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

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SACRAMENTO, CALIFORNIA

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A P P E A R A N C E S

ADVISORY COMMITTEE MEMBERS:
Christy Adams, RN, BSN, MPH (telephonically)
Wes Alles, PhD, Director, Co-chair (telephonically)
Paul Glassman, DDS, MA, MBA (telephonically)
Rebekah Kharrazi, MPH, CPH
Diana Cassady, PhD
Caroline Peck, MD, Co-chair
Dan Spiess, EMS Administrator (telephonically)
Samuel Stratton, MD, MPH (telephonically)
Wilma Wooten, MD, MPH (telephonically)
Nathan Wong, PhD (telephonically)

STAFF MEMBERS/PRESENTERS:
Anita Butler, Block Grant Coordinator
Karen L. Smith, CDPH Director
Susan Fanelli, CDPH Assistant Director
Brandon Nunes, Chief Deputy Director of Operations
Claudia Crist, Chief Deputy of Policy Programs

ALSO PRESENT:
Dan Smiley, EMSA
Monica Morales, Fusion Center Deputy

P R O C E E D I N G S

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GRANT BLOCK COORDINATOR BUTLER: Welcome to the Preventive Health and Health Services Block Grant Advisory Committee Meeting.

Is Dr. Wes Alles on the line?

CO-CHAIRPERSON ALLES: I am.

GRANT BLOCK COORDINATOR BUTLER: Hi, Dr. Alles. How are you today.

CO-CHAIRPERSON ALLES: I'm fine. Thank you. And I hope everyone on the call is as well.

GRANT BLOCK COORDINATOR BUTLER: Thank you. I will go ahead and turn it over to you.

CO-CHAIRPERSON ALLES: Okay. Thank you. I want to begin even before roll call to just mention two things. You'll hear two names on the call as they go through the roll call -- I mean, that I want to alert you to. First thing is that Manal Aboelata has stepped down from her position on the advisory committee. But before doing that, she spoke with one of her colleagues, Rebekah Kharrazi at the Prevention Institute and talked with her about the committee. And Rebekah has agreed to replace Manal on the committee, and so you will hear her name during roll call.

And the second thing is that Dr. Steven McCurdy, who's professor and director of the UC Davis MPH program is unable to attend the meeting today, and so representing him and speaking on behalf of his program is Diana Cassidy. And so welcome both Diana and Rebekah.

And now I'll ask that roll call of the committee members be taken.

GRANT BLOCK COORDINATOR BUTLER: Thank you, Dr. Alles.

Christy Adams?

ADVISORY COMMITTEE MEMBER ADAMS: Here.

GRANT BLOCK COORDINATOR BUTLER: Paul Glassman?

ADVISORY COMMITTEE MEMBER GLASSMAN: Here.

GRANT BLOCK COORDINATOR BUTLER: Rebekah Kharrazi?

ADVISORY COMMITTEE MEMBER KHARRAZI: Here.

GRANT BLOCK COORDINATOR BUTLER: Samuel Stratton?

ADVISORY COMMITTEE MEMBER STRATTON: Here.

GRANT BLOCK COORDINATOR BUTLER: Wilma Wooten?

ADVISORY COMMITTEE MEMBER WOOTEN: (No response.)

GRANT BLOCK COORDINATOR BUTLER: Nathan Wong?

ADVISORY COMMITTEE MEMBER WONG: Here.

GRANT BLOCK COORDINATOR BUTLER: Are there any

other advisory committee members on the line?

Oh, Diana Cassady?

ADVISORY COMMITTEE MEMBER CASSADY: Here. Sorry.

GRANT BLOCK COORDINATOR BUTLER: Diana is joining us in person. I will turn it back over to you, Dr. Alles.

CO-CHAIRPERSON ALLES: Okay. Thank you. I want to issue everybody a warm welcome and thank you for spending your afternoon with us today. The primary purpose of today's meeting is for us to have an opportunity to hear from Karen Smith, the director for the public health department, to provide the committee and members of the public who are joining us today, to share her vision with us. And this will give us an opportunity to listen and to -- we'll have an opportunity to ask questions and perhaps to provide some informed input.

Our role really is to use our varied expertise the way we look at issues, to be constructive and informative to the Department of Public Health, and specifically, to Director Smith. And in order to be helpful, I think we need to listen, we need to question, and we need to advise. That's what we are being asked to do as committee members and certainly on the

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individual presentations that will be made, not only by Karen, but by Susan Fanelli, who is the assistant director; Brandon Nunes, who is the chief deputy director of operations; and by Claudia Crist, chief deputy of policy and programs.

So with that -- oh, I need to say that our committee is very transparent. We have a court reporter at all of our committee meetings. The minutes are derived from the notes that are taken by the court reporter. We do invite the public to join in our meetings. And I would guess that we have some members of the public on the call today and perhaps in the room, and there will be two opportunities for input from members of the public.

Also, information is available on the department's website. I want to remind the committee members that before speaking, I know it's hard, but before speaking, so that the court reporter can get the name accurate, if you would say your name. So just a reminder, "I'm Nathan Wong and I have this to say," as an example.

So I want to just give Caroline a couple of moments to also welcome you. And, Caroline, there may be people in the room there that you would like to introduce, and I'll leave that to you to recognize

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everybody who needs to be recognized.

CO-CHAIRPERSON PECK: Thank you so much, Dr. Alles.

Well, I think I will just recognize our directors office, our director, Dr. Karen Smith, we are so glad to have her here as well her team, who will be able to share a little bit about all the wonderful initiatives and work they've been doing since -- since starting with us a couple years ago.

So with that, I'll just turn it over to Dr. Smith.

DIRECTOR SMITH: Well, thank you. Hello everyone. Nice to meet you all, virtually and in person.

Yeah. So my name is Karen Smith. And what I thought I would do is, there's a lot going on in the department, so I thought would just kind of reflect on we have kind of -- we have a -- we named an initiative just to keep track of all the things we are doing, basically. But when I first came to the department, one of things that I was really -- I was a -- I've been a client of the department -- or customer, I guess -- before I came, for about 18 years, first as the deputy health officer in Santa Clara County and then as a health officer in Napa County for almost ten years.

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So I had a lot of ideas of the way that the department could better work with local health departments, you know, change some of its business practices. I have to say that, quite obviously, there's a lot more to the department than the work that we do with health departments, but I remain firm in my belief that the -- perhaps the most important interactions that we have, most important stakeholders are the local health departments, because they are boots on the ground for public health. But I also believe really strongly that the department and field of public health in general is changing rapidly, particularly over the last ten years, and the department needs to begin to change to keep up. We will become rapidly anachronistic if we don't.

So I just want to kind of touch on some of the reasons -- the reasons that I think that we need to change, what some of the drivers of change are that are happening in the world of public health these days.

First and most obviously I'm sure to everyone on the phone is the fact that we are no longer expected just to provide, you know, safety net services and immunizations, but rather, as we've learned more about the ultimate determinants of health, we are expected now to take into consideration, and where we can, intervene

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in things like poverty, homelessness, poor educational attainment. All the social determinants of health that we know are arguably the strongest determinants of your ultimate health outcome, and that especially true in the world of chronic diseases.

The other than thing, though, is our population is changing. We are growing. More people, more diverse population, and actually -- and a population that's become older and older. And all of those things lead to the need to change, but they also reflect the fact that change isn't going to stop happening. And similarly with the department, I think that one of the most important things that we need to do is to actually become able to change, to evolve over time, and so that's part of what we are doing.

The other thing that has -- is really for me personally really important is the increasing focus on the community as the level at which intervention to approve health, and in particular, upstream determinants, is the place where that can be most effectively done, and the need to engage those communities and empower those communities. I'm going to talk a little bit more about that later, but that's a really important change as well.

And I think it's obvious to everyone that

healthcare reform hasn't just impacted the health care system, it's impacted public health pretty substantially. As physicians and clinics and hospitals are being told that they have to work more with the community in which they are -- they exist, but also -- and take more responsibility for the health of the population, we find ourselves in a world where things that were traditionally public health are now at, least to some extent, being of interest as well to the health care system. So taking advantage of that to allow us to redirect some of our energy on things that are maybe upstream in an opportunity, I think, not to be missed.

And then, finally, we have up -- we have a lot more data sources. We have a lot more information available to us. We have big data is a -- is -- may well be a game-changer, although, at this point, it's not really accessible. It's kind of like seeing your doctor. It's not just, is there a doctor? Is it -- are there hours? Do they operate when you can get there? Do they speak your language?

Well, access to data is similar too. It's not just, is it out there; do we have the skill sets and the technology that we need, both the people and the tech, to actually take advantage of that? There's tremendous promise, but there's also some significant challenges.

And, certainly, the-- where the department is right now, I think we are not taking maximal use of the data that's there. Maybe -- but also speaking at the local level, I think that some of the most exciting stuff is the ability to map much more closely and in detail where health problems are so that resources can be targeted, rather than having to sort of put -- if you are going to do an education campaign, trying to create something that you can roll out to an entire diverse community is very different and probably less effective than being able to really target a communications campaign to a neighborhood or two with in which you are already working. And so there's a lot of opportunity, I think, to be had with our limited categorical funding to actually be able to be more effective. And I think we have to.

The other final thing I'll say about the drivers of change isn't really a driver of change. It's one of the biggest barriers. And that is that our funding really is limited and it's very, very categorical. It's very disease-specific, and -- which gets in the way of finding new ways to do kind of broader, less specific things like working on social determinants. But I think it -- that challenge also has its opportunities.

So that said, what we are trying to do with Public Health 2035 -- that's what we are calling it. And I intentionally asked the department to look out that far, because I wanted to be clear that we are talking about creating a strategic plan, that we have a really good strategic map, we have strategic plans for many of the different areas that we work in. What I wanted was to say, put all these amazing people's minds who we have in the department looking at what is public health, and in -- for us in particular, what is the department -- what is the department going to have to look like? What -- who's going to -- what kind of people are we going to have to have working for us? What tools are we going to have available? What kind of work are we actually going to be doing that far into the future? Because the trends I think are there. It's really, can we envision what that looks like?

And I will tell you, some of the key principles that came out of that conversation have been being a collaborative, transformative -- which speaks to the need for us to change, but also be able to continuously evolve -- and more transparent in the way that we work and the work that we do and the outcomes that we have.

And the focus also changes a little bit. For one thing, I think that one of our -- one of our most important missions is to really work to increase health equity. And increasing health equity by its very nature means working on those upstream determinants. So the challenge for us is to figure out how do we do that? Who do we partner with? What resources do we use? What interventions work? It's kind of a brave new world, but it's the single most important thing, I think, that we have to do. The best way that we can do that is to work on building healthy communities, and that's really at the heart of what public health has always tried to do. I think it's really incumbent upon us to figure out how we start moving in that direction.

For one thing, I think our services -- and I'm not sure exactly what those will be in 2035, though I have some ideas -- what I do know is that they need to be data driven, they have to be focused on outcomes, and we have to be able to articulate the values of those services. They have to be collaborative.

By its very nature, public health cannot -- and governmental public health in particular -- simply can't do this work by ourselves. We need to be able to bring that leading edge science-based practice to bear in the settings of communities that are empowered to really decide what their priorities and then move toward becoming healthier.

And, ultimately, what we really want to do is

decrease the dependence on the health care system. The health care system is extremely expensive thing to do, and it's expensive not just in cost but in human suffering. The more we do our job well, the less people need the health care system, and that's frankly good for all of us.

So I still -- our tools at the state level certainly are going to continue to be public health policy. I don't think that's going to change. Similarly, issuing guidelines and providing technical assistance and also helping communities to find funding opportunities to pay for some of the cutting-edge work that we hope we'll be doing. So those are some of our challenges.

