

**California FY 2016  
Preventive Health and Health Services  
Block Grant**

**Work Plan**

**Original Work Plan for Fiscal Year 2016**

**Submitted by: California**

**DUNS: 799150615**

**Printed: 8/12/2016 4:43 PM**

**Governor: Edmund G. Brown Jr.**

**State Health Officer: Karen L. Smith MD MPH**

**Block Grant Coordinator:**

**Hector Garcia**

**1616 Capitol Avenue, Suite 74.414**

**PO Box 997377, Mailstop 7208**

**Sacramento CA 95899-7377**

**Phone: 916-552-9917**

**Fax: 916-445-7729**

**Email: [Hector.Garcia@cdph.ca.gov](mailto:Hector.Garcia@cdph.ca.gov)**

**CDC Work Plan ID: CA 2016 V0 R0**

**Created on: 2/23/2016**

**Submitted on: 6/30/2016**

<b>Contents</b>	<b>Page</b>
Executive Summary	4
<b>Statutory and Budget Information</b>	<b>5</b>
Statutory Information	5
Budget Detail	6
Summary of Allocations	7
<b>Program, Health Objectives</b>	<b>10</b>
Accountable Communities for Health Pilot	10
ECBP-10 Community-Based Primary Prevention Services	11
California Active Communities: Older-Adult Falls Prevention	14
IVP-23 Deaths from Falls	14
California Health Alert Network	18
PREP-1 Public Health Emergency Alert	19
California Wellness Plan Implementation, Program A	22
PHI-15 Health Improvement Plans	22
California Wellness Plan Implementation, Program B	26
PHI-14 Public Health System Assessment	26
Cardiovascular Disease Prevention Program	29
HDS-2 Coronary Heart Disease Deaths	30
Commodity-Specific Surveillance: Food & Drug Program	34
FS-2 Outbreak-Associated Infections Associated with Food Commodity Groups	35
Community Water Fluoridation Implementation Project	37
OH-13 Community Water Fluoridation	38
Emergency Medical Dispatch Program/EMS Communications	41
AHS-8 Rapid Prehospital Emergency Care (EMS) EMS for Children	42
AHS-8 Rapid Prehospital Emergency Care (EMS) EMS Health Information Exchange	45
AHS-8 Rapid Prehospital Emergency Care (EMS) EMS Partnership for Injury Prevention and Public Education	46
AHS-8 Rapid Prehospital Emergency Care (EMS) EMS Poison Control System	48
IVP-9 Poisoning Deaths	49
EMS Prehospital Data and Information Services and Quality Improvement Program	52
AHS-8 Rapid Prehospital Emergency Care (EMS) EMS STEMI and Stroke Systems	53
AHS-8 Rapid Prehospital Emergency Care (EMS) EMS Systems Planning and Development	56
AHS-8 Rapid Prehospital Emergency Care (EMS)	57
	59
	60
	64
	65
	68
	68
	69

EMS Trauma Care Systems	72
AHS-8 Rapid Prehospital Emergency Care (EMS)	73
Let's Get Healthy California Dashboard and Website	78
PHI-14 Public Health System Assessment	78
Microbial Diseases Laboratory Branch/Select Agent and Biosafety	81
PHI-11 Public Health Agencies Laboratory Services	81
Microbial Diseases Laboratory Branch/Valley Fever	85
PHI-11 Public Health Agencies Laboratory Services	86
Nutrition Education and Obesity Prevention Branch	89
NWS-10 Obesity in Children and Adolescents	90
Office of AIDS: Re-engagement in HIV Care and Partner Services Using HIV Surveillance Data	93
HIV-1 HIV Diagnoses	93
Office of Health Equity	97
PA-15 Built Environment Policies	98
Office of Quality Performance and Accreditation	101
PHI-17 Accredited Public Health Agencies	102
Prescription Drug Overdose Surveillance Project	105
IVP-11 Unintentional Injury Deaths	106
Preventive Medicine Residency Program	109
PHI-1 Competencies for Public Health Professionals	110
Rape Prevention Program	113
IVP-40 Sexual Violence (Rape Prevention)	113
Receptor Binding Assay for Paralytic Shellfish Poisoning Control	116
EH-22 Monitoring Diseases Caused by Exposure to Environmental Hazards	116
Safe and Active Communities Branch	120
IVP-11 Unintentional Injury Deaths	121

## **Executive Summary**

This is California's Preventive Health and Health Services Block Grant (PHHSBG) Work Plan for Federal Fiscal Year (FFY) 2016. California plans to expend these funds in State Fiscal Year (SFY) 16/17 (July 1, 2016 – June 30, 2017).

