Preventive Health and Health Services Block Grant: FFY 2024 State Plan

Version Date: June 25, 2024

Executive Summary

This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2024. The California Department of Public Health (CDPH) will turn in this plan as the designated state agency for the allocation and administration of PHHSBG funds.

Program Descriptions

Program Title	Program Description	Allocation
Advancing Climate Change and Health Programs at local health departments, tribes and within CDPH	This program will support California Department of Public Health (CDPH) programs, tribes, and local health departments to prepare for and prevent the health and equity impacts of climate change. It will also support CDPH programs, tribes and local health departments to improve social determinants of health and meet existing health program objectives through engagement with climate change policy and planning.	$989,126
Alzheimer's Disease Program	This program supports the Healthy Brain Initiative (HBI), a statewide initiative to partner with local health departments to grow and foster the California Healthy Brain Initiative State and Local Public Health Partnerships to address Alzheimer's Disease and related dementias at the local and community level. Using the Updated 2023-2027 HBI Road Map developed by the Alzheimer's Association and the Centers for Disease Control and Prevention, HBI advances cognitive health as an integral component of public health and supports local activities that incorporates eliminating health disparities, improving health equity, collaborating across multiple sectors, and leveraging public and private resources for sustained impact.	$550,000
CA Asylum Seeker Health Surveillance and Linkage to Care	This program is an active surveillance and rapid public health response program for individuals seeking asylum and intending to reside in CA. Active surveillance increases early identificaton of infectious diseases of public health significance, and services facilitate linkage to healthcare services and disease control.	$230,447

CA Behavioral Risk Factor Surveillance System (BRFSS) Program	BRFSS is a CA-specific surveillance system that surveys adults 18 years and older on self-reported health behaviors. Questions in the survey relate to nutrition, physical activity, tobacco use, hypertension, blood cholesterol, alcohol use, inadequate preventive health care, and other risk factors. Because the survey is conducted on an annual basis, the continuous use of this system allows analysis of trends over time.	$525,000
Cardiovascular Disease Prevention Program	This program aims to improve the cardiovascular health of all Californians to reduce illness and death associated with heart disease and stroke. The program utilizes prevention-based, upstream approaches to combat heart disease, which remains the leading cause of death in California, the United States, and worldwide. This program promotes cardiovascular health through collaboration with a wide range of partners and sectors including education, government, healthcare, nonprofits, and is actively working to develop relationships at the community level. CDPP is updating California's Master Plan for Heart Disease and Stroke Prevention and Treatment as well as evaluating a recent Comprehensive Medication Management pilot with the goal of achieving better hypertension control in post-stroke patients to reduce the risk of stroke recurrence.	$700,000
Emergency Medical Services (EMS) Prehospital Data and Information Services and Quality Improvement Program	This program provides for pre-hospital EMS data submissions into the state EMS database system and unites the EMS system under a single data warehouse, fostering analyses on patient care outcomes, public health system services, and compliance with CA state and federal EMS service laws. The Program improves pre-hospital EMS services and public health systems statewide by providing measurable quality improvement oversight, resources, and technical assistance.	$1,207,869

EMS Systems Operations, Planning, and Specialty Care	Emergency Medical Services Authority, through its EMS Systems Division is mandated to provide oversight of EMS systems, the statewide Trauma System, Stroke and ST-Elevation Myocardial Infarction (STEMI) Systems, EMS for Children, and the CA Poison Control system. The EMS Systems Division has statutory and regulatory oversight responsibility of the EMS system for the State of CA and promulgates regulations for use by local EMS agencies and EMS providers, reviews and approves annual local EMS system plans ensuring statutory and regulatory compliance, and manages the state's EMS data collection, performance management and quality assurance. EMS Systems Division staff provide state leadership and oversight, to ensure the EMS Act is upheld and the best quality of care is available, reducing the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care in an emergency.	$1,450,242
Healthy People 2030 Program	This program supports the overall efforts of the PHHS Block Grant by enhancing the accountability and transparency of the PHHS Block Grant through measuring progress and impact of funded programs through quality improvement initiatives, as well as communicating current accomplishments.	$816,704
Injury Prevention Program	This program seeks to maintain and strengthen injury prevention as a core public health function and ensure capacity to address on-going and emerging cross-sector issues through programming, surveillance, and strategic planning for a range of topics, including: healthy aging, childhood injuries, transportation-related, and firearm-related injuries and fatalities. These injury areas stretch across the lifespan, affecting all age groups, and present significant opportunities to impact and increase longevity and well-being through evidence-based prevention strategies.	$1,281,393

The Office of Policy and Planning	This program builds cross-sectoral engagement in CDPH's State Health Assessment (SHA) and State Health Improvement Plan (SHIP) by enhancing capacity to address crosscutting priorities defined by public health through Comprehensive Assessment, Integrated Planning, and Collective Action addressing crosscutting priorities defined by public health with the purpose of organizing for impact.	$943,753
Public Health Accreditation Program	CDPH has been accredited by the Public Health Accreditation Board (PHAB) since 2014. The Public Health Accreditation Program (PHA) coordinates all internal activities relating to maintaining CDPH's accreditation status and provides technical assistance and support to all California Local Health Jurisdictions (LHJs) that are pursuing or considering PHAB accreditation or reaccreditation.	$240,000
Public School Health Center Support Program (PSHCSP)	CDPH is mandated in Section 124174.6 of the Health and Safety Code to implement the PSHCSP in support of new and existing school-based health centers (SBHCs). The program supports SBHCs through providing training and technical assistance to schools and coordinating a collaborative partnership with cross-sectoral stakeholders at the state and local level.	$178,000
Rape Prevention Program	This program prevents the perpetration and victimization of sexual violence through a public health approach. It builds the capacity of California's local organizations to implement community-level sexual violence primary prevention strategies that promote health equity.	$825,408
Toxicological Outbreaks Program	This program supports the administrative and technical infrastructure at CDPH to conduct non-infectious toxicological disease outbreak investigations and provides expertise to local health jurisdictions.	$122,074

Tuberculosis Free CA	This program promotes prevention strategies to reduce tuberculosis (TB) disease among populations at higher risk in CA. This is the sole statewide program focused on TB prevention, with the aim of reducing morbidity, mortality, health disparities, and healthcare costs associated with TB disease. Program activities include measurement of testing and treatment of TB infection at key clinical sites, development of culturally and linguistically appropriate patient education, community engagement of patients at higher risk for TB, and training for medical providers on evidence-based testing and treatment for TB infection. Program also disseminates best practice strategies for TB prevention throughout the state.	$700,000
Wildfire Smoke Mitigation Program	This program enables better, more equitable clean air solutions for California communities in the face of increasing wildfire smoke events in a changing climate. The program measures key smoke-associated chemical exposures under different air conditions, community characteristics, and protection strategies, and uses them to evaluate mitigations in partnership with State & community partners.	$200,000
Workforce Development Preventive Medicine Residency (PMR) and CA Epidemiologic Investigation Service (Cal-EIS) Fellowship	PMR and Cal-EIS programs are the key workforce pipeline for hard-to-fill epidemiology and public health physician positions in CA state and local public health agencies. Trainees perform data and policy analyses, provide disease outbreak and emergency preparedness response; community needs assessments and planning, clinical preventive medicine, systems quality improvement, etc.	$1,088,825

Advancing Climate Change and Health Programs at LHDs, tribes and within CDPH

Healthy People 2030 Objective

EH-D02: Reduce heat-related morbidity and mortality

Health Objective

Between July 1, 2024 and June 30, 2025, Program will provide support and expertise to state, local, and Tribal health programs to plan to prevent and reduce health impacts of climate change through their health programs, plans, policies, and communications.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $989,126
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Local Health Departments and Tribal Health Departments/Agencies.
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of total funding that is PHHS Grant: Less than 10% - Minimal source of funding
- Existing funding source(s): State or local funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 5
- Number of FTEs in this program funded by the PHHS Block Grant: 5

Issue/Problem

Local health departments (LHDs), Tribal health programs, and CDPH and CalHHS programs have not received sufficient resources nor technical assistance to prevent and reduce climate change health-related impacts, which include heat-related illness and death, air pollution-related exacerbations of cardiovascular and respiratory diseases, impacts on healthy food and clean water access, injury and death due to severe storms and flooding, vector-borne and water-borne disease,

and stress and mental trauma from loss of livelihoods, property loss, and displacement. Climate change is considered the greatest global public health threat of the 21st Century and is impacting human health now. In California, communities across the State have responded to increasing, and sometimes devastating, health impacts associated with climate change in recent years, including injury, illness, and death from wildfires and wildfire smoke, extreme heat, drought, floods, landslides, extreme weather events, vector-borne diseases, and associated mental health impacts. Climate change affects every Californian, but it harms those already facing inequities first and worst, including communities of color, immigrants, people with disabilities, people inadequately housed, pregnant people, and the very young and elderly, among others. Local health departments (LHDs), Tribal health programs, and CDPH and CalHHS programs are preparing for and responding to the health impacts of climate change; however, many express the need for increased public health resources to adequately address the crisis. Health departments and Tribal health program staff have extensive knowledge of their communities and are well-positioned to advance health and equity while preventing the most dire exposures and health impacts of climate change through planning, coordination, and additional resources. CDPH and CalHHS programs have reach all across California, directly and via LHDs through their policies and programs, and have requested technical assistance to support local jurisdictions in addressing the health impacts of climate change.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)
- Identified via surveillance systems or other data sources
- Governor (or other political leader) established as a priority
- Legislature established as a priority

Key Indicator(s) affected by this problem: Increasing temperatures associated with increasing climate change can lead to heat-related illnesses and deaths in absence of sufficient preparation and protective resources. Extreme heat kills more people directly than any other climate-related health hazard.

Baseline value of the key indicator described above: 1.66 hospitalizations per 100,000 population (age-adjusted) in California.

Data source for key indicator baseline: Tracking California Website, Heat-related hospitalizations by county, 2000-2020

Date key indicator baseline data was last collected: 2020

Program Strategy

Goal: Support local health departments, Tribes, and CDPH and CalHHS programs to prevent and reduce the health impacts of climate change.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Social and Community Context (e.g., discrimination, low civic participation, poor workplace conditions, incarceration)
- Neighborhood and Built Environment (e.g., poor quality of housing, limited access to transportation, food desert, poor water/air quality, neighborhood crime and violence)

Summary of Program Strategy: Program proposes to provide technical assistance to support LHDs, Tribes, and CDPH and CalHHS programs to prepare for and prevent the health impacts of climate change. Program will offer technical assistance to support and build the capacity of LHDs, Tribes, and CDPH and CalHHS programs throughout the state to strengthen climate change policy and planning and incorporate the same into existing public health programs to further improve the social determinants of health and meet existing health program objectives.

Primary Strategic Partners

External:

1. California local health departments
2. California Tribes

Internal:

1. Environmental Health Investigations Branch
2. California Conference of Local Health Officers
3. Regional Public Health Office
4. Office of Health Equity, Advancing Community Equity Branch
5. Indoor Airy Quality

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids
- Other: Communications and strategic planning support, communities of practice

Evaluation Methodology: Program will evaluate progress toward objectives using: 1) process evaluation, including the numbers of meetings conducted, number of LHDs and

Tribes receiving technical assistance; 2) outcome evaluation such as LHDs and Tribes addressing climate change in plans, program objectives, policies, or communications; and 3) impact evaluation by tracking heat-related emergency department visits and deaths.

Program Settings:

- State Health Department
- Local health department
- Tribal nation or area

Target Population of Program

- *Target population data source*: American Community Survey 2022
- *Number of people served:* 38,965,193
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- CDPH programs
- LHDs
- Tribes

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Support LHD Programs to Address Climate Change and Health

Objective: Between 07/2024 and 06/2025, Program will increase the number of LHDs that incorporate climate change considerations into their health programs, plans, policies, or communications from nine (9) to eleven (11).

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Program will help LHDs incorporate climate change into health programs, plans, and policies. The intervention will include support to LHDs to conduct environmental scans of local climate change planning activities, potential partners, as well as gaps and assets. Program will work with LHD staff to utilize data and local knowledge to assess vulnerability to climate change-related health impacts and develop plans to respond and prevent harms to health. Program will also host a Community of Practice to provide further support to LHDs.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Model Practices Database (National Association of City and County Health Officials)
- Other: APHA's "Climate Change, Health & Equity: A Guide for Local Health Departments

Rationale for choosing the Intervention: LHDs have requested technical assistance and support to integrate climate change considerations into their program work. Evidence suggests that when provided with technical assistance, health programs can simultaneously reduce the health impacts of climate change while advancing their existing public health objectives.

- *Item to be measured:* Program will help LHDs incorporate climate change into health programs, plans, and policies
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 9
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 04/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 10
- *Final target value to be achieved by the Final Progress Report:* 11

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Support LHDs to conduct environmental scans. Between 07/2024 and 06/2025, Program will provide technical assistance to at least three (3) additional LHDs to conduct environmental scans of local climate change planning activities, possible partners, gaps, and opportunities.

Description of Activity: Between 07/2024 and 06/2025, the Health Program Specialist I will provide technical assistance to at least three (3) additional LHDs to conduct environmental scans of local climate change planning activities, possible partners, gaps, and opportunities.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Support local health departments to assess climate and health vulnerability data. Between 07/01/2024 and 06/30/2025, Program will provide technical assistance to at least six (6) LHDs to utilize data tools and local knowledge to assess local vulnerability to the health impacts of climate change.

Description of Activity: Between 07/01/2024 and 06/30/2025, the Health Program Specialist I will provide technical assistance to at least six (6) LHDs to utilize data tools and local knowledge to assess local vulnerability to the health impacts of climate change.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Host Local Health Jurisdiction Climate and Health Community of Practice. Between 07/01/2024 and 06/30/2025, Program will host at least six (6) meetings of the Local Health Jurisdiction Climate and Health Community of Practice.

Description of Activity: Between 07/01/2024 and 06/30/2025, Program will host at least six (6) meetings of the Local Health Jurisdiction Climate and Health Community of Practice to provide a space for LHDs to increase the connectedness of California LHD staff working on climate with each other and with CDPH to share resources, strategies and best practices, opportunities, and support through barriers and challenges.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 2:

Title: Support Tribes to Address Climate Change and Health

Objective: Between 07/2024 and 06/2025, Program will increase the number of California Tribes or Tribal health programs that incorporate climate change considerations into their health programs, plans, policies, and/or communications from six (6) to eight (8).

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Program will help at least two (2) additional Tribes integrate climate and health-related programs and plans. Program will provide technical assistance to at least two (2) additional Tribes, Tribal-serving organizations, and Tribal health programs to incorporate climate change into their health programs, plans, policies, and communications, and/or to incorporate health into climate change programs, plans, policies, and communications. The intervention will include technical assistance to Tribes and Tribal health programs to conduct environmental scans of local climate change planning activities, identifying potential partners, as well as gaps and opportunities to address climate change's impact on health. Program will also work with Tribal partners to utilize data tools and local knowledge to assess Tribal communities' vulnerability to the health impacts of climate change and to respond and prevent harms to health.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Model Practices Database (National Association of City and County Health Officials)

Rationale for choosing the Intervention: Tribes and Tribal health programs have requested technical assistance and support to integrate climate change considerations into their health program work, and health considerations into climate work. Evidence suggests that when provided with technical assistance, Tribal programs can simultaneously reduce the health impacts of climate change while advancing their existing public health objectives. The crosscutting consequences of climate change may require Tribal governmental programs and departments to collaborate on planning initiatives, as well as identify and involve partners like Tribal health clinics, LHDs near their territories, schools, county agencies, and municipal departments.

- *Item to be measured:* Tribes or Tribal health programs that integrate climate and health programs and plans
- *Unit of measurement:* Number

- *Baseline value for the item to be measured:* 6
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 04/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 7
- *Final target value to be achieved by the Final Progress Report:* 8

Target Population

The target population of this Program SMART Objective is the Sub-set of the Program.

Target Population of Objective

- *Target population data source*: Indian Health Service (IHS), 2020
- *Number of people served:* 631,016
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- Native Hawaiian or Other Pacific Islander

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban

- Rural

Location:

- Federally recognized and non-federally recognized Tribal territories, Tribal clinics, and Tribal health organizations service areas within State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Activity 1

Technical assistance to Tribes with climate and health planning and programs. Between 07/2024 and 06/2025, Program will assist two (2) additional Tribes or Tribal health programs to integrate climate change considerations into their plans and programs, and/or to incorporate health considerations into climate change programs, plans, policies, and/or communications.

Description of Activity: Between 07/2024 and 06/2025, Program will assist two (2) additional Tribes or Tribal health programs on integrating considerations related to minimizing the health impacts of climate change into new or existing plans and programs, and/or to incorporate health considerations into climate change programs, plans, policies, and/or communications. The Tribal Program Specialist will assist Tribes in utilizing data

tools, making data requests, and integrating local knowledge to assess Tribal communities' vulnerability to the health impacts of climate change, and to respond and prevent harms to health. Relevant plans might include comprehensive community plans, climate vulnerability assessments, climate adaptation plans, Tribal or Local Hazard Mitigation Plans (HMPs), or Community Health Improvement Plans (CHIPs).

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Connect Tribes with appropriate climate and health funding opportunities. Between 07/2024 and 06/2025, Program will assist two (2) additional Tribes or Tribal health programs with identifying one or more appropriate funding opportunities to support climate and health work.

Description of Activity: Between 07/2024 and 06/2025, Program will assist two (2) additional Tribes or Tribal health programs with identifying one or more appropriate funding opportunities to support climate and health work, such as by researching and distributing appropriate State and/or federal funding opportunities.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 3:

Title: Support CDPH and CalHHS Programs to Address Climate Change and Health

Objective: Between 07/2024 and 06/2025, Program will increase the number of CDPH and CalHHS programs that incorporate climate change considerations into their health programs, plans, policies, or communications from 15 to 18.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Program will incorporate climate change into CDPH and CalHHS health programs and plans. The intervention will include meetings with interested program staff from different CDPH and CalHHS programs to collaboratively identify and assess needs for support, develop program and activity plans, and facilitate resource and experience sharing on strategies to address climate change. Program will provide technical assistance that includes the utilization of data sources and other tools that assess climate and health vulnerability and social determinants of health to inform program planning and resource allocation. In addition, Program will provide support by advising in the design

and dissemination of messaging and communications regarding climate change, such as fact sheets, health warnings, and communicating program objectives.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Model Practices Database (National Association of City and County Health Officials)
- Other: CDC, American Public Health Association, CDPH, and journal articles.

Rationale for choosing the Intervention: CDPH programs and other Health and Human Services departments have requested technical assistance and support to integrate climate change considerations into their program work. Evidence suggests that when provided with technical assistance, health programs can simultaneously reduce the health impacts of climate change while advancing their existing public health objectives.

- *Item to be measured:* Programs that incorporate climate change considerations into their health programs, plan, and policies.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 15
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 03/15/2024
- *Interim target value to be achieved by the Annual Progress Report:* 16
- *Final target value to be achieved by the Final Progress Report:* 18

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Host meetings of Cross-CDPH Climate Change & Health Equity Working Group. Between 07/2024 and 06/2025, Program will host at least four (4) meetings of the Cross-CDPH Climate Change & Health Equity Working Group with interested staff from across CDPH to collaboratively assess needs for support, plan and coordinate activities, and share resources addressing climate change.

Description of Activity: Between 07/1/2024 and 06/30/2025, Program will host at least four (4) meetings of the Cross-CDPH Climate Change & Health Equity Working Group with interested staff from across CDPH to collaboratively assess needs for support, plan and coordinate activities, and share resources addressing climate change.

- *Does the activity include the collection, generation, or analysis of data?* No

- *Does the data collection involve public health data?* No

Activity 2

Provide technical assistance to CDPH and CalHHS programs. Between 07/2024 and 06/2025, Program will provide technical assistance to seven (7) CDPH and CalHHS programs regarding climate change in the forms of communications, policy recommendations, fact sheets, health warnings, and program objectives.

Description of Activity: Between 07/1/2024 and 06/30/2025, Program will provide technical assistance to seven (7) CDPH and CalHHS programs to integrate climate change messages, metrics, and considerations into program communications, fact sheets, health warnings, and program objectives.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Provide data and vulnerability assessment tool assistance to CDPH and CalHHS programs. Between 07/2024 and 06/2025, Program will provide technical assistance to three (3) CDPH and CalHHS programs regarding the utilization of data sources and tools that address climate and health vulnerability and social determinants of health (e.g., Climate Change and Health Vulnerability Indicators and Healthy Places Index) in prioritizing resources or program planning.

Description of Activity: Between 07/1/2024 and 06/30/2025, Program will provide technical assistance to three (3) CDPH and CalHHS programs regarding the utilization of data sources and tools that address climate and health vulnerability and social determinants of health (e.g., Climate Change and Health Vulnerability Indicators and Healthy Places Index) in prioritizing resources or program planning.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Alzheimer's Disease Program

Healthy People 2030 Objective

DIA-03 Increase the proportion of adults with subjective cognitive decline who have discussed their symptoms with a provider

Health Objective

From 07/01/2024 to 06/30/2029, awareness of integrating brain health into public health practice and knowledge of resources supported by the California Healthy Brain Initiative (HBI) will increase among rural and tribal communities statewide by 10%. The Healthy Brain Initiative (HBI) aims to implement public health strategies that promote brain health, address dementia and support people with dementia and their caregivers. The HBI program activities are consistent with the United States Centers for Disease Control and Prevention's published Healthy Brain Initiative: State and Local Public Health Partnerships to Address Dementia, 2023–27 Road Map (PDF, 20.4 MB) (Road Map).

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: State Health Department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of total funding that is PHHS Grant: Less than 10% - Minimal source of funding
- Existing funding source(s): State or local funding
- Role of PHHS Block Grant Funds in supporting this program: Enhance or expand the program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 1
- Number of FTEs in this program funded by the PHHS Block Grant: 1

Issue/Problem

Alzheimer's disease is now the second leading cause of death in California, and communities such as tribal and rural communities, lack data to assess the impact of Alzheimer's disease on their communities throughout the state. Program aims

to build meaningful partnerships with these communities to help collect data, inform the work that we do, bring awareness of the impact to tribal and/or rural communities, and build our understanding of existing infrastructure, services, resources, and needs to address ADRDs. California (CA) is uniquely positioned in that it has the second longest life expectancy in the nation at 81 years, & with age being the greatest risk factor for Alzheimer's disease and related dementias (ADRDs), the overall state is at greater risk. (The State of US Health) More American Indian or Alaska Native (AIAN) elders reside in CA than any other state, with over 100 federally recognized tribes and an estimated 11% of NA aged 55+ [California Health Interview Survey (CHIS)]. AIAN are more likely to develop ADRDs than White Americans & it is estimated that one in three NA aged 65+ will receive a dementia diagnosis within the next 25 years. (HBI Road Map for Indian Country) Higher prevalence of modifiable risk factors in the AIAN community increase ADRD risk across a myriad of chronic conditions, including rates of heart disease, hypertension, & diabetes, which are higher among AIAN than in their white counterparts. In tribal and rural communities, geographical, economic, & cultural barriers reduce access to timely, quality care including services to detect, diagnose, and manage dementia. AIAN aged 65+ are less likely to discuss memory loss with their healthcare provider & believe it is a normal part of aging. As Californians live longer, there is a need for more healthcare informed by geriatric expertise, yet only about 5% of providers have this training. There are limited geriatricians & specialists who can meet the needs of tribal and/or rural communities. Older AIAN adults (aged 65 & older) are more likely to have difficulty accessing healthcare than their peers in the non-native U.S. population. AIAN are more likely to report racial & ethnic barriers to quality care & are twice as likely as their White counterparts to say they would not see a doctor if they were experiencing thinking or memory problems (Alzheimer's Association, 2021). Two in five NA (40%) believe their race makes it harder to get care for ADRDs (Alzheimer's Association, 2021). Findings suggest that there is a need to build trust & cultural capacity of ADRD care providers reaching AIAN across the state.

Public health program was prioritized as follows:

- Legislature established as a priority
- Identified via surveillance systems or other data sources
- Governor (or other political leader) established as a priority

One paragraph the key indicator(s) affected by this problem:

A key indicator affected by this problem is sufficient data on the prevalence of ADRD among tribal and rural communities. The estimated number of people age 55+ with Alzheimer's disease among AIAN communities is 3,031. Because the number of reported cases is low, it is difficult to calculate the Alzheimer's disease prevalence among AIAN adults as well as other reliable statistical measures.