What we are doing is, we have several things going on that are -- we think are really going to help. One is really pertinent to this committee, which is, we've landed on a particular approach to becoming a change oriented organization. That essentially means that what we are trying to do is not sort of up end everything and do things differently from day one. What we are trying to do is find those areas, those business practices that we currently have that are amenable to change, and changing them.

So, for example, it may sound a little esoteric

to those of you who don't work with the State, but the process by which a department asks for money in the system is called a budget change proposal. So we had a process for developing budget change proposals that was very programs-specific, so individual programs looked at their program and said, we need X, Y, or Z, and those things were written up in a particular form and thrown on the table, and the executive team figured out, you know, what to do.

Instead of that, instead of doing that, what we are currently doing, trying in particular to look at collaboration and working differently, was to ask the department to look across programs and more across centers, to really look for opportunities to make -- take advantage of the collaborative nature of the work that we need to do, and really, rather than trying to fix programs in small increments, look at doing things differently, and really trying to push the envelope a little bit. So that's an example.

The other place that we've identified early on was taking a look at how we are using what flexible funding we do have. And I don't think it's comes as a surprise to anybody on the advisory committee, but the Block Grant is one of the few sources of flexible funding that we have. And so knowing that we are

getting -- really getting our money's worth out of the work that the Block Grant is turned to is really important. And so we wanted to use those same kind of approaches looking at collaborative work, focusing on foundational public health issues. That's one thing I didn't mention.

We are really trying to be clear that we need to -- we need to retain those basic public health functions that no one else does. We still need to have communicable disease control. We still need to have chronic disease prevention and control. We have to do environmental health. There are things this public health does, there are capabilities that are foundational, so we want to try to build those back where we've lost ground, but also make sure that the foundation is really strong before we start building lots of new seemingly exciting opportunities on top of that. So being strategic about how we use funding is really at the heart of all of it.

And then finally, I'll stop by saying, the other thing that we are doing is trying to across -- not just the department -- but across our agency and then with other partners out in the community, create alignment and shared goals. And we are using the Let's Get Healthy California plan as an a set of shared priorities

that we can align around. It helps us to make sure that we collectively, as I said, within our -- within our agencies, but then also with our partners in the health care system and throughout the local health departments, say, we've all -- we have a set of priorities that have been identified by people who work very hard to get them. There are goals and there are indicators of progress and so we are -- every single program of the 200-plus programs in the department is looking at Let's Get Healthy California and figuring where in there what they do works, what are they speaking to, where are they moving the dialogue. And so that kind of alignment also helps us when we are trying to articulate what public health does. I don't think it will come as a surprise to anybody who has worked with public health or in public health. We have challenges getting people to understand what we do and why it's important, and so using a common language, I think, can really help with that.

This does not detract from the other plans that we have. For example, the Portrait of Promise, California's strategic plan for achieving health and mental health equity, and the Wellness Plan are two complement plans of this work over all. So we still have our disease-specific strategic plans that we create

with other partners, and we have, as we say, sort of chronic disease overarching plans, health equity overarching plans. But really they all roll up into -- within the sort of umbrella of Let's Get Healthy.

So let me see if there's anything I've left out in that much longer than I intended conversation about public health 2035. Oh, yeah, there is.

So when we talked about where -- what we are trying to create in this sort of brave new world of public health, really starting to talk systems of prevention, as opposed to just prevention, but really a set of over -- of overlapping and mutually reinforcing levels of prevention that will ultimately, we hope, really drive down rates of in particular chronic disease, but also many of the other challenges that we have.

If you think about tobacco control, for example, you can get a feel for the way that individual interventions, community interventions, and high-level policy interventions can really reinforce each other. And so that -- working towards systems of prevention, that's a language that we are taking on really intentionally within the department to talk about, but also using it in our communications externally.

And then with respect to empowering communities

to take ownership of their health and to really advocate for their health, we are deeply involved in the Accountable Communities for health work that's going on in California. The California Accountable Communities for Health Initiative, which is being funded by six of our foundation partners, is about to launch and that -- this model of bringing together communities, letting the community -- giving the community the information it needs to understand where health is coming from and what their challenges are to helping letting them set the priorities, sharing those priorities in a cross-sectoral land and creating plans that address it from this systematic point of view is, I think, a very promising new practice, and we are really looking forward to seeing how that rolls out over the next three years. And it's a model that is getting a lot of attention across the country, but in California, our model is a little bit different than what, say, the CMS is taking on with their Accountable Health Communities.

There, the goal really is the look for rapid return on investment into the health care system in California. The goal is more to see how -- what the return is for a community as a whole to this kind of collaborative collective impact work across sectors, so taking account of not just savings in the health care

world, but savings, say, in the correctional facilities, improved educational attainment, et cetera. So across the entire society, what are the benefits that we gain from this kind of collective focus on shared priorities and improving health.

So those are some of the things that are happening. It's very busy time, as you can imagine, but we are really looking for this conversation with the advisory committee about the Block Grant. We've had a conversation now for a year with the department saying that we are going to take a different approach to looking at where the funding goes. That doesn't mean that we are necessarily even going to change where the funding goes. We are just going to start from the beginning, look back at the intent of the funding, both our -- the funder's intent, the CDC's intent, but also what's best for the department and for the people of California in our work there.

So with that, I'm going to turn it over to my colleagues. Who's going first? Susan?

ASSISTANT DIRECTOR FANELLI: Yes.

DIRECTOR SMITH: Oh, so I didn't say, one of the most important structural changes that we've made in the department largely because of Public Health 2035 to have created the Fusion Center, which is within Susan's

scope, and so she's going to talk to you specifically about that.

ASSISTANT DIRECTOR FANELLI: So a lot of what I'll talk about will reference what Karen's been talking about in Public Health 2035. Really, to make change, takes the whole department, and I see the Fusion Center as sort of a -- maybe a kick start to some of the changes we want to make in terms of bringing people together across our 200-plus programs with distinct and categorical funding to look at the way that we do business a little bit differently, where are the opportunities to better collaborate, how do we sort of -- people come to public health with all kinds of backgrounds; some with a lot of knowledge about public health, some with less knowledge.

So how do we teach those models and approaches to public health; how do we look at things like systems of prevention, social determinants of health, defining return on investment a little differently than just savings in the health care delivery system; how do we build that culture of health and how we move the whole department that direction; and then how do we understand the State's role in public health and our partner's role, either in local public health or in the communities.

And so how do we align public health with health care with community-based organizations; and how does the work that we do across our 200 programs align the that effort.

How do we strengthen those internal collaborations? A lot of work we've been doing in the Fusion Center first has to be internal before we look externally, although I'll give you some of the examples of the work that we are doing both internally and externally.

How do we then look at -- I really think our biggest asset is our people and how do we make sure that they have the training and the background and the skills that we need to really move to that public health department of the future; and how do we maybe use the resources that we have and the talent that we have in one program across the department; and how do we find funding mechanisms to do that or use the funding sources that we have and understand that there's more flexibility in some of the funding than we might originally.

And then how do we coordinate our efforts to include health equity in all of our programs.

So the key functions. We tend to be the conveners and the bringing together of people from

diverse sectors or diverse parts of our department when we have a new issue or issues that needs a little bit of a highlight or may need external partners to work with across either departments within our agency or foundations or others where the ability to research out independently program by program is difficult, versus bringing people together for more of a collective gathering of people and resources.

How do we really build a -- one of things I'll say is, there more collaboration happening than I thought, and I think we tend to think we work in these silos and we don't collaborate, but what I will say, in the last year that I've been doing this job -- I've been with the department for 14 years, but in doing this job for the last just over a year, how -- what we do across the department is, by natural, collaborative largely. But how do we increase that? How do we make sure that we know everybody who's touching a certain population or a -- you know, in all of work we are doing and all of data that we may have on that particular subject, how do we start to bring that together across our programs?

And then how do we promote that innovation and that not doing the same thing we've always done but looking for new and different ways and perhaps more collaborative ways for some of the work we've already

been doing?

How do we start to really look at health economics and not health care economics but health economics? And there's not a lot of work done in that area, I have to say. We've checked with CDC. We thought they would have like this model or some way of looking at health -- public health economics or generally health economics. There's not a lot of work done there, so most of the models we have are actuarials or health care delivery system, but how do we start to really start to understand and evaluate programs in a different way, and what are all of those other maybe softer or more difficult to quantify benefits to some of the things that we are most interested in doing?

And then how do we build that our internal knowledge or knowledge transfer? Because we know, as a state or as government, we are not going to be able to keep everybody forever. And so how do we, you know, understand that we may have people come and go but we have a process in place that knowledge transfer happens?

Some examples of the work being doing by the Fusion Center, we are working to help implement the Public Health 2035 framework that Karen talked about, and really to start to get the ball rolling a little bit on those first steps, how do we start in the direction

towards that vision.

We manage the Let's Get Healthy California goal teams, although they are led and made up of people across the department. And I think the only way to actually make that work is to be representative of the whole department. And we are trying our best to not only represent the program side, but the administrative side of the house as well, and recognizing the need that -- Let's Get Healthy, I think, is a good platform in the sense of the fixed-goal area, not necessarily just the metrics -- because the metrics are very much focused on chronic disease, which is great, but there's another part of the department and how do we see ourselves under the development umbrella as far as we improve the goal area.

The Innovation Challenge. I don't know if any of you are familiar with it, but the Innovation Challenge is a way to collect from the community from local health departments. What are the things they are most proud of that they are moving the dial on public -- the public's health, and many of those Innovation Challenges -- we got about 100 of them last year. We just reached out in our first effort, we were worried what we might get, but the innovations challenges -- or the innovations that came in were very cross-sector

based. They were doing some amazing work at the local level, and it gave them an opportunity to just share that work. We are going to be releasing Innovation Challenge 2.0 this week, and that will be much more focused on social determinants on health, not just the Let's Get Healthy goal areas. But now how do you tie it to work being done to move -- to move the work upstream?

We designed the website, the letsgethealthy.ca.gov website. If you haven't had a chance to take a look at that, I think it's really innovative in the way we are trying to have two-way communications, not only with local health departments, but boarder than that, and really look at, you know, to make the changes we are trying to make, we really need to reach out beyond public health into the health care community and essential services; and how do we have a platform to have that information come together.

Some of the emerging issues we worked on, opioid overdose prevention, violence prevention, really taking some issues that are of key focus right now, bringing the necessary subject matter experts from across the department together. Sometimes not only across the department, but across government and the private sector -- public and private sector to make a difference

Health care reform. Dana Moore, I know, is

here. She's been working a lot on building that public health and health care integration, more collaboration with our sister department and the medical program, really trying to understand their world, because I think we come at it a thinking, oh, we should just make all these teams. But the only way we are going to make real teams is to understand the world in which our partners live and how we come to the table with them to make change.

Accountable Communities for Health, which I won't talk a lot about because we mentioned that in terms of what the future may look like for that model. But that's only to say, what does that evaluation component look like, and how do we use that evaluation methodology to not only look at the Accountable Communities for Health, the six pilot projects that are happening, but as a model for future projects and future work.

And then the California Reducing Disparities Project has an equal evaluation component. And so how do we bring those together to really understand what are those things we need to be looking at to evaluate our programs?

Looking at econometrics, we are building that better model, and looking at staff. I gave you an org

chart of our small but mighty team in the Fusion Center, and some of the doted lines, you'll see that there are six staff people. And I will say that some of is it funded through the Block Grant. And so six staff people who work on a variety of the projects that I've talked about. And then you'll see some doted liens where we are taking a more creative look at how do we buy portion of people's time because they have really good skills that we need, and rather than hiring people full-time, how do we use the resources already in the department and purchase some of their time or have them work in time for long time and then purchase some of their time if you can do it.