The PHHSBG is administered by the United States Department of Health and Human Services through its administrative agency, the Centers for Disease Control and Prevention (CDC). The California Department of Public Health (CDPH) is designated as the principal state agency for the allocation and administration of the PHHSBG within the State of California.

The PHHSBG Advisory Committee (AC) updated the Principles for Allocation in 2014, which CDPH considered when allocating funding to programs. PHHSBG funds will be used for the development and implementation of programs and activities to decrease the morbidity and mortality that results from preventable disease and injury; and to optimize the health and well-being of the people in California.

California adhered to federal requirements that the PHHSBG Advisory Committee (AC) review and approve the FFY 2016 Work Plan. The AC voted unanimously to approve it during the June 22, 2016, AC Meeting. As is required, the State Plan was made available to the public and public comments were requested. Members of the public were invited to attend the June 23, 2016 Public Hearing and/or submit written comments.

**Funding Assumptions** - The FFY 2016 State Plan is based on CDC's total award of \$10,542,099. The Rape Set-Aside Program (RPSA) receives \$832,969 of the total award, which leaves a balance of \$9,709,130 (Base Award). PHHSBG Administrative Costs are 10% (or \$970,912) of the remaining balance, are in accordance with federal and state statute, regulations, and policies; and will be used to support administering the program, including providing administrative, budgetary, fiscal, and technical assistance to 29 PHHSBG Programs, including RPSA. The remaining funds (\$8,738,218) are distributed between CDPH and the Emergency Medical Services Authority (EMSA), with CDPH receiving 70 percent and EMSA receiving 30 percent of the base award. The 70/30 funding split is based on the historical categorical distribution.

**Funding Priority:** State Plan (2016)

## Statutory Information

### **Advisory Committee Member Representation:**

College and/or university, Community-based organization, County and/or local health department, Dental organization, Foundation, State health department, State or local government

**Dates:**

**Public Hearing Date(s):**

6/23/2016

**Advisory Committee Date(s):**

2/8/2016

6/22/2016

**Current Forms signed and attached to work plan:**

Certifications: Yes

Certifications and Assurances: Yes

<b>Budget Detail for CA 2016 V0 R0</b>	
<b>Total Award (1+6)</b>	\$10,542,099
<b>A. Current Year Annual Basic</b>	
1. Annual Basic Amount	\$9,709,130
2. Annual Basic Admin Cost	(\$970,912)
3. Direct Assistance	\$0
4. Transfer Amount	\$0
(5). Sub-Total Annual Basic	\$8,738,218
<b>B. Current Year Sex Offense Dollars (HO 15-35)</b>	
6. Mandated Sex Offense Set Aside	\$832,969
7. Sex Offense Admin Cost	\$0
(8.) Sub-Total Sex Offense Set Aside	\$832,969
<b>(9.) Total Current Year Available Amount (5+8)</b>	<b>\$9,571,187</b>
<b>C. Prior Year Dollars</b>	
10. Annual Basic	\$8,552,610
11. Sex Offense Set Aside (HO 15-35)	\$832,969
(12.) Total Prior Year	\$9,385,579
<b>13. Total Available for Allocation (5+8+12)</b>	<b>\$18,956,766</b>

<b>Summary of Funds Available for Allocation</b>	
<b>A. PHHSBG \$'s Current Year:</b>	
Annual Basic	\$8,738,218
Sex Offense Set Aside	\$832,969
Available Current Year PHHSBG Dollars	\$9,571,187
<b>B. PHHSBG \$'s Prior Year:</b>	
Annual Basic	\$8,552,610
Sex Offense Set Aside	\$832,969
Available Prior Year PHHSBG Dollars	\$9,385,579
<b>C. Total Funds Available for Allocation</b>	<b>\$18,956,766</b>

## Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG \$'s	Prior Year PHHSBG \$'s	TOTAL Year PHHSBG \$'s
Accountable Communities for Health Pilot	ECBP-10 Community-Based Primary Prevention Services	\$240,000	\$208,600	\$448,600
<b>Sub-Total</b>		<b>\$240,000</b>	<b>\$208,600</b>	<b>\$448,600</b>
California Active Communities: Older-Adult Falls Prevention	IVP-23 Deaths from Falls	\$590,841	\$612,788	\$1,203,629
<b>Sub-Total</b>		<b>\$590,841</b>	<b>\$612,788</b>	<b>\$1,203,629</b>
California Health Alert Network	PREP-1 Public Health Emergency Alert	\$375,000	\$358,551	\$733,551
<b>Sub-Total</b>		<b>\$375,000</b>	<b>\$358,551</b>	<b>\$733,551</b>
California Wellness Plan Implementation, Program A	PHI-15 Health Improvement Plans	\$330,000	\$391,400	\$721,400
<b>Sub-Total</b>		<b>\$330,000</b>	<b>\$391,400</b>	<b>\$721,400</b>
California Wellness Plan Implementation, Program B	PHI-14 Public Health System Assessment	\$112,500	\$112,500	\$225,000
<b>Sub-Total</b>		<b>\$112,500</b>	<b>\$112,500</b>	<b>\$225,000</b>
Cardiovascular Disease Prevention Program	HDS-2 Coronary Heart Disease Deaths	\$524,819	\$524,819	\$1,049,638
<b>Sub-Total</b>		<b>\$524,819</b>	<b>\$524,819</b>	<b>\$1,049,638</b>
Commodity-Specific Surveillance: Food & Drug Program	FS-2 Outbreak-Associated Infections Associated with Food Commodity Groups	\$160,000	\$140,000	\$300,000
<b>Sub-Total</b>		<b>\$160,000</b>	<b>\$140,000</b>	<b>\$300,000</b>
Community Water Fluoridation Implementation Project	OH-13 Community Water Fluoridation	\$263,813	\$260,560	\$524,373
<b>Sub-Total</b>		<b>\$263,813</b>	<b>\$260,560</b>	<b>\$524,373</b>
Emergency Medical Dispatch Program/EMS Communications	AHS-8 Rapid Prehospital Emergency Care (EMS)	\$90,711	\$90,711	\$181,422
<b>Sub-Total</b>		<b>\$90,711</b>	<b>\$90,711</b>	<b>\$181,422</b>
EMS for Children	AHS-8 Rapid Prehospital Emergency Care (EMS)	\$123,800	\$123,800	\$247,600
<b>Sub-Total</b>		<b>\$123,800</b>	<b>\$123,800</b>	<b>\$247,600</b>
EMS Health	AHS-8 Rapid	\$389,580	\$389,580	\$779,160

Information Exchange	Prehospital Emergency Care (EMS)			
<b>Sub-Total</b>		<b>\$389,580</b>	<b>\$389,580</b>	<b>\$779,160</b>
EMS Partnership for Injury Prevention and Public Education	AHS-8 Rapid Prehospital Emergency Care (EMS)	\$78,515	\$78,515	\$157,030
<b>Sub-Total</b>		<b>\$78,515</b>	<b>\$78,515</b>	<b>\$157,030</b>
EMS Poison Control System	IVP-9 Poisoning Deaths	\$108,691	\$108,691	\$217,382
<b>Sub-Total</b>		<b>\$108,691</b>	<b>\$108,691</b>	<b>\$217,382</b>
EMS Prehospital Data and Information Services and Quality Improvement Program	AHS-8 Rapid Prehospital Emergency Care (EMS)	\$651,256	\$595,573	\$1,246,829
<b>Sub-Total</b>		<b>\$651,256</b>	<b>\$595,573</b>	<b>\$1,246,829</b>
EMS STEMI and Stroke Systems	AHS-8 Rapid Prehospital Emergency Care (EMS)	\$269,178	\$269,178	\$538,356
<b>Sub-Total</b>		<b>\$269,178</b>	<b>\$269,178</b>	<b>\$538,356</b>
EMS Systems Planning and Development	AHS-8 Rapid Prehospital Emergency Care (EMS)	\$651,198	\$651,198	\$1,302,396
<b>Sub-Total</b>		<b>\$651,198</b>	<b>\$651,198</b>	<b>\$1,302,396</b>
EMS Trauma Care Systems	AHS-8 Rapid Prehospital Emergency Care (EMS)	\$258,536	\$258,536	\$517,072
<b>Sub-Total</b>		<b>\$258,536</b>	<b>\$258,536</b>	<b>\$517,072</b>
Let's Get Healthy California Dashboard and Website	PHI-14 Public Health System Assessment	\$300,000	\$280,000	\$580,000
<b>Sub-Total</b>		<b>\$300,000</b>	<b>\$280,000</b>	<b>\$580,000</b>
Microbial Diseases Laboratory Branch/Select Agent and Biosafety	PHI-11 Public Health Agencies Laboratory Services	\$150,000	\$150,000	\$300,000
<b>Sub-Total</b>		<b>\$150,000</b>	<b>\$150,000</b>	<b>\$300,000</b>
Microbial Diseases Laboratory Branch/Valley Fever	PHI-11 Public Health Agencies Laboratory Services	\$340,800	\$319,500	\$660,300
<b>Sub-Total</b>		<b>\$340,800</b>	<b>\$319,500</b>	<b>\$660,300</b>
Nutrition Education and Obesity Prevention Branch	NWS-10 Obesity in Children and Adolescents	\$468,039	\$468,039	\$936,078
<b>Sub-Total</b>		<b>\$468,039</b>	<b>\$468,039</b>	<b>\$936,078</b>
Office of AIDS: Re-engagement in HIV	HIV-1 HIV Diagnoses	\$375,000	\$375,000	\$750,000