Baseline value of the key indicator described above: 3,031

Data source for key indicator baseline: Alzheimer's Disease Program Data, Statistics, and Reports

Date key indicator baseline data was last collected: 2019 (disease prevalence)

Program Strategy

Goal: Expand the CA HBI work to include tribal/rural communities that are currently not funded to conduct HBI work, utilizing the HBI Road Map for Indian Country strategies.

Is this program specifically addressing a Social Determinant of Health (SDOH)?: Yes

- Education (e.g., low high school graduation rates, low literacy levels, poor early childhood education)
- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)

Summary of Program Strategy: Our program strategy includes expanding CA HBI work to include tribal/rural communities that are currently not funded to conduct HBI work. It will help them build capacity to implement local public health strategies that promote brain health, address dementia and support people with dementia and their caregivers. We will utilize the HBI Road Map for Indian Country strategies to effectively engage tribal/rural leaders/members/partners in collaborative discussions regarding brain health and risk reduction for ADRDs. We will partner with tribal/rural health departments to bring a culturally adapted HBI to NA populations. We will do this by creating and engaging a Community of Practice (CoP) collaborative made up of tribal/rural health departments that we will provide HBI resources, technical assistance (TA), and training too.

Primary Strategic Partners

External:

1. International Association for Indigenous Aging
2. CA Dept of Aging
3. UCSF Geriatric Workforce Enhancement Program
4. Currently funded HBI LHJ partners

Internal:

1. CHC Branches: Tobacco, NPAB, IVPB (Healthy Aging Initiative)
2. Office of Health Equity (OHE)
3. Cardiovascular Disease Prevention Program
4. Diabetes Prevention Program

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: Our program's HBI evaluation methodology includes both process and outcome evaluation measures. Process evaluation includes utilizing bi-annual progress reports to collect ongoing HBI program data that is used to gauge and improve program effectiveness. Progress report data is used to provide tailored feedback and TA to improve each local health department's effectiveness in implementing public health strategies that promote brain health, address dementia and support people with dementia and their caregivers in their communities. These progress reports are also used to collect quantitative evaluation outputs and outcomes that span the following HBI goals: 1) Education and empowerment of communities with regard to brain health and cognitive aging; 2) Mobilizing public and private partnerships to engage local stakeholders in effective community-based interventions and best practices; 3) Ensuring a competent workforce by strengthening the knowledge, skills, and abilities of health care professionals who deliver care and services to communities affected by ADRDs and their family caregivers. Outputs and outcomes are typically measured by the number of community members educated, the number of partnerships built/sustained, and the number of ADRD healthcare professionals that are trained. The use of standardized evaluation and data collection tools allows us to generate reports of collective statewide outcomes across all local health departments that are implementing HBI programs.

Program Settings:

- Community based organization
- Local health department
- Medical or clinical site
- State health department
- Tribal nation or area

Target Population of Program

- *Target population data source*: USA: California, Population Estimate 2022-07-01
- *Number of people served:* 850,693
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Community Needs Assessment

Objective: By June 30, 2025, Program will have conducted one (1) Tribal/Rural community needs assessment on existing ADRD services, resources, and partners that will inform the development of a Tribal/Rural Communities of Practice and resource hub in Year 2.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is a subset of the larger problem.

Problem for this Objective: **The State lacks tribal/rural partnerships to assess cognitive decline of adults in their communities**. In tribal/rural communities, geographical, economic, and cultural barriers reduce access to cutting-edge research as well as timely, quality care including services to detect, diagnose, and manage dementia, and there are limited geriatricians and specialists who can meet the needs of tribal communities. In addition, due to historical trauma AIAN communities had to endure, partnerships between the state government and tribal communities in California are limited. These findings suggest that there is a need to build trust and cultural capacity of ADRD care providers reaching NA across the state. Furthermore, existing ADRD treatments through ADP's 10 California Alzheimer's Disease Centers (CADCs) and community interventions through HBI-funded projects primarily serve metropolitan counties. Tribal and rural communities are hardly reached. This objective aims to bridge gaps in California's efforts to promote brain health in underserved populations such as those in tribal/rural areas that have limited access to cutting-edge research, treatments, care, services, resources, etc.

Key indicator(s) affected by this problem:

1. The number of tribal and/or rural partnerships.
2. The number of AIAN adults who were assessed on their subjective cognitive decline through these partnerships.

Baseline value for the key indicator: 0

Data source for key indicator baseline: There is no existing data of key indicators

Date key indicator baseline data was last collected: Not applicable

Intervention Information

Conduct a Tribal/Rural community needs assessment on existing ADRD services, resources, and partners that will inform the development of a Tribal/Rural Communities of Practice and resource hub. The needs assessment will collect the following information:

- A directory of contacts of potential partners and existing partners
- A directory of existing online resources such as CDC HBI Road Map for Indian Country, CDC Healthy Brain Resource Center, ADP's "Take on Alzheimer's" media campaign materials page and "Dementia Care California

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Communities in California that are often overlooked in public health data collection are populations where limited information on ADRD prevalence is available and further understanding is needed to understand the impacts of ADRDs in diverse groups. Research is warranted to establish an understanding and address the greater prevalence of dementia in communities identifying as American Indian or Alaska Natives, as well as residents in rural/isolated areas of California. Before research and data collection can be conducted and gaps in California's efforts to promote brain health can be bridged, CDPH must establish trustworthy partnerships with these communities. ADP will use the "Health Belief Model" to frame the needs assessment.

- *Item to be measured:* Community needs assessment
- *Unit of measurement:* Assessment Report
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program records
- *Date baseline was last collected:* 07/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Hire 1.0 FTE HPS I. Program to hire 1.0 FTE HPS I position to serve as the Program Lead (i.e., Community Education Specialist) who will conduct and complete the tribal/rural needs assessment.

Description of Activity: The 1.0 FTE HPS I position will be posted and hired to serve as the Program Lead (i.e., Community Education Specialist) who will conduct and complete the tribal/rural needs assessment. ADP will actively work to fill this position by staying up to date with CDPH Human Resources Branch, post the exam and vacancy announcement online to reach candidates within and outside of Sacramento County, share exam and vacancy information with potential applicants that expressed interest at career fairs or to current staff.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Conduct and complete a community needs assessment. Program will conduct and complete one (1) community needs assessment to collect data on currently available aging, ADRD, and HBI services, resources and potential partners for Tribal/Rural communities.

Description of Activity: Program will conduct and complete one (1) community needs assessment to collect data on currently available aging, ADRD, and HBI services, resources and potential partners for Tribal/Rural communities. The assessment will identify data sources and data collection methods. The Community Engagement Specialist will coordinate and facilitate face to face meetings or virtual meetings, as needed, to conduct the needs assessment that will identify priority issues related to Alzheimer's and other dementias, make recommendations regarding programs and policies to address priority issues, motivate stakeholders to act on priority issues, and communicate with the stakeholders throughout the process. Synthesize community assessment data, assess the population affected and gather data in categories as applicable to the project. The needs assessment will collect the following information, but is not limited to:

- A directory of contacts of potential partners and existing partners (i.e. outreach list of partners)

- A directory of existing online resources and websites such as CDC HBI Road Map for Indian Country, CDC Healthy Brain Resource Center, ADP's "Take on Alzheimer's" media campaign materials page and "Dementia Care California.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

California Asylum Seeker Health Surveillance and Linkage to Care

Healthy People 2030 Objective

AHS-04: Reduce the proportion of people who can't get medical care when they need it

Health Objective

Between July 1, 2024 and June 30, 2025, Program will seek to reduce the number of asylum seekers unable to obtain or delayed in obtaining medical care, screen for medical needs and provide a referral to a primary care provider; and evaluate asylum seekers for health insurance eligibility and assist with enrollment when eligible.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $230,447
- Amount of funding to local agencies or organizations: $230,447
- Type of supported local agency/organization: Local health department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: No

Issue/Problem

Asylum seekers face barriers in accessing and navigating new health systems, and there is limited health surveillance to understand complex medical needs of these new arrivals to California. Asylum seekers face barriers in accessing and navigating new health systems, and there is limited health surveillance to understand complex medical needs of these new arrivals to California. Every year thousands of migrants of diverse ethnic backgrounds globally, including countries in Southeast Asia, the Middle East, Central America, and East Africa among others, arrive in California seeking asylum or protection from persecution. The asylum process can take up to two years for an interview date and decision to be made, yet there is no mechanism in place to ensure outreach, linkage to health care and disease surveillance while asylum seekers remain in California. Asylum seekers may not seek out preventive health services (i.e., immunizations), and may delay accessing needed healthcare. In addition, many newcomers may be unfamiliar with their health insurance enrollment options. Prior to

entering the United States (U.S.), many of these migrants wait in overcrowded shelters in Mexico or other congregate settings at California Border Patrol facilities under conditions which increase risks for exposure to various communicable diseases. Recent surveillance in Mexico and California have identified COVID-19, influenza, tuberculosis (TB), measles, varicella, ectoparasites, and other infectious conditions. Also, current surveillance data of those whose asylum has been granted show a higher prevalence of Hepatitis B and C compared to refugees. However, no data currently captures those who have not yet been granted asylum. Therefore, outreach efforts to increase linkage to care and improve surveillance for asylum seekers is necessary for monitoring infectious conditions and reducing disease transmission.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)

Key Indicator(s) affected by this problem: Screen participating asylum seekers for medical needs and link them with a primary care provider. Key Indicators: 1. the number of asylum seekers screened for medical needs and 2. linked with a primary care provider; 3. Evaluate asylum seekers for insurance eligibility and enroll if qualified.

Baseline value of the key indicator described above: 99

Data source for key indicator baseline: Program FY 23-24

Date key indicator baseline data was last collected: 11/17/2023

Program Strategy

Goal: Increase linkage to care and improve surveillance for asylum seekers to monitor infectious conditions and reduce disease transmission.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)

Summary of Program Strategy: The California Asylum Seeker Health Surveillance and Linkage to Care program staff will promote the program among asylum seekers and legal and NGO service providers in Northern California to enroll participants in the program. Working with San Francisco DPH, staff will screen and evaluate patient medical/mental health and social needs and provide referrals for comprehensive health screening and resources for other food, housing, legal and other supportive services. In addition, SF DPH staff will work with patients to identify a primary care home and evaluate eligibility for Medi-Cal or other health insurance and provide enrollment support. Data collected

from the comprehensive health screening will be used for health surveillance and will be analyzed and developed into a published report for distribution.

Primary Strategic Partners

External:

1. County of San Francisco Department of Public Health

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Other: Reports will be distributed to healthcare providers working with asylum seekers in the region

Evaluation Methodology: Project evaluation will be conducted with data reports from the ASHS database enhanced for asylum seekers, including number of patient encounters, referrals, demographics, mental health and disease surveillance outcomes and insurance enrollment.

Program Settings:

- Local health department

Target Population of Program

- *Target population data source*: TRACImmigration: Asylum Decisions, March 2023
- *Number of people served:* 150
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- Asian
- Black or African American
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 25-34 years

- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban

Location:

- San Francisco County Public Health Department and Clinic

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Active Disease Surveillance of Asylum Seekers in California

Objective: July 1, 2024 and June 30, 2025, Program will collect 150 cases of asylum seeker health screening data including infectious diseases, immunizations and general demographic and heath data indicators.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Active disease surveillance data collection. SF DPH will utilize the Asylum Seeker Health Surveillance database in California to collect active surveillance data to identify diseases of public health concern and mental health conditions among asylum seekers. Between 07/2024 and 06/2025, ORH will provide technical assistance to LHJ to conduct active surveillance of approximately 150 asylum seekers annually for the monitoring and detection of infectious disease and mental health conditions, and prevention of vaccine-preventable diseases. This will include collection of specimen and health data, processing of labs, and review and analysis of health and laboratory data. Data collection may also include follow-up to collect health data from primary or specialty care providers where patients have been linked to health services by LHJ. Patient health data will then be entered into the ASHS database where it will be accessible for program monitoring and disease surveillance reporting. The Asylum Seeker Health Surveillance database will be used to capture surveillance data and reports of infectious diseases of public health concern and mental health conditions among asylum seekers, and monitoring referrals for linkage to health care.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Public health surveillance provides and interprets data to facilitate the prevention and control of disease and provides early identification of emerging issues of public health significance.

- *Item to be measured:* Asylum seeker health data and linkage to healthcare and insurance
- *Unit of measurement:* Individual health screening data

- *Baseline value for the item to be measured:* 99
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 11/17/2023
- *Interim target value to be achieved by the Annual Progress Report:* 70
- *Final target value to be achieved by the Final Progress Report:* 150

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Asylum Seeker Active Surveillance. Between 07/2024 and 06/2025, the ORH will provide technical assistance to SF DPH to conduct active surveillance of approximately 150 asylum seekers annually for the monitoring and detection of infectious diseases and mental health conditions.

Description of Activity: Between 07/2024 and 06/2025, the ORH will provide technical assistance to SF DPH to conduct active surveillance of approximately 150 asylum seekers annually for the monitoring and detection of infectious diseases and mental health conditions. This will include collection of specimen and health data, processing of labs, and review and analysis of health and laboratory data. Data collection may also include follow-up to collect health data from primary or specialty care providers where patients have been linked to health services by LHJs. Patient health data will then be entered into the ASHS database for asylum seekers where it will be accessible for program monitoring and disease surveillance reporting.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 2

Maintain Health Data Collection. Between 07/2024 and 06/2025, Program will review data in the asylum seeker health surveillance system database (ASHS database) quarterly (4 times annually) for completeness and accuracy. Data is used to capture surveillance data and reports of infectious diseases of public health concern and mental health conditions among asylum seekers, and monitoring referrals for linkage to health care.

Description of Activity: Patient health data will be entered into the ASHS database for asylum seekers by local health jurisdictions and reviewed for completeness and accuracy. The ASHS database is used to capturing surveillance data and reports of infectious diseases of public health concern and mental health conditions among asylum seekers,

and monitoring referrals for linkage to health care. Surveillance reports will be developed annually for distribution to local healthcare providers and public health.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 3

Analyze and Publish Asylum Seeker Surveillance Data. July 1, 2024 and June 30, 2025, Program will analyze one (1) sample of asylum seeker health data and publish prevalence estimates.

Description of Activity: Analyze surveillance data collected as part of the asylum seeker screening and linkage to medical care. Key Indicator: primary health conditions of asylum seeker health screening data is analyzed in published in a report.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

California Behavioral Risk Factor Surveillance System (BRFSS) Program

Healthy People 2030 Objective

PHI – R06 Enhance the use and capabilities of informatics in public health

Health Objective

To enhance the use of California BRFSS data in public health decision making.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $525,000
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: State Health Department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of total funding that is PHHS Grant: 50-74% - Significant source of funding
- Existing funding source(s): Other federal funding (CDC): Behavioral Risk Factor Surveillance System Program
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: No

Issue/Problem

BRFSS data are used for directing program planning, evaluating programs, establishing program priorities, developing specific intervention and policies, assessing trends, and targeting relevant population groups. CA BRFSS provides mission critical data to CDPH and meets CDPH PHHSBG grant funding criteria. Surveys conducted annually are used to determine the proportion of California residents who engage in health behaviors that increase the probability of both positive and negative health outcomes. BRFSS data supports core public health programs and services representing all foundational area of CDPH. The data are used for directing program planning, evaluating programs, establishing program priorities, developing specific

interventions and policies, assessing trends, and targeting relevant population groups towards meeting Health People 2030 objectives.

Public health program was prioritized as follows:

- Other: Collects data for CDC and CDPH programs

Key Indicator(s) affected by this problem: BRFSS is one of the sources of baseline data for Healthy People 2030 Objectives. The CA BRFSS Program interviews and collects data from 6,000 adults annually and provides analytic support to programs that will use BRFSS data as a source of baseline data for achieving a state health objective. BRFSS data is one of the main sources of baseline data for Healthy People 2030.

Baseline value of the key indicator described above: CA BRFSS Program is one of the main sources of baseline data for Healthy People 2030.

Data source for key indicator baseline: Tracking California Website, Heat-related hospitalizations by county, 2000-2020

Date key indicator baseline data was last collected: 2024

Program Strategy

Goal: Collect and disseminate high quality statewide BRFSS data for CDC and CDPH programs.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)
- Education (e.g., low high school graduation rates, low literacy levels, poor early childhood education)
- Adverse Childhood Experiences (ACEs)
- Social and Community Context (e.g., discrimination, low civic participation, poor workplace conditions, incarceration)
- Neighborhood and Built Environment (e.g., poor quality of housing, limited access to transportation, food desert, poor water/air quality, neighborhood crime and violence)

Summary of Program Strategy: CA BRFSS Program will follow methodology provided by the CDC for the collection of BRFSS data which is used for all 50 states and territories.

Primary Strategic Partners

External:

1. American Cancer Society
2. Alzheimer's Association
3. National Institute of Occupational Safety and Health

Internal:

1. Nutrition and Physical Activity Branch
2. Chronic Disease Control Branch
3. Injury Prevention and Violence Branch
4. Substance Abuse and Prevention Branch
5. Oral Health Program

Evaluation Methodology: CA BRFSS Program's Process and Evaluation Plan developed and accepted by CDC BRFSS Program. The goal of this evaluation is to determine the effectiveness of the CA BRFSS Survey Program in monitoring the prevalence of health risk behaviors that are associated with chronic health problems to better understand and adequately describe and address the health status, health risk behaviors, and health disparities among Californians. This evaluation will investigate components of the CA BRFSS with respect to planning, engaging partners, data collection and surveillance, and dissemination and use of BRFSS data and data finding.

Program Settings:

- State health department

Target Population of Program

- *Target population data source*: U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, data retrieved on March 10, 2023
- *Number of people served:* 30,462,921
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else
- I don’t know the answer

Gender Identity:

- Male
- Female
- Transgender
- None of these

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School

- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Maintain Statewide Collection and Analysis of BRFSS Data

Objective: Program will manage the integration of processes and services to the data collection call center to collect at least 6,000 BRFSSS survey from July 2024 to June 30, 2025.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Monitoring processes and services of survey call center. Between July 1, 2024 to June 30, 2025, Program will oversee and coordinate the overall operations of the collection of CA BRFSS survey data that meets required CDC guidelines and include the timely submission of data to CDC. Program monitors data collection and quarterly submission to CDC.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Monitoring the number of collected surveys will help with meeting CDC guidelines and timely submission of BRFSS data to CDC.

- *Item to be measured:* Completed surveys
- *Unit of measurement:* Number of surveys
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Data Collection Partner
- *Date baseline was last collected:* 07/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 3,000
- *Final target value to be achieved by the Final Progress Report:* 6,000

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Maintain Statewide Collection of BRFSS Data. Program will oversee and coordinate the overall operations of the collection of CA BRFSS data that meets required CDC guidelines and include the timely submission of data to CDC quarterly from July 1, 2024 to June 30, 2025.

Description of Activity: Between July 1, 2024 and June 30, 2025, Program will oversee and coordinate the overall operation of the collection of CA BRFSS survey data that meets required CDC guidelines and include the timely submission of data to CDC. Programs monitors data collection and quarterly submission to CDC.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 2

Provide Data to BRFSS Users. Program will provide one (1) data set to external and internal BRFSS data users from July 1, 2024 to June 30, 2025.

Description of Activity: Program will provide one (1) BRFSS data set to external and internal BRFSS data users by September 30, 2024.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 3

Produce Four Factsheets. Between July 1, 2024 and June 30, 2025, Program will produce four (4) factsheets.

Description of Activity: Between July 1, 2024 and June 30, 2025, Program will produce four (4) factsheets highlighting four health risk behaviors.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 4

Host BRFSS users Webinars. Between July 1, 2024 and June 30, 2025, Program will host a biannual (2) BRFSS users webinar.

Description of Activity: Between July 1, 2024 and June 30, 2025, Program will host a biannual BRFSS users webinar. Webinars will highlight findings of BRFSS data and updates on survey collection.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 5

Update CDPH BRFSS Website. Between July 1, 2024 and June 30, 2025, Program will update information on one CDPH BRFSS website.

Description of Activity: Between July 1, 2024 and June 30, 2025, Program will update information for one (1) CDPH BRFSS website on upcoming webinars, schedule for adding questions onto BRFSS questionnaire, and price per question and fiscal charge schedule.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* Yes

Cardiovascular Disease Prevention Program

Healthy People 2030 Objective

HDS-01 Increase overall cardiovascular health in adults

Health Objective

From 07/01/2024 to 06/30/2029, hypertension prevalence in California adults ever diagnosed with high blood pressure will be reduced by one (1) point percentage from 29.8% to 28.8%.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $100,000
- Type of supported local agency/organization: Other: CDPP is working this fiscal year (23/24) to identify organizations working in prevention-based, upstream work to whom CDPP can potentially provide Local Assistance in subsequent fiscal years (24/25 and beyond).
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Enhance or expand the program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 4
- Number of FTEs in this program funded by the PHHS Block Grant: 2

Issue/Problem

Heart disease remains the number one cause of death in California, as well as the United States and worldwide, so it is critical to address cardiovascular health from a prevention-based approach so Californians may have healthier hearts and lives. Heart disease has been the number one cause of death in the United States for over 100 years (CDC). And while there has been a decline in the age-adjusted death rates, heart disease still kills more Americans each year than any other thing. Heart disease also persists as the number one cause of death for Californians (CDC). In 2021 alone, heart disease claimed the lives of 65,471 Californians (CDC), all of whom contributed to the lives of others and to our State in their own unique way. As the California Department of Public Health and the Cardiovascular Disease Prevention Program, we have a civic

responsibility to aggressively address the number one cause of death in the State so Californians can live healthier, longer lives.

Public health program was prioritized as follows:

- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: The key indicator affected is percentage of adults diagnosed with hypertension in California (hypertension prevalence in California adults).

Baseline value of the key indicator described above: 29.8% hypertension prevalence in California adults.

Data source for key indicator baseline: California Health Interview Survey (CHIS) data, accessed March 25, 2024 (adults 18-99).

Date key indicator baseline data was last collected: 2018

Program Strategy

Goal: CDPP works to reduce the hypertension prevalence in California adults by preventing Californians from developing high blood pressure in the first place, thus reducing the potential for high blood pressure-related disease and death for Californians and reducing the demand on the State's healthcare infrastructure.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)

Summary of Program Strategy: CDPP plans to combat heart disease in the coming year(s) by shifting from a historically management- and treatment-based approach where the goal has been to increase the number of adults successfully controlling their high blood pressure to now focusing on a prevention-based approach where the goal is to reduce the number of adults ever diagnosed with high blood pressure. CDPP will shift towards a more prevention-based approach by 1) updating California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) with an upstream focus, and 2) strengthening CDPP's capacity to work in prevention-based upstream cardiovascular health by creating and developing new partnerships with those already working in prevention-based upstream efforts including, but not limited to, reducing Adverse Childhood Experiences (or ACEs).

Primary Strategic Partners

External:

1. American Heart Association (AHA)/American Stroke Association (ASA)
2. California State University Sacramento (CSUS)
3. Office of the California Surgeon General (OSG)

Internal:

1. Chronic Disease Control Branch (CDCB) Health Information and Statistics Section (HISS)
2. Injury and Violence Prevention Branch (IVPB)

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: CDPP will evaluate the implemented annual activities on progress and outcomes on a yearly basis. This evaluation includes 1) using registration and attendees information to determine the attendance of the webinar to promote the new Plan, 2) using web analytics for link clicks to determine how many are accessing the new Plan, and 3) using web analytics for link clicks to determine how many are accessing the new cardiovascular health and trauma handout.

Program Settings:

- Community based organization
- Local health department
- State health department

Target Population of Program

- *Target population data source*: California Health Interview Survey (CHIS), 2018
- *Number of people served:* 8,857,000
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander

- White

Age:

- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree

- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Update California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015)

Objective: Between 07/2024 and 6/2025, Program will update California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) based on current data and best practices by meeting with the Plan Writer/Editor at least six (6) times, creating one (1) draft Plan, working with Leadership to have one (1) approved new Plan, promoting the new Plan with one (1) update on the Chronic Disease Control Branch website and one (1) update on the Cardiovascular Disease Prevention Program website, and hosting one (1) webinar to promote the release of new Plan.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

CDPP will update California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) and broadly promote and disseminate the new Plan. California's Master Plan on Heart Disease and Stroke Prevention and Treatment (2007-2015) was published in 2007 with data from 2004 and earlier. Heart disease remains the number one cause of death in California, the United States, and worldwide. With California home to nearly 40 million people and being the fifth largest economy in the world, it is critical California's plan to address heart disease be updated to include the

most current data and best practices so this resource can offer recommendations and strategies to effectively combat heart disease in our State and elsewhere.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Updating California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) will allow various partners and stakeholders to utilize the Plan as a road map to reduce heart disease and improve cardiovascular health throughout California.

