. 16 But in a way, proven interventions, as you start to 17 shift to a paradigm of measuring health and improving 18 health -- interviewing health and measuring it -- it 19 would rely more on evidence-based at this point in time 20 as opposed to proven intervention. 21 ADVISORY COMMITTEE MEMBER WOOTEN: Exactly. 22 CO-CHAIRPERSON PECK: This is Caroline. Can I 23 interject? I think it says, innovation in area for 24 which there are few proven interventions. 25 CO-CHAIRPERSON ALLES: Oh, it does. Yeah.</p>
<p style="text-align: right;">83</p> <p>1 presented. 2 I would also like to say that I think in order 3 for the committee to be able to do a good job on the 4 assignment of reconsidering a list of criteria, that if 5 we were able to have some inservice presentation that 6 would extend the concepts in a little bit more detail, 7 we'd be able to do a better job. Understand that might 8 not be possible to do. In the absence of that, we will 9 do the best that we can. But I'd think the more we 10 understand the directions of the plan, the better we 11 will be able to help identify our principles for 12 allocation. 13 So now I'd like to invite the committee members 14 to comment on what you are thinking about whether it 15 speaks to the priorities we already have or something to 16 be thought about as the speakers were presenting. 17 ADVISORY COMMITTEE MEMBER WOOTEN: This is in 18 San Diego. The information provided by the speakers was 19 really great in thinking about the future, and one of 20 the things that really rang well was highlighted in the 21 presentations from Karen's perspective was talking about 22 having a business case or having -- basically, spoke to 23 having operational excellence. That's obvious not one 24 of our criteria, and I think criteria that we -- you've 25 just read off really still stands true in trying to help</p>	<p style="text-align: right;">85</p> <p>1 CO-CHAIRPERSON PECK: So I think the whole 2 concept of evidence-based is actually missing. 3 ADVISORY COMMITTEE MEMBER WOOTEN: Yes, it is. 4 Yes. 5 CO-CHAIRPERSON ALLES: Yeah. And I think that 6 the concept of innovations is something that by itself 7 could stand in in addition to the evidence-based. 8 ADVISORY COMMITTEE MEMBER WOOTEN: I agree, 9 yeah. 10 ADVISORY COMMITTEE MEMBER KHARRAZI: We also 11 talk about at Prevention Institute, we preferred it 12 described as evidence informed. Recognizing I think 13 that, you know, there are certain populations that tend 14 to be the ones that the evidence builds for and, you 15 know, when you take something out of the neat box of a 16 study, there are implications. So evidence informs 17 gives a little bit more flexible on being able to pull 18 from community experience, for instance. So that could 19 be another way we might want to approach that. 20 While I'm talking, I might as well just -- I'm 21 obviously looking at this for the first time, and I 22 think you all have done a really great job over the 23 years of capturing really important criteria for 24 determining how these funds are to be spent. So I just 25 wanted to highlight a few that really stood out for me.</p>

<p style="text-align: right;">86</p> <p>1 You know, one is sort of -- and my question</p> <p>2 earlier alluded to this. How are we balancing the</p> <p>3 infrastructure needs versus the opportunity for new</p> <p>4 innovative pilots, for instance.</p> <p>5 I really like the criteria about the ability to</p> <p>6 cross over multiple sectors and disciplines. I think</p> <p>7 really was emphasized what's -- again and again today</p> <p>8 that this is one of the very few flexible funding</p> <p>9 options, so I don't think there's a lot of opportunity</p> <p>10 for this type of work to be done otherwise.</p> <p>11 Clearly innovation falls under that, and from</p> <p>12 the perspective of Prevention Institute, for us, equity</p> <p>13 is always a top priority, and so it's really great to</p> <p>14 see that here. Dr. Smith emphasized the needs of the</p> <p>15 community, so falling right under that is really</p> <p>16 fantastic to see.</p> <p>17 And one thing I don't know if it's, you know --</p> <p>18 it's here, but not necessarily explicit is spending</p> <p>19 funds in a way that go to where the highest need is or</p> <p>20 highest community need is. So that would be one</p> <p>21 suggestion that I would have for consideration to add to</p> <p>22 the list.</p> <p>23 CO-CHAIRPERSON ALLES: Okay. We've made note of</p> <p>24 those. Other committee members?