Care and Partner Services Using HIV Surveillance Data				
<b>Sub-Total</b>		<b>\$375,000</b>	<b>\$375,000</b>	<b>\$750,000</b>
Office of Health Equity	PA-15 Built Environment Policies	\$491,689	\$491,688	\$983,377
<b>Sub-Total</b>		<b>\$491,689</b>	<b>\$491,688</b>	<b>\$983,377</b>
Office of Quality Performance and Accreditation	PHI-17 Accredited Public Health Agencies	\$193,483	\$187,500	\$380,983
<b>Sub-Total</b>		<b>\$193,483</b>	<b>\$187,500</b>	<b>\$380,983</b>
Prescription Drug Overdose Surveillance Project	IVP-11 Unintentional Injury Deaths	\$150,000	\$140,000	\$290,000
<b>Sub-Total</b>		<b>\$150,000</b>	<b>\$140,000</b>	<b>\$290,000</b>
Preventive Medicine Residency Program	PHI-1 Competencies for Public Health Professionals	\$534,600	\$528,464	\$1,063,064
<b>Sub-Total</b>		<b>\$534,600</b>	<b>\$528,464</b>	<b>\$1,063,064</b>
Rape Prevention Program	IVP-40 Sexual Violence (Rape Prevention)	\$832,969	\$832,969	\$1,665,938
<b>Sub-Total</b>		<b>\$832,969</b>	<b>\$832,969</b>	<b>\$1,665,938</b>
Receptor Binding Assay for Paralytic Shellfish Poisoning Control	EH-22 Monitoring Diseases Caused by Exposure to Environmental Hazards	\$206,250	\$192,500	\$398,750
<b>Sub-Total</b>		<b>\$206,250</b>	<b>\$192,500</b>	<b>\$398,750</b>
Safe and Active Communities Branch	IVP-11 Unintentional Injury Deaths	\$309,919	\$244,919	\$554,838
<b>Sub-Total</b>		<b>\$309,919</b>	<b>\$244,919</b>	<b>\$554,838</b>
<b>Grand Total</b>		<b>\$9,571,187</b>	<b>\$9,385,579</b>	<b>\$18,956,766</b>

**State Program Title: Accountable Communities for Health Pilot**

**State Program Strategy:**

**Goal: *Create social and physical environments that promote good health for all.*** The social determinants of health—shaped by where we live, work and play—contribute to the incidence and prevalence of multiple chronic conditions, including diabetes, cardiovascular disease, stroke, and asthma. Increasing the number of community-based organizations that provide population-based primary-prevention services, including convening stakeholders across multiple sectors, is one key way the California Department of Public Health (CDPH) Accountable Communities for Health (ACH) program is working to reduce the impact of these social determinants of health.

**Health Priority: *Increase population-based primary-prevention services in California.*** The CDPH Fusion Center, through its ACH pilot project, will implement measures to increase the number of community-based organizations that provide population-based primary-prevention services. This includes building and fostering systems of prevention, identifying and convening partners, and creating a framework by which community-based organizations can evaluate success in increasing prevention services. The Fusion Center explores new models and approaches to public health and seeks to more closely align public health, the health care delivery system, and community-based innovations to improve population health.

**Role of Block Grant Funds:** PHHSBG funds support salaries of staff who facilitate meetings with partners and stakeholders, conduct policy analysis, develop multi-disciplinary teams, pilot innovative ways to support local agencies, and prepare and disseminate informational reports and tools. All activities focus on increasing the number of community-based organizations that provide population-based primary-prevention services and address the social determinants of health. Vacancy is to be filled by October 2016.

**Primary Strategic Partnerships:**

**Internal:**

California Conference of Local Health Officers  
Office of Quality Performance and Accreditation  
Office of Health Equity  
Center for Health Statistics and Informatics  
Center for Chronic Disease Prevention and Health Promotion

**External:**

California Health and Human Services Agency  
Department of Health Care Services  
The California Endowment  
Department of Social Services  
Kaiser Permanente

**Evaluation Methodology:** The CDPH Fusion Center will evaluate progress toward reaching program goals with *process evaluation* (input and feedback on meetings and draft documents, and tools from partners and stakeholders via in-person meetings, online surveys, calls, and e-mails), and *performance evaluation* (monitoring selected Fusion Center Program objectives).