- *Item to be measured:* Updated California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015)
- *Unit of measurement:* One updated Plan
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* California Health Interview Survey (CHIS) data, accessed March 25, 2024 (adults 18-99)
- *Date baseline was last collected:* 2018
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Meet with Plan Writer/Editor to Monitor and Support Forward Progress on New Plan. By 6/2025, Program will work with Plan Writer/Editor to update California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) and conduct at least six (6) meetings.

Description of Activity: By 6/2025, Program will work with Plan Writer/Editor to update California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) and conduct at least six (6) meetings with the Plan Writer/Editor and other Chronic Disease Control Branch staff as needed to discuss progress, address questions, and move the draft Plan ahead. The deliverable for this activity will be at least six (6) meeting minutes/notes.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* Answer: No

Activity 2

Work with Plan Writer/Editor to Create Draft New Plan. By 6/2025, Program will work with Plan Writer/Editor to update California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) to create one (1) draft new Plan.

Description of Activity: By 6/2025, Program will work with Plan Writer/Editor to update California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) to create one (1) draft new Plan. This draft will be then sent on for approval at the Branch, Center, and Department levels. The deliverable for this activity is one (1) draft new Plan.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Work with CDPH Leadership to Receive Approval for New Plan. By 6/2025, Program will work with CDPH Leadership to receive approval for one (1) approved new Plan, the update to California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015).

Description of Activity: By 6/2025, Program will work with CDPH Leadership to receive approval for one (1) approved new Plan, the update to California's Master Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015). This will likely involve discussing recommended changes, working with Plan Writer/Editor to process edits, and revising document until reviewers can approve. The deliverable for this activity is one (1) approved new Plan.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 4

Promote New Plan On Branch and Program Level Websites. By 6/2025, Program will promote the new Plan by providing one (1) update on the Chronic Disease Control Branch website and one (1) update on the Cardiovascular Disease Prevention Program website.

Description of Activity: By 6/2025, Program will promote the new Plan by providing one (1) update on the Chronic Disease Control Branch website and one (1) update on the Cardiovascular Disease Prevention Program website. The promotion of the new Plan is an important component of letting the public and stakeholders know this resource is available and encourage sharing widely across partners. The deliverable for this activity is screenshots of one (1) update on the Chronic Disease Control Branch website and one (1) update on the Cardiovascular Disease Prevention Program website.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 5

Promote New Plan On CDPP Webinar. By 6/2025, Program will host one (1) webinar to promote the release of the new Plan.

Description of Activity: By 6/2025, Program will host one (1) webinar to promote the release of the new Plan and will invite Branch, Center, and Department Leadership, internal partner departments and programs, external partners and stakeholders, and the public to attend and learn more about the newly released Plan. The deliverable for this activity is the webinar recording.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 2:

Title: Strengthen CDPP's Capacity to Work in Prevention-Based Upstream Cardiovascular Health (CVH)

Objective: Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by attending at least two (2) meetings with potential partners, identifying and developing at least two (2) new partnerships, identifying at least one (1) organization for Local Assistance funding in subsequent fiscal years, creating one (1) handout outlining the connection between early childhood trauma and subsequent cardiovascular health (CVH) issues later in life, and providing one (1) update about CDPP's upstream shifts on the Cardiovascular Disease Prevention Program website.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

CDPP will strengthen its capacity to work in prevention-based upstream cardiovascular health. The Chronic Disease Control Branch has four (4) programs dedicated to cardiovascular health: California Well-Integrated Screening and Evaluation for Women Across the Nation (CA WISEWOMAN) Program, Cardiovascular Disease Prevention Program (CDPP), Cardiovascular Health (CVH) Innovation Program, and HeartBeatCA Program. These programs often focus on the risk factors for heart disease and stroke as well as screening and managing those risk factors, including high blood pressure. CDPP will distinguish itself from the other three CVH programs by focusing on prevention-based strategies at the policy, systems, and environment (PSE) level, rather

than the individual level. This transition to upstream work will include developing new partnerships and creating a handout to outline the connection between early childhood trauma and subsequent CVH issues later in life.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Guide to Clinical Preventive Services (Task Force on Community Preventive Services)
- Other: Applications of System Dynamics Models in Chronic Disease Prevention: A Systematic Review

Rationale for choosing the Intervention: Scientific evidence suggests using upstream, prevention-based strategies are effective in addressing hypertension and other heart disease-related risk factors. Additional evidence has demonstrated the connection between an increased number of Adverse Childhood Experiences (ACEs) and CVH-related issues later in life. One (1) new handout outlining the connection between early childhood trauma and subsequent cardiovascular health (CVH) issues later in life.

- *Item to be measured:* One (1) new handout outlining the connection between early childhood trauma and subsequent cardiovascular health (CVH) issues later in life
- *Unit of measurement:* One (1) new document
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Behavioral Risk Factor Surveillance System (BRFSS)
- *Date baseline was last collected:* 2021
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Strengthen Upstream Capacity by Attending Meetings with Potential or New Partners. Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by attending at least two (2) meetings with potential or new partners.

Description of Activity: Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream CVH by attending at least two (2) meetings with

potential partners. CDPP's efforts have historically been more mid- and downstream, focusing on the management and treatment of CVH issues. CDPP will expand beyond its historical and traditional partners to establish and grow new partnerships with those already making upstream CVH efforts. This change starts with meeting and talking with potential partners. The deliverable for this activity will be at least two (2) meeting minutes/notes.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Strengthen Upstream Capacity by Establishing New Partnerships. Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by identifying and establishing at least two (2) new partnerships.

Description of Activity: Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by identifying and establishing at least two (2) new partnerships. As part of CDPP's shift to more upstream efforts, CDPP will work to establish and grow new partnerships with those already making upstream CVH efforts. The deliverable for this activity will be contact and organizational information for at least two (2) new partnerships CDPP is now working with on upstream CVH efforts.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Strengthen Upstream Capacity by Identifying Organization for Future Local Assistance Funding. Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by identifying at least one (1) organization for Local Assistance funding in subsequent fiscal years.

Description of Activity: Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by identifying at least one (1) organization for Local Assistance funding in subsequent fiscal years. CDPP has not historically provided Local Assistance funding; however, CDPP is looking to expand its funding scope as part of a larger shift to be more prevention-based. CDPP sees value in supporting existing or proposed work on a community level and will work to identify an organization appropriate for Local Assistance funding moving forward. The deliverable for this activity will be contact and organizational information for at least one (1) organization for Local Assistance funding in subsequent fiscal years.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Additional information: Selecting a credible and worthwhile organization for Local Assistance funding will likely require the analyzing of any data, outcomes, results, etc. of any potential organizations.

Activity 4

Create Handout on Connection Between Early Childhood Trauma and Cardiovascular Health (CVH) Issues. Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by creating one (1) handout outlining the connection between early childhood trauma and subsequent cardiovascular health (CVH) issues later in life.

Description of Activity: Between 07/2024 and 6/2025, Program will create one (1) handout outlining the connection between early childhood trauma (such as Adverse Childhood Experiences) and subsequent cardiovascular health (CVH) issues later in life. There have been established studies on the connections of ACEs and CVD; however, these studies and this important connection could be better communicated and highlighted to the public. Additionally, understanding the connection between ACEs and CVD may support a shift towards more upstream efforts where policy, system, and environment (PSE) level changes are considered and funded. This will allow people to start their lives healthier so they can live healthier lives overall. The deliverable for this activity will be one (1) approved handout.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 5

Provide Public and Staff with Updates on CDPP's Upstream Shifts Via the CDPP Website. Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by providing one (1) update about CDPP's upstream shifts on the Cardiovascular Disease Prevention Program website.

Description of Activity: Between 07/2024 and 6/2025, Program will strengthen its capacity to work in prevention-based upstream cardiovascular health (CVH) by providing one (1) update about CDPP's upstream shifts on the CDPP website. The communication and promotion of the CDPP's shift towards prevention is important to keep the public, as well as CDPH staff, informed of the programmatic changes and broadening scope of CDPP's work. The deliverable for this activity is screenshots of one (1) update on the Cardiovascular Disease Prevention Program website.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Emergency Medical Services (EMS) Prehospital Data and Information Services and Quality Improvement Program

Healthy People 2030 Objective

HC/HIT-D06 Increase the proportion of hospitals with access to necessary electronic information

Health Objective

Between 07/2024 and 06/2025, the Emergency Medical Services Authority (EMSA) will maintain one Emergency Medical Services (EMS) Prehospital Data and Information Services and Quality Improvement Program by providing statewide collection and analysis of patient-level EMS data from emergency medical services systems and quality improvement measuring and patient care assessments based on 911 call volume indicated in EMS Plan submissions.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Health Department/Agency
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 5
- Number of FTEs in this program funded by the PHHS Block Grant: 4.50

Issue/Problem

The California Emergency Medical Services Information System (CEMSIS), the statewide data repository for EMS data, receives voluntary EMS data from the local EMS agencies (LEMSAs) in a two-tiered system which reduces the quality of data received. Determining morbidity and mortality rates is complicated by the State's data-collection system. The best use of mortality and morbidity rates is to provide a meaningful tool to support infrastructure development, such as roads, schools, hospitals, and power and water utilities. Optimally, data from local areas would be available in a timely and easily accessible manner; however, California does not have an enforceable mandate for

the electronic collection or submissions of patient-care information by local agencies to EMSA and with the two-tiered system, each jurisdiction has their own policies and procedures. Therefore, participation in data-related activities by local stakeholders is voluntary. EMSA has worked with stakeholders and software vendors to develop state data standards, and adopt national data standards, and continues to encourage local participation in the state database system, CEMSIS. Although EMS data may exist at the EMS provider, trauma center, or LEMSA level, statewide data is not captured centrally. Thus, the comprehensive collection of EMS data is limited and directly affects program efficacy in establishing QI measures and objectives.

Public health program was prioritized as follows:

- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: The Quality Core Measures develop and refine indicators to reflect ongoing LEMSA efforts at quality improvement aimed at clinic and transport activities that are reflective of quality improvement activities at the local level. To increase the quality of data and documentation, the Quality Core Measures look at the percentage of transports to trauma hospitals, treatment administered for hypoglycemia, prehospital screening for suspected stroke patients, respiratory assessment for pediatric patients, 911 requests for services that includes lights and/or sirens response, and 911 requests for services that includes a lights and/or sirens transport. To evaluate system impact on patients, the continuum of care from dispatch to prehospital to hospital disposition must be connected. Until all LEMSAs participate in Quality Core Measures, we cannot begin to fully understand how care is provided by EMS personnel and how it translates to improved outcomes and system effectiveness statewide.

Baseline value of the key indicator described above: 30

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2023

Program Strategy

Goal: The program goal is to have all 34 LEMSAs submitting the Core Quality Measures.

Is this program specifically addressing a Social Determinant of Health (SDOH)? No

Summary of Program Strategy: EMSA will continue to work with stakeholders and a Core Measure workgroup to amend the Core Quality Measures for more participation. Meeting(s) will be held based on need and Core Measures will be discussed with the Executive team at EMSA for final approval for publishing.

Primary Strategic Partners

External:

1. EMS Administrators' Association
2. EMS Medical Directors Association

Internal:

1. EMS Commission
2. California Highway Patrol
3. California Department of Public Health

Planned non-monetary support to local agencies or organizations:

- Technical Assistance

Evaluation Methodology: Statewide data activities, including annual review and revision of CA EMS Core Quality Measures reported by LEMSAs and development of an annual EMS Report will provide evidence-based decision-making information for EMSA and other statewide EMS stakeholders to improve delivery of EMS care throughout California.

Program Settings:

- State health department

Target Population of Program

- *Target population data source*: US Census Bureau, July 1, 2022
- *Number of people served:* 39,029,342
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years

- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? No

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: EMS Prehospital Data and Information Services and Quality Improvement

Objective: Between 07/2024 and 06/2025, Program will increase accurate representation of EMS data for all LEMSAs that voluntarily submit data into CEMSIS which will unite the EMS system under a single data warehouse, fostering analyses on patient-care outcomes, public health system services, compliance with California state and federal EMS service laws, and provide measurable quality improvement resources to LEMSAs. Data submitted into CEMSIS will be analyzed and shared with LEMSAs to increase transparency. Program will provide technical assistance and outreach to the LEMSAs to encourage participation in CEMSIS while increasing transparency with a target of 165 engagements among the 34 LEMSAs.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Data submitted into CEMSIS will be analyzed and shared with LEMSAs to increase transparency. Provide technical assistance and outreach to the LEMSAs to encourage participation in CEMSIS while increasing transparency. Data submitted by the LEMSAs into the CEMSIS database will be analyzed to ensure accuracy of data submitted. This will allow for successful QI and QA data reporting on the overall status of EMS in California.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- National EMS Information System (NEMSIS)/National Highway Traffic Safety Administration

Rationale for choosing the Intervention: Increased participation by LEMSAs in the submission of EMS pre-hospital data will establish EMS service baselines and metrics, key components of QI and help analyze outcome data with hospitals.

- *Item to be measured:* TA, outreach, and engagement with LEMSAs regarding data submissions into CEMSIS
- *Unit of Measurement*: Number of email engagements with each LEMSA regarding data submissions into CEMSIS
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2024
- *Interim target value to be achieved by the Annual Progress Report:* 66
- *Final target value to be achieved by the Final Progress Report:* 165

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Develop the Core Quality Measures Process Manual. Between 07/2024 and 06/2025, Program will develop one (1) Core Quality Measures Process Manual.

Description of Activity: Between 07/2024 and 06/2025, Program will develop one (1) Core Quality Measures Process Manual to include the lifecycle of measure adoption and re-specification; the approach to research and testing of measures; the project objectives, approach, deliverables, and approvals process; and all other relevant components of the project such as reporting and evaluating data results.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Develop the Annual Core Quality Measures Report. Between 07/2024 and 06/2025, Program will produce one (1) Annual Core Quality Measures Report based on analyzing 100% of the aggregated data provided by LEMSAs to show the current status of statewide EMS QI measurement.

Description of Activity: Between 07/2024 and 06/2025, Program will develop one (1) summary report of all LEMSA Core Quality Measures data submitted for the previous

calendar year to present data to the public and EMS stakeholders. If appropriate, the report will be published on the EMSA website.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Publish One EMS Data Report. Between 07/2024 and 06/2025, Program will produce one (1) Annual EMS Report based on analyzing 100% of the NEMSIS/CEMSIS data set to show the current status of the EMS System.

Description of Activity: Between 07/2024 and 06/2025, Program Staff will compile and analyze 100% of one (1) EMS data set submitted by LEMSAs into the CEMSIS database and develop the annual CY 2024 EMS Report which will be published to the EMSA website by the 6/2025 deadline.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 4

Send out LEMSA CEMSIS Letters. Between 07/2024 and 06/2025, Program will analyze EMS data for each LEMSA and provide a letter (34 letters in all) that outlines the previous year's data submission, providers based on LEMSA's EMS Plans, and previous year's data submissions.

Description of Activity: Program Staff will compile and analyze 100% of the EMS data set submitted by LEMSAs into the CEMSIS database and develop 34 individual LEMSA CEMSIS letters.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 5

EMS Data Research Report. Between 07/2024 and 06/2025, Program will publish one (1) Data Matching Report on the EMSA Website.

Description of Activity: Between 07/2024 and 06/2025, Program staff will publish one (1) report on EMSA's website detailing the successes and outcomes of matching EMS data with a different data source.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Emergency Medical Services (EMS) Systems Operations, Planning, and Specialty Care

Healthy People 2030 Objective

AHS-04 Reduce the proportion of people who can't get medical care when they need it

Health Objective

Between 07/2024 and 06/2025, The Emergency Medical Services (EMS) Authority (EMSA) will maintain one EMS Systems Division Operations and provide statewide coordination and leadership to Local EMS Agencies (LEMSAs) for the planning, development, and implementation of local EMS systems to determine the need for additional EMS, coordination of EMS, and effectiveness of EMS, assisting with adherence to California EMS statutes and regulations for optimum patient care. EMS Systems Division staff provide state leadership, oversight, and regulation to ensure the best quality of care is available, reducing the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care in an emergency.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Health Department/Agency
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: No
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 8
- Number of FTEs in this program funded by the PHHS Block Grant: 7.50

Issue/Problem

The EMS Authority is charged with providing leadership in developing and implementing EMS systems throughout California and plays a central role in improving the quality of emergency medical services available for all Californians through its work with Local EMS Agencies (LEMSAs). California's emergency care is fragmented and emergency departments, ambulance transportation, and trauma centers need effective coordination to avoid unmanaged patient flow. Training and certification of

emergency medical technicians needs to consistently conform to national and state standards to ensure trained and qualified personnel are working the front lines of EMS. Critical-care specialists need to be available to provide emergency and trauma care for patients of all ages to ensure the emergency-care system is fully prepared to handle major disasters and pandemics.

Public health program was prioritized as follows:

- Other: Mandated by statute and regulation

Key Indicator(s) affected by this problem: Emergency Medical Services Authority, through its EMS Systems Division is mandated to provide oversight of EMS systems, the statewide Trauma System, Stroke and ST-Elevation Myocardial Infarction (STEMI) Systems, EMS for Children, and the CA Poison Control system. The EMS Systems Division has statutory and regulatory oversight responsibility of the EMS system for the State of CA and promulgates regulations for use by local EMS agencies and EMS providers, reviews and approves annual local EMS system plans ensuring statutory and regulatory compliance, and manages the state's EMS data collection, performance management and quality assurance. EMS Systems Division staff provide state leadership and oversight, to ensure the EMS Act is upheld and the best quality of care is available, reducing the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care in an emergency.

Baseline value of the key indicator described above: 34

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2024

Program Strategy

Goal: Conduct assessment of California's 34 local EMS systems in order to coordinate EMS activities based on community needs for the effective and efficient delivery of EMS services, ensuring no person is unable to obtain or delayed in obtaining medical care.

Is this program specifically addressing a Social Determinant of Health (SDOH)? No

Summary of Program Strategy: Increase quality patient-care outcomes through statewide coordination and leadership for the planning, development, and implementation of local EMS and critical care systems.

Primary Strategic Partners

External:

1. EMS Administrators' Association

2. EMS Medical Directors Association

Internal:

1. EMS Commission
2. California Health and Human Services Agency
3. California Department of Public Health

Planned non-monetary support to local agencies or organizations:

- Technical Assistance

Evaluation Methodology: LEMSAs are required by law to submit annual EMS Plans which EMSA uses to evaluate progress toward the goal of statewide coordination for transportation, quality improvement, planning, and development and implementation for any specialty care systems in place such as Stroke and STEMI Critical Care Systems and EMS for Children. Separate plans for Trauma Systems are required from the 34 LEMSAs.

Program Settings:

- Local health department
- Medical or clinical site
- State health department
- Other: Local EMS Agencies

Target Population of Program

- *Target population data source*: US Census Bureau, July 1, 2022 & 2023
- *Number of people served:* 39,029,342
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years

- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? No

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Maintain the EMS for Children Program

Objective: Between 07/2024 and 06/2025, Program will maintain one (1) EMS for Children (EMSC) program providing statewide coordination and leadership by implementing regulations regarding specialized medical care for children with acute illness or injuries and providing guidance for EMSC program implementation at the LEMSA level. Program will provide technical assistance and advisory service to LEMSAs wishing to implement an EMSC program. Using the California EMS Information System (CEMSIS) data to establish quality-improvement measures, EMSA will evaluate additional needs for LEMSAs to enhance their EMSC programs. Review of at least eight (8) EMS Plans will be conducted to ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? Subset of the larger population.

Problem for this Objective: **Children across California need specialized medical care to treat injuries and illness**. Healthy development dramatically affects children's ability to excel in cognitive, socio-emotional, and educational growth. To ensure that California's children receive optimum emergency medical care, EMSC must be integrated into the overall EMS system. Based on California Title 22, Division 9, Chapter 14, EMSC programs are not mandatory for LEMSAS, therefore have not yet been implemented statewide. Continued development of these programs to a standardized and optimum level of care across California is needed. Program staff oversee implementation and interpret regulations to ensure LEMSAs implementing EMSC programs are compliant with the EMSC regulations.

Key indicator(s) affected by this problem: Number of LEMSAs that have implemented EMSC into their EMS systems.

Baseline value for the key indicator: 5

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2024

Intervention Information

Program will provide technical assistance and advisory service to LEMSAs wishing to implement an EMSC program and ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California. Program will provide technical assistance and advisory service to LEMSAs wishing to implement an EMSC program and ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California. Using CEMSIS data to establish quality-improvement measures, EMSA will evaluate additional needs for LEMSAs to enhance their EMSC programs.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: CA Health & Safety Code, Division 2.5 & CA Code of Regulations, Title 22, Division 9, Chapter 14

Rationale for choosing the Intervention: When a LEMSA implements an EMSC program, EMSA is mandated to oversee the prehospital and hospital pediatric care components integrated into an existing LEMSA's EMS System for pediatric emergency care. EMSA provides oversight through review and approval of EMSC and pediatric care components of the LEMSA's local EMS Plan ensuring compliance with the Health and Safety Code.

- *Item to be measured:* EMS Plan review of EMSC and pediatric care components
- *Unit of Measurement*: Number of EMS Plans
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2024
- *Interim target value to be achieved by the Annual Progress Report:* 5
- *Final target value to be achieved by the Final Progress Report:* 8

Target Population

The target population of this Program SMART Objective is the sub-set of the Program.

- *Target population data source*: US Census Bureau, July 1, 2022 & 2023.
- *Number of people served:* 8,742,573
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years

Sexual Orientation:

- I don’t know the answer

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- N/A

Education Attainment:

- Some High School

- High School Diploma

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? No

Activity 1

Host Educational Forum. Between 07/2024 and 06/2025, Program will provide education on trends in emergency medical care of pediatric patients by conducting one (1) California EMSC Educational Forum.

Description of Activity: Between 07/2024 and 06/2025, Program will conduct one (1) California EMSC Educational Forum to provide educational opportunities for EMS and hospital providers related to medical treatment of pediatric patients. EMSA staff host the event and coordinate with an accredited institution to provide Continuing Education (CEs) hours to eligible attendees.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Provide Technical assistance to EMSC Programs. Between 07/2024 and 06/2025, Program will provide technical assistance to at least five (5) LEMSAs who have or are developing EMSC plans.

Description of Activity: Between 07/2024 and 06/2025, Program will provide technical assistance to at least five (5) LEMSAs with EMSC program implementation in their jurisdiction. Technical assistance will be provided by email, phone, and resources on the EMSA website.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Review EMS Plans. Between 07/2024 and 06/2025, Program will review at least eight (8) EMS Plans to ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California.

Description of Activity: Between 07/2024 and 06/2025, Program will review of at least eight (8) EMS Plans to ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 2:

Title: Proactively Maintain and Support One EMS Trauma Care System Program

Objective: Between 07/2024 and 06/2025, Program will maintain one (1) EMS Trauma Care System Program by reviewing and approving local trauma system plans to provide statewide leadership for the planning, development, and implementation of a state trauma plan that incorporates 34 LEMSA county/region trauma plans and is informed by CEMSIS-Trauma Registry data submissions from 80 trauma centers. Program will review at least eight (8) EMS Trauma Care System Plans for local Trauma Care Programs.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? It is a subset of a larger problem.

Problem for this Objective: **Injuries from trauma and traumatic illness is a leading cause of death for Californians.** In California, a leading cause of death and permanent disability among people aged 1–44 years is traumatic illness and injury; less-traumatic injuries have an even greater mortality rate in the elderly. Trauma, however, impacts all age groups. Transporting trauma patients to an appropriate facility within a 60-minute window known as the “golden hour” is essential. Beyond the golden hour, positive outcomes decline rapidly. The target and disparate populations are the same, the total population of California.