And then just a quick look at the Block Grant funding that we have used in the past year of -- we are just bringing on our econometric person, our health and economics. You start down that path, and then we have our Let's Get Healthy dashboard and website that I talked about, and then staff that are supporting the Accountable Communities for Health.

And there if there's any questions, I'll be happy to take them.

CO-CHAIRPERSON ALLES: Susan, are you going to remain available?

ASSISTANT DIRECTOR FANELLI: Sure.

CO-CHAIRPERSON ALLES: I think it would be better if we had the other two presentations and then what I'll do is ask for questions specifically to Karen and then to you and, you know, on down the line so that we don't get into a conversation as questions about all four areas at the same time.

ASSISTANT DIRECTOR FANELLI: Sounds great.

CO-CHAIRPERSON PECK: This is Caroline. If I would just interject. For those who are listening by webinar, can you please put yourselves on mute, because sometimes the typing gets in the way.

Now we'll turn it over to Brandon

CHIEF DEPUTY DIRECTOR NUNES: My name is Brandon Nunes. I'm the chief deputy director for operations here at the department.

I've been asked to provide a little bit of a funding history and kind of project history of the Block Grant itself. So we'll get into that right now.

A little bit of a road map as far as where we'll go in this presentation. Talk a little bit about the recent history of the Block Grant, some of the federal changes that happen organizationally within the CDC and where the grant now sits basically, and then a little bit on the funding history.

It's been an -- it was the declining funding

source for a lot of years until, I think, FFY '14, so we'll kind of show how that's changed over time and specifically what California's allocation has been.

We'll get a little bit into the federal award process and timeline because, of course, we are, you know, restricted to when the federal budget passes as far as when the note is provided to us and when we can actually start spending the money that the feds provide, and so we'll get a little bit into that time frame and what we are expecting to occur in FFY '17. And then we'll give you a little bit about where we sit with the 2016 award, as well as a very high level overview of which areas of the department have been funded by the Block Grant. My colleague called Claudia Crist will get into a little more of the details. I'll just provide a high level overview of where it's gone.

So a little bit on the history. In federal fiscal year 2014, there were some changes to Block Grant, both from a funding perspective and organizationally. The Block Grant doubled in size that particular year. It had been declining pretty steadily since 2002. And 2013 was its lowest point at about 75 million at the federal level. That doubled in size to about 140 million in 2014. And this really just brings us back to about where the funding was maybe at

the 2002 levels.

Organizationally, the Block Grant used to be a separate line item within the federal budget, and now since '14, it's now a part of the prevention and public health fund, which is now a portfolio of about 16 different federal grants and programs totally about 950 million, of which the 160 million that we get out of the Block Grant is one of those allegation out of that portfolio of projects in the fund

From the organizational perspective, the responsibility for the grant also changed. It was within the center for chronic disease within the CDC, and now it's within the Office for State, Tribal, Local, and Territorial Support, which is now an office that reports directly to the CDC's director, so a little bit more visibility there at the federal level.

So I mentioned this a little bit. I talked about the federal allocations that have occurred. This is how the recent funding history, this represents California's allocation from the Block Grant. So you'll see that low point there and FFY '13 where we had our lowest point in a decade of 5 million dollars that went to California. And, again, in 2014, it doubled in size, and we've been remaining around that 10.5 million allocation since '14, and that's also what we got in

federal fiscal year 2016. And while we don't have a budget in place yet, we are still anticipating we'll be right around that 10.5 million mark for FFY '17.

So the Block Grant is provided to us on an annual basis. Thankfully, because of the way the federal budget rolls out, we do have two years to spend that funding, and we'll go into a little bit about how that process works. As I mentioned there in the slide, only -- we only actually have one year to spend that funds, and it's mainly because of the way that the federal budget comes in. It's typically the budget is past late, which delays our allocation being received.

The Block Grant, once CDC actually gets the Block Grant appropriation, the preliminary award that as they go through their allocation and determine what each state will get, the timing on that typical varies and can be part of the process of delaying when we get our award.

And but typically for us, the notice of grant award isn't provided until about nine months after the federal budget is actually passed, so hence why we really only have one year to spend the funds.

Based on that timeline, what we are anticipating for 2017 is to get the preliminary award from the CDC actually in sometime in the spring of 2017. Shortly

after that or while in August roughly of 2017, we are anticipating actually getting the actually grant award notice after we submit our state plan. And the thing that makes obviously 2017 a little bit unique is that it is an election year, and that could cause further delays to when the federal budget passes. But based on where we've seen, you know, the budget go historically, these are the time frames that we're work under right now, and we will adjust those exceptions accordingly as things occur.

Regarding the California award, as Dr. Smith mentioned in her remarks, it is truly one of the few flexible funding sources that we have. Even -- we are a department that has about 4 percent general funds associated with all the rest come from very specific federal -- restrictive federal funds or state funding sources, and even our general fund has certain restrictions on it, that it has to go to certainly things. So the Block Grant is very unique to us in the sense that it does represent a flexible funding source.

Historically, the Block Grant funding did go to fund chronic disease prevention. That did change as we kind of laid out how the funding occurred or came in for us. '14 being that year that it doubled. That was also the first year that we actually started to fund program

areas outside the Center For Chronic Disease within our department, and we I'll get to it on the last slide, kind of where the funding goes to now. But it was in that year that the Block Grant doubled for us that we started to expand beyond the Center for Chronic Disease.

So, again, in 2016 we received an award of 10.5 million after the 800,000 set aside for rape prevention activities and the 9 percent that's allocated for administration. The feds allow us 10 percent but I think we usually spend around the nine percent mark.

The remaining funding is split between the Department of Public Health and the Emergency Medical Services Authority, roughly 70-30. And back in -- I think way back in the days when these were separate categorical funding sources, this is kind of how -- before it was all rolled up into Block Grant, I think it was in '81, but this is how those separate funding sources actually played out. So about 70 percent came to Public Health and about 30 went to Emergency Medical Services Authority. So we've maintain that funding split, if you will, for this award since that time.

And finally based on that 70-30 split, this is how the 2016 grant currently split out. There are 19 different programs within Public Health that receive funding from the Block Grant. About half of our

6 million, about 3 million of it or so, 3.1 million, goes to Center for Chronic Disease and the rest split between these four areas -- environmental health, infectious disease, emergency preparedness -- and these are the things that Susan mentioned in the directors office and Fusion Center. And then the remaining 30 percent goes to fund nine different programs within EMSA.

So that's a very kind of high-level overview of the funding history and where we sit current with the Block Grant, and I'm happy to pass it over to my colleague Claudia Crist to continue on.

CHIEF DEPUTY CRIST: Well, I get to cover with you, and I know that most of if not all of the Advisory Committee members are familiar with the actual projects that we set out to do fiscal year '15-'16, including all the objectives and many of the projects underneath. I know that you have access to the detail of that, but I wanted to highlight a few areas for a couple of reasons. One of them is, I wanted to share with you CDC's feedback from a site visit they did of us earlier this year to look at how we administer the Block Grant, as well as just some examples of all the breadth of programs and areas that the funding has been used to kind of underscore the messages that have been shared by

my colleagues.

So if you were to go to the CDC website right now, you would see, under the title where they highlight projects for each state, that a lot of them tend to be in the area of chronic disease and chronic disease prevention. And so I would be amiss if I didn't just underscore that chronic disease, as we all know, is still very much an issue nationwide and worldwide and in the state of California. Leading cause of preventable deaths, and according to the CDC, 7 out of 10 deaths are attributed to chronic disease. As far as on a national level, it is 86 percent of the nation's health care cost every year.

And, obviously, health inequities in chronic disease are dependent on place as well as social determinants of health. And we know that successful public health interventions can reduce the burden on individuals in the health care systems as it relates to chronic disease.

All states, territories, and tribes are funded by the Block Grant and can keep the Block Grant flexible to address emerging health issues, sometimes gaps as well; decrease premature death and disabilities focusing on leading preventable risk factors, focusing on health equity; and eliminating health disparities by addressing

social determinants of health; support local programs, achieve healthy communities; and establish data and surveillance systems.

And that said, in -- California does have, as you know, the autonomy to decide on the funding priorities, take into consideration our particular needs, address core public health issues, as mentioned by Dr. Smith and my colleagues here as well, and we -- just to underscore, the funding priorities do have to align with 1 of the 1200 or so Healthy People 2020 Objectives.

So going to the CDC -- so the Office of State, Tribal, Local, and Territorial Support, OSTLTS, as they lovely call themselves, not just us, but they actually came for a site visit in May of this year, took a look at everything that we do as it relates to Block Grant. Anything from how we handle the money, accounting, controls, programs, and making sure that the money is actually being used as allowed and by the Block Grant and further criteria.

So on a high level, the feedback back from the CDC was that California exceeds the goals and objectives for the Block Grant, that we deliver high-level work, including the state projects and evaluations. They felt we had very robust stakeholder engagement as well. They

said that, per the review, we've used the funds in a flexible and creative -- in creative ways and in ways that allow pivoting and budgets and priorities changed and that are critical to the existence of programs.

And lastly, they shared that we have very solid internal fiscal controls, and that's very good to know. They did make a recommendation that we did need to perform an annual audit, and we have been monitoring the program but we haven't done an annual audit in the way that they are asking us to do now. And so moving forward, we already have plans to implement that, and so we should be fine there.

So those findings really great. Kudos by the CDC, and it was a pleasure meeting with the folks there. And I hope that you are happy with that feedback as well.

So currently, we are using the Block Grant funds in alignment with the Advisory Committee principles for the allocation. We support state-level public health infrastructure that include essential services and core functions. We have filled and we do fill gaps in public health foundational areas and capabilities, and we address the emerging issues.

So this now goes to again -- these are not my favorite projects. These are just projects -- well,

they are all my favorite, but these are areas that I wanted to highlight that tie into several of the areas that have just been mentioned, and really underscore the breadth of how the funding is being used.

So starting with Accountable Communities for Health that you've heard about now, we've prepared comparative analysis and a crosswalk for the initiative, and also a crosswalk and analysis of the federal Accountable Health Communities grant, and three of the Medi-Cal 1115 waiver projects, which include the Whole Person Care Pilot, the Dental Transformation Initiative, and then PRIME, which is the Public Hospital Redesign and Incentives in Medi-Cal.

Also, you heard already about the -- how your funding has supported Let's Get Healthy and a lot of work through the Fusion Center. And then as it relates to the California Wellness Plan and chronic disease, specifically, there are several objectives that were outlined in the plan and that we've been able to really provide work for. Publishing various fact sheets and tools and information, held two trainings on economic evaluation using decision-making tools and methods, and facilitated a CalPERS insurance coverage of the Nationality Diabetics Prevention Program.

Again, kind of scanning across the breadth of

how -- the funding has supported public health. We've been able to enhance laboratory capacity to identify human fungal pathogens, and specifically to valley fever, we've been able to provide a lot of assistance because of the Block Grant funding developed real-time PCR assay reference laboratory services that are able to determine the exact etiologic agent of valley fever for our local public health agencies, and have looked at over 100 isolates so far.

Also, sequencing types of etiologic agents have been performed, and that leads to the development of genotyping tools for valley fever outbreak investigations, and so far -- and over 30 cell samples have isolated five strains. So overall, that is certainly an issue that is very near and dear to California as well some of our surrounding states.

As far as public health accreditation, we've provided technical assistance to 55 local public health agencies, arranged Accreditation Readiness Conference, and convened two trainings specific to tribal public health accreditation as well.