**State Program Setting:**

State health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Kelly Bertenthal  
**Position Title:** Associate Government Program Analyst  
State-Level: 100% Local: 0% Other: 0% Total: 100%  
**Position Name:** Terica Thomas  
**Position Title:** Associate Government Program Analyst  
State-Level: 100% Local: 0% Other: 0% Total: 100%  
**Position Name:** Vacant  
**Position Title:** Environmental Scientist  
State-Level: 100% Local: 0% Other: 0% Total: 100%

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

**National Health Objective: HO ECBP-10 Community-Based Primary Prevention Services**

**State Health Objective(s):**

Between 10/2015 and 09/2017, Fusion Center staff will increase by **six** the number of community-based organizations that provide population-based primary prevention services (including local health jurisdictions, tribal entities, non-governmental organizations, and state agencies) that address the social determinants of health. This in turn will build and foster systems of prevention that can address multiple chronic diseases and community conditions throughout the State.

ACH will develop an evaluation framework and a data- and information-sharing toolkit or resource guide for use by ACH pilots. The framework will include evaluation of clinical-community linkages and measuring collective impact at the local level. The development of these resources will include identifying the state role in building a sustainable system for supporting the scaling up of the ACH concept.

**Baseline:**

*National baseline data: 50% of community-based organizations (including local health departments, tribal health services, nongovernmental organizations, and state agencies) provided population-based primary-prevention services in chronic-disease programs in 2008.*

**Data Source:**

Healthy People 2020 and National Profile of Local Health Departments (NACCHO Profile), National Association of County and City Health Officials

**State Health Problem:**

**Health Burden:**

Six common chronic conditions (arthritis, asthma, cardiovascular disease, diabetes, depression, and cancer) represent approximately 42% of all health care expenditures in the State. The **target** and **disparate populations** are the same: populations with the above chronic conditions. Trends in disparities among the six conditions: (1) In California, ethnic minorities and individuals who are poor have higher rates of diabetes. (2) Blacks have **40%** higher asthma prevalence than Whites, **four times** higher asthma emergency department (ED) visits and hospitalization rates, and **two times** higher asthma death rates. (3) Asthma hospitalization and ED visit rates are higher among Hispanics (all subgroups combined) when compared to Whites, especially among children. (5) Mexican Americans have even more dramatic mental health disparities than other Latino groups. (6) More Native Americans and African Americans under age 35 have seriously thought about committing suicide (**27%** and **18%**, respectively).

**Target Population:**

Number: 1,200,000  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No

**Disparate Population:**

Number: 1,200,000  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No  
Location: Entire state  
Target and Disparate Data Sources: U.S. Census Bureau, 2016

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

Other: (1) Accountable Communities for Health: Strategies for Financial Sustainability (2015), and (2) The Accountable Communities for Health: An Emerging Model for Health Systems Transformation (2016). Both provide particular guidance to support emerging ACH implementation efforts in California.

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

Total Current Year Funds Allocated to Health Objective: \$240,000  
Total Prior Year Funds Allocated to Health Objective: \$208,600  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: Start-up  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Select and implement pilot Accountable Communities for Health.**

Between 10/2015 and 09/2016, Fusion Center staff will review **two** resources generated by Fusion Center, Blue Sky Consulting, and UC Berkeley (e.g., toolkit of best practices, description of the public health role, performance measures, evaluation framework of the statewide effort with partners), to support establishment of ACHs in California to reduce cost, improve population health, and improve the quality of health care.

**Annual Activities:**

**1. Encourage prevention activities.**

Between 10/2015 and 09/2016, Fusion Center staff will participate in **at least two** pilot partner

convenings to ensure collective impact in prevention, and leverage partnerships, including in-person and virtual participation in the statewide chronic-disease–prevention Community of Practice, to enhance the efforts of the ACH pilots.

**2. Provide expertise in the selection of pilot sites.**

Between 10/2015 and 09/2016, Fusion Center staff will provide subject-matter expertise in selection and oversight of the implementation of six ACH pilot sites statewide.

**3. Develop metrics and evaluation framework for pilot.**

Between 10/2015 and 09/2016, Fusion Center staff will assist Blue Sky Consulting and the California Health and Human Services Agency in the development of one set of metrics in an evaluation framework, to ensure that the ACH pilot efforts effectively address community conditions and chronic diseases for target and high-risk populations.

**4. Develop toolkit outlining data and information needs.**

Between 10/2015 and 09/2016, Fusion Center staff will assist the Center for Health Organizational Innovation Research at UC Berkeley in the development of one report summarizing the findings of the program and intervention index and literature review and one toolkit that outlines the spectrum of data and information needs of an ACH (including a description of an optimal system), and share at least one option that could/should be employed by an ACH to create a data- and information-sharing capacity where none exists, or improve upon and maximize an existing system to meet optimum standards.

**State Program Title: California Active Communities: Older-Adult Falls Prevention**

**State Program Strategy:**

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

**Health Priorities:** *Decrease the annual incidence rate of fall-related deaths among adults age 65 and older* in California (California Wellness Plan 2014) from 39 to **29 per 1,000** by 2020.