</p> <p>25 ADVISORY COMMITTEE MEMBER WONG: Hi, Wes. This</p>	<p style="text-align: right;">88</p> <p>1 The question you just asked I think gets to the</p> <p>2 issue of are there some definite changes relative to</p> <p>3 what would be the high-ranking priorities and what would</p> <p>4 be the lower-ranking priorities.</p> <p>5 So do you want the follow-up on that Nathan?</p> <p>6 ADVISORY COMMITTEE MEMBER WONG: Yeah. Yeah, I</p> <p>7 guess -- I mean -- yeah, I mean, I agree where you. I</p> <p>8 think the process has worked pretty well. You know,</p> <p>9 obviously, there's pros and cons to having an objective</p> <p>10 scoring system, but of course, many times, grants these</p> <p>11 days like NIH grants, for example, get evaluated on a,</p> <p>12 you know, fairly objective rating system on different</p> <p>13 criteria. So, you know, I'm in the sure -- you know, I</p> <p>14 don't know the answer as to whether we should go in that</p> <p>15 direction or not, but it's just a question -- question I</p> <p>16 raise, you know, that would, you know, influence how</p> <p>17 objectively these type of proposals get reviewed.</p> <p>18 CO-CHAIRPERSON ALLES: And one thing is for</p> <p>19 sure, it would get a little bit more difficult when you</p> <p>20 are talking about collaboration as opposed to silos.</p> <p>21 Typically, we looked project by project, and a number of</p> <p>22 times it came up today that there would be cross funding</p> <p>23 or that programs would be braided together, funding</p> <p>24 sources even could be braided together, and it feels to</p> <p>25 me like the paradigm is a big enough shift that we need</p>
<p style="text-align: right;">87</p> <p>1 is Nathan. I was just curious, is there a way that the</p> <p>2 different criteria are -- are weighted or, you know, you</p> <p>3 create a score and kind of prioritize in funding?</p> <p>4 CO-CHAIRPERSON ALLES: No. We haven't done in</p> <p>5 it that way. We have asked the committee members to</p> <p>6 keep these priorities at the forefront of their</p> <p>7 thinking, and that often -- that required that as they</p> <p>8 were thinking this through, they needed to weigh and</p> <p>9 balance a variety of factors. And obviously somebody</p> <p>10 would look at one thing with more weight than somebody</p> <p>11 else would. But in terms of the work that was required</p> <p>12 of us, it seemed to work pretty well in recommending</p> <p>13 which programs were at the top of the priority list for</p> <p>14 funding and whether those programs should receive more</p> <p>15 or less or the same amount of funding.</p> <p>16 My sense of it is that if we were all in the --</p> <p>17 if the committee was all in the room together and we</p> <p>18 were looking at the list, we'd all create a different</p> <p>19 numeric value for each one.</p> <p>20 And I guess my thinking is that we should maybe</p> <p>21 have a meeting, a phone conference call just of the</p> <p>22 advisory committee, early on coming up that would enable</p> <p>23 us to kind of put everything out on the table -- it</p> <p>24 would all be scrambled at that point -- and then try to</p> <p>25 reassemble it again.</p>	<p style="text-align: right;">89</p> <p>1 to re-examine almost from scratch -- I mean we don't --</p> <p>2 we have good criteria, so we don't have to go back</p> <p>3 further than that, but how do we put these together in a</p> <p>4 way that are -- that would demonstrate that our</p> <p>5 recommendation is supportive of the concept of Public</p> <p>6 Health's 2035 and all of the specific points that were</p> <p>7 made as differentiators from what was and what will be.</p> <p>8</p> <p>9 CO-CHAIRPERSON PECK: Wes, this is Caroline, and</p> <p>10 I have a suggestion that the advisory committee might</p> <p>11 want to consider. And that I think -- yeah, there is a</p> <p>12 big shift, like you said, and I don't think we've had an</p> <p>13 in-person advisory committee meeting for a while. And I</p> <p>14 think with the -- you know, we have salary savings and</p> <p>15 things, and if we were to be able to pay for travel, do</p> <p>16 you think the advisory committee would want to come</p> <p>17 together to have an in-person meeting to discuss and</p> <p>18 really come up maybe with a new numerical objective</p> <p>19 rating or whatever they want to do -- a higher ranking</p> <p>20 versus lower ranking way to help the department?</p> <p>21 Because, you know, I think this is a time of change in</p> <p>22 this whole Block Grant, and it may be worthwhile for</p> <p>23 that -- for us to, you know, collectively to invest with</p> <p>24 the time and the funds that we do still have that are</p> <p>25 available to allow the advisory committee to do that.</p>