Workforce development. As you know, this is key. This is a very, very big topic guess for us at the State department and for public health in general, so wanted to highlight that one. And that would be,

through the preventive medicine residency program have been able, with the Block Grant funding, train residents. And also to let you know that of the 111 graduates overall, 66 percent are actually working in public -- California Public Health agencies, institutes, community clinics, or university, which is tremendous. And also, we currently have three health offices that are actually graduates from that program.

And the California Epidemiologic Investigation Service or Cal EIS program, with the funding, we've trained 13 fellows. And those who are not particular with it, this is the program that takes fellows for one or two years and take what I understand to be graduated but green epidemiologist, and really partners them with an -- and provides them with hands-on experience working with a presector at local or state health departments.

So those were just some of the highlights. You can see the full extent of everything, but I thought it did a great job of just outlining some of the breadth that it provides and want to leave you with something that the CDC shared with us as they exited their -- on their site visit, and that is really that they have been really tasked with focusing on the evaluation of -- and so they are working on the evaluation framework. And as the CDC mentioned, the value of the public -- of the

Block Grant is the opportunity to innovate, address emerging issues, plug gaps in some issues, build partnerships, integrate across systems, implement evidence-based practice, increase reach, build public health infrastructure, and be what they -- what we call a "force multiplier."

So that said, there will be more details, but they are definitely working on a very solid evaluation, framework, and more information on that to come.

Thank you.

CO-CHAIRPERSON ALLES: Well, that was a lot of dense information in a short period of time. Thank you for the preparation that you put into the presentations. And it's clear to me that there's a lot of alignment within each of the four presentations. It seems that there has been a lot of conversation and planning to bring focus to this idea of Public Health 2035, recognizing some of the social determinants and looking at the importance of collaboration, flexible of funding, and so forth that the -- were the kinds of things that were repeated.

And I think this brings us then to the time where I would like to open it up to the advisory committee to ask questions, and I would like the begin, first of all, with individuals who have questions that

you would like to ask Karen Smith. And let's focus on the presentation that she made, which was the vision of Public Health 2035, and then we'll move to Susan and then to Brandon and then to Claudia.

So I would entertain, again -- I would entertain anybody kind of jumping in, but remember to say your name first so that the court reporter can get this accurate.

ADVISORY COMMITTEE MEMBER GLASSMAN: This is Paul Glassman. I'll jump in if that's okay.

CO-CHAIRPERSON ALLES: Absolutely.

ADVISORY COMMITTEE MEMBER GLASSMAN: So Dr. Smith, first of all, thank you for that. I loved your presentation. I thought that many of the things you said in terms of the vision of the department and the focus on much bigger picture and introducing focus. I think that -- that one of things I mentioned that other people might be thinking and I am as well is, maybe could be characterized as a balancing act, which would be necessary going forward. You mentioned making sure that the foundational public health functions still remain and use the vaccinations as an example. And I'm just wondering your thoughts about how that balancing act between looking at crosscutting measures, more focusing on communities and sort of determinants will be

balanced with the need to maybe continue some foundational activities that are at the core of public health. So just your thoughts about that balancing act would be helpful.

DIRECTOR SMITH: Sure. So one of the -- again, this is Karen Smith. So one strategy it a fairly broad strategy is looking at where we can build capacity to serve multiple purposes. So a really good example of that is epidemiology. So right now, the way we are structured, and the way we function, we have epidemiologists in the Center for Infectious Diseases. We have epidemiologists in almost every single one of the branches within Infection Diseases, and they focus on their particular programs or branches. So if you were a tuberculosis epidemiologist, you do tuberculosis. And we have, as it turns out, epidemiologists in almost every single one of our centers, if not every single one of our centers, but they tend to say pretty focus in the area they are working.

So one of the things -- and this is true actually across, I would say, pretty much all the technical skills sets. And so we have begun to bring them together, which as I realize is a shocking concept, and have it at what is called an epiform. So everyone still has their primary affiliation that is the work

that they do, but they have the opportunity to talk to each other. And that has already elicited some really sort of novel approaches to doing things. And their skill sets are, while they are all epidemiologist, they are different and one -- you mentioned working with community, so building community epidemiology expertise is actually really important, because we need to know how to really maximize the use, both the pros and cons of things like geocoding, using geocoded data to map where resources are going or where problems are -- has potential, great potential in my opinion, but it also has some challenges, and it can be misinterpreted. And I've personally seen some stunning examples of that. Completely unintended consequences.

So instead of us having to now create a program of a decision around community-based epidemiology, what we can do is the next time we are hiring an epidemiologist in any program, we can actively look for skill sets that enhance our capacity to where we don't currently have it.

The other approach is that we are looking really hard at how to grade funding. It's a challenge for us because most of the department doesn't currently have systems to track -- to do essentially -- those of you who've ever worked in IT, know what project costing is,

so you divide your day up by how much of it you spent on a given project and it's actually coded to those sources. At my previous employer, we did that in 15-minute segments, and it sounds onerous. The truth is it's not. And it's tremendously powerful in demonstrating -- you can take multiple funding streams and bring them together to support an individual or a project and yet be 100 percent able to document the accountability to each funding stream. And that's very important to me.

One of the pieces I didn't talk about but is right up front in our work right now is, we are working really hard at improving our business processes, because I'm of the opinion that, unless we are a really high performing business entity, we can't do any of our real work. So our back office functions have to be really -- they have to be impeccable.

So we are trying really hard. We are spending a lot of resources addressing all audit findings in those areas, that kind of stuff, so that when we do something new, those organizations that are funding us will know that they can trust the information they are getting back and that their funding is in fact being used in the way they intended it to be used.

So it's finding those kinds of opportunities.

The other thing is that of all the -- I'm an infectious disease physician by background, and I actually started my career doing communicable disease control before I went to medical school. So, you know, I love a good outbreak as much as anybody else. It is probably the one area where we are likely to get funding; however, even that is at risk.

So throughout the recession, one of the areas that we lost a lot of capacity across California was in communicable disease control, and in particular, those diseases that don't have a specific funding source. So tuberculosis has a specific funding source. Immunization, preventable diseases, vaccine preventable disease have has funding source, but things like STD control -- sexually transmitted diseases, no funding source. Guess what happened to the capacity. It vanished. And what is happening now is we are seeing, with about the delay you would predict, around five years, a dramatic increase in rates.

So what we have to be able to do is be really good at articulating what it takes and what it takes in the absence of something like Zika or Ebola to keep the communicable diseases from reoccurring -- and I'm actually on sort of a two-mirror -- one of my personal missions is I'm on a two-year time course to really make

the case in California in whatever forms I can for the need to support basic communicable disease control. And part of it -- part of where you get an extra bang for that is that if you fund an epidemiologist, you can -- yes, they do your -- your STD control or your TB control, but if you are smart, you are going to get one who either is really to train or already has skills. Those same mapping skills that you use to map an outbreak can be used to map a lot of other community health issues. And so I love epidemiologist in case you can't tell, partly because they -- it is such an incredibly valuable yet flexible skill set. And so it -- that's a kind of an oblique answer to your question, but we are not -- I don't think that there's ever going to be a magical new source of funding and -- for public health. We are just not that sexy and we are just not that good at articulating what we do.

Also, I have to say, for all I've spent -- too many years to actually mention on a public call -- you know, whining about how health care gets all the money and we don't, if I was sitting in the seat of somebody who has to vote, am I going to provide care to all those people who have diabetes or am I going to instead direct it toward, you know, active living and healthy foods, you can get that it's a challenge. And so what we have

to do is make the case that you can take a tiny sliver off of that and get a whole lot of prevention out of it. And none of that is new, but we are trying to do it in way that says, look, we are open to, you know, sort of having conversations about ways of doing business differently in public health as well.

CO-CHAIRPERSON ALLES: Dr. Glassman, did you want to have a follow-up question to that?

ADVISORY COMMITTEE MEMBER GLASSMAN: No. Thank you. That was a great answer. And as she said, it was extensive compared to the question, but I didn't expect an exact detailed answer but I just really wanted to put on the table the point of the balancing act. And I think that you've given some great examples of way that things can be levered, so no, I appreciate the answer.

ADVISORY COMMITTEE MEMBER KHARRAZI: Rebekah Kharrazi. Thank you so much for the presentation. It's really great to see -- to see the department moving this direction, and obviously a lot of it is aligned with what Prevention Institute works on every day.

DIRECTOR SMITH: Thank you for the systems of prevention, by the say. I should have given them credit. It's on my slide. I promise.

ADVISORY COMMITTEE MEMBER KHARRAZI: It's wonderful to hear you say it is.

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(Conference call momentarily disconnected.)
GRANT BLOCK COORDINATOR BUTLER: This is Anita again. We lost contact, but we are back now.
CO-CHAIRPERSON ALLES: Okay. Very good.
So Rebekah, you were asking a question.
ADVISORY COMMITTEE MEMBER KHARRAZI: Yeah. This is Rebekah Kharrazi again. I was just thanking Dr. Smith for a great presentation and to see the department moving in this direction towards upstream social determinants of health initiatives, and so thank you for that.
My question actually builds nicely off of Paul's. And I'm interested in your thoughts on, you know, we are envisioning 2035. This Block Grant may not be here in 2035. What does it look like to try to move all that we are doing within the Block Grant into the functioning that, you know -- that the department gets already from the State, from the federal government, if -- should it go away?
At the same time, should it continue, how are we starting, you know, what efforts are being made to move those infrastructure needs more and more away from the Block Grant.
And then also a third piece would be taking the sort of innovative efforts under the Block Grant and

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starting to make them into more infrastructure.
DIRECTOR SMITH: Well, thank you. I'll see if I can --
ADVISORY COMMITTEE MEMBER KHARRAZI: Sorry. That was a lot.
DIRECTOR SMITH: No, no. It's okay. It's actually a really interesting question. So I'll go really broad. Ultimate first. Ultimately, I don't think governmental public health is going to be doing most of this work. I mean, if we do our job right, the only way that we can make sustainable changes in health is this culture of health is when we empower communities to really take it on, like own it, and then we provide the technical assistance and that sort of thing.
So I would hope that we won't be the only entities doing it. In fact, and this is heresy, I realize, to a lot of people, but I see a smaller more focused governmental public health role, where one of the things that we can do that almost no one else can do -- well, one in California, obviously, is bring in money from the federal government, but state level policy will also have two piece, the advocates external to the government, but then it needs to have the internal to the government as well. And I'm a big

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believer in the power of policy to affect change. So I that role is always going to be there.
Similarly, I think -- so we will be better able to do what we do when we have better data systems. So that's another area that we are really moving to improvement. If we have to spend less human hours generating the kind of analyses that we currently have to grab from multiple databases and it take months of many people's work, that is another way of getting cost savings.
So I don't think the way that we currently do public health is necessarily sustainable. If we don't get better at prevention, nothing in health or health care is sustainable. So -- but I actually am very optimistic about the power of the models that are currently coming out to do that. I don't think like -- the Block Grant is -- the Block Grant is an incredibly important source of funneling because it's one of the few that allows for innovation. I think there are ways to gain from innovation in any of the areas in the department.
I actually had a conversation with Judy Monroe, who is the director of OSTLTS, which is where the Block Grant is currently located, about the move that occurred. That was done explicitly to recognize that

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while chronic disease has always been in the forefront with this particular, but also with innovating, because quite frankly, there was never an infrastructure. There didn't need to be one until we started living the way we currently do.
There was a recognition that all of the areas of public health really do have a need to innovate. And so it wasn't because someone else got tired of, you know, kind of handling the Block Grant. It moved because that, and in particular, because that -- the whole function of that program as its name, indicates is to support state and local governments. And that's a recognition on CDC's part that they're are less able to do innovation and cutting-edge work. And the closer you get to community, The more able you are -- you are to do that. And for me, it's been about one of our key principles is facilitating the work of local health departments, getting out of their way, making the funding as flexible as possible.
So I have dreams of more of the Block Grant being used wherever it is going to get the biggest bang for the buck. I'm also cautiously optimistic about being able to make our case for core -- well, I should use -- the better terminology is foundational public health capabilities and activities. Because now that we

are not in the throes of a recession, I think people have begun to come back around to the fact that we actually really do need things like environmental health. They -- the issues of climate change and sustainability, the people outside the field of public health are now drawing the connections.