Key indicator affected by this program: Each of the 34 LEMSA's have an approved trauma plan representing their EMS county/region. Only 28 LEMSAs (40 counties) have designated trauma centers. California has 78 designated trauma centers throughout the state. Key indicators are the number of LEMSAs with approved trauma plans.

Baseline value for the key indicator: 34

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2024

Intervention Information

Develop, implement, and review local trauma systems to ensure timely access to optimal trauma care. Management of a State Trauma Registry complying with National Trauma Data Standards provides CEMSIS-Trauma data that assess the outcome of the statewide Trauma systems: primary (preventing the event), secondary (reducing the degree of injury), and tertiary (optimizing outcome for injuries) data, to ensure optimum trauma care. Data collected assists LEMSAs in the development of comprehensive performance improvement and patient safety (PIPS) programs to improve mortality outcomes for trauma patients in California.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Div 2.5, CA H&SC; Resources for the Optimal Care of Injured Patient, American College of Surgeons

Rationale for choosing the Intervention: California's trauma system is comprised of 34 LEMSAs with 78 designated trauma centers located in 40 counties. Each LEMSA must annually update their approved trauma plan for their county/region with guidance and leadership provided by EMS Systems program staff.

- *Item to be measured:* EMS Trauma Care System Programs
- *Unit of Measurement*: Number of trauma plan status updates reviewed from LEMSAs to include submission of trauma data
- *Baseline value for the item to be measured:* 5
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 8

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Review and Analyze Trauma Plan Status Updates (TSSRs). Between 07/2024 and 06/2025, Program will review and analyze at least seven (7) LEMSA Trauma Plan Status Updates submitted to EMSA.

Description of Activity: Between 7/2024 and 6/2025, Program will analyze a minimum of seven (7) trauma plan status updates submitted to EMSA. Program will provide LEMSAs with feedback of analysis as part of EMS plan submission approvals/denials.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Collection of Trauma Registry Data. Between 07/2024 and 06/2025, Program will provide oversight of one (1) trauma registry data collection.

Description of Activity: Between 07/2024 and 06/2025, Program will oversee and coordinate the overall data collection of one (1) trauma registry into CEMSIS-Trauma from 78 trauma centers for a minimum of 80,000 trauma incidents.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Develop and Host a Virtual Trauma Summit. Between 07/2024 and 06/2025, Program will create and host a one-day (1), virtual Trauma Summit.

Description of Activity: Between 07/2024 and 06/2025, Program will create a one-day (1) virtual Trauma Summit with 4.5 hours of educational sessions and will seek subject matter guidance from the State Trauma Advisory Committee. EMSA staff host the event and coordinate with an accredited institution to provide Continuing Education (CEs) hours to eligible attendees.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 4

Strengthen State Trauma System Development. Between 07/2024 and 06/2025, Program will facilitate four (4) quarterly meetings with State Trauma Advisory Committee meetings to promote the development of the state trauma system with trauma stakeholders.

Description of Activity: Between 07/2024 and 06/2025, Program will facilitate four (4) quarterly meetings with State Trauma Advisory Committee members to continue in the development and implementation of the state trauma system.

- *Does the activity include the collection, generation, or analysis of data?* Yes

- *Does the data collection involve public health data?* No

Objective 3:

Title: Maintain EMS Partnership for Injury Prevention and Public Education

Objective: Between 07/2024 and 06/2025, Program will maintain one (1) EMS Partnership for Injury Prevention and Public Information program by providing statewide coordination and leadership for the planning, development and implementation of Illness and Injury Prevention resources for California EMS partners within the EMS community. Inclusion of an EMS role in statewide prevention and public-education initiatives, programs, and policies will be used to evaluate the success of the overall program goal of ensuring the recognition of EMS as a vital partner in prevention and public-education activities. Prevention resources will be maintained on the Illness and Injury Prevention website, which is expected to receive 50 unique page views.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? It is a subset of a larger problem.

Problem for this Objective: **The mortality rate for injury deaths in California is the highest in the U.S.** California historically has the highest number of injury deaths in the country. California also has the highest number of unintentional injury deaths. Although the numbers remain high throughout the country and for our state, California ranked among the lowest in the country in terms of rate of fatalities from injuries.

Key indicator affected by this program: Inclusion of an EMS role in statewide prevention and public-education initiatives, programs, and policies will be used to recognize EMS as a vital part of prevention and public-education activities. The key indicators are the number of EMS partners attending the Injury Prevention workshops at the Annual Trauma Summit.

Baseline value for the key indicator: 50

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2024

Intervention Information

Increase access to and effectiveness of rapid prehospital EMS by providing statewide injury-prevention training and initiatives with local EMS providers and stakeholders. Increase access to and effectiveness of rapid prehospital EMS by providing statewide injury-prevention training and initiatives with local EMS providers and stakeholders. Inclusion of an EMS role in statewide prevention and public-education initiatives, programs, and policies will be used to evaluate the success of the overall

program goal of ensuring the recognition of EMS as a vital partner in prevention and public education activities.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: The American College of Surgeons, "Resources for Optimal Care of the Injured Patient: 2023 Standards

Rationale for choosing the Intervention: EMTs and paramedics, first on the scene of traumatic injuries, have witnessed the need for reducing preventable injuries. Providing Illness and Injury Prevention resources for California EMS partners within the EMS community is a critical factor in being able to provide rapid and effective response to injured patients in order to reduce injury-related deaths.

- *Item to be measured:* Usage of Injury Prevention and Public Information resources established by EMSA
- *Unit of Measurement*: Number of EMS Injury Prevention and Public Information program webpage visits
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2024
- *Interim target value to be achieved by the Annual Progress Report:* 25
- *Final target value to be achieved by the Final Progress Report:* 50

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Maintain EMS Partnership for Injury Prevention and Public Information Program webpage. Between 07/2024 and 06/2025, Program will maintain one (1) injury and illness-prevention web page on the EMSA website.

Description of Activity: Between 07/2024 and 06/2025, Program will maintain one (1) illness and injury prevention web page that will provide sources for education and promote injury prevention in the EMS community. On a quarterly basis, Program will review 64 links to ensure they are accessible, updated, and working.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Attend Trauma Managers Association of California (TMAC) General Membership meetings. Between 07/2024 and 06/2025, Program will attend three (3) TMAC General meetings to provide leadership in the coordination of injury prevention activities at the local and regional level.

Description of Activity: Between 07/2024 and 06/2025, Program will attend three (3) TMAC General meetings to provide leadership in the coordination of injury prevention activities at the local and regional level.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Two meetings on best practices for implementation of injury and illness prevention programs. Between 07/2024 and 06/2025, Program will hold one workshop and one meeting with participation of federal, state and local EMS stakeholders to discuss and set up implementation processes for injury and illness prevention programs.

Description of Activity: Between 07/2024 and 06/2025, Program will hold one workshop and one meeting with participation of federal, state and local EMS stakeholders to discuss and set up implementation processes for injury and illness prevention programs.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 4:

Title: Maintain and Support One STEMI Critical Care System Program Statewide

Objective: 07/2024 and 06/2025, EMSA Program will maintain one (1) EMS STEMI program by providing leadership for the implementation of the state STEMI regulations. Program will also provide statewide coordination and support to entities developing a STEMI Critical Care System, and those that have the system in place, through education and technical support to improve and increase the level of care for STEMI patients in California. Program will provide technical assistance to encourage LEMSAs without an existing STEMI Critical Care System to create one and become part of the system statewide and provide leadership to the LEMSAs with existing systems to improve the system based on the newest technology and evidence-based studies, on aspects of both clinical and system management to provide the highest level of care for STEMI patients. At least 70 stakeholder engagements will be conducted in the form of annual plan reviews, technical assistance emails, phone calls, meetings, and educational events.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? It is a subset of a larger problem.

Problem for this Objective: **Currently there is no Standardized STEMI Critical Care System Statewide.** Based on the California Title 22, Division 9, Chapter 7.1, the STEMI Critical Care System is not a mandatory program for LEMSAs, therefore, critical care systems are not yet implemented statewide. The LEMSAs that develop STEMI Critical Care Systems are obligated to follow state regulations. Program staff oversee implementation and interpret regulations to ensure LEMSAs are compliant with the STEMI Critical Care System regulations.

Key indicator affected by this program: The key indicators are the number of LEMSAs which have this system in place. The standardized system is based on the STEMI Critical Care regulations to provide the highest level of Care for the patient in the shortest time at the specialty care facilities equipped with the highest technology, equipment, and expert staff required by law for the specific level of care for STEMI patients.

Baseline value for the key indicator: 26

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2024

Intervention Information

Program will provide leadership, oversight, education, and technical assistance to encourage LEMSAs to implement a STEMI Critical Care System and become part of the system statewide. Program will provide oversight, technical assistance and advice to LEMSAs who want to create a STEMI Critical Care System based on the California State STEMI Critical Care System regulations. Program staff will also provide leadership to the LEMSAs with an existing system and maintain the program to improve the system based on the newest technology and evidence-based study, on aspects of both clinical and system management in order to provide the highest level of care for STEMI patients.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: AHA Guidelines' Mission Lifeline, the Ameri. College of Cardiology recs, Nat'l Institute of Health

Rationale for choosing the Intervention: Since the evidence-based care for this time-sensitive emergency is continually updated according to new literature, and the newest innovative technologies become available over time, it is essential to provide frequent

educational updates and technical support for LEMSAs, specialty care centers, health care providers, public, and other stakeholders. This will increase the level of care and reduce morbidity and mortality for patients experiencing STEMI in California. 26 LEMSAs out of 34 have the approved standardized STEMI Critical Care System. Per regulations, LEMSAs who have implemented a STEMI Critical Care System are required to submit an annual plan, to report any changes and the QI activities to the EMSA for approval; EMSA Staff program reviews to ensure the program is compliant with regulations and provide feedback for any improvement needed in the system.

- *Item to be measured:* TA in interpretation of regulations, annual plan review, and other guidance provided to LEMSAs, etc.
- *Unit of Measurement*: Number of stakeholder engagements
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2024
- *Interim target value to be achieved by the Annual Progress Report:* 40
- *Final target value to be achieved by the Final Progress Report:* 70

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Facilitate and Coordinate Technical Advisory Committee (TAC) Meetings. Between 07/2024 and 06/2025, the TAC meets in a regular basis to advise EMSA Director and the STEMI program on all aspects of the specialty care systems. Program staff facilitate and coordinate at least four (4) virtual meetings.

Description of Activity: Between 07/2024 and 06/2025, Program staff facilitate and coordinate at least four (4) virtual meetings each year to discuss the status of the state specialty care systems, receiving advice from the TAC to increase the level of care and improve the system for STEMI patients in California. This committee also has sub committees that meet separately as needed to plan the annual educational summit and related activities. The TAC also develops plans to improve the State STEMI data collection system to create QI activities at the state level in the future, which will be facilitated and organized by the EMSA program staff.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Review and Analyze STEMI Critical Care System Annual Plans. Between 07/2024 and 06/2025, Program will analyze a minimum of 11 STEMI Critical Care System Annual Plans submissions from LEMSAs.

Description of Activity: Between 07/2024 and 06/2025, Program will analyze a minimum of 11 STEMI Critical Care System Annual Plans submitted to EMSA. Program will provide LEMSAs with feedback of analysis as part of EMS plan submission approvals/denials.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Objective 5:

Title: Maintain and Support One Stroke Critical Care System Program Statewide

Objective: Between 07/2024 and 06/2025, EMSA Program will maintain one (1) EMS Stroke program by providing leadership for the implementation of the state Stroke regulations. Program will also provide statewide coordination and support to entities developing Stroke Critical Care Systems, and those that have the system in place, through education and technical support to improve and increase the level of care for Stroke patients in California. Program will provide technical assistance to encourage LEMSAs without an existing Stroke Critical Care System to create one and become part of the system statewide and provide leadership to the LEMSAs with existing systems to improve the system based on the newest technology and evidence-based studies, on aspects of both clinical and system management to provide the highest level of care for Stroke patients. At least 75 stakeholder engagements will be conducted in the form of annual plan reviews, technical assistance emails, phone calls, meetings, and educational events.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? It is a subset of a larger problem.

Problem for this Objective: **Currently there is no Standardized Stroke Critical Care System Statewide.** Based on the California Title 22, Division 9, Chapter 7.2, the Stroke Critical Care System is not a mandatory program for LEMSAs, therefore, Stroke Critical Care Systems are not yet implemented statewide. The LEMSAs that develop Stroke Critical Care Systems are obligated to follow state regulations. Program staff oversee implementation and interpret regulations to ensure LEMSAs are compliant with the state Stroke Critical Care System regulations.

Key indicator affected by this program: The key indicator is the number of LEMSAs which have this system in place. The standardize system created based on the Stroke Critical Care System regulations can provide highest level of care for the patient in the shortest

time at the specialty care facilities equipped with the highest technology and expert staff required by regulations for each specific level of care for stroke patients.

Baseline value for the key indicator: 24

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2024

Intervention Information

Program will provide leadership, oversight, education, and technical assistance to encourage LEMSAs without an existing Stroke Critical Care System to create one and become part of the system statewide. Program will provide technical assistance and advisory service to LEMSAs who want to create a Stroke Critical Care System based on the California State Stroke Critical Care System regulations. Program staff will also provide leadership to the LEMSAs with an existing system and maintain the program to improve the system based on the newest technology and evidence-based study, on aspects of both clinical and system management in order to provide the highest level of care for Stroke patients.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: American Heart Assn., Coverdell Nat'l Acute Stroke Program, and the Nat'l Inst. Of Health Studies

Rationale for choosing the Intervention: Since the evidence-based care for this time-sensitive emergency is continually updated according to new literature, and the newest innovative technologies become available over time, it is essential to provide frequent educational updates and technical support for LEMSAs, specialty care centers, health care providers, the public, and other stakeholders. This will increase the level of care and reduce morbidity and mortality for patients experiencing stroke in California. 24 LEMSAs out of 34 have an approved standardized Stroke Critical Care System. Per regulations, LEMSAs with Stroke Critical Care Systems are required to submit an annual plan and report any changes and the QI activities to the EMSA for approval. EMSA Program staff reviews annual plans to ensure the program is in compliant with the regulations.

- *Item to be measured:* TA in interpretation of regulations, annual plan review, and other guidance provided to LEMSAs, etc.
- *Unit of Measurement*: Number of stakeholder engagements in the form of plan reviews
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA

- *Date baseline was last collected:* 7/1/2024
- *Interim target value to be achieved by the Annual Progress Report:* 40
- *Final target value to be achieved by the Final Progress Report:* 75

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Facilitate and Coordinate Technical Advisory Committee (TAC) Meetings. Between 07/2024 and 06/2025, Program staff will facilitate and coordinate at least four (4) virtual meetings each year to discuss the status of the state specialty care systems, receiving advice from the TAC to increase the level of care and improve the system for Stroke patients in California.

Description of Activity: Between 07/2024 and 06/2025, Program staff will facilitate and coordinate at least four (4) virtual meetings each year to discuss the status of the state specialty care systems, receiving advice from the TAC to increase the level of care and improve the system for Stroke patients in California. This committee also has sub committees that meet separately as needed to plan the annual educational summit and related activities. The TAC also develops plans to improve the State Stroke data collection system to create QI activities at the state level in the future, which will be facilitated and organized by the EMSA program staff.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Review and Analyze Stroke Critical Care System Annual Plans. Between 07/2024 and 06/2025, Program will analyze a minimum of 11 Stroke Critical Care System Annual Plans submitted to EMSA.

Description of Activity: Between 07/2024 and 06/2025, Program will analyze a minimum of 11 Stroke Critical Care System Annual Plans submitted to EMSA. Program will provide LEMSAs with feedback of analysis as part of EMS plan submission approvals/denials.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 6:

Title: Provide Oversight to California Poison Control Service (CPCS)

Objective: Between 07/2024 and 06/2025, EMSA Program will provide oversight to one (1) CPCS required to provide poison control services to 100% of Californians for the prevention of unnecessary ambulance transports and emergency department visits through coordination and monitoring of activities, in accordance with statutory and regulatory authorities, and contractual requirement. Program will conduct assessments of one CPCS in order to monitor poison control service activities provided to Californians. Program will review one (1) annual report to ensure compliance with state standards for poison control services and contractual scope of work.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? It is a subset of a larger problem.

Problem for this Objective: **Statute & regulations mandate a CA poison control center (PCC) or regional PCC be designated by EMSA.** EMSA has designated CPCS as the sole provider of poison control services for the State of California to reduce health care expenditures by preventing unnecessary ambulance transports and emergency department visits. CPCS manages an average of 236,146 total cases per year, with 65% of the human exposure cases managed on site (caller/patient was able to remain at call location). Of the 70,433 cases involving children aged five and under, 86.69% were managed on site. Without CPCS services, emergency department visits would substantially increase.

Key indicator affected by this program: EMSA requires one (1) annual progress report be submitted to evaluate and monitor CPCS operations and ensure compliance with state standards for poison control services and contractual scope of work.

Baseline value for the key indicator: 0

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2023

Intervention Information

EMSA will conduct an assessment of one CPCS in order to monitor poison control service activities provided to Californians. EMSA will increase quality patient-care outcomes through statewide coordination and leadership for the planning, development, and implementation of a CPCS. Conduct assessments of one CPCS to monitor poison control service activities provided to Californians in the prevention of unnecessary ambulance transports and emergency department visits for the effective and efficient delivery of poison control services.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: CA Health & Safety Code, Division 2.5 and California Code of Regulations, Title 22, Division 9

Rationale for choosing the Intervention: EMSA oversight of CPCS is mandated by statute and regulations.

- *Item to be measured:* Compliance with contractual requirements as reported in Quarterly reports received from CPCS
- *Unit of Measurement*: Annual report
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2024
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Collect and Review Annual Report Submission. Between 07/2024 and 06/2025 program will collect and review one (1) annual report submission.

Description of Activity: Program will provide oversight to one (1) CPCS through coordination and technical assistance of one (1) annual report submission with the CPCS Business Director, in accordance with statutory and regulatory authorities and contractual requirements.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Objective 7:

Title: Maintain EMS Systems Planning and Oversight to LEMSAs

Objective: Between 07/2024 and 06/2025, Program will provide oversight to 34 LEMSAs required to submit annual EMS plans through coordination of EMS plan submission by LEMSA Administrators, technical assistance, and EMS plan determinations, in accordance with statutory and regulatory authorities. Program will review at least eight (8) EMS plans.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Conduct assessment of California's 34 local EMS systems in order to coordinate EMS activities based on community needs for the effective and efficient delivery of EMS services. Increase quality patient-care outcomes through statewide coordination and leadership for the planning, development, and implementation of local EMS systems.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: CA Health and Safety Code, Division 2.5 and CA Code of Regulations, Title 22, Division 9

Rationale for choosing the Intervention: Statutory authority mandates the EMS Authority oversee the planning, development, and implementation of local EMS systems.

- *Item to be measured:* EMS plans
- *Unit of Measurement*: One plan per LEMSA
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2024
- *Interim target value to be achieved by the Annual Progress Report:* 4
- *Final target value to be achieved by the Final Progress Report:* 8

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Collect EMS Plan Submissions. Between 07/2024 and 06/2025, Program will provide oversight to 100% of LEMSAs required to submit annual EMS plans through coordination of at least eight (8) EMS plan submissions with LEMSA Administrators, technical assistance, and EMS plan determinations, in accordance with statutory and regulatory authorities.

Description of Activity: Between 07/2024 and 06/2025, Program is responsible for providing coordination, technical assistance, and developing annual EMS plan determinations to LEMSA Administrators in accordance with statutory and regulatory authorities.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Track and Monitor EMS Plans. Between 07/2024 and 06/2025, Program will provide coordination of receipt of EMS plan submissions from LEMSA Administrators, assignment of EMS plan reviews to EMS Authority subject matter experts, and overall tracking and monitoring of EMS plan review from receipt to decision to approve or deny. Program will track and monitor by updating one (1) internal work-flow management application.

Description of Activity: Between 07/2024 and 06/2025, Program will keep current and update one (1) internal work-flow management application to reflect EMS plan activity, including receipt of EMS plans, status of active EMS plans within the EMS Authority, plan outcomes, coordination with LEMSA Administrators and staff, and collaboration with EMSA staff on EMS plan review, to ensure effective oversight of the internal EMS plan review process for timely, comprehensive, and effective plan development and decisions.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Collect and Review Quarterly Report Submissions. Between 07/2024 and 06/2025, Program will provide coordination and technical assistance to six (6) multicounty LEMSA Administrators.

Description of Activity: Between 07/2024 and 06/2025, Program will provide oversight to six (6) multicounty LEMSAs required to submit quarterly reports through coordination and technical assistance of quarterly report submissions, in accordance with statutory and contractual authorities.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 4

Review forms submitted as the transportation component of the EMS Plans. Between 07/2024 and 06/2025, Program will review all transportation components (Ambulance Zone Summary Form(s) and Table 8 Resource Directory(s)) for approval and maintain Exclusive Operating Area (EOA) and EMS Responder spreadsheets. EMSA anticipates eight (8) EMS Plans with associated transportation components will be submitted for review during this time period.

Description of Activity: Between 7/2024 and 6/2025, Program will review and approve or deny the transportation components of an EMS Plan based on statute, regulation, and case law. The date is then tracked in a transportation data spreadsheet. EMSA

anticipates eight (8) EMS Plans with associated transportation components will be submitted for review during this time period.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 5

Maintain LEMSA competitive process transportation service log. Between 07/2024 and 06/2025, Program will update one (1) internal service log to track contract start and end dates of the competitive processes.

Description of Activity: Between 07/2024 and 06/2025, Program will maintain one (1) competitive process transportation log through a continuous update with each EMS Plan and competitive process approval/denial. Log will be used monthly for formal LEMSA notification of status of exclusive rights.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 6

Review LEMSA transportation competitive processes. Between 07/2024 and 06/2025, Program will review at least one (1) competitive process regarding EOAs for transportation, as they are submitted by LEMSAs.

Description of Activity: Between 07/2024 and 06/2025, Program will review at least one LEMSA competitive process for emergency ambulance services, regarding prospective EOAs and discuss any changes needed to approve the competitive process. EMSA's collaboration with LEMSAs promotes successful competitive bidding for local ambulance services, which in turn assures patient care during an emergency.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 7

Provide Technical Assistance. Between 07/2024 and 06/2025, Program will answer at least 25 requests for technical assistance with EMS transportation issues via email, phone calls, formal correspondence, and face-to-face inquiries.

Description of Activity: Between 07/2024 and 06/2025, Program will provide assistance in all areas related to EMS ambulance transportation for all requests received. Requests are received from LEMSAs, the general public, EMS Providers, and other state agencies through email, phone calls, zoom calls, formal correspondence, and face-to-face

meetings. While it is impossible to know how many requests for assistance will be received, based on previous years it is anticipated that there will be at least 25 instances of technical assistance provided.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Healthy People 2030 Program

Healthy People 2030 Objective

PHI-R07 Explore the use and impact of quality improvement as a means for increasing efficiency and/or effectiveness outcomes in health departments

Health Objective

Between 07/2024 and 06/2025, the Healthy People Program (HPP) 2030 will implement one quality improvement (QI) process, using the CDC evaluation framework and the Plan Do Check Act (PDCA) QI model, to increase efficiency and effectiveness of the Preventive Health and Health Services Block Grant (PHHSBG)-funded programs.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: No funding to local agency/organization
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 4
- Number of FTEs in this program funded by the PHHS Block Grant: 3.25

Issue/Problem

Funding for public health in California is low, so there is a need to ensure that the PHHSBG is being utilized efficiently and effectively for state priorities. California has the opportunity to use the PHHSBG for state priorities developed in conjunction with stakeholders. Once the funds have been allocated to critical public health programs, services, and activities, it is imperative that program statuses and outcomes are tracked and evaluated to assure that the funds are used in the most efficient and effective way possible. If there is a lack of progress or impact, decision makers will be alerted, and funds can be allocated elsewhere. With recent success in program quality improvement experienced this past year, HPP 2030 will continue to use the CDC evaluation framework

and the QI Model- Plan Do Check Act, to analyze all PHHSBG-funded programs for further QI opportunities.

Public health program was prioritized as follows:

- Other: Supports CDPH's mission dedicated to optimizing the health and wellbeing of the people of CA

Key Indicator(s) affected by this problem: The number of PHHSBG-funded Programs that have met or not met objectives and associated activities in the previous year.