**Role of Block Grant Funds:** PHHSBG funds are used to (1) pay Safe and Active Community Branch (SACB) staff salaries; (2) train individuals from local health departments (LHDs) to conduct Tai Chi: Moving for Better Balance (TCMBB) and Stepping On (SO) fall-prevention programs; (2) conduct community-based TCMBB and SO workshops for older adults; (3) promote strategic planning for universal-design and mobility programs; (4) enhance local agency ability to create safer older-adult mobility options; and (5) develop a Safe Routes for Seniors Toolkit.

**Primary Strategic Partnerships**

**Internal**

- Chronic Disease Control Branch
- California Obesity Prevention Program
- Health in All Policies Program

**External**

- California Department of Aging
- State Falls Coalition
- Local public health departments
- Stanford University
- University of California, San Diego

**Evaluation Methodology:** EpiCenter: California Injury Data Online data will be used to evaluate changes in the death rate due to unintentional falls in older adults. *Process evaluation* will measure the extent to which objectives are met (e.g., number of trainings conducted, number of participants trained). *Impact evaluation* will assess immediate and intermediate outcomes, using multiple measures, including evaluations.

**State Program Setting:**

Community based organization, Local health department, State health department

**FTEs (Full Time Equivalent):**

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

**Position Name:** Nancy Bagnato

**Position Title:** Health Program Manager II

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Position Name:** Pam Shipley

**Position Title:** Staff Services Manager I

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Position Name:** Karissa Anderson

**Position Title:** Health Program Specialist I

State-Level: 45% Local: 30% Other: 0% Total: 75%

**Position Name:** Vacant

**Position Title:** Health Education Consultant III

State-Level: 25% Local: 25% Other: 0% Total: 50%

**Total Number of Positions Funded:** 4

**Total FTEs Funded:** 1.75

**National Health Objective: HO IVP-23 Deaths from Falls**

**State Health Objective(s):**

Between 10/2015 and 09/2016, *maintain California baseline death rate of 36.8 per 100,000 population aged 65 years and older due to unintentional falls.*

**Baseline:**

*36.8 deaths per 100,000 population aged 65 years and older were caused by unintentional falls in 2013.*

**Data Source:**

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

**State Health Problem:**

**Health Burden:**

As of 2010, California has 4.3 million adults over the age of 65 (**target population**), the largest older-adult population in the nation. In California, falls cause 41% of the injury deaths and 70% of injury-related hospitalizations among seniors. In 2013, 1,733 Californians ages 65 and older died from a fall, and 74,945 were hospitalized. In addition, 208,564 people ages 65 and older were treated for falls in California's emergency departments.

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

**Target Population:**

Number: 4,281,051

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 4,281,051

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: EpiCenter California Injury Data Online, CDPH-OVR-DSM, March 30, 2016

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

Other: (1) Guide to Community Preventive Services (CDC); (2) CDC recognizes Tai Chi: Moving for Better Balance and the Stepping On Programs as evidence-based interventions for falls prevention.

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

Total Current Year Funds Allocated to Health Objective: \$590,841

Total Prior Year Funds Allocated to Health Objective: \$612,788

Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$300,000  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Conduct fall-prevention classes for older adults.**

Between 10/2015 and 09/2016, SACB staff will conduct **27** SO or TCMBB Program community-based classes throughout California to prevent falls by promoting strength and balance among older adults at risk for falls.

### **Annual Activities:**

#### **1. Fund LHDs to provide fall-prevention classes to older adults.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will provide funding to **seven** LHDs to implement and evaluate community-based SO and TCMBB Program classes for older adults within their jurisdictions to promote strength and balance among older adults at risk for falls.

### **Objective 2:**

#### **Increase LHDs' ability to implement TCMBB Program.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will establish **four** LHD staff or their designees as new TCMBB instructors, to provide them with the ability to promote strength and balance among older adults at risk for falls.

### **Annual Activities:**

#### **1. Fund LHDs to participate in TCMBB training.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will provide funding for **a minimum of four** LHD staff or their designees to participate in TCMBB leader trainings, increasing the LHDs' ability to implement TCMBB in their counties.

#### **2. Conduct TCMBB training activities.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will conduct **at least one** two-day training to certify LHD staff or their designees as TCMBB Instructors/ Master Trainers, and provide video-based fidelity checks, support webinars, and technical assistance consultations to newly trained Instructors/Master Trainers.

### **Objective 3:**

#### **Increase LHDs' ability to implement the SO Program.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will establish **ten** LHD staff or their designees as new SO Leaders or Master Trainers, to provide them with the ability to promote strength and balance among older adults at risk for falls.