So I think that twenty years is going to show a pretty big change, unless of course there's a big economic meltdown, in which case, we'll go back to the way we were. Unfortunately, that's -- so I don't really have an answer except to say that I hope to see the Block Grant doing what it's intended to do, which is stimulating innovation and different ways of doing things, not just filling holes. And you can ask around, I've said that inside the department as well.

ADVISORY COMMITTEE MEMBER WOOTEN: Karen, great presentation by everyone. This is Wilma in San Diego.

DIRECTOR SMITH: Hi, Wilma.

ADVISORY COMMITTEE MEMBER WOOTEN: Hi. I wanted to ask and get your thoughts on how you feel the prevention block grants can support public health accreditation, particularly for those very small and smaller jurisdictions.

DIRECTOR SMITH: So I'm -- I think accreditation can be incredibly valuable to a health department. We

were, as you know when I was in Napa, going through accreditation. And I can tell you from walking into this department, it did -- it had some tremendous benefits. I don't want to -- I think that if accreditation at the local level can really make a huge difference in some of the -- in particular for me, it was that the areas that are benefited most were those business practices areas again. You know, what is it? 11 and 12, or 10, 11, and 12?

ADVISORY COMMITTEE MEMBER WOOTEN: 11 and 12, yes. Administrative and governmental -- the governance.

DIRECTOR SMITH: Right. As tedious as they are, and they are -- not the areas, but the actually doing those things -- they are critical to your ability to do anything else. And so I think -- and it also makes you -- we are governmental public health. We have responsibility to be good fiscal stewards. It's the public's money we are spending after all.

So I'm supportive of accreditation. I don't want to go too far out in saying what I think should happen in the Block Grant, because I'm committed to that being a collaborative process.

ADVISORY COMMITTEE MEMBER WOOTEN: Totally, yeah.

DIRECTOR SMITH: That's why we are really

looking forward to the recommendations of the advisory committee, and then that will all -- those will go along with kind of our overarch in guiding principles, not just for Block Grant, to the rest of the department as well, so that we can feel like we are actually reflecting the will of the people, if you will. The will of those people who you all, who are -- have charged to think seriously about where the Block Grant can do California the most good, and us internally in the department in where both our program people who are much closer to the strengths and challenges of the individual programs than certainly I am.

ADVISORY COMMITTEE MEMBER WOOTEN: Great. Thank you.

CO-CHAIRPERSON ALLES: Do we have another committee member that would like to ask Karen a question?

Karen, I'd like to ask you one. Do you have a timeline for when you -- when you will begin the processes that are necessary, and then what would be your expectation for a timeline in terms of when you would begin to see some of the results of the different orientation and process that support that?

DIRECTOR SMITH: I'm assuming you are talking of -- the phone disconnected again.

(Conference call momentarily disconnected.)

DIRECTOR SMITH: It's Karen Smith. My big feet apparently touched the wrong wire.

CO-CHAIRPERSON ALLES: Are you okay?

DIRECTOR SMITH: No. I'm fine. It was just a telephone wire, but what were we talking about? Oh, yeah, processes, etc.

So we've actually already started. We have changed, as I said, the way we make decisions about funding. We've -- we are in -- you are living and breathing the change to how we allocated the funding for -- the process by which the funding for the Block Grant will be allocated. We have already -- we've increased resources in several key administrative divisions to help with our focus on really becoming much more administratively adept. The Fusion Center now exists, and it is incredibly active in working on some really significant work. There are several multi departmental and cross-sectoral initiatives that are being undertaken. So there are a lot of changes. They are not necessarily visible from the outside at this point, but the fact that we now have a process whereby when a -- an issue comes to the floor as violence did during the spring and summer, we actually have a process -- a standard process by which we were -- we will evaluate

that issue both from the perspective of what are we already doing, but also, are there gaps in what we are doing, should we be putting more energy or resources toward this issue? If so, what does that look like? And which was not something that was in place before, and it worked extremely well when -- in addressing the questions and the challenges that people put forth to us in terms of violence prevention as a public health issue.

And so you probably get a better answer from people who are actually in the department of about whether or not it feels different in the department. I -- I can tell you because I'm -- I pay very close attention, a lot of moving pieces are happening. One thing we are going to be doing and Claudia is taking the lead on this, and this is indicative of -- and I'll mention just briefly another -- one thing -- so we have many, many registries. We have cancer registries. We have immunization registries, and they are scattered all about the department and they function in different ways. None of them are -- with the exception of vital records, actually reside in our Center for Statistics and Informatics.

So -- so we are going to bring all the registries together this week -- next week. Sometime in

September, and just talk about what do you do, what things do you have in common, are -- is the structure as it currently -- I'm a big believer that structure and function are interdependent. So when you look at functions, if there are challenges with the function, one of the things that you have to look at besides resources is structure, and really just take a deep look at that.

On the radar is taking on for me chronic disease. We have a center for chronic disease, but I'm still challenged when people say to me, what's California's approach to chronic disease, or what are you doing about chronic disease. I don't have a, you know, I could sit down and have a 30-minute conversation with somebody over coffee, but the 3-minute elevator speech kind of eludes me. And I don't mean that flippantly. I think that what it feels to me as an outsider is missing a coherent, explainable, and therefore supportable approach to chronic disease as opposed to the, we have to give more money to diabetes, we have to give more money to Alzheimer's. All of these things I agree with, but we don't have that more money. So the question becomes, are we doing it right? Are we doing the right things? Are we doing enough of each thing? Is the structure the way it ought to be?

So for me, that's a really important piece. It's especially important because you don't come from the world of chronic disease, so we don't take anything about the way that the -- this department is approaching chronic disease for granted, because I don't have a perfect vision in mind. So that conversation first and foremost will be with the Center for Chronic Disease, the people who live and breathe in that center, to talk about it.

We don't have a director yet, and that's a big challenge, but we are waiting for the right person. And I think that our chances are better when we have a better sense and can articulate where we want the center to go. Because I want to bring in somebody who's looking to the future, who really wants to join with all the incredibly smart and capable people that we have in this center and really move it forward. But I don't know what forward looks like yet. So that's -- so that's the kind of -- we are also looking at laboratories.

I threw a challenge down to the California Association of Public Health Laboratory Directors to come back and tell me what the public health laboratory system in California should look like 20 years from now. They are going to answer me back next month, actually.

And so we are going to do the same thing with all of our various and assorted laboratories. So it's a systematic but not necessarily kind of entirely longitudinal approach.

CO-CHAIRPERSON ALLES: And I'd like to do a follow-up on that. And the issues that I'd like to raise are metrics that demonstrate income as rates or percents or whole numbers. And for so many years, those metrics being the determination of success and recognizing that a change, as you've described, it in the beginning will take a lot more conversation to get to the collaboration, a lot more adjusting of what a lab -- what the lab system should look like, and that while the transformation is happening, it could happen that the traditional metrics will suffer from that. And I think you've already given an example of that, was the issue of the violence and then I think you also referenced rape as another issue.

So public health people are really good people, and my guess is they will sign on on this, with this, and they will think of it as an exciting journey of something that is an improvement to what we've had since we've begun public health.

Do you think that you'll be able to make the case -- not you personally -- but do you think the case

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will be made about the change in the paradigm before people -- it's going to take time to be able to get new metrics and in sync that those new metrics are even more important.

I guess the question I'm asking is how optimistic are you that the public, whoever -- whatever that contingency -- is will give you the time to get there?

DIRECTOR SMITH: Well, so the issue of -- let me break that apart a little bit. The issue of performance appearing to deteriorate as you makes change, that's one of the reasons we are making evolutionary change and not revolutionary change. I want to keep my job. So I -- I want to -- so we are -- that's -- and that's the other reason why we are focusing on business practices, because frankly, if you live in this particular world where we are, everybody is really happy if you just get your audits fixed. And so if we can do that while at the same time actually providing better service to our customers, and realize that the -- at the State level, the customer isn't really the general public. It is in terms of, you know, the ultimate effective policy and a lot of our communications because do a huge amount of public communication, and that's one of the areas where we've increased resources. But it's local health

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departments and communities that with work with in our stakeholder groups.

I think it's possible that if we don't message things well, some advocacy groups will feel like they are somehow being left out if they hear of other advocacy groups that -- where the issue comes -- sounds like it's coming to the floor.

You know, I'm pretty optimistic, though, because the other thing is the Accountable Communities for Health is a really interesting intervention, not just because I think it will make real sustainable change, but because you have to measure it differently. The whole field of public health that this focused on did your disease rates go down, if you are in governmental public health, that's a lose-lose situation, because nothing that you do is ever going to make that rate of tuberculosis go down. You always are extrapolating to affect.

However, what we failed to do in public health and I think we really need to do is learn from the arena of social services not government -- but social science. We look at numbers of disease, you know, numbers of individuals, case rates, morbidity rates, et cetera, things that, as governmental public health, you have very little ability to actually affect. But what we

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don't look at necessary -- we don't tend to quantify the very real differences that we can make when we do collaboration well. And there actually are ways to measure that. We just haven't taken advantage of though -- that.

And I am no expert. Let me just put that out there, but I have colleagues who are, and who are like, well, of course you can measure the value -- and for me, what I'm trying to communicate is the value of what we do, which is different than impact. Impact implies numbers, and this is especially true when talking to the general public or to legislatures. They want to know why they should be paying for your service, and they don't want to know why in terms of there will be fourteen, you know, less syphilis case this is year. They want to know what's the value to them. And it's a different way of talking about what we do from the very strict science base, so we do have a challenge with people pulling in different directions.

I'm a scientist I go way back. In case you haven't noticed, I do have a little bit of an epidemiology, but I started in microbiology, so that's a very -- we do numbers, by God, and, you know, life cycles and hard science.

But on the other hand, the work that -- of

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addressing issues like poverty and some of the more subtle mental health issues, addiction, you can't measure those in the same way and you can't measure a community's satisfaction with your services in the same way.

So some of the challenge, I think, is to change the way we talk about -- not to stop, you know, giving the funders the data that they need, not to stop, God forbid, tracking disease rates and that sort of thing. That's always going to be core to what we do. But to add to the conversation information, as opposed to data, that's actually persuasive to the people that I personally think need to understand what we do and why they should care, and that's the general public as well as the people that have the power to fund what do.

CHIEF DEPUTY CRIST: Could I add to that?

DIRECTOR SMITH: Please someone else talk.

CHIEF DEPUTY CRIST: I think it was Dr. Alles that asked the question. This is Claudia. One thing I wanted to add to that is, I'm looking at -- not the microphone, so I hope you can hear me -- is I come from health care and I have a 26-plus-year health care background, anything from bedside care to enroll in urban settings and international settings, but mainly in California and as well as administration, and just

trying to -- on a business end as well. And one of my -- so I'm going to tie this into why that is important because you asked a very good question about measurements. And one of the other things we need to do as part of this is to really connect with the world of health care and health care needs to connect with public health. And I can tell you by now having spent about five minutes on the public health side, and I'm learning every day from an amazing array of colleagues and experts here, but also having spent a lot time on the health care side, that neither side understands each other still. We talk about having the come close to each other, but I speak a little bit of both now and my personal mission is to try to help facilitate bringing those two worlds together.