Baseline value of the key indicator described above: 0

Data source for key indicator baseline: FFY 2023 Final Annual Progress Report (APR)

Date key indicator baseline data was last collected: 11/2023

Program Strategy

Goal: The goal of this program is to enhance the accountability and transparency of the PHHSBG through the HPP 2030 by measuring progress and impact of funded programs, as well as communicating current accomplishments.

Is this program specifically addressing a Social Determinant of Health (SDOH)? No

Summary of Program Strategy: Utilizing the QI Model- PDCA Cycle to assess and evaluate all programmatic and fiscal deliverables associated with PHHSBG-funded programs will strengthen public health infrastructure to improve public health outcomes, decrease health disparities, premature death, and disabilities, and improve health equity.

Primary Strategic Partners

External:

1. Emergency Medical Services Authority
2. Centers for Disease Control and Preventions

Internal:

1. Center for Healthy Communities
2. Office of Policy and Planning
3. Office of Health Equity
4. Office of Environmental Health

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: The program objectives and activities are monitored and evaluated biannually. Monitoring tools include a program work plan, program procedures, monthly fiscal reports, quarterly fiscal analyses, biannual program outcome reports, biannual Advisory Committee meetings, an annual Public Hearing, and an annual program audit.

Program Settings:

- State health department

Target Population of Program

- *Target population data source*: United States Census Bureau, 2023
- *Number of people served:* 38,965,193
- *Ethnicity:* Hispanic or Latino/ Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- All California counties

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? No

Is the entire target population disproportionately affected by the program, or only part? All

Objectives and Activities

Objective 1:

Title: Provide Administrative Support to Ensure all Programmatic and Fiscal Deliverables are Met

Objective: Between 07/2024 and 06/2025, Program will provide administrative oversight and support to 15 PHHSBG funded programs to ensure programmatic and fiscal deliverables are met timely in accordance with CDC's guidelines. The oversight and support will include a series of webinars, technical assistance, and quality improvement models.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Utilize CDPH best practices, fundamentals of project management, and the QI Model- PDCA Cycle. Utilizing CDPH best practices and fundamentals of project management will ensure all CDC deliverables are met timely and accurately. Utilizing the QI Model- PDCA Cycle to assess and evaluate all PHHSBG-funded programs will strengthen public health infrastructure to improve public health outcomes, decrease health disparities, premature death, and disabilities, and improve health equity.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Best Practice Initiative (U.S. Department of Health and Human Services)

Rationale for choosing the Intervention: Continuous quality improvement will help ensure that PHHSBG is being utilized efficiently and effectively for state priorities.

- *Item to be measured:* Objectives and Activities statuses and outcomes for 17 PHHSBG-funded programs
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* FFY 2023 Final APR
- *Date baseline was last collected:* 11/2023
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 17

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Perform QI Analysis of all programmatic and fiscal processes. Between 07/2024 and 06/2025, Program will analyze the FFY 2023 Final APR to determine quality improvement opportunities.

Description of Activity: Between 07/2024 and 06/2025, Program will analyze the FFY 2023 Final APR to determine quality improvement opportunities with internal processes and technical assistance to ensure all funded programs are provided with adequate resources and assistance to meet all of their programmatic and fiscal deliverables.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Provide Technical Assistance to Program Staff. Between 07/2024 and 06/2025, Program will provide continuous Technical Assistance (TA) to all 17 PHHSBG Program Staff.

Description of Activity: Between 07/2024 and 06/2025, Program will provide continuous Technical Assistance (TA) to all 17 PHHSBG Program Staff via email, phone, or virtual meetings, as appropriate.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Provide Technical Assistance to Fiscal Staff. Between 07/2024 and 06/2025, Program will provide continuous Technical Assistance (TA) to all 17 PHHSBG Fiscal Staff.

Description of Activity: Between 07/2024 and 06/2025, Program will provide continuous Technical Assistance (TA) to all 15 PHHSBG Fiscal Staff to ensure each program properly maintains their program budgets, report any changes or concerns throughout the State Fiscal Year, and upkeep their Monthly Expenditure Reports.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 4

Communication of PHHSBG Outcomes and Achievements. Between 07/2024 and 06/2025, Program will implement two (2) communication strategies to effectively communicate the program outcomes and successes to all internal and external stakeholders.

Description of Activity: Between 07/2024 and 06/2025, Program will implement two (2) communication strategies via email, webinars, or published documents on the Department's webpage to highlight program outcomes and successes to all internal and external stakeholders.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Injury Prevention Program

Healthy People 2030 Objective

IVP-01: Reduce fatal injuries

Health Objective

Between 07/2024 and 06/2025, Program will strive to reduce by 5% the crude rate of total, unintentional, and intentional injury deaths in California from the current 2022 rates (71.7, 53.9 and 16.8 per 100,000 California residents, respectively).

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Health Department/Agency
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of funding for this program that is PHHS Block Grant: 10-49% - Partial source of funding
- Existing funding source(s): Other: CDC Core SIPP funding as well as CA Office of Traffic Safety (OTS) funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 11
- Number of FTEs in this program funded by the PHHS Block Grant: 4.15

Issue/Problem

Injuries are the leading cause of death for Californians ages 1 - 44 years old and contribute to a substantial burden of morbidity across the life span, with significant impacts on individuals, their communities, and the economy. Injuries are the leading cause of death for people ages 1 - 44 years old in California. Across the life span, injuries in California lead to over (1) 27,000 deaths, (2) 300,000 hospital visits, and (3) 2.5 million visits to emergency departments each year. This burden of mortality, morbidity, and disability has substantial impacts and consequences for the economy, communities, and the well-being of the State's population. The CDC has estimated the cost of only FATAL

intentional and unintentional injuries in California, based on medical and work-lost costs (not including quality of life measures), to be $20.984 billion annually.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)
- Conducted a topic- or program-specific assessment (e.g., tobacco assessment, environmental health assessment)
- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan
- Governor (or other political leader) established as a priority
- Legislature established as a priority

Key Indicator(s) affected by this problem: Rate of injury deaths in California for three indicators: total injuries, unintentional injuries, intentional injuries.

Baseline value of the key indicator described above: Total = 71.7 per 100,000; Unintentional = 53.9 per 100,000; Intentional = 16.8 per 100,000

Data source for key indicator baseline: EpiCenter: California Injury Data Online

Date key indicator baseline data was last collected: 2022

Program Strategy

Goal: Decrease injuries in California by supporting development of data-informed, evidence-based prevention policies, practices, and programs at state and local levels.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)
- Neighborhood and Built Environment (e.g., poor quality of housing, limited access to transportation, food desert, poor water/air quality, neighborhood crime and violence)

Summary of Program Strategy: The California Wellness Plan includes 15 goals/objectives consistent with this program, including the goals of increasing accessible and usable health information and expanding access to comprehensive statewide data. There are several specific objectives for injury and violence, including objectives to decrease the annual incidence rate of unintentional injury deaths in California.

Primary Strategic Partners

External:

1. Local Public Health Departments
2. California Department of Education
3. California Safe Kids Coalition
4. California Department of Aging
5. Office of Traffic Safety

Internal:

1. Chronic Disease Control Branch
2. Office of Health Equity
3. Maternal, Child, and Adolescent Health Branch
4. The Office of Policy and Planning
5. Health in All Policies Program

Evaluation Methodology: Injury numbers/rates overall and for specific injury types will be tracked using vital statistics and administrative health data. Process evaluation will focus on measuring whether objectives are met (e.g., number of trainings/participants, data products created). Impact evaluation will assess immediate and intermediate outcomes of activities using multiple measures (e.g., surveys, evaluations).

Program Settings:

- Local health department
- Medical or clinical site
- State health department
- Other: Community-based organizations; Senior residence or community

Target Population of Program

- *Target population data source*: California Department of Finance, state population estimate for 7/1/2022
- *Number of people served:* 38,028,571
- *Ethnicity:* Hispanic or Latino and Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- I don’t know the answer

Gender Identity:

- Male
- Female
- Transgender
- No of these

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School

- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? No

Is the entire target population disproportionately affected by the program, or only part? All

Objective 1:

Title: Increase capacity for Local Childhood Unintentional Injury Prevention Programs

Objective: Between 07/2024 and 6/30/2025, Program will conduct twenty-seven (27) technical assistance activities for the childhood unintentional injury prevention community and Kids' Plates grantees to increase knowledge, best practice programs, and partnership efforts across California.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? It is a subset of a larger problem.

Problem for this Objective: **Children 0-19 are at risk for unintentional injuries and need caregivers, safe spaces, and policies.** According to the CDC, unintentional injury is the leading cause of death to children ages 1-19, and third most common for children under the age of 1. In 2019, 7,444 youth ages 0-18 died from unintentional injuries in the United States, while millions more children suffered from injuries requiring treatment in the emergency department. Leading causes of child injury include motor vehicle crashes, suffocation, drowning, poisoning, fires, and falls. Child injury is predictable and preventable, and it's also among the most under-recognized public health problems. To increase access to statewide education, tools, resources, and interventions, CDPH can facilitate this coordination and collaboration with local public health departments through the Kids' Plates grantees and other advocates and organizations to disseminate information and best practices to better protect California's children.

Key indicator(s) affected by this program: Children/youth die from unintentional injury in disproportionate numbers. As such, we will track the number and rate of children who die as the result of unintentional injuries.

Baseline value for the key indicator: 678

Data source for key indicator baseline: CDPH EpiCenter (Vital Statistics Death Data), 2020

Date key indicator baseline data was last collected: 2020 or 2021

Intervention Information

Provide technical program support to unintentional childhood injury prevention staff in California. In partnership with the Kids' Plates program, which is used exclusively to fund local interventions, CDPH provides the staff to support the annual dissemination, monitoring and success of the Kids' Plates program while supporting all local unintentional childhood injury prevention programs. California's local public health departments (58) rely on CDPH to provide childhood unintentional injury prevention research, program best practice and when possible, safety equipment and funding.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Aligns with the National Action Plan from CDC

Rationale for choosing the Intervention: Based on the model by the National Action Plan for Child Injury Prevention, developed by the CDC, childhood unintentional injury prevention best practices include: to raise awareness about the problem of child injury and the effects on our nation, highlighting prevention solutions by uniting stakeholders around a common set of goals and strategies, and mobilize mobilizing action on coordinated effort to reduce child injury. The role of CDPH is to provide information on these best practices and will do this through technical and program support to the California unintentional childhood injury prevention community, including the current Kids' Plates grantees, local public health departments, Safe Kids Coalitions, and advocates and organizations in the field.

- *Item to be measured:* Technical assistance opportunities including contracts, emails, phone calls, meetings, or webinars
- *Unit of Measurement*: The number of technical assistances, contracts, and webinars
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Internal tracking of number of contracts, TA activities and webinars

- *Date baseline was last collected:* 7/1/2024
- *Interim target value to be achieved by the Annual Progress Report:* 14
- *Final target value to be achieved by the Final Progress Report:* 27

Target Population

The target population of this Program SMART Objective is the sub-set of the Program.

- *Target population data source*: California DOF Demographic Research Unit. Population Projections, 2010-2060 (Baseline 2019)
- *Number of people served:* 13,116,130
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not (lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban

- Rural

Location:

- State of California

Occupation:

- N/A

Education Attainment:

- Some High School

Health Insurance Status:

- Uninsured
- Medicaid
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Activity 1

Contract to implement various childhood unintentional injury prevention activities. Between 07/2024 and 06/2025, Program will contract with 2-3 individuals/organizations to update/develop or conduct interventions/education/resources to improve childhood unintentional injury prevention materials/knowledge/outcomes/support.

Description of Activity: Program staff will contract with 2-3 individuals or organizations to update/develop or conduct interventions, education/outreach and/or resources to address childhood unintentional injury risks and improve educational/resource materials, topic specific intervention best practice, outreach practices to local communities and special populations.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Quarterly Webinars. Between 07/2024 and 06/2025, Program will facilitate four (4) childhood unintentional injury prevention webinars to childhood unintentional injury prevention community and Kids' Plates grantees.

Description of Activity: CDPH program staff will coordinate four (4) webinars total (one each quarter) on unintentional childhood injury prevention topics to local public health departments, the Kids' Plates grantees, and the California unintentional childhood injury prevention community. The webinars will support local program interventions to provide current injury data, research, and innovative prevention efforts to promote and expand partnerships across the state.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Technical Assistance with Kids Plates Grantees or other local Unintentional Injury Organizations. Between 07/2024 and 06/2025, Program will provide twenty total (20) technical assistance activities for Kids' Plates grantees or other local unintentional injury organizations for program development and childhood unintentional injury prevention expertise to enhance and maintain program interventions and activities.

Description of Activity: CDPH program staff will provide a total of twenty (20) individual technical assistance activities for the Kids' Plates grantees (6-10 grantees) and/or other local unintentional injury organizations to support deliverables for unintentional injury prevention interventions. Technical assistance may include the following: virtual meetings, emails and/or phone calls. Grantees or local organizations are local public health departments, Safe Kids Chapters/Coalitions and/or other non-profit organizations working on the topics of drowning prevention, vehicle occupant safety, gun safety, sports safety, poisoning prevention, fall prevention, bicycle, and pedestrian safety. At least five technical assistance opportunities will be provided quarterly.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 2:

Title: Increase Capacity for Older Adult Unintentional Injury Prevention Program - Healthy Aging Initiative

Objective: Between 07/2024 and 06/2025, Healthy Aging Initiative (HAI) will provide at least forty-five (45) activities to support healthy aging across California Department of Public Health and partner organizations.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? It is a subset of a larger problem.

Problem for this Objective: **Older adults in California face disproportionate levels of chronic disease and death from heart disease, cancer, Alzheimer's disease, lower respiratory diseases, stroke, diabetes, unintentional injury, and influenza and pneumonia. COVID-19 has only added to these health challenges for older adults.** California is a large state, made up of 58 counties, many of which span both rural and urban areas of the state. Public health programing for Californians requires a diverse and flexible approach to ensure all communities and residents receive the care and support they need. Older adults in California face disproportionate levels of chronic disease and death from heart disease, cancer, Alzheimer's disease, lower respiratory diseases, stroke, diabetes, unintentional injury, and influenza and pneumonia. COVID-19 has only added to these health challenges for older adults. To increase access to resources and promote better health, there needs to be better coordination and collaboration among state and local stakeholders to better serve older adults across California.

Key indicator(s) affected by this program: As mentioned in the problem statement above, older adult deaths are affected disproportionately by a variety of chronic disease conditions and unintentional injuries. As such, we will track number and rate of older adult deaths.

Baseline value for the key indicator: 272,220

Data source for key indicator baseline: CDPH EpiCenter (Vital Statics Death Data)

Date key indicator baseline data was last collected: 2022

Intervention Information

The HAI will provide TA to expand capacity for serving older Californians and their caregivers. The Healthy Aging Initiative (HAI) will provide technical assistance across CDPH and to partner organizations. HAI will work to maintain current relationships and build new partnerships with aging related organizations, as well as provide consultation and guidance to state agencies, Local Health Jurisdictions (LHJ), community agencies, or members of the public, to expand capacity for serving the health needs of older Californians and their caregivers.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Older adults in California face many challenges accessing prevention services, especially driven by racial, ethnic, and socioeconomic inequities.

- *Item to be measured:* Technical Assistance Activities

- *Unit of Measurement*: Number of Activities Provided
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Internal tracking of number of TA activities
- *Date baseline was last collected:* 07/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 20
- *Final target value to be achieved by the Final Progress Report:* 45

Target Population

The target population of this Program SMART Objective is the sub-set of the Program.

- *Target population data source*: Department of Finance (2024) Projection.
- *Number of people served:* 11,700,392
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not (lesbian or gay)
- Bisexual

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Graduate
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Activity 1

California's Master Plan for Aging (MPA). Between 07/2024 and 06/2025, HAI will support implementation of the California MPA by strengthening the relationships with internal and external healthy aging partners through coordination and participation in at least twenty-five (25) related meetings.

Description of Activity: Between 07/2024 and 06/2025, HAI staff will strengthen relationships with healthy aging partners through collaboration with the California Department of Aging, California Department of Public Health's Office of Suicide Prevention and Alzheimer's Disease Program staff, as well as fall prevention partners in

California. HAI will compile and complete all MPA related reporting requirements and co-create the annual Older Adult Suicide in California data brief with CDPH's Office of Suicide Prevention.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Age-Friendly Public Health Systems. Between 07/2024 and 06/2025, HAI staff will provide at least ten (10) coordination and outreach activities to key stakeholders, promoting Age-Friendly Public Health Systems/activities.

Description of Activity: Between 07/2024 and 06/2025, HAI staff will provide coordination and outreach to key stakeholders on Age-Friendly Public Health System activities. This will include sharing best practices around older adult and caregiver health and providing educational resources with an emphasis on Age-Friendly Public Health Systems.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Technical Assistance. Between 07/2024 and 06/2025, HAI staff will provide ten (10) technical assistance consultations to advise state agencies, Local Health Jurisdictions (LHJ), community agencies, or members of the public on healthy aging related issues.

Description of Activity: Between 07/2024 and 06/2025, HAI staff will provide technical assistance consultations to state agencies, LHJs, community agencies, or members of the public to enable sharing of best practices and healthy aging related resources. CDPH will also serve as the license holder and technical assistance provider for the evidence-based fall prevention program "Stepping On.".

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 3:

Title: Reduce Serious and Fatal Injuries that Result from Motor Vehicle Traffic Collisions

Objective: Between 07/2024 and 06/2025, Program will increase access to its transportation injury data by linking six (6) years of law enforcement traffic crash record data to hospital and emergency department (ED) injury data, making those six (6) years of linked Crash-Medical Outcomes Data (CMOD) available through an online data

dashboard, and providing three (3) technical assistance sessions to support use of the linked CMOD data.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The program is the same.

Intervention Information

Traffic collision and medical injury data will be linked and made available to the public to help inform traffic injury prevention. Crash reports document the circumstances and nature of crashes while medical records describe the extent and nature of the injuries sustained in crashes. For this objective, Program will link crash reports with medical records to provide California's traffic safety community with valuable insights into the relationship between modifiable crash characteristics and resulting injuries. For example, the relationship between seat belt use and injury severity for vehicle occupants. Specifically, Program will develop and use probabilistic data linkage methods to link six (6) years of law enforcement traffic crash record data to hospital and emergency department (ED) injury data, make those six (6) years of linked Crash-Medical Outcomes Data (CMOD) available through an online data dashboard, and support responsible use of the data by providing three (3) technical assistance sessions to traffic injury prevention stakeholders.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Model Practices Database (National Association of City and County Health Officials)

Rationale for choosing the Intervention: The linked Crash-Medical Outcomes Data (CMOD) and technical assistance that will be developed and provided will help bring a public health perspective to traffic injury surveillance and transportation safety work throughout the state. These resources will provide useful information to help guide the implementation of preventive measures in reducing serious injuries and death among Californians involved in traffic crashes.

- *Item to be measured:* Years of data linked; years of data posted online; technical assistance (TA) activities
- *Unit of Measurement*: Number of years of data linked; years of data posted online; technical assistance (TA) activities
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Internal Activity Tracking Log
- *Date baseline was last collected:* 03/13/2024
- *Interim target value to be achieved by the Annual Progress Report:* 0

- *Final target value to be achieved by the Final Progress Report:* 15

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Linking crash data with medical outcomes to make connections between injury and crash risk factors. Between 7/2024 and 6/2025, Program will identify a contractor who will develop a custom probabilistic data linkage methodology to link six (6) years of law enforcement crash record data to medical outcome injury data.

Description of Activity: Between 7/2024 and 6/2025, Program will develop a scope of work and use a competitive bidding process to select and contract with a vendor to develop a replicable probabilistic data linkage methodology to link California Highway Patrol (CHP) crash data maintained in the Statewide Integrated Traffic Records System (SWITRS) with California Department of Health Care Access and Information (HCAI) emergency department (ED) and hospitalization data. A probabilistic data linkage methodology is required to link SWITRS and HCAI data because the two data sources do not contain common unique identifiers. Instead, they must be linked on a series of common variables (age, sex, date of collision/treatment) that together can be used to identify "probable" matches. The chosen vendor will apply its probabilistic data linkage methodology to six (6) years of SWITRS and HCAI data from 2016-2021.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Make linked Crash-Medical Outcome Data (CMOD) accessible to the public. Between 07/2024 and 06/2025, Program will make six (6) years of linked Crash-Medical Outcome Data (CMOD) accessible to the public through its online data dashboard and direct request.

Description of Activity: Between 07/2024 and 06/2025, Program will develop an online data dashboard user interface for the linked Crash-Medical Outcome Data (CMOD), which will appear on IVPB's existing EpiCenter injury surveillance dashboard or a standalone site. Program data scientists will make the six (6) years of linked CMOD data, 2016-2021, available on the online data dashboard. A data dashboard interface will support use of the linked CMOD data by various traffic injury prevention stakeholders through customizable visualizations and data tables. If/when the data summaries available through the online data dashboard do not meet users' needs, Program will

create and share custom CMOD data tables by request and within the limits of Agency data de-identification guidelines (see DMP for details).

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Technical assistance (TA) to support use of linked Crash-Medical Outcome Data (CMOD). Between 07/2024 and 06/2025, Program will provide at least three (3) Technical Assistance (TA) activities to relevant entities focused on use of linked Crash-Medical Outcome Data (CMOD) for injury prevention purposes.

Description of Activity: Between 07/2024 and 06/2025, Program will complete at least three (3) TA activities focused on use of linked Crash-Medical Outcome Data (CMOD) for injury prevention purposes. TA activities may include participation in calls/meetings, responses to queries, and/or presentations made to various groups. TA audiences include stakeholders, data partners, local health jurisdictions, and others working to prevent injury and death that may result from motor vehicle traffic collisions.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 4:

Title: Statewide General Injury Surveillance System

Objective: Between 07/2024 and 06/2025, Program will continue to operate its statewide general injury surveillance system by (a) developing state-level injury death, hospitalization, and emergency department visit datasets for the 2023 calendar year, (b) making these three (3) new injury datasets publicly available on its EpiCenter online injury surveillance data dashboard, and (c) analyzing the new injury datasets to inform three (3) injury prevention activities, totaling nine (9) measurable objectives.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Provide timely, accurate, and easy-to-access injury data. Accurate and up-to-date injury data are essential for planning and delivering evidence-based injury prevention activities. This objective will ensure that IVPB continues providing the foundational injury data that it and other injury prevention stakeholders require to work effectively. IVPB will develop the next year of injury surveillance data according to current national standards;

make the injury data easily accessible via its online injury data dashboard, EpiCenter; and use the new data to inform its various injury prevention activities.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)
- Other: Aligns with NCIPC's data science strategy

Rationale for choosing the Intervention: Surveillance is the foundation of public health. By expanding the availability and utility of timely data for injury and violence prevention, IVPB can support its own injury prevention work, as well as myriad practitioners across California, helping the state identify and respond to emerging injury and violence trends.

- *Item to be measured:* 2023 death, hospital, and ED data processed and used to inform injury prevention
- *Unit of measurement:* # of datasets processed; # of datasets posted on dashboard; # of data analyses conducted
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EpiCenter injury data dashboard
- *Date baseline was last collected:* 03/12/2024
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 9

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Develop State Injury Data. Between 07/2024 and 06/2025, Program will develop three (3) state injury datasets from the most recently available, 2023 calendar year state death, hospital, and emergency department (ED) visit data.

Description of Activity: IVPB will maintain its data use agreement with the CDPH Center for Health Statistics and Informatics (CHSI) to continue receiving annual files for California deaths, hospital discharges, and emergency department visits from state partners. By June 30, 2025, IVPB will obtain these data sets for calendar year 2023. Also, by June 30, 2025, IVPB research staff will process these data according to guidance produced by the CDC's National Center for Injury Prevention and Control (NCIPC) to identify, classify, and extract injury-related deaths, hospitalizations, and ED visits.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Make State Injury Data Accessible to the Public. Between 07/2024 and 06/2025, Program will make three (3) calendar year 2023 state injury datasets accessible to the public through its online data dashboard and direct request.