### **Annual Activities:**

#### **1. Fund LHDs to participate in SO Program training.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will provide funding for **a minimum of ten** LHD staff or their designees to participate in SO Program leader trainings. This enables the goal of increasing the LHDs' ability to implement the SO Program.

#### **2. Conduct SO Program training activities.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will conduct **at least one** three-day training to certify LHD staff or their designees as new SO Leaders/Master Trainers, and

conduct follow-up video-based fidelity checks, support webinars, and technical-assistance consultations to newly trained Leaders/Master Trainers, to provide trainers with the ability to promote strength and balance among older adults at risk for falls.

**Objective 4:**

**Promote safer community mobility for older adults.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will develop **one** Safe Routes for Seniors toolkit, to promote strength and balance among older adults at risk for falls.

**Annual Activities:**

**1. Develop a Safe Routes for Seniors toolkit.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will conduct **one** background literature search, research **three** potential elements, perform **two** key informant interviews, and field test **one** draft Safe Routes for Seniors Toolkit, to promote strength and balance among older adults at risk for falls.

**Objective 5:**

**Promote universal design and older-adult mobility in community planning.**

Between 10/2015 and 09/2016, Older-Adult Falls-Prevention Program staff will increase the number of LHDs that incorporate universal-design and older-adult mobility programs, planning, and policies into their strategic plans, to promote strength and balance among older adults at risk for falls from zero to **five**.

**Annual Activities:**

**1. Fund LHDs to participate in strategic planning.**

Between 10/2015 and 09/2016, Older Adult Falls Prevention Program staff will fund **five** LHDs to conduct universal-design and older-adult mobility strategic planning with their local partners, to promote strength and balance among older adults at risk for falls.

**State Program Title: California Health Alert Network**

**State Program Strategy:**

**Goal: *Direct specific, targeted, and rapid alerts around the clock to those who can act on the information.*** The California Health Alert Network (CAHAN), operated by the California Department of Public Health (CDPH) Emergency Preparedness Office (EPO), is the official public health alerting and notification system for California. The system allows for rapid information sharing with and between federal, state, tribal, and local partners across public health, environmental health, emergency medical services, health care, and emergency response.

**Health Priority: *Prevent large-scale public health impacts from disease outbreaks, natural disasters, and terrorist attacks through quick, well-directed alerts.*** CAHAN, California's information sharing program for public health and medical emergency preparedness and response, provides round-the-clock, web-based notification for health alerts, dissemination of treatment and prevention guidance, and coordinating of disease investigations in a time-critical manner.

**Role of Block Grant Funds:** PHHSBG funding will (1) cover the 2016–17 CAHAN information system contract; (2) support quality-improvement initiatives within the program's preparedness objectives as outlined below; and (3) support three staff positions dedicated to disaster information management and coordination.

**Primary Strategic Partnerships**

**Internal**

- California Department of Public Health

**External**

- California Hospital Association
- California Association of Health Facilities
- California Conference of Directors of Environmental Health
- California Conference of Local Health Officers
- California Consortium of Urban Indian Health Clinics

**Evaluation Methodology:** CAHAN program staff will capture *quantitative data*, such as user populations, alert frequency and types, policy compliance, and tribal participation, through reports directly generated by the CAHAN system. *Qualitative data* will include feedback from CAHAN coordinators and enrollees across the State.

**State Program Setting:**

Community health center, Local health department, Medical or clinical site, Senior residence or center, State health department, Tribal nation or area

**FTEs (Full Time Equivalents):**

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

**Position Name:** Kala Haley

**Position Title:** Associate Governmental Program Analyst

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Hannah Strom-Martin

**Position Title:** Associate Governmental Program Analyst

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Armando Arroyo

**Position Title:** Health Program Specialist II

State-Level: 15% Local: 0% Other: 0% Total: 15%

**Total Number of Positions Funded:** 3

**Total FTEs Funded:** 2.15

## **National Health Objective: HO PREP-1 Public Health Emergency Alert**

### **State Health Objective(s):**

Between 10/2015 and 09/2016, (1) Maintain the California Health Alert Network online alerting platform; (2) Continue to develop policies, procedures, guidance documents, training programs, and other outreach materials for local jurisdictions so they can reduce the time to issue information about a public health emergency; and (3) Continue to build program capabilities for rapid, targeted, actionable alerting and notification.

### **Baseline:**

*There are **25,431** individual contacts on CAHAN, including participants from acute-care hospitals, local public and environmental health departments, clinics, skilled nursing facilities, and CDPH programs and centers across California. Of these contacts, **617** have requested the ability to alert and manage contacts within their jurisdictions, but only **203** have completed the necessary training. This gap speaks to a need for further outreach so that more HAN coordinators can take full advantage of the system, increase CAHAN participation, and improve the scope of the alerting platform.*

### **Data Source:**

CAHAN training logs, September 2015 to April 2016.