And I tell you that on the health care side, the measurements are very, very, very, very, very different of what we measure in public health. And what we need to measure in the future, so that -- I wanted to just underscore what you said, and I wanted to add to that by saying and it's even more complex because now we have the figure out how to connect a couple of worlds that really have very different ways of measuring success and at different focus for very good reasons.

So thank you for that great question and

challenge.

CO-CHAIRPERSON ALLES: Thank you. And I think one of the other paradigms shifts that's is occurring at the same time was -- I think you mentioned that -- Karen -- was the issue of changing from a mindset related to disease to a mindset related to health. And doing the measurement that would demonstrate that we were becoming a healthier nation. And through that, you talked about structure and function, that by thinking in those ways about becoming healthier instead of becoming sicker, that will resonate with a lot of constituencies, and that will be exciting to communities as stakeholders and even for individuals as for medicine scientist to become engage in the work of public health.

So I want to just do a time check here. We have -- you had indicated on hour and a half and possibly you may -- one or all four of you may have made some other plans or have other appointments. Can you let me know if you want like to continue with questions and whether you would entertain questions for other speakers.

DIRECTOR SMITH: Please. Everybody is nodding that they can stay for a little while, so I don't want to hog the airwaves, so -- besides, I have to write down what you just said a minute ago because I really liked

it.

CHIEF DEPUTY CRIST: This is Claudia. Maybe having it be kind of one after the other, Susan and Brandon and me, maybe if you wanted to open a question for either of us and then we can answer and I can defer to my colleagues to answer my questions too. Just kidding.

CO-CHAIRPERSON ALLES: Okay. So somebody on the committee jump on in.

ADVISORY COMMITTEE MEMBER GLASSMAN: So this is Paul Glassman again. So when I introduced myself before, I didn't point out on the member list that I'm a dentist and the oral health representative on the committee. I work at the University of Pacific School of Dentistry.

So first of all, Dr. Smith Smith, when you were saying earlier that want to start moving away from filing holes, I assumed you were talk about dentist.

DIRECTOR SMITH: You should see, I have so many cavities I practically have more metal in my mouth than anything else. I love a good dentist.

ADVISORY COMMITTEE MEMBER GLASSMAN: The question I wanted to ask is a little bit broader than -- related to, I think, Claudia said a few minutes ago about the differing roles between Department of Health

Care Services and Department of Public Health and around the topic that you were bringing up around metrics. And so even the opposite end on the spectrum, you are talking about trying to enhance or thinking about metrics to look more at bigger social determinant type of issues. But even if you are looking at very specific sort of data driven metrics, from my perspective, and I talked to number of other people who have similar kinds of experiences, it is extraordinarily difficult to get data from the Department of Health Care Services that would help to measure the outcomes of public health programs even though that data does reside in databases in the Department of Health Care Services.

I know the oral health program in the Department of Public Health has just done some extraordinary work and negotiations in trying to set up some way to query the Department of Health Care Services database to give up some of that information, but to me it's a ripe opportunity to departmental cooperation that would help to enhance stability of public health programs to have some data that's already there and be able to get at it to be able to demonstrate value and some of the interventions that are taking place.

CHIEF DEPUTY CRIST: Thank you, Dr. Glassman. This is Claudia. I'd like to take the first crack at

this since -- that's also the teeth, isn't it? Sorry -- since Dr. Jay Kumar, our state dental officer, is -- resides within the department here, and specifically within this Center for Chronic Disease prevention and health promotion. And I'm very pleased to share that not only have we been able to negotiate, but he is, in part, funded by DHCS.

We together own and take both ownership, even though we own him much more so, and we -- in Dr. Jay's work and -- Dr. Kumar's work, and he provides consultation to DHCS, but also we have an interagency agreement that we can take advantage of in helping to share data so it should be -- and there's a fairly new elements to it agency wide. We've come to the conclusion that we need to be able to do a better job and easier share data with each. So that is fairly new and so it's made easier from that perspective, but also Dr. Kumar has great connections with DHCS, specifying Renee Mollow, who is over the dental side over on the DHCS side, but also with the team as a whole. And with them being part of and participating very actively in the advisory committee that he had convened to look at creating the oral health plan as well that is in the process of being finalized.

So I acknowledge what you are saying. You are

absolutely correct. Sometimes is a lot harder than it seems to be, not just specific to DHCS, but in general to get data out of our systems, and we feel we have a good partnership there now. So I'm hoping this will be a much better path forward.

ADVISORY COMMITTEE MEMBER GLASSMAN: Great. Thank you.

ASSISTANT DIRECTOR FANELLI: I was going to add that our information person here Jim Green from our health and statistics group is meeting with a health -- with the data person from Medi-Cal and really looking at requests for data and how do we streamline them, how do we put them together better so that we understand and make the request for data easier. Because if you don't know the Medi-Cal system and what you can and can't get from the system, we spend a lot of time trying to fix those data requests. And I think more we can bring the two sides together and, you know, streamline that process, we're working on that.

CHIEF DEPUTY DIRECTOR NUNES: This is Brandon. That's one of the things that our agency has identified as an issue in trying to make it a little bit easier. They've recently finalized a data-sharing agreement among all the 13 or 14 departments that are under our agency that where it will ease with the sharing of

information between the two departments. That way you don't have to start from the beginning with the data-sharing agreement. You can start, at least, you know, three, four steps down the path, and kind of, you know, make that process a little faster and a little more efficient, standardize among all our departments of the agency.

CHIEF DEPUTY CRIST: And I do realize coming from a private sector, to me, when I first came, was like what, you can't just send an e-mail, but it is a little bit more complicated than that. And also to protect the information of the individuals which makes sense. I think it's a lot easier now.

CO-CHAIRPERSON ALLES: Another question? Well, let me ask -- try it a different way.

Susan, you've heard a couple of the questions and you probably were thinking about how you might answer some of the questions that were asked of Karen. Was there anything that came up that you said -- you said to yourself, I wish I had a chance to just comment on that question related to the Fusion program?

ASSISTANT DIRECTOR FANELLI: I think it, for me, stems down to how we use the resources that we have and how we look at the vast resources that we do have in the department and become more creative about how we use

those resources. And so the way that we are going to make changes is not by great new dollars, but taking advantage of opportunities like the Block Grant to use them for the innovation pieces, to use them to really look at how do we do business a little differently, how do we -- and the braided funding. I think that's the other opportunity.

We are doing a project on how do we get dollars out the door, and so how do we look at our local partners and say, we spent a lot of time and effort just getting dollars out the door, and trying to get the -- all the information back that we need for that. If we could find a better and easier way to get dollars out the door with less restriction, understanding dollars have to be used according to what's allowable and what's not allowable, but if we could come up with easier ways like allocations or grants versus cooperative agreements versus different types of contract vehicles.

The more we can do to free up our time to do the program work, the better off we are all going to be, and so how do we look at that a little differently? And I that's really in terms of how do with get there with what we have. It's really being more creative with the resources we have.

CO-CHAIRPERSON ALLES: Thank you. And Karen, a

little further down on the agenda, there's a little bullet point called "future use of funding." Do you have additional things that you would like to say relative to that?

DIRECTOR SMITH: No. I'm really interested in hearing what the advisory committee comes up with and -- no, I think it's going to be really interesting. I mean -- yeah. Can't wait.

CO-CHAIRPERSON ALLES: Okay. All right. One more time for advisory committee members. Particularly, I was thinking about EMSA. We haven't talked too much -- we haven't talked at all really about EMSA, so would somebody like to ask a question in that regard to CDPH, the health side and the accident prevention and the --

ASSISTANT DIRECTOR FANELLI: We do have Dan Smiley here from the Emergency Medical services Authority.

CHIEF DEPUTY CRIST: EMSA is here.

CO-CHAIRPERSON ALLES: Say that again.

DIRECTOR SMITH: Dan Smiley from EMSA is here.

ASSISTANT DIRECTOR FANELLI: Do you want to say a few words, Dan?

MR. SMILEY: I wasn't planning on saying a few words, but if you have question, happy to do that. Can

I steal your chair?

ASSISTANT DIRECTOR FANELLI: Yes, you absolutely can.

MR. SMILEY: Okay, thanks. You know, EMSA is, you know, for many years been pleased to be part of the Block Grant program, and I think from the emergency perspective, we had a element to this that is certainly unlike much of the traditional public health programs. And I think one of the benefits and one of the things that we've seen from EMS and having our nine different programs available is that we see our role as kind of a systems integrator. As Dr. Smith said earlier, there's certainly an element of the public health Block Grant that serves as a force multiplier to create unit of effort. And much of what we do in Emergency Medical Services, like so many -- like so much of public health, is we try to coordinate multiple autonomous organizations that are functionally independent. And I think our role and where we come across best is when we are able to empower and enable our local EMS agencies, our private and public EMS providers, hospitals, all to work in a collaborative way to achieve some of those metrics.

And as it relates to metrics, we also struggle with what's a metric, are we able to do anything with

it, and I think, you know, we try to quantify what we do in terms of coordination of the infrastructure because we know that we, with a small State staff, are not going to be able to directly impact the health care, but what we can do is make sure that all of the work that's being done collaboratively across the State is well coordinated to have an overall viewpoint.

As we move forward with metrics, one of our major priorities on EMS side is really to take a look at the data and the metrics, but to also recognize that health information technology and health information exchange can serve as a sustainable direction for us to bring in multiple sources of information, whether it's from health care financing or public health or EMS, and understand that all of this information, when we have good individual patient identifiers and demographic information, if we are able to do matching, that we'll be able to, in a sustainable way, be able to pull those informations up from various registries. All with the ultimate goal aligned with the presidential Precision Medicine Initiative.

I think we can then begin to get those metrics in a way that we ultimately again 15 or 20 years down the road when health information technology is fully -- well, I shouldn't say fully mature -- but more mature

that we can then begin to harvest that important health information. And I think those are some of the things we are looking at from EMS perspective in terms of integrating with other public health activities to reduce morbidity and mortality in the pre health care setting.

CO-CHAIRPERSON ALLES: You know, for somebody who wasn't planning to talk, you did pretty good. Thank you very much.

Does any of the committee members want to ask a question about EMS?

ADVISORY COMMITTEE MEMBER CASSADY: This is Diana Cassidy. I don't have a question, but I want to make a comment about workforce development whenever that is appropriate.

CO-CHAIRPERSON ALLES: I think it's now Diana.

ADVISORY COMMITTEE MEMBER CASSADY: Terrific. So like Steve McCurdy, I teach in the MPH program at UCD and can speak directly to the value that the funding for the Cal EIS program had made to not just UCD graduates but graduates all across the state, as well as the Preventive Medicine Residency program. So I want to applaud the spirit of innovation that I think you addressed, Dr. Smith Smith, in your -- in your opening remarks, and to say that I think these students, these

young graduates, really can make a tremendous contribution to the direction in which you are turning the department. And so, you know, even as funds are short or limited, I encourage you to continue to invest in these programs.

DIRECTOR SMITH: In fact, we are actually centralizing our internship program, which is called internship, but it's really all of that -- students, interns, residents, et cetera, because we value it so much. And, honestly, when you don't have a lot of funding and you want energetic people, that's a great -- that's a great source. And they bring so much enthusiasm into the workplace. And in fact my -- one of my dearest friends is Cal EIS who is now a health officer and the first epidemiologist I ever hired as a local health office was also Cal EIS fellow, so I also value the program tremendously.

CO-CHAIRPERSON ALLES: Okay. Another committee member questions?