Description of Activity: IVPB maintains EpiCenter, an online injury surveillance data dashboard (https://skylab4.cdph.ca.gov/epicenter/). Between 07/2024 and 06/2025, IVPB will update EpiCenter to include calendar year 2023 injury-related deaths, hospitalizations, and ED visits for the state. EpiCenter makes injury data insights quick and easy through customizable visualizations, enabling users to identify risk and protective factors and trends in injury and violence and help inform interventions. EpiCenter also allows users to build custom injury data tables and download them in Excel format. If/when the data available through EpiCenter do not meet users' needs, IVPB will create and share custom injury data tables by request and within the limits of Agency data de-identification guidelines (see DMP for details). Finally, EpiCenter contains an extensive documentation section to facilitate appropriate interpretation of the injury data. IVPB will update this documentation as appropriate to accommodate any changes in the calendar year 2023 data.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Analyze State Injury Data to Inform Prevention. Between 07/2023 and 06/2024, Program will analyze calendar year 2023 state injury datasets to inform at least three (3) of its injury prevention activities.

Description of Activity: IVPB uses a data-driven and evidence-based approach to injury prevention. State death, hospitalization, and ED visit injury data are fundamental to this approach. Between 07/2024 and 06/2025, IVPB will analyze calendar year 2023 state injury datasets to inform at least three of its injury prevention activities. Activities include, but are not limited to, the tracking of general injury surveillance indicators, internal strategic planning, analysis of proposed injury prevention legislation, and various population and/or cause-specific injury prevention programs (e.g., childhood injury prevention, pedestrian safety). For all analyses, methods will be documented and communicated to ensure appropriate interpretation of results.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

The Office of Policy and Planning

Healthy People 2030 Objective

PHI-04: Increase the proportion of state and territorial jurisdictions that have a health improvement plan

Health Objective

Between 07/01/2024 and 06/30/2025, the Office of Policy and Planning (OPP) will strengthen the primary prevention, heath equity focus, and cross-program alignment of California's State Health Assessment and State Health Improvement Plan (SHA/SHIP) Let's Get Healthy California (LGHC).

OPP conducts a comprehensive SHA that brings together data and information across populations and systems to inform public health priorities reflected as the SHIP in LGHC. The SHA builds on existing assessment efforts such as the California Community Burden of Disease Engine (CCB) using comparative statistical analyses; incorporates data and information about health conditions, disease burden, quality of life, health outcomes, disparities, social determinants, and health care costs and access. Results inform the evaluation and planning of actions through the SHIP to improve health, the development of priorities identified through a wide range of stakeholder input, garnering resources, adopting or revising policies, and addressing emerging issues and contextual factors in the policy landscape.

SHA process summary findings are reported annually through the: LGHC website; California Health and Human Services Agency (CalHHS); annual State of Public Health (SoPH) legislative testimony and biennial report; outlining major trends and disparities in health outcomes, and public health action and policy recommendations to address priority issue areas. This process informs the SHIP as the LGHC initiative. OPP supports improvement efforts further upstream through multisector and interdisciplinary initiatives; CDPH collective action around primary prevention and policy, systems, and environmental change strategies to address public health priorities; and alignment of community health improvement plans. The focus of these efforts includes enhanced data, messaging, collaborative planning and policy approaches incorporating social and structural determinants of health, and regional disparities.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: No funding to local agency/organization

- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: 10-49% - Partial source of funding
- Existing funding source(s): Future of Public Health (State) & CASPHI (Federal)
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 4
- Number of FTEs in this program funded by the PHHS Block Grant: 3

Issue/Problem

This program addresses the need for comprehensive information and integrated approaches to both assess and address complex inequities and current challenges in the current population health landscape in California. In California, significant disparities across health outcomes continue to persist. There are limited opportunities for better health among groups that have been historically marginalized, including people of color and low socioeconomic status. These differences in opportunity are often a result of historical policies and structural practices. The cumulative effect is that the opportunity to live a long and healthy life does not exist for everyone equally. The underlying principles that guided the identification of priorities and strategies in this plan was that in order to advance a safe and healthy California for all, we must address the systemic barriers that have led to these inequities in the first place. Factors that impact these outcomes require action across multiple systems and sectors, and through state, local and community collaboration. Challenges were exacerbated by the COVID-19 pandemic. Underlying inequities contributed to many communities experiencing disproportionate harmful impacts of COVID-19 exposure and severity, as well as disparities in the capacity to buffer the negative impacts of socioeconomic and behavioral health outcomes of the pandemic. Many public health services were delayed or deferred as resources were intensely focused on the most acute aspects of the COVID-19 response. The full impact of the pandemic on population health in California is not yet fully known and will require proactive assessment and monitoring to promote recovery and ongoing health improvement. The pandemic illuminated limitations in statewide capacity to identify and adequately address the experiences of disproportionately impacted and historically underrepresented populations, and the available assets and resources that could be mobilized to effectively address those priorities. Assessing and addressing the new landscape of population health in California and the complex underlying inequities requires comprehensive information and an integrated strategic response.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)
- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: Key indicators affected by this problem are the number of strategies adopted in the State Health Improvement Plan (SHIP) that have an explicit equity focus. The State Health Assessment (SHA) leverages a wide range of data and information to assess, monitor and report on the health status of California including large-scale inequities in the conditions residents live and their opportunities to be healthy. Building on SHA, the SHIP supports integrated planning and collective action to address upstream strategies and root causes of health inequities. The number of strategies employed in the SHIP that build equity into its implementation is a key indicator of progress.

Baseline value of the key indicator described above: The current baseline value is three (3) initiatives.

Data source for key indicator baseline: Program tracking is based on key initiatives and evidence-based strategies identified in the SHIP

Date key indicator baseline data was last collected: 2023

Program Strategy

Goal: Program will use the State Health Assessment and State Health Improvement Plan (SHA/SHIP) process to strengthen public health capacity to address inequities.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- Education (e.g., low high school graduation rates, low literacy levels, poor early childhood education)
- Social and Community Context (e.g., discrimination, low civic participation, poor workplace conditions, incarceration)
- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)
- Neighborhood and Built Environment (e.g., poor quality of housing, limited access to transportation, food desert, poor water/air quality, neighborhood crime and violence)
- Adverse Childhood Experiences (ACEs)

Summary of Program Strategy: The SHA/SHIP process will be employed to increase the Department's capacity to address priority public health burdens, root causes and contributing factors of health disparities and inequities. As the SHA/SHIP, Let's Get Healthy California (LGHC) contributes to building a safe, healthier California for all by monitoring progress on health improvement priorities; promoting community innovations; and informing and convening cross-sector collaborations. The program will maintain a current SHA/SHIP by conducting ongoing activities and implementing enhancements related to research and data analysis, strategic planning, and collective action. Research and data analysis activities will provide a shared understanding of disparities within population health and identify and prioritize person-centered and data-driven improvement opportunities – including exploring underlying inequities and tracking the long-term impact of the COVID-19 pandemic. LGHC also supports state and local public health in addressing emerging issues and complex challenges through a collective action approach. Collective action efforts focus on shared activities that advance equity through policy, systems, and environmental change strategies that require collaboration across internal and external partners. Through the SHA/SHIP process the OPP will continue to facilitate new and ongoing cross-disciplinary CDPH efforts to proactively address emerging issues, as well as support movement of public health efforts upstream to improve community health outcomes by addressing social determinants of health. These activities are also required for the maintenance of accreditation of CDPH by the national Public Health Accreditation Board.

Primary Strategic Partners

External:

1. California Conference of Local Health Officers
2. California Health and Human Services Agency
3. Office of the Surgeon General
4. Philanthropic Partners (The California Endowment, Blue Shield of California Foundation, California Healthcare Foundation)
5. Department of Health Care Services

Internal:

1. Office of Health Equity
2. Center for Health Statistics and Informatics
3. Center for Healthy Communities
4. Office of Legislative and Governmental Affairs
5. Office of Communications

Planned non-monetary support to local agencies or organizations:

- Technical Assistance

- Training

Evaluation Methodology: The LGHC, CHA/CHIP/SHA/SHIP evaluation process incorporates various data types and sources, providing a holistic picture of health in the state and laying a foundation for targeted program and policy interventions.

1. Assess Population Health Status: Utilizing comparative analysis, the assessment collates data from multiple sources, examining factors like mortality, morbidity, and health disparities. This is enriched by insights from assessments and information shared by partners, which aid in data interpretation.
2. Review National and State Priorities: The evaluation considers the influence of external changes, including new state and national priorities and strategic shifts in policies. This is crucial for aligning the SHA with broader health initiatives.
3. Identify and Elevate Community Needs: Engagement with local communities to understand specific health needs including CHAs/CHIPs, and partnerships with community and cross-sector stakeholders extend the assessment's reach, ensuring it captures diverse perspectives.
4. Collect Stakeholder Feedback: Diverse stakeholders contribute through meetings, interviews, surveys, and other engagements. Feedback is vital for confirming health issues, filling gaps, setting priorities, and refining strategies for health improvements.
5. Synthesize and Share Findings: Information and insights are synthesized and shared with partners to validate findings and foster collaboration. This includes reviewing policy agendas and leveraging community insights to prioritize health issues and align strategies across initiatives.

Key Outputs are the SHA-Core module (SHA-CM): Annual analysis providing standardized health measures; SoPH Report: Biennial report and annual testimony to the California State Legislature highlighting critical public health issues. Through these processes, the SHA ensures a responsive, inclusive, and data-driven approach informing the SHIP to improving health outcomes across California.

Program Settings:

- Local health department
- State health department

Target Population of Program

- *Target population data source*: 2023 evaluation methods include stakeholder input, surveys, participation, analytics, and other metrics
- *Number of people served:* 39,000,000
- *Ethnicity:* Hispanic or Latino/Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- All California counties

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the program, or only part? All

Objectives and Activities

Objective 1:

Title: Conduct a Comprehensive State Health Assessment

Objective: Between 7/01/2024 and 6/30/2025, Program will conduct two (2) activities to enhance the State Health Assessment (SHA).

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

The program will conduct the State Health Assessment and Improvement Plan process. The State Health Assessment (SHA) provides a snapshot of health for the entire population across a range of conditions and factors. This includes defining health issues and contributing factors, elevating disparities across communities and populations, and

identifying assets and resources that can be mobilized to address health improvement opportunities. The State Health Improvement Plan builds on the SHA to define shared priorities and indicators to track progress, establish cross-cutting strategies, and facilitate policy and interventions to address upstream factors.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: The SHA/SHIP is an accreditation, and CDCs Public Health Systems and Best Practices

Rationale for choosing the Intervention: The SHA grounds program and policy planning in a shared understanding of population health status and health improvement opportunities. The SHIP guides the development and implementation of policies, programs, and actions. Together the SHA/SHIP identifies key health improvement opportunities and creates an overarching framework and strategic approach to unify efforts across the state that are working to address shared priorities. These priorities are cross-cutting in nature and are meant to engage across sectors so that all stakeholders – state and local government agencies, private and nonprofit organizations, health care systems, academic institutions, and communities – can collaborate to advance the health and wellbeing of California's individuals, families, and communities.

- *Item to be measured:* Activities implemented to enhance and conduct the SHA/SHIP
- *Unit of measurement:* Activity
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activity tracking
- *Date baseline was last collected:* 2024
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 2

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Conduct and Enhance the Annual SHA. Between 7/01/2024 and 6/30/2025, Program will conduct a comprehensive state health assessment (SHA). Between 7/01/2024 and 6/30/2025, Program will conduct two (2) activities to enhance the State Health Assessment (SHA).

Description of Activity: Program will conduct the SHA based on standard sets of inputs and measures. enhance documentation of systems for collecting, integrating, analyzing, and sharing information on health outcomes, social determinants of health (SDoH), population characteristics, and other data to improve assessment of burden of disease, link social determinants with health outcomes including mental health and substance use disorders using inpatient discharge and ED visit data.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 2

Improve measures and methods to compare health experience and outcomes across social strata. Between 7/01/2024 and 6/30/2025, Program will conduct two (2) activities to enhance equity-relevant measures and methods.

Description of Activity: Approach SHA with a lens on the structural determinants of health including structural racism; develop and refine equity measurement approaches that promote a structural understanding of system factors at play and account for historical and life course disadvantages.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Objective 2:

Title: Leverage the SHIP process to advance health equity and policy goals

Objective: Between 7/01/2024 and 6/30/2025, Program will conduct four (4) activities to advance health equity and policy goals as part of the SHIP process.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

The program will leverage the State Health Improvement Plan process to advance shared health equity and policy goals. The State Health Improvement Plan process builds on the SHA by facilitating cross-sector partnerships to define and advance shared public health priorities, equity and policy goals, and indicators to track progress, as well as to establish cross-cutting prevention strategies and policy opportunities to address upstream factors.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Public health accreditation standards and CDCs Public Health Systems and Best Practices

Rationale for choosing the Intervention: The SHA grounds program and policy planning in a shared understanding of population health status and health improvement opportunities. The SHIP guides the development and implementation of policies, programs, and actions. Together the SHA/SHIP identifies key health improvement opportunities and creates an overarching framework and strategic approach to unify efforts across the state that are working to address shared priorities. These priorities are cross-cutting in nature and are meant to engage across sectors so that all stakeholders – state and local government agencies, private and nonprofit organizations, health care systems, academic institutions, and communities – can collaborate to advance the health and wellbeing of California's individuals, families, and communities.

- *Item to be measured:* Activities implemented to enhance the SHIP's health equity and policy goals
- *Unit of measurement:* Activity
- *Baseline value for the item to be measured:* 3
- *Data source for baseline value:* Program activity tracking
- *Date baseline was last collected:* 2024
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 4

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Enhance the State Health Improvement Plan (SHIP) to promote upstream strategies. Between 7/01/2024 and 6/30/2025, Program will conduct two (2) activities as part of SHIP implementation to advance health equity and policy goals.

Description of Activity: Program will promote upstream public health promotion and prevention strategies as part of the SHIP process by coordinating across CDPH programs to develop a public health policy platform and the annual State of Public Health legislative testimony, outlining structural and systemic factors embedded in historical and current policies that create conditions that negatively impact health and well-being for people of color and other marginalized groups.

- *Does the activity include the collection, generation, or analysis of data?* Yes

- *Does the data collection involve public health data?* Yes

Activity 2

Advance cross-cutting public health priorities through collective action initiatives. Between 7/01/2024 and 6/30/2025, Program will conduct two (2) activities as part of SHIP implementation to build collective action across the state to address shared public health priorities.

Description of Activity: Program will coordinate with intra and inter-departmental, local, and multisector partners to advance collective action on shared public health priorities, including but not limited to behavioral health and violence prevention. These collective action initiatives will focus on elevating the public health role, promoting an upstream focus on influencing systems toward more equitable outcomes, and exploring strategies to expand state and local resources to support these priority areas.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Public Health Accreditation

Healthy People 2030 Objective

PHI-02 Increase the proportion of local public health agencies that are accredited

Health Objective

Between 10/01/2024-09/30/2029, the Public Health Accreditation (PHA) program will provide accreditation-related training, technical assistance, and networking opportunities to all 61 California Local Health Departments (LHDs) and will provide focused accreditation-related training and/or technical assistance to LHDs with the goal of increasing the number that have achieved initial Public Health Accreditation board (PHAB) accreditation, reaccreditation, or Pathways Recognition.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $240,000
- Amount of funding to local agencies or organizations: 0
- Type of supported local agency/organization: Local Health Department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Funding role of the PHHS Block Grant for this program: 10-49% - Partial source of funding
- Existing funding source(s): State or local funding
- Role of PHHS Block Grant Funds in supporting this program: Enhance or expand the program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 1
- Number of FTEs in this program funded by the PHHS Block Grant: 1

Issue/Problem

As an accredited state public health department, the California Department of Public Health (CDPH) leverages resources and provides accreditation-related support to California LHDs to increase the number that have achieved PHAB accreditation, reaccreditation, or Pathways Recognition. Up to thirty-nine million people in California may receive public health services from local and tribal health

departments. Public Health Accreditation Board accreditation assesses a health department's capacity to carry out the 10 Essential Public Health Services and Foundational Capabilities. To receive accreditation, a health department must undergo a rigorous, multi-faceted, peer-reviewed assessment to ensure it meets or exceeds a set of evidence-based standards and measures. Accreditation helps public health agencies improve the provision of public health services and improve health outcomes for the communities served by these facilities. Many California local health departments have limited resources to devote to the accreditation process. The Public Health Accreditation program at CDPH provides them with needed accreditation-related technical assistance, training, and support.

Public health program was prioritized as follows:

- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: Currently, of 61 local health departments in California (58 counties and 3 cities), 25 have achieved PHAB accreditation (23 counties and 2 cities). All of the 25 accredited LHDs are either preparing for or are in the process of reaccreditation. Another 31 LHDs have either started the process of initial accreditation or have reported that they are considering accreditation. PHAB also offers "Pathways Recognition," a program designed to support accreditation readiness and performance improvement, strengthen infrastructure, and facilitate public health system transformation for public health departments not yet ready for accreditation and can serve as a first step toward accreditation. However, many LHDs do not have adequate funding for the training and technical assistance (TA) required to meet PHAB accreditation standards and measures or begin the Pathways recognition process. PHA provides accreditation-related training and TA to LHDs seeking accreditation, reaccreditation, or Pathways recognition to help them meet PHAB requirements.

The key indicator is how many California LHDs achieve initial accreditation, reaccreditation, or Pathways recognition.

Baseline value of the key indicator described above: 25

Data source for key indicator baseline: CDPH Public Health Accreditation Program/PHAB website

Date key indicator baseline data was last collected: August 2023

Program Strategy

Goal: Program will increase the capacity of LHDs to pursue PHAB accreditation, reaccreditation, or Pathways Recognition, which will contribute to the improvement of public health services and health outcomes for Californians.

Is this program specifically addressing a Social Determinant of Health (SDOH)? No

Summary of Program Strategy: Between 07/2024 and 06/2025, the PHA program will provide accreditation-related training, technical assistance, and other support to all local health department staff and provide focused accreditation-related training and technical assistance to at least Local Health Departments seeking PHAB accreditation, reaccreditation, or Pathways Recognition. These services will help LHDs meet Public Health Accreditation Board (PHAB) standards and measures, thereby demonstrating readiness and capacity for national public health accreditation, reaccreditation, or Pathways Recognition.

Primary Strategic Partners

External:

1. California Accreditation Coordinators Collaborative
2. Centers for Disease Control and Prevention
3. Public Health Accreditation Board (PHAB)
4. Public Health Institute

Internal:

1. Regional Public Health Office
2. California Conference of Local Health Officers
3. The Office of Policy and Planning
4. Office of Health Equity

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: PHA will track participation in all training and networking opportunities provided to LHDs and LHD staff. PHA will administer regular surveys of accreditation readiness, including how many California LHDs report they are pursuing accreditation, reaccreditation, or Pathways Recognition.

Program Settings:

- Local health department
- State health department

Target Population of Program

- *Target population data source*: US Census Bureau estimate of California population as of 2023
- *Number of people served:* 39,000,000
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? No

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Increase the proportion of California local public health departments that achieve accreditation, reaccreditation, or Pathways Recognition

Objective: Between 07/1/2024 and 6/30/2025 the PHA program will provide accreditation-related training, technical assistance, networking and information sharing to staff at all California local health departments and focused accreditation-related training and

technical assistance to at least three (3) Local Health Departments seeking PHAB accreditation, reaccreditation, or Pathways Recognition.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

PHA will provide accreditation-related training, technical assistance, and other support to staff at all California local health departments, including LHDs seeking accreditation, reaccreditation, or Pathways Recognition, to help them meet PHAB standards and measures. PHA will provide focused technical assistance and training to support accreditation readiness at LHDs that report they are pursuing PHAB accreditation, reaccreditation, or Pathways Recognition. PHA will facilitate training and technical assistance on workforce development, quality improvement, strategic planning, health equity, and/or performance management, all of which are required for PHAB accreditation. PHA will also facilitate and offer training that promotes accreditation-readiness to staff at all 61 California local health departments. PHA will also facilitate networking among LHD accreditation staff and collect and share information on accreditation, including results of any accreditation readiness assessments conducted by PHA.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Accreditation provides a framework for a public health department to identify performance improvement opportunities, to improve management, develop leadership, and improve relationships with the community. However, many LHDs do not have funding for the training and technical assistance required to meet PHAB accreditation standards and measures. PHA provides accreditation-related training and TA to LHDs seeking accreditation, reaccreditation, or Pathways recognition to help them meet PHAB requirements.

- *Item to be measured:* Number of LHDs that receive focused training and/or technical assistance
- *Unit of measurement:* Number of LHDs
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* PHA Program
- *Date baseline was last collected:* 07/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 3

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Focused accreditation-related technical assistance and/or training for local public health departments. Between 07/01/2024 and 06/30/2025, Program will provide focused accreditation-readiness TA and/or training to three (3) local health departments that have indicated they are pursuing PHAB accreditation, reaccreditation, or Pathways Recognition.

Description of Activity: This TA and/or training will support accreditation readiness and may include workforce development, quality improvement, strategic planning, health equity, and performance management-related training, and may also include technical assistance with Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) development and alignment, or document selection.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Training to support accreditation readiness at all California LHD. Between 07/01/2024 and 06/30/2025, Program will facilitate and offer training that promotes accreditation-readiness to staff at all 61 California local health departments.

Description of Activity: This TA and/or training will broadly support accreditation-related activities, and may include workforce development, quality improvement, strategic planning, health equity, or performance management-related training.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity3

Networking and Information Sharing. Between 07/01/2024 and 06/30/2025, Program will facilitate networking among accreditation staff at all 61 LHDs and collect, maintain, and share information on accreditation, including results of any accreditation readiness assessments conducted by PHA.

Description of Activity: PHA will maintain a network of accreditation coordinators from all 61 LHDs, hold regular convenings, provide content as needed. PHA will also maintain

and update a collaborative SharePoint of information and resources relating to accreditation for all LHD Accreditation Coordinators.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Public School Health Center Support Program

Healthy People 2030 Objective

AH-01 Increase the proportion of adolescents who had a preventive health care visit in the past year

Health Objective

Improve access to preventive health care services among California's adolescents by increasing the total amount of school-based health and wellness centers in California by at least 5% by July 1, 2029.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: State Health Department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of total funding that is PHHS Grant: 10-49% - Partial source of funding
- Existing funding source(s): State or local funding
- Role of PHHS Block Grant Funds in supporting this program: Restore program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 1
- Number of FTEs in this program funded by the PHHS Block Grant: 1

Issue/Problem

The program supports preventive health care access among adolescents through providing training and technical assistance to school-based health centers (SBHCs) and coordinating a collaborative school health partnership with cross-sectoral stakeholders at the state and local level. The national Community Preventive Services Task Force has recommended SBHCs in low-income communities as an effective service to improve educational outcomes including school performance, grade promotion, and high school completion. CDPH is mandated in Section 124174.6 of the Health and Safety Code to implement the PSHCSP in support of new and existing SBHCs. The program supports SBHCs through providing training and technical

assistance to schools and coordinating a collaborative partnership with cross-sectoral stakeholders at the state and local level.

Public health program was prioritized as follows:

- Legislature established as a priority

One paragraph the key indicator(s) affected by this problem:

Number of California school-based health and wellness centers, defined as being a building or portable located physically on campus. Mobile vans and off-campus "school-linked" facilities located off campus are also included in this measurement.

Baseline value of the key indicator described above: 377 school-based health and wellness centers in California

Data source for key indicator baseline: California School-based Health Alliance

Date key indicator baseline data was last collected: Data for metric is current and was published in 2024

Program Strategy

Goal: Expand the CA HBI work to include tribal/rural communities that are currently not funded to conduct HBI work, utilizing the HBI Road Map for Indian Country strategies.

Is this program specifically addressing a Social Determinant of Health (SDOH)?: Yes

- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)

Summary of Program Strategy: Academic research and publications by federal and state health agencies have long identified school-based health centers as a key strategy to increase access to preventive care among adolescents in underserved communities. School-based health centers provide low-income and minority students with health care and health education as an effective service to improve educational outcomes including school performance, grade promotion, and high school completion.