<p style="text-align: right;">90</p> <p>1 CO-CHAIRPERSON ALLES: Would anybody be opposed 2 to doing that?</p> <p>3 ADVISORY COMMITTEE MEMBER WOOTEN: No. No 4 opposition.</p> <p>5 ADVISORY COMMITTEE MEMBER GLASSMAN: No.</p> <p>6 ADVISORY COMMITTEE MEMBER WOOTEN: Seeing it's 7 just the primary issue.</p> <p>8 CO-CHAIRPERSON ALLES: Okay. Well, Caroline, 9 let's put that together then, and maybe we can figure 10 out a good time to make that happen and we can check 11 with the advisory committee to help us come up with a 12 specific date. I think that's a great suggestion that 13 you made.</p> <p>14 Just one more time, I want to ask if anybody on 15 the committee would like to make a point about this 16 issue of the criteria?</p> <p>17 Okay. So Caroline, I'm not quite sure how we 18 would do this, mechanically, but I know that the 19 committee is always interested in public comment, and 20 generally we don't get a lot of people coming to our 21 meetings. And I expected there probably are people who 22 are on the line now who are from the public. And do the 23 capable also of being able to ask questions?</p> <p>24 CO-CHAIRPERSON PECK: Yes. We do have some 25 members of the public, and why don't we just open it up</p>	<p style="text-align: right;">92</p> <p>1 And the advisory committee had actually requested they 2 have an opportunity to give recommendations to the 3 director as to how the funding should be spent. And so 4 we have heard some comments for advisory committee 5 members. As -- but we are also open to any 6 recommendations that members of the public have on how 7 the Block Grant should be used. So if you have any 8 particular recommendations, we'd be open to hearing 9 those now.</p> <p>10 As Ms. Anita Butler said before, we have a court 11 reporter, we will have minutes, and although the 12 director and her staff had to leave, we will be able to 13 communicate to her what your recommendations would be.</p> <p>14 The -- there will be a process after the all the 15 advisory committee members have had a chance to give 16 their input, public has had a enhance to give their 17 input, then the director is going to go through a 18 process internally about how she thinks the money should 19 best be used in the department. And she will be taking 20 input from the staff of the department as well.</p> <p>21 And at the next advisory committee meeting, the 22 draft funding allocations and the department's 23 recommendations will be presented and there -- advisory 24 committee and the public will have an opportunity to 25 weigh in at that point as well. But I think if there's</p>
<p style="text-align: right;">91</p> <p>1 to them to unmute their phones and ask questions if they 2 have in.</p> <p>3 CO-CHAIRPERSON ALLES: Sure. So at this point, 4 I would ask any member of the public who would like to 5 make a comment or ask a question or encourage some 6 thinking by the advisory committee to, if you are 7 willing to do that, state your name. If you prefer not 8 to do it, you can just start your question.</p> <p>9 PUBLIC MEMBER: Hi there. This is Christina 10 Hildebrand from a Voice for Choice. Thank you for 11 your -- all of the information from today.</p> <p>12 My understanding from the last meeting on the 13 Block Grant earlier this year was that this meeting 14 would be to decide where the funding went, and I haven't 15 heard that yet. So I was wondering if that was going to 16 happen or if -- or if that was not the purpose of this 17 meeting, then when will that -- when will it be 18 determined what the funding will go to?</p> <p>19 CO-CHAIRPERSON ALLES: Okay. Caroline, could 20 you answer that one?</p> <p>21 CO-CHAIRPERSON PECK: Yes. Thank you very much, 22 Christina. The purposes of this meeting was for -- the 23 advisory committee has requested to hear from the 24 director, what her vision was on how to use the Block 25 Grant, and so it was really an informational meeting.</p>	<p style="text-align: right;">93</p> <p>1 a burning issue you would like to recommend now, I would 2 go ahead and say it.