ADVISORY COMMITTEE MEMBER KHARRAZI: Rebekah Kharrazi again. Maybe Susan would be the right person for this. I'm really interested in the work that's going on with health economics and bridging in economists into this world, because as you pointed out in your presentation, very much underdeveloped and new

for public health really. So I'm curious -- I haven't heard too much about what that person's meant to be working on, but I'm curious how it's going to touch some of these concepts of highlighting values of moving upstream, and so make you can speak that a little bit.

ASSISTANT DIRECTOR FANELLI: Sure. So we brought on someone who I would say is not necessarily an economist as much as has an epidemiology background and data background and is first looking at what are we doing in evaluation of our programs today. So looking at starting with some of the chronic disease programs, what are they looking at and are there some parameters that we could build upon that sort of lead to that evaluation structure. And we are trying very hard to take it to the next level, which is, how do you get to that return on investment in a formula that really, you know, has some science to it to say, how do we value all relationship building, how do we value these softer kinds of things. And so first we are starting with a scan of what we are doing already in the department. We are looking at models that are out there. ASTHO has a model, and there's a few models that are trying to take the return on investment into public health, not so much into health care delivery.

We are working with CDC. We have a couple of

academic institutions that we are working with that have given us at least starting place. But I will say that health economists are hard to come by. Health care economist are hard to come by. They sort of describe to when I was look for a health economist this meeting once a year in San Francisco where all the students coming out with a master's degree in economics get together and they write them checks on the spot to go work for health care. You know, very hard to complete in government with that. And so we have worked with a few folks who we've brought on to do some training, but we'll be looking at developing modes with our epidemiologist with some of our folks and looking at social services as well. So a lot of work to be done.

ADVISORY COMMITTEE MEMBER KHARRAZI: Thank you.

ASSISTANT DIRECTOR FANELLI: I wanted to take a minute to introduce Monica Morales who is the deputy for the Fusion Center and brought on board -- you've been here about.

MS. MORALES: Two months. I've made it.

DIRECTOR SMITH: She's on old hand now.

CO-CHAIRPERSON ALLES: Thank you.

DIRECTOR SMITH: I'm going to have to excuse myself. I have another meeting, but it's really been a pleasure to talk with you all. Thank you for the -- for

listening, and look forward to hearing what you all come up with.

CO-CHAIRPERSON ALLES: We're going to move into the area of discussion now on the funding criteria that we came up with and advisory group and so somebody will pass along that information to you, the conversation that we have.

So, one of the agenda items, and it was Document 7, that you received, presents the advisory committee's recommendations for funding, the way in which funding is determined by us as we make our recommendation. And I want to go through just some of them to give both the people who are in the department but who probably know what these are, but also the public and a better understanding of the way we've -- the issues that we looked at to concrete our priority.

So one was the size of the problem, how many people are involved. Second was the severity of the condition. Third was equity and health status. Fourth was community concern. Fifth was programs that engage community at the local level. Sixth was cost of the condition. Seven was cost effectiveness of interventions that were being implemented. Concordance with the healthy people objectives. Other resources that are available, that is if there are other resources

such as Prop 99 for smoking, and perhaps our money wouldn't be able to add very much to the work that was already being done on that initiate because of the money they had. The ability to leverage funds, that is to be for programs to find other groups, organizations, to collaborate with in terms of bringing more funds in. And performance programs metrics.

Now, those have served us pretty well for, I don't know, I guess the last 15 years. We've brought this up every several years. We brought it up again this year. And in that conversation, many of these seem to be useful. I would say that there were several of them, perhaps only several of them, that in a new paradigm would already be accounted for.

So, for instance, equity would be a good example of that, and community concern would be another example of that. It's clear that -- it's clear to me anyway, that the committee ought to take a look at the ASTHO recommendations. I think that there are probably -- there's probably more consistency with what Karen and the other speakers presented with their funding priorities. And of course the California Department of Public Health has even had to make some changes in the way that they are thinking about how priorities should be adjusted in order to accommodate a plan that was

presented.

I would also like to say that I think in order for the committee to be able to do a good job on the assignment of reconsidering a list of criteria, that if we were able to have some inservice presentation that would extend the concepts in a little bit more detail, we'd be able to do a better job. Understand that might not be possible to do. In the absence of that, we will do the best that we can. But I'd think the more we understand the directions of the plan, the better we will be able to help identify our principles for allocation.

So now I'd like to invite the committee members to comment on what you are thinking about whether it speaks to the priorities we already have or something to be thought about as the speakers were presenting.

ADVISORY COMMITTEE MEMBER WOOTEN: This is in San Diego. The information provided by the speakers was really great in thinking about the future, and one of the things that really rang well was highlighted in the presentations from Karen's perspective was talking about having a business case or having -- basically, spoke to having operational excellence. That's obvious not one of our criteria, and I think criteria that we -- you've just read off really still stands true in trying to help

us determine the priority for the funding source. So the information provided is really good at thinking for the future, but I don't think it changes our criteria, unless we add a criteria -- actually, do we have a criteria focused on evidence-based? That might be a way to link to some of the factors that Karen spoke about.

CO-CHAIRPERSON ALLES: That's a good observation, Wilma. Thank you.

ADVISORY COMMITTEE MEMBER WOOTEN: Do we -- I didn't recall.

CO-CHAIRPERSON ALLES: We do not.

ADVISORY COMMITTEE MEMBER WOOTEN: So that might be another criteria to add in.

CO-CHAIRPERSON ALLES: We do have something that's close to that. It's called proven interventions. But in a way, proven interventions, as you start to shift to a paradigm of measuring health and improving health -- interviewing health and measuring it -- it would rely more on evidence-based at this point in time as opposed to proven intervention.

ADVISORY COMMITTEE MEMBER WOOTEN: Exactly.

CO-CHAIRPERSON PECK: This is Caroline. Can I interject? I think it says, innovation in area for which there are few proven interventions.

CO-CHAIRPERSON ALLES: Oh, it does. Yeah.

CO-CHAIRPERSON PECK: So I think the whole concept of evidence-based is actually missing.

ADVISORY COMMITTEE MEMBER WOOTEN: Yes, it is. Yes.

CO-CHAIRPERSON ALLES: Yeah. And I think that the concept of innovations is something that by itself could stand in in addition to the evidence-based.

ADVISORY COMMITTEE MEMBER WOOTEN: I agree, yeah.

ADVISORY COMMITTEE MEMBER KHARRAZI: We also talk about at Prevention Institute, we preferred it described as evidence informed. Recognizing I think that, you know, there are certain populations that tend to be the ones that the evidence builds for and, you know, when you take something out of the neat box of a study, there are implications. So evidence informs gives a little bit more flexible on being able to pull from community experience, for instance. So that could be another way we might want to approach that.

While I'm talking, I might as well just -- I'm obviously looking at this for the first time, and I think you all have done a really great job over the years of capturing really important criteria for determining how these funds are to be spent. So I just wanted to highlight a few that really stood out for me.

You know, one is sort of -- and my question earlier alluded to this. How are we balancing the infrastructure needs versus the opportunity for new innovative pilots, for instance.

I really like the criteria about the ability to cross over multiple sectors and disciplines. I think really was emphasized what's -- again and again today that this is one of the very few flexible funding options, so I don't think there's a lot of opportunity for this type of work to be done otherwise.

Clearly innovation falls under that, and from the perspective of Prevention Institute, for us, equity is always a top priority, and so it's really great to see that here. Dr. Smith emphasized the needs of the community, so falling right under that is really fantastic to see.

And one thing I don't know if it's, you know -- it's here, but not necessarily explicit is spending funds in a way that go to where the highest need is or highest community need is. So that would be one suggestion that I would have for consideration to add to the list.

CO-CHAIRPERSON ALLES: Okay. We've made note of those. Other committee members?

ADVISORY COMMITTEE MEMBER WONG: Hi, Wes. This

is Nathan. I was just curious, is there a way that the different criteria are -- are weighted or, you know, you create a score and kind of prioritize in funding?

CO-CHAIRPERSON ALLES: No. We haven't done in it that way. We have asked the committee members to keep these priorities at the forefront of their thinking, and that often -- that required that as they were thinking this through, they needed to weigh and balance a variety of factors. And obviously somebody would look at one thing with more weight than somebody else would. But in terms of the work that was required of us, it seemed to work pretty well in recommending which programs were at the top of the priority list for funding and whether those programs should receive more or less or the same amount of funding.

My sense of it is that if we were all in the -- if the committee was all in the room together and we were looking at the list, we'd all create a different numeric value for each one.

And I guess my thinking is that we should maybe have a meeting, a phone conference call just of the advisory committee, early on coming up that would enable us to kind of put everything out on the table -- it would all be scrambled at that point -- and then try to reassemble it again.

The question you just asked I think gets to the issue of are there some definite changes relative to what would be the high-ranking priorities and what would be the lower-ranking priorities.

So do you want the follow-up on that Nathan?

ADVISORY COMMITTEE MEMBER WONG: Yeah. Yeah, I guess -- I mean -- yeah, I mean, I agree where you. I think the process has worked pretty well. You know, obviously, there's pros and cons to having an objective scoring system, but of course, many times, grants these days like NIH grants, for example, get evaluated on a, you know, fairly objective rating system on different criteria. So, you know, I'm in the sure -- you know, I don't know the answer as to whether we should go in that direction or not, but it's just a question -- question I raise, you know, that would, you know, influence how objectively these type of proposals get reviewed.

CO-CHAIRPERSON ALLES: And one thing is for sure, it would get a little bit more difficult when you are talking about collaboration as opposed to silos. Typically, we looked project by project, and a number of times it came up today that there would be cross funding or that programs would be braided together, funding sources even could be braided together, and it feels to me like the paradigm is a big enough shift that we need

to re-examine almost from scratch -- I mean we don't -- we have good criteria, so we don't have to go back further than that, but how do we put these together in a way that are -- that would demonstrate that our recommendation is supportive of the concept of Public Health's 2035 and all of the specific points that were made as differentiators from what was and what will be.

CO-CHAIRPERSON PECK: Wes, this is Caroline, and I have a suggestion that the advisory committee might want to consider. And that I think -- yeah, there is a big shift, like you said, and I don't think we've had an in-person advisory committee meeting for a while. And I think with the -- you know, we have salary savings and things, and if we were to be able to pay for travel, do you think the advisory committee would want to come together to have an in-person meeting to discuss and really come up maybe with a new numerical objective rating or whatever they want to do -- a higher ranking versus lower ranking way to help the department? Because, you know, I think this is a time of change in this whole Block Grant, and it may be worthwhile for that -- for us to, you know, collectively to invest with the time and the funds that we do still have that are available to allow the advisory committee to do that.

CO-CHAIRPERSON ALLES: Would anybody be opposed to doing that?

ADVISORY COMMITTEE MEMBER WOOTEN: No. No opposition.

ADVISORY COMMITTEE MEMBER GLASSMAN: No.

ADVISORY COMMITTEE MEMBER WOOTEN: Seeing it's just the primary issue.

CO-CHAIRPERSON ALLES: Okay. Well, Caroline, let's put that together then, and maybe we can figure out a good time to make that happen and we can check with the advisory committee to help us come up with a specific date. I think that's a great suggestion that you made.

Just one more time, I want to ask if anybody on the committee would like to make a point about this issue of the criteria?

Okay. So Caroline, I'm not quite sure how we would do this, mechanically, but I know that the committee is always interested in public comment, and generally we don't get a lot of people coming to our meetings. And I expected there probably are people who are on the line now who are from the public. And do the capable also of being able to ask questions?

CO-CHAIRPERSON PECK: Yes. We do have some members of the public, and why don't we just open it up

to them to unmute their phones and ask questions if they have in.

