

Preventive Health & Health Services Block Grant (PHHSBG) Funding Criteria – D5

California PHHS Block Grant Advisory Committee Principles for Allocation

These six Principles will be taken into account when making funding decisions and weighted equally.

1. Size of the Problem/Condition

Explanation:

Size of the Problem/Condition can be evaluated in various ways: age-adjusted mortality rate, age-adjusted morbidity rate, attributable risk from exposures, years of potential life lost, disability adjusted life years, quality adjusted life years, number of hospitalizations, total hospital charges, disparities in outcomes by race/ethnicity, gender, class, disability, sexual characteristics, etc.

Example of Data for Evaluation:

[Heathy People National Drug and Alcohol Use Statistics](#)

2. Cost-effectiveness of Interventions

Explanation:

Cost-effectiveness analysis is a form of economic evaluation that compares the relative costs and outcomes of different courses of action. Cost-effectiveness analysis is distinct from cost-benefit analysis, which assigns a monetary value to the measure of effect. If there is no available cost-effectiveness analysis, economic impact analysis, programmatic cost analysis, cost-benefit analysis or cost-utility analysis may be used. [CDC Economic Evaluation PowerPoint](#)

Example of Data for Evaluation:

Page 7 [Task Force Finding and Recommendation Statement - Diabetes Prevention and Control: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk \(thecommunityguide.org\)](#)

Economic Evidence An economic review of 28 studies (search period January 1985 - April 2015) showed that combined diet and physical activity promotion programs for people at increased risk for type 2 diabetes are cost-effective. All monetary values reported are in 2013 U.S. dollars. Twelve of the included studies provided information on program costs, primarily costs attributable to program implementation and delivery, though 4 of these studies also reported the cost of identifying people at increased risk for type 2 diabetes. They found a median cost per participant of \$653 (IQR: \$383 to \$1,160), and a median program cost per participant per session of \$30 (IQR: \$16 to \$54). The variation in program costs per participant is partly explained by the number of sessions, delivery mode of the core sessions (individual vs. group), setting (clinical trial vs. community or Task

Force Finding and Rationale Statement 8 primary care), and type of personnel used (health professionals vs. trained laypeople). Subgroup analyses indicated that program costs per participant were lower for group-based programs (median \$417, IQI: \$341 to \$600; 8 studies) and for programs that translated the intervention tested in the DPP study into community or primary care settings (median \$424, IQI: \$340 to \$793; 8 studies). Twenty-one studies assessed the cost-effectiveness of combined diet and physical activity promotion programs by estimating incremental cost-effectiveness ratios (ICER) from the health system perspective. The health system perspective considered only direct medical costs, which included costs associated with program delivery and the medical costs averted from preventing or delaying diabetes and its complications. Included studies reported cost-effectiveness estimates derived from data collected in actual programs or simulation modeling. The median ICER of combined diet and physical activity promotion programs per quality-adjusted life year (QALY) was \$13,761 (IQI: \$3,067 to \$21,899; 16 studies). The variation in ICERs is partially explained by variation in cost and effectiveness of the programs, program delivery modes, patient follow-up times, and delivery settings. Subgroup analyses of five studies that reported ICER for both individual and group-based programs indicate that group-based programs were more cost-effective. The group-based programs had a median ICER of \$1,819 (IQI: -\$5,027 to \$16,443) per QALY saved. The individual-based programs had a median ICER of \$15,846 (IQI: \$7,980 to \$72,723) per QALY saved. Two studies reported ICERs of \$21,195 and \$50,707 per disability-adjusted life year averted from the health system perspective. Six other studies reported a median ICER of \$2,684 per life year gained (IQI: -\$2,444 to \$17,410).

3. Health Equity

Explanation:

Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. Achieving this requires ongoing societal efforts to: address historical and contemporary injustices; overcome economic, social, and other obstacles to health and health care; and eliminate preventable health disparities.