Primary Strategic Partners

External:

1. California School-based Health Alliance
2. Department of Health Care Services
3. California Health and Human Services Agency
4. Department of Health Care Access and Information

5. National Association of Chronic Disease Directors

Internal:

1. Maternal Child and Adolescent Health
2. Injury and Violence Prevention Branch
3. Office of Oral Health

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Other: Coordination and facilitation of collaborative partnership

Evaluation Methodology: Program will develop a daily management system and A3 focused on school-based health centers to ensure ongoing evaluation through all stages of program implementation. Lean and RBA methods will be used to establish Objectives and Key Results and performance metrics that will be used for ongoing evaluation and iterative development through using the Plan Do Study Act framework. Performance metrics and OKRs will provide the basis for ongoing evaluation from multiple evaluation perspectives including goal-based, process-based, and outcomes-based. Program will be hiring an Research Scientist III to conduct a more formal research and scientific analysis to evaluate the program's impact.

Program Settings:

- Other: TK-12 schools

Target Population of Program

- *Target population data source*: CA Dept of Education enrollment summary for charter and non-charter schools 2022-2023
- *Number of people served:* 5,852,544
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- 5-14 years
- 15-24 years

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Rural

Location:

- State of California

Occupation:

- N/A

Education Attainment:

- Some High School

Health Insurance Status:

- Uninsured
- Medicaid
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Trainings to schools and communities to support new SBHCs and enhance existing SBHCs

Objective: From July 1, 2024 to June 30, 2025, Program will provide at least two (2) trainings on school-based health center topics to schools and community stakeholders over the next five years through utilizing a webinar format.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is a subset of the larger problem.

Problem for this Objective: **Training is needed because funding, implementing, and sustaining SBHCs is complex and challenging**. Funding, implementing, and sustaining school-based health centers is complex and challenging for many schools and communities. Schools and communities often lack the training and expertise needed to start and sustain new school-based health centers in high priority communities. Without the training and expertise needed to plan and sustain new school-based health centers, new centers do not get established in many high priority communities. Thus, access issues for preventive care for adolescents continue persist in many of these California communities.

Key indicator(s) affected by this problem:

Number of California school-based health and wellness centers, defined as being a building or portable located physically on campus. Mobile vans and off-campus "school-linked" facilities located off campus are also included in this measurement.

Baseline value for the key indicator: 377

Data source for key indicator baseline: California School-based Health Alliance

Date key indicator baseline data was last collected: March 2023

Intervention Information

SBHCs increase access to preventive care and reduce income-based health disparities among adolescents. SBHCs reduce barriers to preventive care, particularly for children from low-income families. Their location at schools reduces transportation challenges, alleviates the need for parents to take time away from work, and reduces difficulties in identifying a clinician that accepts their insurance. SBHCs can proactively promote services that families are unaware of or underestimate the value of receiving.

Research has shown that SBHCs may reduce income-based health disparities among adolescents.

Type of Intervention: Evidence-Based Intervention

- Other: Journal of the American Medical Association

Rationale for choosing the Intervention: CDPH is legislatively mandated to support SBHCs and peer reviewed literature confirms that SBHCs are a key strategy to increase access to preventive care among adolescents.

- *Item to be measured:* Number of trainings
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program internal records
- *Date baseline was last collected:* 04/12/2024
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 2

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

SBHC Workgroup. From July 1, 2024 to June 2025, Program will form a state-wide school-based health center workgroup and convene at least twice (2) a year.

Description of Activity: From July 1, 2024 to June 2025, Program will restart CDPH's state-wide school-based health center workgroup as part of a larger collaborative partnership. Workgroup will be co-chaired by the California School-based Health Alliance and convene at least twice (2) this year. The workgroup will focus on building policy support for SBHCs and provide communications and resources for schools and communities to implement new SBHCs and enhance existing SBHCs.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Rape Prevention Program

Healthy People 2030 Objective

IVP-D05 Reduce contact sexual violence

Health Objective

Between July 1, 2024, and June 30, 2025, the Program will implement 16 local prevention projects, from local rape crisis centers (RCCs) with community-based organization (CBO) partnerships, and CBOs with RCC partnerships, using community/societal-level strategies sexual violence prevention strategies that focus on health equity in priority populations.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $825,408
- Amount of funding to local agencies or organizations: $678,502
- Type of supported local agency/organization: Local organization
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 10-49% - Partial source of funding
- Existing funding source(s): Other federal funding (CDC): Rape Prevention and Education
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 2
- Number of FTEs in this program funded by the PHHS Block Grant: 0.75

Issue/Problem

This program will prevent sexual violence perpetration and victimization. This program will prevent sexual violence perpetration and victimization in communities throughout California. Victims of sexual violence often have long-term emotional and health consequences as a result of this “adverse experience,” such as chronic diseases,

emotional and functional disabilities, harmful behaviors, and intimate relationship difficulties (CDC, 2008).

Public health program was prioritized as follows:

- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: Rate of sexual harassment or assault among adults (18+) during the past year.

Baseline value of the key indicator described above: 9%

Data source for key indicator baseline: California Violence Experiences Survey (CalVEX)

Date key indicator baseline data was last collected: 2023

Program Strategy

Goal: Stop first-time perpetration and victimization of sexual violence by implementing evidence-informed sexual violence prevention strategies.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- Education (e.g., low high school graduation rates, low literacy levels, poor early childhood education)
- Social and Community Context (e.g., discrimination, low civic participation, poor workplace conditions, incarceration)
- Neighborhood and Built Environment (e.g., poor quality of housing, limited access to transportation, food desert, poor water/air quality, neighborhood crime and violence)

Summary of Program Strategy: Program will implement sixteen local prevention projects using community/societal-level prevention strategies by local rape crisis centers (RCC) and Community Based Organizations (CBOs), aligned with the best practices of the Centers for Disease Control and Prevention (CDC) to prevent sexual violence.

Primary Strategic Partners

External:

1. *ValorUS*

2. *University of California, San Diego*
3. *California Partnership to End Domestic Violence*

Internal:

1. CDPH Domestic Violence Prevention Program
2. CDPH Violence Prevention Initiative
3. CDPH Essentials for Childhood

Evaluation Methodology: RPP implements a standardized evaluation process that includes collection of process and outcome data from local organizations. These organizations are able to access their own data to inform their own program and processes, and CDPH receives data from all organizations, which is used to determine the impact of the program throughout the state.

Program Settings:

- Community based organization
- Rape crisis center

Target Population of Program

- *Target population data source*: CA, DOF, Report P-1B: Population Projections by Individual Year of Age, CA, 2010-2060. 3/2024.
- *Number of people served:* 38,99,721
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- 5-14 years
- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years

- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- N/A

Education Attainment:

- Some High School
- High School Diploma
- Some College

Health Insurance Status:

- Uninsured
- Medicaid
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Community/Societal-level Prevention Strategies

Objective: Between July 1, 2024, and June 30, 2025, Program will implement sixteen (16) local prevention projects using community/societal-level prevention strategies by RCCs and CBOs that provide sexual violence prevention programs to victims, potential victims, and potential perpetrators to create environmental and community changes.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Community/societal-level prevention strategies. Program will implement sixteen local prevention projects using community/societal-level prevention strategies by local RCCs and CBOs that provide sexual violence prevention programs to victims, potential victims, and potential perpetrators, aligned with the CDC resources to prevent sexual violence.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: CDC Sexual Violence Prevention Resource for Action: A Compilation of the Best Available Evidence 2016

Rationale for choosing the Intervention: The CDC has documented that sexual violence is a preventable, public health issue. The program's intervention aligns with the framework established by the CDC's Sexual Violence Prevention Resource for Action, which recommends evidence-based or evidence-informed strategies and has served as a guide to developing interventions (prevention programs) implemented in local jurisdictions.

- *Item to be measured:* Number of local projects implemented
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* RPP process data; Annual reports
- *Date baseline was last collected:* 07/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 16
- *Final target value to be achieved by the Final Progress Report:* 16

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Fund Community/societal level projects. Between July 1, 2024 and June 30, 2025, Program will fund four (4) local comprehensive community-based projects using a coalition building or community mobilization strategy to create change at the community/societal level.

Description of Activity: Between July 1, 2024 and June 30, 2025, Program will fund four (4) local comprehensive community-based projects using a community mobilization or coalition building strategy. Through June 2025, Program and partners (University of California, Berkley and ValorUS) will provide training and technical assistance to the 4 local projects to educate about the need for social norm change in communities. Program will meet monthly with partners to coordinate program implementation and evaluation of sexual violence prevention efforts.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Toxicological Outbreaks Program

Healthy People 2030 Objective

IVP-04 Reduce emergency department visits for nonfatal unintentional injuries

Health Objective

Reduce statewide morbidity and mortality associated with exposure to toxic substances by building capacity for CDPH and LHJs to identify, respond to, and manage toxicological outbreaks in an effective, coordinated, and timely manner.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 10-49% - Partial source of funding
- Existing funding source(s): State or local funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 1
- Number of FTEs in this program funded by the PHHS Block Grant: 0.5

Issue/Problem

CA lacks sufficient infrastructure to identify and respond to non-infectious toxicological outbreaks. Toxic agents are substances that arise outside the human body and can cause injury, illness, or even death. Examples of toxic agents include heavy metals (e.g., mercury, lead), organophosphate pesticides, gases (e.g., chlorine, ammonia) and even certain biological substances (e.g., ricin). Toxicological outbreaks caused by toxic agents (non-infectious disease outbreaks) occur periodically in California, including the dramatic 2019 outbreak of lung injuries associated with vaping. The National Association of County and City Health Officials has identified that local health

departments report being less prepared for responses to toxic agent incidents than any other emergency. CDPH has the authority to conduct special investigations into the sources of injury and illness, including their causes and means of prevention (Health and Safety Code, section 100325). CDPH's successes are most visible when responding to infectious disease outbreaks, and public health has substantial history and capacity responding to infectious diseases. In contrast, CDPH does not have a core team dedicated to noninfectious disease outbreak investigations, and previous investigations have been mostly ad hoc.

Public health program was prioritized as follows:

- Governor (or other political leader) established as a priority

Key Indicator(s) affected by this problem: Create standardized approaches to case finding and data infrastructure necessary for managing toxicological outbreaks. Key indicator: standardized approaches to case finding in collaboration with local health jurisdictions and an operationalized system to support management of toxicological outbreaks.

Baseline value of the key indicator described above: 0

Data source for key indicator baseline: Implementation of case finding system(s) and data management system platform

Date key indicator baseline data was last collected: N/A; pending hiring

Program Strategy

Goal: Build capacity for CDPH and LHJs to identify, respond to, and manage toxicological outbreaks in an effective, coordinated, and timely manner.

Is this program specifically addressing a Social Determinant of Health (SDOH)? No

Summary of Program Strategy: The program uses multiple strategies to build capacity to identify and respond to toxicological outbreaks. For the '24-'25 fiscal year, the Block Grant will fund strategies 1, 2, and 4.

1. Build data infrastructure to facilitate outbreak identification and response.
2. Develop workflows, tools, and protocols to guide CDPH and LHJs in outbreak identification and response.
3. Provide learning opportunities to increase knowledge and skills in outbreak identification and response.
4. Create partnerships to facilitate an effective and coordinated outbreak identification and response.
5. Provide TA, coordination, and leadership to identify and respond to outbreaks.

Primary Strategic Partners

External:

1. *California Poison Control System*
2. *Local health jurisdictions*
3. *CDC*
4. *CalEPA*

Internal:

1. *Center for Preparedness and Response*
2. *Information Technology Service Division*
3. *Center for Laboratory Sciences*
4. *Food and Drug Branch*
5. *Division of Communicable Disease Control*

Planned non-monetary support to local agencies or organizations

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: Progress will be evaluated by the completion of steps outlined in the objective and activities: 1) the creation of tools and protocols used to manage and respond to toxicological outbreaks; 2) acquisition and implementation of a data software management system; and 3) strengthen existing collaborations and establish partnerships with internal and external stakeholders.

Program Settings:

- State health department
- Local health department

Target Population of Program

- *Target population data source*: 2020 U.S. Census Bureau (decennial), Census, and 2023 American Community Survey (annual)
- *Number of people served:* 39,500,000
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian

- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? No

Is the entire target population disproportionately affected by the program, or only part? All

Objectives and Activities

Objective 1:

Title: Build Toxicological Outbreak Response, Network Capacity, and Data Related Capabilities

Objective: Between 07/2024 and 06/2024, Program will develop a (1) data management platform, develop five (5) survey tools for deployment during outbreak investigations, and establish an (1) interagency community of practice focused on sharing expertise, problem solving, increasing capacity and strengthening collaboration.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Program will secure a data management platform, develop survey tools for toxicological outbreaks, and continue engaging with stakeholders to create a community of practice. Program is exploring scalable data software systems that will store, organize, query, and analyze data. Program is developing online deployable surveys using its acquired data capture and collection software. Program will continue its

internal and external outreach efforts to foster and strengthen collaborations and form a community of practice stakeholder group.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)
- Other: National Center for Environmental Health Toxicological Outbreak Toolkit

Rationale for choosing the Intervention: Increase state and local capacity to effectively investigate and respond to toxicological outbreaks.

- *Item to be measured:* Activity with stakeholders to build capacity to identify and respond to toxicological outbreaks
- *Unit of measurement:* Activity
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Established community of practice, survey tools, and data management platform
- *Date baseline was last collected:* 07/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 7

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Acquire data management platform. From 7/1/2024 to 6/30/2025, Program will acquire a (1) data management platform that will provide scalable data storage, security, organized search capabilities, and analyzation tool.

Description of Activity: Program's current data management platform does not allow for efficient scalability, multiple data query retrieval, or refined user security. This impacts the program's ability to respond efficiently to toxicological outbreaks.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Develop Program's database of deployable surveys. From 7/1/2024 to 6/30/2025, Program will develop three surveys for deployment when responding to toxicological outbreaks.

Description of Activity: Program acquired an electronic survey data capture and collection software. Currently, Program's database of deployable surveys is not sufficient to quickly respond to a sudden widespread toxicological outbreak event.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Engage with stakeholders to foster collaboration and form a community of practice. From 7/1/2024 to 6/302025, Program will engage stakeholders to form a (one) toxicological outbreak community of practice.

Description of Activity: Program currently does not have a forum for engaging internal and external expertise needed for creating best practices and responding to toxicological outbreaks. This places the Program at a disadvantage in responding to widespread toxicological outbreak events or outbreaks with complex causes that require diverse expertise to understand the etiology and spread.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Tuberculosis Free CA

Healthy People 2030 Objective

IID-17 Reduce tuberculosis cases

Health Objective

Approximately 80% of California's annual tuberculosis (TB) cases arise from untreated latent TB infection (LTBI). TB disease is preventable through the diagnosis and treatment of LTBI, however, persons with LTBI are often unaware of their infection and do not seek treatment. The TB Free California Program provides technical assistance to >90% of local public health programs and community healthcare clinics that request assistance with LTBI care, education, and quality improvement projects. Activities include measurement of LTBI testing and treatment at clinic sites, patient education for high-risk populations with a goal of reducing TB health disparities based on race and ethnicity, and provider training and consultation for LTBI care. By treating LTBI, we will avert morbidity, mortality, and healthcare costs associated with TB disease and improve health equity related to TB outcomes. Our aim is to reduce the California TB case rate over a five-year performance period.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: No

Issue/Problem

TB disease in California occurs primarily in people with longstanding LTBI and could be prevented by treating LTBI; because LTBI is asymptomatic and no other statewide programs exist to specifically address LTBI, many patients do not seek testing or treatment. The incidence of TB disease in California is nearly twice the national incidence. Californians born outside the U.S., as well as racial and ethnic

minorities, experience disproportionately high rates of TB disease. TB disease in California occurs primarily in people with longstanding LTBI, and because LTBI is asymptomatic, many patients do not seek testing or treatment. The goal of our program is to identify and treat those with LTBI, in order to prevent cases of TB disease in California. The TB Free California program aims to avert TB disease based on evidence-based practices, which will in turn improve overall health status and health equity throughout California.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)
- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: Our key indicator is the California TB case rate. Due to the long latency period of TB disease, and the fact that the vast majority of public health and medical efforts currently focus on TB control rather than prevention, we rely on intermediate outcomes for our yearly program evaluation (described in evaluation methodology).

Baseline value of the key indicator described above: 5.4

Data source for key indicator baseline: California Department of Public Health, TB Control Branch, TB in California: 2023 Snapshot

Date key indicator baseline data was last collected: 2023

Program Strategy

Goal: The goal of our program is to identify and treat those with LTBI in order to prevent cases of TB disease in California.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)

Summary of Program Strategy: Californians born outside the U.S., as well as racial and ethnic minorities, experience disproportionately high rates of TB disease. In 2023, the TB rates among Asian, Black, and Hispanic persons born outside the U.S., were 43, 28, and 21 times greater, respectively than of U.S.-born white persons; nearly half (47%) of all California's TB cases occurred in Asians. The TB Free California program engages groups disproportionately impacted by TB and the providers that serve them to coordinate patient education and targeted testing and treatment for high-risk populations and

produces culturally and linguistically appropriate materials for use with a diverse group of patients.

Primary Strategic Partners

External:

1. *Association of Asian Pacific Community Health Organizations*
2. *Federally Qualified Health Centers (North East Medical Services)*
3. *San Diego County Tuberculosis Elimination Initiative*
4. *UC Berkeley University Health Services*
5. *Merced County Department of Public Health*

Internal:

1. *Office of Public Affairs*
2. *Office of Refugee Health*
3. *Office of Border and Binational Health*
4. *Chronic Disease Control Branch*
5. *Department of Health Care Services, Medi-Cal Managed Care*

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Other: Patient and provider health education materials, printed and online

Evaluation Methodology: Program will evaluate progress towards objectives using process evaluation with the following measures: the number of clinics or health systems partnered with to measure LTBI testing and treatment practices, number of medical providers trained, proportion of requesting clinics who receive trainings or clinical consultation, and number of patient education materials created and distributed. Additionally, Program will assess feedback from partners and stakeholders, electronic and paper surveys, emails, and intermediate outcome evaluations, which may include: 1) proportion of at-risk patients receiving testing for LTBI, 2) proportion of persons testing positive for TB infection who are prescribed LTBI treatment, and 3) proportion of patients who are motivated to speak to a medical provider about LTBI testing and treatment after reviewing patient education materials.

Program Settings:

- Community based organization
- Local health department
- Medical or clinical site
- State health department

- University or college

Target Population of Program

- *Target population data source*: CDPH TB Control Branch: Report on Tuberculosis in California 2021
- *Number of people served:* 2,100,000
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Technical assistance to measure LTBI Test Positivity and Treatment Practices

Objective: Between 07/2024 and 06/2025, program will support analysis of TB laboratory or clinical data in at least two (2) sites to understand local LTBI test positivity and treatment practices of at least 70 cases of persons diagnosed with LTBI who start treatment in a key clinical site.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? Subset of the larger problem.

Problem for this Objective: **Preventing cases of TB disease in California depends on identifying and treating LTBI, yet there are few estimates of LTBI testing and treatment practices in local health jurisdictions and community healthcare settings.** Preventing cases of TB disease in California depends on identifying and treating LTBI, yet there are few estimates of LTBI testing and treatment practices in local health jurisdictions and community healthcare settings. We aim to measure LTBI testing and treatment practices at key sites across California, with the hope of identifying barriers to care and spurring quality improvement interventions to address these barriers.

Key indicator(s) affected by this problem: Key steps in the diagnosis, and treatment of LTBI can be measured and represented in a LTBI Care Cascade. LTBI Care Cascades can be compared across clinical settings, used to identify points of attrition in care and used to prioritize outreach and interventions. The proportion of persons testing positive for TB infection who are prescribed LTBI treatment in California is one of the final steps of the LTBI Care Cascade

Baseline value for the key indicator: 50

Data source for key indicator baseline: Civil surgeon report, California Department of Public Health (unpublished)

Date key indicator baseline data was last collected: 2021

Intervention Information

Analyze electronic health information to enable measurement of key LTBI metrics at two (2) sites in California. Between 07/2024 and 06/2025, Program will provide technical support in the form of data collection from electronic medical records, designing pilot interventions, modifying data collection systems, performing analysis, and/or creating LTBI care cascades at least two (2) clinical sites. Program will help clinics identify gaps in each site's LTBI care cascade and problem-solve barriers to LTBI testing and treatment. Program will additionally provide support for a new electronic data system: CalCONNECT for TB is a platform which supports local programmatic activities including latent TB infection management follow-up for patients with positive results for TB infection via electronic laboratory reporting (ELR).

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)

- Other: (1) California Tuberculosis Elimination Advisory Committee. California TB Elimination Plan 2021-2025. Richmond, CA).

Rationale for choosing the Intervention: One of the TB Free California objectives is to define baseline rates of testing and treatment in California, in order to identify and address gaps in care and measure incremental improvement in performance. Our work with individual clinics promotes the development of LTBI management programs, quality improvement interventions related to LTBI, and allows local health jurisdictions (LHJs) understand their local practice patterns and plan direct public health actions. Some LHJ programs will also act as providers of last resort when there are gaps in LTBI care within the jurisdiction's health care systems. Measurement of care cascades informs work with state and national partners to build infrastructure to collect data on LTBI testing and treatment. Additionally, by piloting a new TB LTBI management platform in two LHJs, we hope to support direct public health action, such as identification of care gaps, targeted outreach and training for medical providers who have high proportion of positive tests, community outreach for populations with high test positivity, or case management for patients who need LTBI treatment.

- *Item to be measured:* Persons with LTBI who start treatment
- *Unit of measurement:* Number of persons diagnosed with LTBI who start treatment in a key clinical site
- *Baseline value for the item to be measured:* 50
- *Data source for baseline value:* TBF clinical partner
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 60
- *Final target value to be achieved by the Final Progress Report:* 70

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Support Healthcare Clinics in Measuring LTBI Testing and Treatment. Between 07/2024 and 06/2025, Program will assist with data collection, management, and analysis at a minimum of two (2) clinical sites with key metrics regarding LTBI testing and treatment; program will provide consultation to >90% of clinics statewide that request support.

Description of Activity: Between 07/2024 and 06/2025, Program will assist with data collection, management, and analysis at clinics with metrics including: 1) proportion of at-risk population receiving testing for LTBI, and 2) proportion persons who test positive for TB infection who are prescribed LTBI treatment, at a minimum of two (2) community clinic

sites. We will provide technical assistance to clinics through direct consultation, provision of data management tools and templates with modifiable data fields, and analysis of collected data. Program Epidemiologist is primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Promote use of a standardized LTBI Care Cascade through direct technical assistance to clinics and webinars. Between 07/2024 and 06/2025, Program will convene a minimum of one (1) webinar training detailing how to develop, measure and evaluate a LTBI care cascade.

Description of Activity: A standardized LTBI care cascade was developed by TB Free California in prior fiscal years and includes stepwise instructions on how to generate key metrics in LTBI testing and treatment using existing electronic medical record data. Between 07/2024 and 06/2025, Program will convene a minimum of one (1) virtual training detailing how to develop, measure and evaluate a LTBI care cascade. Program Epidemiologist is primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Provide technical assistance to local health departments in piloting a TB data platform. Between 07/2024 and 06/2025, Program will provide high level of support, both remote and/or on-site, to two (2) pilot local health jurisdictions in onboarding and adopting the CalCONNECT for TB module.

Description of Activity: Support for the new CalCONNECT data system may include designing and implementing a needs assessment with each pilot local health jurisdiction, attending weekly meetings with pilot local health jurisdictions, providing TB-specific trainings and demos of workflows, crafting reference guides and resources, soliciting feedback and documenting observations of challenges during onboarding, and contributing to modifications to the platform's design to better meet local needs. Program Epidemiologist is primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Objective 2:

Title: Engage Communities at Higher Risk for TB and Their Providers

Objective: Between 07/2024 and 06/2025, Program will partner with at least six (6) California LHJs, community-based organizations (CBOs), or community clinics serving patients at higher risk of TB infection to promote TB prevention initiatives, provide TB health education materials, and/or organize community health worker training, in order to reach communities at higher risk and reduce TB health disparities.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? Subset of the larger problem.

Problem for this Objective: **TB disease disproportionately impacts non-U.S.-born and non-white persons in California.** TB disease is a health disparity issue in California, disproportionately impacting non-U.S.-born and non-white persons. In 2023, nearly half (47%) of California's TB cases occurred in Asian persons, and 40% of cases occurred in Hispanic/Latinx persons. Although TB disease can often be avoided through treatment of LTBI, most patients do not know they are infected and do not seek preventive treatment. Outreach to communities at higher risk for TB infection, as well as the providers that serve them, is needed to motivate patients to seek appropriate testing and treatment for LTBI.