CO-CHAIRPERSON ALLES: Sure. So at this point, I would ask any member of the public who would like to make a comment or ask a question or encourage some thinking by the advisory committee to, if you are willing to do that, state your name. If you prefer not to do it, you can just start your question.

PUBLIC MEMBER: Hi there. This is Christina Hildebrand from a Voice for Choice. Thank you for your -- all of the information from today.

My understanding from the last meeting on the Block Grant earlier this year was that this meeting would be to decide where the funding went, and I haven't heard that yet. So I was wondering if that was going to happen or if -- or if that was not the purpose of this meeting, then when will that -- when will it be determined what the funding will go to?

CO-CHAIRPERSON ALLES: Okay. Caroline, could you answer that one?

CO-CHAIRPERSON PECK: Yes. Thank you very much, Christina. The purposes of this meeting was for -- the advisory committee has requested to hear from the director, what her vision was on how to use the Block Grant, and so it was really an informational meeting.

And the advisory committee had actually requested they have an opportunity to give recommendations to the director as to how the funding should be spent. And so we have heard some comments for advisory committee members. As -- but we are also open to any recommendations that members of the public have on how the Block Grant should be used. So if you have any particular recommendations, we'd be open to hearing those now.

As Ms. Anita Butler said before, we have a court reporter, we will have minutes, and although the director and her staff had to leave, we will be able to communicate to her what your recommendations would be.

The -- there will be a process after the all the advisory committee members have had a chance to give their input, public has had a enhance to give their input, then the director is going to go through a process internally about how she thinks the money should best be used in the department. And she will be taking input from the staff of the department as well.

And at the next advisory committee meeting, the draft funding allocations and the department's recommendations will be presented and there -- advisory committee and the public will have an opportunity to weigh in at that point as well. But I think if there's

a burning issue you would like to recommend now, I would go ahead and say it.

PUBLIC MEMBER: Okay. Thank you so much for that explanation. I have two -- I guess two cement comments. So in the block funding where the block funding went for this year, that was determined two years ago, that was very, very specific. So it was specific -- specific organizations or projects that were being worked on and certain amount of money went to that. I didn't hear -- I heard more general suggestions here today, but I didn't hear any of those kind of specifics.

So just before I give where -- I do have some ideas, so I'm going to give those to you, but before I do that, where is that piece of the process? So if there's an organization or a project that somebody from the advisory committee or outside of it wanted to money to go to, where is that -- I'm guessing there's some sort of formal proposal or request or something that goes to the director, or how does that piece of it work?

Because the money this year, it seems to be very, very specific on what projects or what organizations it went to.

CO-CHAIRPERSON PECK: Yes. Well, there is not a formal RFT process for use of this money. So I think

traditionally it's been, you know, an internal use within the health department and through the programs in the health department, it may then go out to communities for use. But as I said, the director will be determining what process will be used this year, but it will be an internal determination. So if -- so -- I think what -- it's a very general thing. Like if you feel there's an area that should be funded, that would be what you would talk about now, not about -- we can't say who the money would go to at this point, but it's likely to be towards a State program or a local government program. That's traditionally what the money --

PUBLIC MEMBER: Got it. Understood. So I think my area which I would ask for funding to be put towards, and one of it is something that came up, which is chronic disease, not only treating chronic disease, but looking for the reasons for the increase in chronic disease.

We've seen huge increases, especially among children, of chronic disease and, you know, one -- I think it's 1 in 54 children has a chronic disease or disability. And so to look at rather than just treating those, to look at what is the reason for those -- for that increase in chronic disease, because I think we

need to look at the stem of the problem rather than the -- I mean, we need to obviously treat those children that have chronic disease and adults that have chronic disease, which has also been on the rise, but to look at what is causing it, because we've never seen numbers like we've seen now.

CO-CHAIRPERSON PECK: Thank you so much. We will definitely share that request.

PUBLIC MEMBER: Thank you.

CO-CHAIRPERSON ALLES: Other members of the public? Are there any members of the public in the room there that would like to make a comment?

Okay. Hearing none, then we'll move forward.

I'd like to -- we don't have much more business to do. And there's a -- where we are on the agenda, it's take a break for 10 minutes. Let me ask Anita or Hector, if there is no business reason for doing that, could we just work through this, the rest of the agenda, and finish without a break?

GRANT BLOCK COORDINATOR BUTLER: Absolutely, Dr. Alles.

CO-CHAIRPERSON ALLES: Okay. So the next topic, then, is the committee review and discussion of the minutes, if there are -- if there is any discussing -- for the meeting that was held on June 22nd. And this

was Document No. 8 in the package that you received. Just wanted to give a couple of highlights from that to give the public a sense of some of the things that were discussed in the minutes. Likely that you would not have had a chance to see these unless you would have requested them. But the couple of things we recognize, the separation of percentage between the 70 percent going to CDPH and the 30 percent to EMSA, we approved the February 8th meetings, and we discussed the federal fiscal year 2016 and '17 funding as an update, we talked about the CDC visit, and you heard all of the positive comments from the executive staff who presented that the monies were being used appropriately. It was making a big difference to the people of the State of California. It recognized that there was flexibility in these funds, and it's a way in which new programs or innovative opportunities can receive some initial funding.

There was a compliance review that was favorable in pretty much all aspects to the department. One expectation to that was that there was an expectation that external audits would be done every year, and that hadn't happened and the department owned up to that, recognized it, and said that were going to ensure that that would happen.

And I wanted to say that it was also made clear

that that was general across the United States. Most state health departments did not follow that particular recommendation.

Let's see. Another point that was made by the committee was that the advisory committee had done on extraordinary job in process and content -- process and delivery, I should say, and one of the person who was the chief evaluator said that California should be used, -- the advisory committee should be used as a model for what an advisory committee would do in all 50 states.

We talked a little bit about whether objectives were met or not. In fact, that was an issue that was raised by Nathan, and we asked that a form be developed so that we could take a look at whether the previous year's goals had been met. The -- it's a very detailed form. I think it did the work that the committee was hoping it would do, and we would like to see that kind of accountability in the future, even if there's modifications in the form itself. But seemed to me that -- that the form took us where we wanted to go.

There was an indication of the -- in the minutes of the 20 CDPH programs that are funded and then also the programs that are funded to EMSA. And so that was the -- kind of a summary of the minutes.

Did anybody want to ask a question from the

minutes that you received or make an comment or suggest an edit?

Hearing none, can I have a motion to approve the minutes? This is an action item.

ADVISORY COMMITTEE MEMBER SPIESS: Dan Spiess. I'll make that motion.

CO-CHAIRPERSON ALLES: Thank you. And I need a second.

ADVISORY COMMITTEE MEMBER GLASSMAN: Paul Glassman. Second.

CO-CHAIRPERSON ALLES: Thank you, Paul.

All in favor of approving the June 22nd meeting minutes may signify by saying aye.

ADVISORY COMMITTEE MEMBERS: Aye.

CO-CHAIRPERSON ALLES: Aye.

Any nays? Any abstentions.

ADVISORY COMMITTEE MEMBER KHARRAZI: This is Rebekah Kharrazi. I'm going to abstain since I was not here.

CO-CHAIRPERSON ALLES: Say that again.

ADVISORY COMMITTEE MEMBER KHARRAZI: This is Rebekah Kharrazi. I'm going to abstain since I was not at the meeting.

CO-CHAIRPERSON ALLES: Thank you. Thank you. So unanimous.

ADVISORY COMMITTEE MEMBER STRATTON: Sam Stratton has to abstain. I wasn't present at that meeting.

CO-CHAIRPERSON ALLES: Okay. Let the minutes show that as well.

So the motion was approved, then, with the exception of Sam, who had to abstain because he wasn't here, and Rebekah, because she was not on the committee at that time.

So the next agenda item, then, is more discussion on the additional information that you heard today. Since the executive staff isn't in the room anymore, I wonder if maybe somebody was bashful or shy, if there was something that you would like to say from the committee, so that we could honor this opportunity for additional conversation.

Okay. Is there anybody public, then, or anybody in the room there with you, Caroline, who would like to make a comment to the content of the meeting?

CO-CHAIRPERSON PECK: I think we are good here, Wes.

CO-CHAIRPERSON ALLES: Yeah, okay. Well, that's being the case, then, is there any further conversation that someone would like to raise?

CO-CHAIRPERSON PECK: This is --

CO-CHAIRPERSON ALLES: Hearing none, then -- go ahead.

ADVISORY COMMITTEE MEMBER SPIESS: Wes, this is Dan. So we will be contacted regarding -- I'll call it a "read evaluation" of our evaluation criteria.

CO-CHAIRPERSON ALLES: Yeah, yeah. We just did that, I think, last year, but given the nature of the paradigm shift, it's probably warranted for us to take a look and see how we can be harmonious with and synchronize our criteria with the direction that department is going.

ADVISORY COMMITTEE MEMBER SPIESS: Good.

CO-CHAIRPERSON ALLES: Caroline, I wanted to ask you a question. Are there other states that are moving in the same way, or you don't know?

CO-CHAIRPERSON PECK: I really don't know. I -- it's very interesting the -- how different states are and actually what they choose to use this money for. And I think it's one of the reasons that there's bipartisan bicameral support in congress. So I would just say, from what I see, there's quite a wide variety of how the money is used. I think California's often the leader, and so I think if we do move toward a different paradigm, I wouldn't be surprised if other states look at it and might want to follow it. I may

put it up as a model approach.

CO-CHAIRPERSON ALLES: Yeah. One of the thoughts that I had as Karen and the others were going through that is, recognizing that this issue of priorities for funding could shift dramatically. The thought that I had was, after the presentation was made, something along the lines of, how come we didn't see this coming and, you know, kind of predict the -- the flow of the current. It seems to make perfect sense to me given the direction of the change, and then it makes sense that the -- there's probably going to need to be a lot of changes that are made, and one of them would be the funding priorities that we would choice to recommend.

Did anybody else get a sense like that or a different sense that you want to express?

Okay. Well --

ADVISORY COMMITTEE MEMBER GLASSMAN: Wes, this is Paul Glassman. I'm not sure if it's generally what you said, but I think I heard something more along the lines of looking for opportunities to collaborate, looking at cross programs, not necessarily a sort of revision immediately of the funding priorities for allocation, because that's slightly different than the way I just heard you say.

CO-CHAIRPERSON ALLES: It think you actually said it better than I did, Paul. That's kind of what I meant to say, that there's a whole new paradigm that has been presented and we can't use old measurements to effectively -- to be effective in our work. So thank you.

ADVISORY COMMITTEE MEMBER GLASSMAN: But on the other hand, that didn't mean slowing up the current processes and plans and starting from a blank state, it meant more of an evolutionary of thinking, at least from what I heard.

CO-CHAIRPERSON ALLES: Correct. All right. I will entertain a motion for adjournment.

CO-CHAIRPERSON PECK: So moved, Caroline.

CO-CHAIRPERSON ALLES: Okay. Need a second.

ADVISORY COMMITTEE MEMBER GLASSMAN: Paul, second.

CO-CHAIRPERSON ALLES: Thank you. Paul.

All in favor say aye.

ADVISORY COMMITTEE MEMBERS: Aye.

CO-CHAIRPERSON ALLES: Any nays? Any abstentions?

Okay. Unanimously voted, then, to adjourn the meeting, and it's 3:28.

So I thank the advisory committee, I thank the

staff, and I thank the members of the public who participated in this conversation today.

We'll talk again soon.

(Concluded at 3:28 p.m.)

REPORTER'S CERTIFICATE

STATE OF CALIFORNIA)
) ss
COUNTY OF SACRAMENTO)

I, JESSICA SOTELO, CSR, hereby certify that I was duly appointed and qualified to take the foregoing matter;

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

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

_____

JESSICA SOTELO, CSR No. 13679