Example of Data for Evaluation:

[Health Equity in Healthy People 2030](#), [Healthy People Oral Health Inequity Statistics](#)

4. Linkage with Strategic Goals of California and Healthy People

Explanation:

[Let's Get Healthy California](#) is a shared vision for the future health of Californians. The six Let's Get Healthy California goals focus on health across the lifespan and pathways to health, with an emphasis on achieving better health, better care, and lower costs and promoting health equity for all Californians: Healthy Beginnings, Living Well, End of Life, Redesigning the Health System, Creating Healthy Communities, Lowering the Cost of Care.

The [Healthy People 2030](#) Vision is a society in which all people can achieve their full potential for health and well-being across the lifespan. The five goals are to: attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death; eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all; create social, physical, and economic environments that promote attaining the full potential for health and well-being for all; promote healthy development, healthy behaviors, and well-being across all life stages; and, engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

Example of Data for Evaluation:

[Let's Get Healthy California Infant Mortality Statistics](#), [Healthy People Leading Health Indicators](#), [Healthy People Flu Vaccination Statistics](#)

5. Engagement of Communities at the Local Level

Explanation:

A program that directs resources (financial, human or technical assistance) to local health departments or community-based organizations.

Example of Data for Evaluation:

Extent to which program objectives and activities direct financial, human or technical assistance resources to engage local communities. An example of a human resource engaged in the local community is the assignment of a state-funded Preventive Medicine Resident or Cal EIS Fellow to a local health department. (PHHSBG State Plan – can be provided by the PHHSBG Program Coordinator).

6. Impact of Termination

Explanation:

Closure of the program and cessation of objectives and activities due to lack of alternative funding source to replace withdrawn PHHSBG funds. The impact can be mitigated if new funding has become available that can be used to replace withdrawn PHHSBG funds.

Example of Data for Evaluation:

Available CDPH data for current investments: Enacted State Fiscal Year (SFY) 2022-23 budget and proposed SFY 2023-24 budget available online for all state-level public health program areas. [Historical Budget Publications | Department of Finance](#) Prior SFY budgets also available. CDC Funding Profiles for California – will overlap with state budget, but county-specific grants for public health program areas are available. [Summary View \(cdc.gov\)](#) If more specific state-level information is needed, can be provided by the PHHSBG Program Coordinator from our internal SharePoint budget documents.

Common Data Sources

National

- [Healthy People 2030](#) (Framework, Health Equity, Leading Health Indicators, Priority Areas, Evidence-Based Resources, National Data)
- [The Community Guide](#) (Evidence-Based Interventions, Economic Analyses, Health Equity)
- [US Preventive Services Task Force](#) (USPSTF)
- [Cochrane Library](#) (Health Systemic Reviews)
- [Cochrane Methods Economics](#)
- [The Campbell Collaboration](#) (Social Science Systemic Reviews)

California

- [Let's Get Healthy](#) (Leading Health Indicators)
- Office of Policy and Planning [California Community Burden of Disease Engine](#) (Statistics)
- [Healthy Places Index](#) (Evidence-Based Interventions)
- California Health Interview Survey [Ask CHIS](#) (Statistics)
- [California Behavioral Risk Factor Surveillance System \(BRFSS\) Data Request](#) (Data)

CDC Aims for the PHHSBG

Use Funding to:

- Address emerging health issues and gaps
- Decrease premature death and disabilities by focusing on the leading preventable risk factors
- Work to achieve health equity and eliminate health disparities by addressing the social determinants of health
- Support local programs to achieve healthy communities
- Establish data and surveillance systems to monitor the health status of targeted populations

Achieve Goals by:

- Using evidence-based methods and interventions
- Reducing risk factors, such as poor nutritional choices, smoking, and the lack of physical activity
- Establishing policy, social, and environmental changes
- Leveraging other funds
- Continuing to monitor and re-evaluate funded programs