</p> <p>3 PUBLIC MEMBER: Okay. Thank you so much for 4 that explanation. I have two -- I guess two cement 5 comments. So in the block funding where the block 6 funding went for this year, that was determined two 7 years ago, that was very, very specific. So it was 8 specific -- specific organizations or projects that were 9 being worked on and certain amount of money went to 10 that. I didn't hear -- I heard more general suggestions 11 here today, but I didn't hear any of those kind of 12 specifics.</p> <p>13 So just before I give where -- I do have some 14 ideas, so I'm going to give those to you, but before I 15 do that, where is that piece of the process? So if 16 there's an organization or a project that somebody from 17 the advisory committee or outside of it wanted to money 18 to go to, where is that -- I'm guessing there's some 19 sort of formal proposal or request or something that 20 goes to the director, or how does that piece of it work?</p> <p>21 Because the money this year, it seems to be 22 very, very specific on what projects or what 23 organizations it went to.</p> <p>24 CO-CHAIRPERSON PECK: Yes. Well, there is not a 25 formal RFT process for use of this money. So I think</p>

<p style="text-align: right;">94</p> <p>1 traditionally it's been, you know, an internal use 2 within the health department and through the programs in 3 the health department, it may then go out to communities 4 for use. But as I said, the director will be 5 determining what process will be used this year, but it 6 will be an internal determination. So if -- so -- I 7 think what -- it's a very general thing. Like if you 8 feel there's an area that should be funded, that would 9 be what you would talk about now, not about -- we can't 10 say who the money would go to at this point, but it's 11 likely to be towards a State program or a local 12 government program. That's traditionally what the 13 money --</p> <p>14 PUBLIC MEMBER: Got it. Understood. So I think 15 my area which I would ask for funding to be put towards, 16 and one of it is something that came up, which is 17 chronic disease, not only treating chronic disease, but 18 looking for the reasons for the increase in chronic 19 disease.</p> <p>20 We've seen huge increases, especially among 21 children, of chronic disease and, you know, one -- I 22 think it's 1 in 54 children has a chronic disease or 23 disability. And so to look at rather than just treating 24 those, to look at what is the reason for those -- for 25 that increase in chronic disease, because I think we</p>	<p style="text-align: right;">96</p> <p>1 was Document No. 8 in the package that you received. 2 Just wanted to give a couple of highlights from that to 3 give the public a sense of some of the things that were 4 discussed in the minutes. Likely that you would not 5 have had a chance to see these unless you would have 6 requested them. But the couple of things we recognize, 7 the separation of percentage between the 70 percent 8 going to CDPH and the 30 percent to EMSA, we approved 9 the February 8th meetings, and we discussed the federal 10 fiscal year 2016 and '17 funding as an update, we talked 11 about the CDC visit, and you heard all of the positive 12 comments from the executive staff who presented that the 13 monies were being used appropriately. It was making a 14 big difference to the people of the State of California. 15 It recognized that there was flexibility in these funds, 16 and it's a way in which new programs or innovative 17 opportunities can receive some initial funding.</p> <p>18 There was a compliance review that was favorable 19 in pretty much all aspects to the department. One 20 expectation to that was that there was an expectation 21 that external audits would be done every year, and that 22 hadn't happened and the department owned up to that, 23 recognized it, and said that were going to ensure that 24 that would happen.</p> <p>25 And I wanted to say that it was also made clear</p>
<p style="text-align: right;">95</p> <p>1 need to look at the stem of the problem rather than 2 the -- I mean, we need to obviously treat those children 3 that have chronic disease and adults that have chronic 4 disease, which has also been on the rise, but to look at 5 what is causing it, because we've never seen numbers 6 like we've seen now.</p> <p>7 CO-CHAIRPERSON PECK: Thank you so much. We 8 will definitely share that request.</p> <p>9 PUBLIC MEMBER: Thank you.</p> <p>10 CO-CHAIRPERSON ALLES: Other members of the 11 public? Are there any members of the public in the room 12 there that would like to make a comment?</p> <p>13 Okay. Hearing none, then we'll move forward.