Key indicator(s) affected by this problem: Number of California LHJs, CBOs, and community clinics that access health educational materials for TB prevention

Baseline value for the key indicator: 6

Data source for key indicator baseline: TBF California midyear survey, unpublished data.

Date key indicator baseline data was last collected: Fiscal year 23-24

Intervention Information

Culturally-appropriate health education, and linkage to care to help reduce TB health disparities. Program will work with community organizations to distribute culturally- and linguistically appropriate health materials to educate patients about their TB risk and promote LTBI treatment. Such resources may include in-language print or electronic materials, support for TB prevention messages at community events, or trainings for Community Health Workers (CHWs) and other non-licensed health care providers who are trusted members of communities.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: CA Tuberculosis Elimination Advisory Committee. CA TB Elimination Plan 2021-2025. Richmond, CA

Rationale for choosing the Intervention: Persons with LTBI often do not know they are infected and therefore do not seek treatment. Persons at higher risk for TB often have little information about LTBI and may have encountered misinformation or stigma about TB. Effective training can inform patients about the importance of TB prevention and encourage them to speak to their providers about getting tested for LTBI, and treated, when necessary. Populations at higher risk for TB benefit from engagement and education by trusted community partners. CHWs and CBOs that already serve these communities are the optimal partners to provide this education and messaging.

- *Item to be measured:* Number of new LHJs, CBOs, and community clinics using TB prevention materials/doing health outreach
- *Unit of measurement:* Number of organizations
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Midyear survey TBF California
- *Date baseline was last collected:* Fiscal year 23-24
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 6

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Promote TB prevention education in LHJs, community-based organizations, and community clinics. Between 7/2024 and 6/2025, Program will partner with at least six (6) community organizations to distribute culturally and linguistically appropriate TB education materials and/or include TB prevention education in outreach efforts.

Description of Activity: Between 7/2024 and 6/2025, Program will partner with at least six (6) California LHJs, CBOs, and community clinics to distribute culturally and linguistically appropriate TB education materials and/or include TB prevention education in outreach efforts. Program will provide health education materials, assistance in planning outreach activities, and/or trainings for Community Health Workers (CHWs), in order reach communities at higher risk of TB infection and reduce TB health disparities. Program Health Educator, in collaboration with the corresponding local TB program, is primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Share best practices in TB prevention by coordinating a regional community of practice. Between 7/2024 and 6/2025, Program will recognize and share best practices in TB prevention by convening one (1) regional community of practice meeting, which includes representatives from at least one high-morbidity LHJ.

Description of Activity: Between 7/2024 and 6/2025, Program will identify and share best practices in TB prevention on topics including patient and provider engagement, education and outreach strategies, quality improvement projects and/or clinic-level interventions throughout California by convening one (1) local or regional community of practice, which includes at representatives from at least one high-morbidity county. Community clinics and community-based organizations will be invited to the meetings and have the opportunity to share their experience with TB prevention activities. Program Health Educator, in collaboration with the corresponding local TB program, is primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 3

Integrate TB prevention messages into patient education materials from at least one CDPH program. Between 7/2024 and 6/2025, Program will partner with one (1) CDPH Program to integrate TB prevention messages into existing or planned patient education materials.

Description of Activity: Between 7/2024 and 6/2025, Program will partner with at least one (1) CDPH Program outside TB Control in order to integrate TB prevention messages into existing or planned patient education materials. By collaborating with and leveraging the outreach efforts of our partners, we hope to increase the amount of patients we can reach with TB prevention education. Program Health Educator is primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 4

Maintain a centralized web location for provider and patient materials on latent TB infection. Between 07/2024 and 06/2025, Program will maintain one (1) centralized web location for providers and patients to access materials on latent TB infection.

Description of Activity: Program will maintain a centralized web location for patients and providers to access materials on LTBI. Program will revise and update content as needed

and upload new materials and resources as they are developed. Program Health Educator and Project Specialist are primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Objective 3:

Title: Provide LTBI Training, Clinical Reference Materials, & Clinical Consultation to Healthcare Providers

Objective: Between 07/2024 and 06/2025, Program will provide technical assistance in the form of LTBI training, clinical consultation, or clinical reference materials to at least three hundred (300) healthcare providers.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? Subset of the larger problem.

Problem for this Objective: **CDC published 2020 "Guidelines for the Treatment of Latent Tuberculosis; but, many PCPs didn't know.** Tuberculosis clinical care involves many diagnostic and therapeutic nuances, including distinguishing latent TB infection from active disease, interpretation of discordant tests, treating special populations including infants and pregnant women, and managing drug side effects. Many primary care providers remain unaware of risk groups, ideal testing strategies, and medication options for treating LTBI. Furthermore, civil surgeons (i.e. providers that evaluate patients immigrating to the U.S.) have a mandate to systematically test for TB infection but are often unfamiliar with prescribing and managing LTBI treatment. There is a high demand for training, consultation and concise clinical tools, including risk assessments, algorithms, treatment cards, and drug fact sheets.

Key indicator(s) affected by this problem: Primary care providers who are comfortable prescribing CDC-preferred LTBI therapy

Baseline value for the key indicator: 30

Data source for key indicator baseline: Provider survey of >100 California primary care providers, unpublished data, TB Free California

Date key indicator baseline data was last collected: 2017-2021; 2022

Intervention Information

Provide clinical consultation or training to the majority of community clinics and/or provider groups (at least 300 medical providers) who request support with LTBI. Between 07/2024 and 06/2025, Program will engage at least 300 healthcare providers to

receive training or consultation related to LTBI. Our goal is to provide the skills training necessary for primary care providers in California to effectively screen, test, and treat patients for LTBI. Program will work in collaboration with local TB control programs, clinics, and training centers to execute evidence-based trainings on LTBI testing and treatment, and as an additional activity, will provide direct clinical consultation on testing and treatment of TB infection and TB prevention strategies for healthcare providers in community and institutional settings.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)

Rationale for choosing the Intervention: Tuberculosis clinical care involves many diagnostic and therapeutic nuances, including distinguishing latent TB infection from active disease, interpretation of discordant tests, treating special populations including infants and pregnant women, and managing drug side effects. Many primary care providers remain unaware of or confused regarding risk groups, ideal testing strategies, and medication options for treating LTBI.

- *Item to be measured:* Number of healthcare providers that receive training or consultation
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 300
- *Data source for baseline value:* Unpublished data, TB Free California
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 100
- *Final target value to be achieved by the Final Progress Report:* 300

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Conduct Training on LTBI Best Practices and Guidelines. Between 07/2024 and 06/2025, Program will work in collaboration with local TB control programs, clinics, and civil surgeon groups to execute trainings on LTBI testing and treatment, reaching a minimum of three hundred (300) healthcare providers per year.

Description of Activity: Between 07/2024 and 06/2025, Program will work in collaboration with local TB control programs, clinics, and civil surgeon groups to execute evidence-based trainings on LTBI testing and treatment. Trainings may take the form of planned statewide webinars with continuing medical education (CME) credit provided, clinical training during regional conference calls, or ad-hoc virtual and in-person clinical trainings, as allowed for by TBF staff time; trainings will reach a minimum of 300 healthcare providers. Trainings will emphasize best practices for providers and will target providers who serve populations that are at higher risk of TB transmission and patients at most risk for progression to TB disease. Particular emphasis will be placed on use of testing with interferon gamma release assay (IGRA) for non-U.S. born patients and use of short-course LTBI treatment regimens, including 12-dose once-weekly isoniazid-rifapentine or four months of daily rifampin. Program Clinicians are primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Provide Expert Consultation to Healthcare Providers who Request Support Regarding LTBI Care. Between 07/2024 and 06/2025, Program will provide clinical consultation and subject matter expertise on testing and treatment of TB infection for >95% (at least 10) healthcare providers in community and institutional settings.

Description of Activity: Between 07/2024 and 06/2025, Program will provide clinical consultation and subject matter expertise on testing and treatment of TB infection for healthcare providers in community and institutional settings. Our goal is to provide support to >95% medical providers that request consultation (and a minimum of 10 medical providers). Common consultation topics include interpretation of discordant tests for TB infection, work-up of TB disease prior to starting LTBI therapy, addressing drug interactions with LTBI medications, and accounting for partially completed LTBI therapy. Program will disseminate clinical algorithms, protocols, fact sheets, and workflow modifications developed by TB Free California to enable clinics to implement screening, testing, and treatment of patients with LTBI. Examples of current clinical tools can be found on the TB Free California website. Program Clinicians are primarily responsible for this activity.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Wildfire Smoke Mitigation Program

Healthy People 2030 Objective

EH-01: Reduce the number of days people are exposed to unhealthy air (Environmental Health Core)

Health Objective

The Wildfire Smoke Mitigation Program will provide better, more equitable clean air solutions to California communities in the face of increasing health risks from wildfire smoke events in a changing climate. The program will inform guidance and clean air solutions for the smoke events that are increasingly contributing to communities' daily pollution burdens and will increase Californians' resilience and emergency preparedness.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: State Health Department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Percentage of total funding that is PHHS Grant: 100% - Total source of funding
- Existing funding source(s): None
- Role of PHHS Block Grant Funds in supporting this program: Startup of a new program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 1
- Number of FTEs in this program funded by the PHHS Block Grant: 1

Issue/Problem

This program enables better, more equitable clean air solutions for California communities in the face of increasing health risks from wildfire smoke events in a changing climate. The program measures key smoke-associated chemical exposures under different air conditions, community characteristics, and protection strategies, and uses them to evaluate health risk mitigations in partnership with State & community partners.

Public health program was prioritized as follows:

- Identified via surveillance systems or other data sources
- Declared as an emergency within your jurisdiction
- Governor (or other political leader) established as a priority

One paragraph the key indicator(s) affected by this problem:

Wildfire smoke days result in significantly elevated risk of out of hospital cardiac arrests and emergency room visits in CA.

Baseline value of the key indicator described above: 1.7 (Odds Ratio for smoke-related cardiac arrest); 1.15 (Odds Ratio for smoke-related ER visits)

Data source for key indicator baseline: Jones et al. 2020 J. Am. Heart Assoc. 9:e014125; Wettstein et al. 2018. J. Am. Heart Assoc. 7:e007492

Date key indicator baseline data was last collected: 2020

Program Strategy

Goal: The Wildfire Smoke Mitigation Program aims to provide better, more equitable clean air solutions to California communities in the face of increasing health risks from wildfire smoke events in a changing climate.

Is this program specifically addressing a Social Determinant of Health (SDOH)?: No

Summary of Program Strategy: The Program will hire a research scientist to measure and evaluate the key airborne chemical exposures from wildfire smoke under different air conditions, community characteristics, and protection strategies. Clean air solutions to these chemical risks with then be evaluated with our community partners. The feasibility and health equity of the recommended clean air solutions will be a key component of these analyses.

Primary Strategic Partners

External:

1. Public Health Institute
2. Sequoia Foundation
3. CalEPA
4. UCSF
5. CA Rural Indian Health Board

Internal:

1. CHC Env Health Investigations Branch
2. CHC OCC Health Branch

3. Office of Health Equity
4. Center for Environmental Health
5. Center for Preparedness & Response

Planned non-monetary support to local agencies or organizations:

- Technical Assistance

Evaluation Methodology: The success of this program will be measured with 1) a completed research scientist hire 2) a report and/or peer-reviewed scientific publication on key wildfire smoke chemical exposure components 3) a report and/or peer-reviewed scientific publication on the feasibility and health equity of the recommended clean air solutions 4) written conclusions on meetings with partners on these clean air solutions, including CalEPA, communities, and other programs within CDPH.

Program Settings:

- Community based organization
- Medical or clinical site
- State health department
- Tribal nation or area
- Other: CalEPA

Target Population of Program

- *Target population data source*: 2020 U.S. Census Bureau (decennial), Census, and 2023 American Community Survey (annual)
- *Number of people served:* 39,100,000
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years
- 15-24 years

- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban and Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? No

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Measure smoke chemical exposures and use the data to evaluate health risk mitigations with our partners

Objective: Between 7/1/2024 and 6/30/2025, Program will measure and evaluate five (5) smoke mitigation methods and evaluate the cost- and health-effectiveness with our partners.

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Measure key smoke-associated chemical exposures under different air conditions, community characteristics, and protection strategies, and use them to evaluate health risk mitigations in partnership with State & community partners. Program will measure key smoke-associated chemical exposures using air sampling for different air conditions, community characteristics, and protection strategies, and use the data to evaluate potential health risk mitigations with our State & community partners. The smoke mitigation methods will be evaluated for both health risk protection for specific smoke chemicals, and feasibility for vulnerable populations.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: CDPH CPR Wildfire Smoke: Considerations for CA's Public Health Officials.

Rationale for choosing the Intervention: More work is needed to evaluate whether smoke mitigation methods offer effective health risk protection for specific smoke chemicals while being feasible for vulnerable populations.

- *Item to be measured:* Smoke mitigation methods evaluated for protection against specific smoke chemicals
- *Unit of measurement:* Evaluated smoke mitigation methods
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* CDPH CPR Wildfire Smoke: Considerations for CA's Public Health Officials
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 5

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Hire a Research Scientist II. Between 7/1/2024 and 6/30/2025, Program will hire one (1) Research Scientist II in the EHLB Air Quality Section Laboratory Unit to conduct Project Activities.

Description of Activity: Program will hire a Research Scientist II in the EHLB Air Quality Section Laboratory Unit to conduct Activities (2) – (4) using their knowledge of wildfire smoke chemistry, air measurement and analysis techniques, and health equity principles.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* No

Activity 2

Evaluate key wildfire smoke chemical exposures. Between 7/1/2024 and 6/30/2025, Program will evaluate two (2) key wildfire smoke chemical exposure risks using air measurement data under different conditions.

Description of Activity: Program will evaluate two (2) key wildfire smoke chemical exposure risks (PM2.5, heavy metals, and gas-phase chemicals) to be reduced using air measurement data under different air conditions, community characteristics, and protection strategies.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 3

Evaluate recommended clean air solutions. Between 7/1/2024 and 6/30/2025, Program will evaluate the cost and health effectiveness of two (2) recommended clean air solutions using operational costs and air measurement data.

Description of Activity: Program will evaluate the health and cost effectiveness of the recommended clean air solutions (e.g., HEPA portable air cleaners, DIY cleaners, masks, furnace filters, community centers) using operational costs and air measurement data.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Activity 4

Evaluate clean air solutions with our partners. Between 7/1/2024 and 6/30/2025, Program will discuss and evaluate (2) clean air solutions with our partners in CalEPA, CDPH, and our community partners.

Description of Activity: Program will discuss and evaluate clean air solutions with CalEPA (OEHHA or CARB), CDPH (OHE, CHC EHIB, CEH, or CPR), and community partners (PHI, SF, or CRIHB).

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* Yes

Workforce Development: Preventive Medicine Residency (PMR) and CA Epidemiologic Investigation Service (Cal-EIS) Fellowship

Healthy People 2030 Objective

PHI-R02: Expand pipeline programs that include service learning or experiential learning components in public health settings

Health Objective

Between 07/2024 and 6/30/2025, program will increase the public health (PH) workforce by graduating at least 25 trainees from the Preventive Medicine Residency (PMR) or the California Epidemiologic Investigation Service (Cal-EIS), to become qualified PH physicians and epidemiologists who contribute to and/or lead efforts to improve the health of Californians.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 50-74% - Significance source of funding
- Existing funding source(s): State and local funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 3
- Number of FTEs in this program funded by the PHHS Block Grant: 2.5

Issue/Problem

Public Health (PH) agencies have difficulty recruiting and hiring qualified, diverse PH physicians and epidemiologists. According to a deBeaumont Public Health National Center for Innovations Research Brief October 2021, state and local governmental PH departments need an 80% increase in their workforce to provide a

minimum set of PH services to the nation. California's state PH workforce is small relative to its population: California has fewer than 10 FTE per 100,000 population, compared to an average of 23 FTE per 100,000 among large states. Nationwide, the average age of state PH employees is 48.3; the median age is 49. As older PH physician and epidemiologist leaders retire, there is a need to replace them with a more diverse cohort that better represents the California population and has novel perspectives and insights into methods of meeting current PH challenges. PMR and Cal-EIS ensure a steady supply of critically needed diverse, well-trained PH physicians and epidemiologists to assume leadership positions in state and local PH agencies in California. These positions include Local Health Officers, state agency Medical Directors, Data Directors and Division/Branch/Section Chief physicians and epidemiologists. California needs trained experts ready to respond to PH emergencies that result in illness, injury, deaths and inequity, such as influenza, COVID-19, floods and wildfires, as well as to respond to the alarming rise in chronic and behavioral conditions that decrease life expectancy.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)
- Conducted a topic- or program-specific assessment (e.g., tobacco assessment, environmental health assessment)
- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan
- Declared as an emergency within your jurisdiction
- Governor (or other political leader) established as a priority
- Other: State and local health department priority, research and educational institution priority

Key Indicator(s) affected by this problem: Number of PH physicians and epidemiologists that graduate each year; ready and available to be employed at state and local PH agencies in California.

Baseline value of the key indicator described above: 25

Data source for key indicator baseline: Annual count of residents and fellows that graduate

Date key indicator baseline data was last collected: 2024

Program Strategy

Goal: The California Department of Public Health (CDPH) will conduct PH professional training through the PMR and Cal-EIS to develop the PH workforce pipeline and graduate

diverse qualified physicians and epidemiologists to be employed in California PH agencies.

Is this program specifically addressing a Social Determinant of Health (SDOH)? Yes

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)
- Education (e.g., low high school graduation rates, low literacy levels, poor early childhood education)
- Adverse Childhood Experiences (ACEs)
- Social and Community Context (e.g., discrimination, low civic participation, poor workplace conditions, incarceration)
- Neighborhood and Built Environment (e.g., poor quality of housing, limited access to transportation, food desert, poor water/air quality, neighborhood crime and violence)

Summary of Program Strategy: PMR and Cal EIS objectives align with the CDPH Interim Strategic Map 2023-24 Strategic Priority - Develop Our People and Strategy -Fostering a culture that supports workforce development as a key part of daily work. The programs strengthen California state and local health departments by developing a workforce of qualified diverse physicians and epidemiologists who possess the competencies needed to work as PH professionals. The program graduates are employed leading and facilitating the work of California PH state and local health departments. This priority relates to Healthy People 2030 Objective (PHI-R02) by expanding pipeline programs that include service learning or experiential learning components in PH settings.

Primary Strategic Partners

External:

1. California Conference of Local Health Officers
2. Alameda County
3. San Francisco Department of Public Health
4. Santa Cruz County
5. Napa County

Internal:

1. California Tobacco Control Program
2. Office of Oral Health
3. Maternal, Child and Adolescent Health Division
4. Immunization Branch

5. Substance and Addiction Prevention Branch

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids
- Other: Evaluation, site visits, preceptor and trainee orientations, educational seminars and trainings

Evaluation Methodology: Program goals and objectives are aligned with physician and epidemiologist national organization requirements and competencies. State health objectives are monitored and evaluated yearly. Monitoring tools include trainee milestone or competency progress, monthly/quarterly trainee reports, preceptor/trainee evaluations, site visits, Advisory Committee, Program Evaluation Committee, program policies and procedures, the American Board of Preventive Medicine resident pass rate and the type and location of employment after completing the program.

Program Settings:

- Local health department
- Medical or clinical site
- State health department
- University or college

Target Population of Program

- *Target population data source*: United States Census Bureau July 1, 2023
- *Number of people served:* 38,965,193
- *Ethnicity:* Hispanic or Latino/Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

Age:

- Under 1 year
- 1-4 years
- 5-14 years

- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years
- 75-84 years
- 85 years and older

Sexual Orientation:

- Gay (lesbian or gay)
- Straight, this is not gay (or lesbian or gay)
- Bisexual
- Something else

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College
- College Degree
- Graduate Degree

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

Are members of this target population disproportionately affected by the problem? Yes

Is the entire target population disproportionately affected by the problem, or only part? All

Objectives and Activities

Objective 1:

Title: Increase # of trainees who achieve either preventive medicine and PH or epidemiology competencies

Objective: Between 07/2024 and 06/2025, Program will increase the number of trainees who, over the course of their training period, have satisfactorily achieved American College of Preventive Medicine (ACPM) competencies or Council of State and Territorial Epidemiologists (CSTE) competencies in state or local PH agency programs and/or completing academic coursework, from 126 residents and 261 fellows (387 total) to at least 127 residents and 285 fellows (412 total).

Is the problem for this objective the same as the problem for the program as a whole, or is it a subset of a larger problem? The problem is the same.

Intervention Information

Physicians and scientists will receive applied training to gain ACPM competencies/CSTE competencies. Applied preventive medicine, public health and epidemiology training in which physicians and epidemiologists achieve ACPM or CSTE competencies to prepare them for employment in California PH agencies. Program will recruit, select, hire, place, monitor, teach and evaluate residents and fellows placed in state and local PH agencies under a doctoral level preceptor, with the curriculum and practical experience targeted to the achievement of the respective competencies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: ACGME Institutional, Common and Preventive. Medicine Requirements for GME; ACPM and CSTE competencies.

Rationale for choosing the Intervention: To address the PH workforce need identified by the deBeaumont Foundation in 2021, California will train a diverse cohort of physicians and epidemiologists to achieve requirements and competencies that are the national standard. The Accreditation Council for Graduate Medical Education (ACGME) accredits all medical specialties, including Preventive Medicine, and has rigorous education and training requirements. Competencies developed by ACPM for Preventive Medicine physicians and by CSTE for epidemiologists are the benchmarks for the respective fields. These national organizations have a vested interest in the training and competence of those practicing in the discipline and have committees to determine the needed knowledge, skills and experience to meet their specifications. Therefore, adopting these requirements and competencies in the CDPH training programs assures that the graduates will be well qualified to practice independently in Preventive Medicine or epidemiology.

- *Item to be measured:* Number of residents and fellows achieving competencies.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 387
- *Data source for baseline value:* Annual count of residents and fellows that achieve competencies
- *Date baseline was last collected:* 07/01/2024
- *Interim target value to be achieved by the Annual Progress Report:* 387
- *Final target value to be achieved by the Final Progress Report:* 412

Target Population

The target population of this Program SMART Objective is the same as the target population of the Program.

Activity 1

Recruit and Interview Applicants for PMR and Cal EIS Positions. Between 07/2024 and 6/2025, the Program Director, PMR Coordinator and Cal-EIS Coordinator are responsible for the recruiting, interviewing, and selecting the top applicants, who are then offered placement sites in the PMR and Cal-EIS programs beginning 07/2024; program will recruit and interview at least four (4) PMR applicants and fourteen (14) Cal-EIS applicants.

Description of Activity: Between 07/2024 and 06/2025, program will recruit and interview at least four (4) PMR applicants and fourteen (14) Cal-EIS applicants. The recruitment process includes distributing PMR and Cal-EIS information to schools of PH, residency programs, local health agencies and posting on various websites, such as FREIDA

Online, Electronic Residency Application Service and PH Employment Connection. The competitive selection process includes review of applications by the PMR and Cal EIS Advisory Committees and their recommendation of top candidates to interview, followed by interviews and choice of top candidates to offer a position in the PMR and Cal-EIS programs.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Develop and Implement PH Practice Curriculum. Between 07/2024 and 06/2025, the PMRP Coordinator schedules presenters from CDPH, local health departments and universities to educate the residents and fellows; these PH/Preventive Medicine Seminars take place between 07/2024 and 06/2025; program will conduct at least 15 Epidemiology or Preventive Medicine Seminars for residents and fellows.

Description of Activity: Between 07/2024 and 06/2025, program will conduct at least 15 Epidemiology or Preventive Medicine Seminars for residents and fellows. These bi-monthly seminars address ACGME Milestones and ACPM/CSTE competencies and provide residents and fellows with knowledge, insights and resources that prepare them to enter the PH workforce.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Place Residents and Fellows in a PH Training Experience. Between 07/2024 and 06/2025, experienced preceptors will mentor and guide residents and fellows to meet competencies through applied state and local PH experiences, providing training needed to develop California's PH workforce. Program will train at least 25 individuals in the relevant competencies.

Description of Activity: Between 07/2024 and 06/2025, program will train at least 25 individuals in the relevant competencies. Experienced preceptors will mentor and guide residents and fellows to meet competencies through applied state and local PH experiences, providing training needed to develop California's PH workforce.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* No