</p> <p>14 I'd like to -- we don't have much more business 15 to do. And there's a -- where we are on the agenda, 16 it's take a break for 10 minutes. Let me ask Anita or 17 Hector, if there is no business reason for doing that, 18 could we just work through this, the rest of the agenda, 19 and finish without a break?</p> <p>20 GRANT BLOCK COORDINATOR BUTLER: Absolutely, 21 Dr. Alles.</p> <p>22 CO-CHAIRPERSON ALLES: Okay. So the next topic, 23 then, is the committee review and discussion of the 24 minutes, if there are -- if there is any discussing -- 25 for the meeting that was held on June 22nd. And this</p>	<p style="text-align: right;">97</p> <p>1 that that was general across the United States. Most 2 state health departments did not follow that particular 3 recommendation.</p> <p>4 Let's see. Another point that was made by the 5 committee was that the advisory committee had done on 6 extraordinary job in process and content -- process and 7 delivery, I should say, and one of the person who was 8 the chief evaluator said that California should be used, 9 -- the advisory committee should be used as a model for 10 what an advisory committee would do in all 50 states.</p> <p>11 We talked a little bit about whether objectives 12 were met or not. In fact, that was an issue that was 13 raised by Nathan, and we asked that a form be developed 14 so that we could take a look at whether the previous 15 year's goals had been met. The -- it's a very detailed 16 form. I think it did the work that the committee was 17 hoping it would do, and we would like to see that kind 18 of accountability in the future, even if there's 19 modifications in the form itself. But seemed to me 20 that -- that the form took us where we wanted to go.</p> <p>21 There was an indication of the -- in the minutes 22 of the 20 CDPH programs that are funded and then also 23 the programs that are funded to EMSA. And so that was 24 the -- kind of a summary of the minutes.</p> <p>25 Did anybody want to ask a question from the</p>

<p>98</p> <p>1 minutes that you received or make an comment or suggest 2 an edit?</p> <p>3 Hearing none, can I have a motion to approve the 4 minutes? This is an action item.</p> <p>5 ADVISORY COMMITTEE MEMBER SPIESS: Dan Spiess. 6 I'll make that motion.</p> <p>7 CO-CHAIRPERSON ALLES: Thank you. And I need a 8 second.</p> <p>9 ADVISORY COMMITTEE MEMBER GLASSMAN: Paul 10 Glassman. Second.</p> <p>11 CO-CHAIRPERSON ALLES: Thank you, Paul.</p> <p>12 All in favor of approving the June 22nd meeting 13 minutes may signify by saying aye.</p> <p>14 ADVISORY COMMITTEE MEMBERS: Aye.</p> <p>15 CO-CHAIRPERSON ALLES: Aye.</p> <p>16 Any nays? Any abstentions.</p> <p>17 ADVISORY COMMITTEE MEMBER KHARRAZI: This is 18 Rebekah Kharrazi. I'm going to abstain since I was not 19 here.</p> <p>20 CO-CHAIRPERSON ALLES: Say that again.</p> <p>21 ADVISORY COMMITTEE MEMBER KHARRAZI: This is 22 Rebekah Kharrazi. I'm going to abstain since I was not 23 at the meeting.</p> <p>24 CO-CHAIRPERSON ALLES: Thank you. Thank you. 25 So unanimous.</p>	<p>100</p> <p>1 CO-CHAIRPERSON ALLES: Hearing none, then -- go 2 ahead.</p> <p>3 ADVISORY COMMITTEE MEMBER SPIESS: Wes, this is 4 Dan. So we will be contacted regarding -- I'll call it 5 a "read evaluation" of our evaluation criteria.</p> <p>6 CO-CHAIRPERSON ALLES: Yeah, yeah. We just did 7 that, I think, last year, but given the nature of the 8 paradigm shift, it's probably warranted for us to take a 9 look and see how we can be harmonious with and 10 synchronize our criteria with the direction that 11 department is going.</p> <p>12 ADVISORY COMMITTEE MEMBER SPIESS: Good.</p> <p>13 CO-CHAIRPERSON ALLES: Caroline, I wanted to ask 14 you a question. Are there other states that are moving 15 in the same way, or you don't know?</p> <p>16 CO-CHAIRPERSON PECK: I really don't know. I -- 17 it's very interesting the -- how different states are 18 and actually what they choose to use this money for. 19 And I think it's one of the reasons that there's 20 bipartisan bicameral support in congress. So I would 21 just say, from what I see, there's quite a wide variety 22 of how the money is used. I think California's often 23 the leader, and so I think if we do move toward a 24 different paradigm, I wouldn't be surprised if other 25 states look at it and might want to follow it. I may</p>
<p>99</p> <p>1 ADVISORY COMMITTEE MEMBER STRATTON: Sam 2 Stratton has to abstain. I wasn't present at that 3 meeting.</p> <p>4 CO-CHAIRPERSON ALLES: Okay. Let the minutes 5 show that as well.</p> <p>6 So the motion was approved, then, with the 7 exception of Sam, who had to abstain because he wasn't 8 here, and Rebekah, because she was not on the committee 9 at that time.</p> <p>10 So the next agenda item, then, is more 11 discussion on the additional information that you heard 12 today. Since the executive staff isn't in the room 13 anymore, I wonder if maybe somebody was bashful or shy, 14 if there was something that you would like to say from 15 the committee, so that we could honor this opportunity 16 for additional conversation.</p> <p>17 Okay. Is there anybody public, then, or anybody 18 in the room there with you, Caroline, who would like to 19 make a comment to the content of the meeting?</p> <p>20 CO-CHAIRPERSON PECK: I think we are good here, 21 Wes.</p> <p>22 CO-CHAIRPERSON ALLES: Yeah, okay. Well, that's 23 being the case, then, is there any further conversation 24 that someone would like to raise?</p> <p>25 CO-CHAIRPERSON PECK: This is --</p>	<p>101</p> <p>1 put it up as a model approach.</p> <p>2 CO-CHAIRPERSON ALLES: Yeah. One of the 3 thoughts that I had as Karen and the others were going 4 through that is, recognizing that this issue of 5 priorities for funding could shift dramatically. The 6 thought that I had was, after the presentation was made, 7 something along the lines of, how come we didn't see 8 this coming and, you know, kind of predict the -- the 9 flow of the current. It seems to make perfect sense to 10 me given the direction of the change, and then it makes 11 sense that the -- there's probably going to need to be a 12 lot of changes that are made, and one of them would be 13 the funding priorities that we would choice to 14 recommend.</p> <p>15 Did anybody else get a sense like that or a 16 different sense that you want to express?</p> <p>17 Okay. Well --</p> <p>18 ADVISORY COMMITTEE MEMBER GLASSMAN: Wes, this 19 is Paul Glassman. I'm not sure if it's generally what 20 you said, but I think I heard something more along the 21 lines of looking for opportunities to collaborate, 22 looking at cross programs, not necessarily a sort of 23 revision immediately of the funding priorities for 24 allocation, because that's slightly different than the 25 way I just heard you say.</p>

<p>102</p> <p>1 CO-CHAIRPERSON ALLES: It think you actually</p> <p>2 said it better than I did, Paul. That's kind of what I</p> <p>3 meant to say, that there's a whole new paradigm that has</p> <p>4 been presented and we can't use old measurements to</p> <p>5 effectively -- to be effective in our work. So thank</p> <p>6 you.</p> <p>7 ADVISORY COMMITTEE MEMBER GLASSMAN: But on the</p> <p>8 other hand, that didn't mean slowing up the current</p> <p>9 processes and plans and starting from a blank state, it</p> <p>10 meant more of an evolutionary of thinking, at least from</p> <p>11 what I heard.</p> <p>12 CO-CHAIRPERSON ALLES: Correct. All right. I</p> <p>13 will entertain a motion for adjournment.</p> <p>14 CO-CHAIRPERSON PECK: So moved, Caroline.</p> <p>15 CO-CHAIRPERSON ALLES: Okay. Need a second.</p> <p>16 ADVISORY COMMITTEE MEMBER GLASSMAN: Paul,</p> <p>17 second.</p> <p>18 CO-CHAIRPERSON ALLES: Thank you. Paul.</p> <p>19 All in favor say aye.</p> <p>20 ADVISORY COMMITTEE MEMBERS: Aye.</p> <p>21 CO-CHAIRPERSON ALLES: Any nays? Any</p> <p>22 abstentions?</p> <p>23 Okay. Unanimously voted, then, to adjourn the</p> <p>24 meeting, and it's 3:28.</p> <p>25 So I thank the advisory committee, I thank the</p>	<p>104</p> <p>1 REPORTER'S CERTIFICATE</p> <p>2</p> <p>3 STATE OF CALIFORNIA)</p> <p>4) ss</p> <p>5</p> <p>6 I, JESSICA SOTELO, CSR, hereby certify that I</p> <p>7 was duly appointed and qualified to take the foregoing</p> <p>8 matter;</p> <p>9 That acting as such reporter, I took down in</p> <p>10 stenotype notes the testimony given and proceedings had;</p> <p>11 That I thereafter transcribed said shorthand</p> <p>12 notes into typewritten longhand, the above and foregoing</p> <p>13 pages being a full, true, and correct transcription of</p> <p>14 the testimony given and proceedings had.</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <hr/> <p>JESSICA SOTELO, CSR No. 13679</p>
<p>103</p> <p>1 staff, and I thank the members of the public who</p> <p>2 participated in this conversation today.</p> <p>3 We'll talk again soon.</p> <p>4 (Concluded at 3:28 p.m.)</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	

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