### **State Health Problem:**

#### **Health Burden:**

The complexity of California's threats, hazards, incidents, and risks has led to increased interaction between public health, environmental health, and medical functions. This interaction drives the need for a coordinated system that articulates common procedures across all functional components of public health and medical emergency operations. An active HAN program is a stipulation of public health accreditation, as well as a recommended practice by many national standards.

PHHSBG funds will ensure that preparedness benefits that the program provides to the citizens of California (**target** and **disparate populations**) continue. The target population includes the strategic partners listed above, as well as all CAHAN users and enrolled recipients. There are over 25,000 program participants. CDPH expects that CAHAN participants use the system to enhance local public health emergency-preparedness and response systems and services for their respective constituents at city and county levels across the State.

#### **Target Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

#### **Disparate Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban  
Primarily Low Income: No  
Location: Entire state  
Target and Disparate Data Sources: U.S. Census Bureau 2016

**Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**  
Best Practice Initiative (U.S. Department of Health and Human Service)

Other: CDC Public Health Emergency Preparedness (PHEP) Cooperative Agreement Budget Period 5 (BP5) Progress Update for period July 1, 2016-June 30, 2017, CDPH, EPO.

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

Total Current Year Funds Allocated to Health Objective: \$375,000  
Total Prior Year Funds Allocated to Health Objective: \$358,551  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Increase CAHAN competency and reduce alert distribution time.**

Between 10/2015 and 09/2016, CAHAN staff will develop **three** outreach programs to increase awareness of, participation in, and competency with the CAHAN program among partners at CDPH, public health and medical designated-response programs at the state level, and local jurisdictions. Outreach program content will help HAN coordinators use the system to its fullest extent, including shortcuts and template tips to reduce alert distribution time.

**Annual Activities:**

**1. Reduce alert distribution time.**

Between 10/2015 and 09/2016, CAHAN staff will conduct **five or more** presentations and develop **two or more** guidance documents to increase awareness of, participation in, and competency with the CAHAN program's CDPH participants. The content included in these presentations and guidance documents will help HAN coordinators use the system to its fullest extent, including shortcuts and template tips to reduce alert distribution time.

**2. Develop relationships that advance capacity building.**

Between 10/2015 and 09/2016, CAHAN staff will conduct **at least three** outreach presentations to public health and medical response partners within California Health and Human Services Agency to increase partner awareness of, participation in, and competency with the CAHAN alerting and notifications. The content included in these presentations will help HAN coordinators use the system to its fullest extent, including shortcuts and template tips to reduce alert distribution time.

**3. Conduct region-specific CAHAN training.**

Between 10/2015 and 09/2016, CAHAN staff will conduct **two or more** advanced regional training sessions with CAHAN local partners to increase HAN coordinator competency in the CAHAN system. The content included in these presentations will help HAN coordinators use the system to its fullest extent, including shortcuts and template tips to reduce alert distribution time.

**4. Develop a training procedure for HAN coordinators.**

Between 10/2015 and 09/2016, CAHAN staff will develop a curriculum of requirements, including **five** basic training objectives, that HAN coordinators must meet to independently train their own HAN coordinators. At the request of local partners, CAHAN staff will also develop **one** comprehensive step-by-step training manual to assist HAN coordinators in frequently used aspects of the new alerting system. A required component for the training procedure will be to demonstrate quick, effective use of the system.

**State Program Title: California Wellness Plan Implementation, Program A**

**State Program Strategy:**

**Goal:** *Equity in health and well-being* is the overarching goal of the California Wellness Plan (CWP), California's chronic disease prevention and health promotion plan. The four CWP goals are: (1) Healthy Communities, (2) Optimal Health Systems Linked with Community Prevention, (3) Accessible and Usable Health Information, and (4) Prevention Sustainability and Capacity.

**Health Priority:** *Prevent and reduce chronic disease in California* (California Wellness Plan Implementation [CWPI] program's health priority). Chronic disease and injury cause the majority of deaths and contribute to poor quality of life, disability, and premature death. In 2010, \$98 billion was the estimated cost of treating arthritis, asthma, cardiovascular disease, diabetes, cancer, and depression in California, 42% of California's health care expenditures.

**Role of Block Grant Funds:** PHHSBG funds support staff salary, state-level monitoring, communication, policy, and coordination capacity, including publications, reports, trainings, conferences, and disseminating reports to advance chronic-disease prevention.

**Primary Strategic Partnerships**

**Internal**

- California Department of Health Care Services
- Covered California
- California Office of Statewide Health Planning and Development
- California Office of Aging
- California Department of Managed Health Care

**External**

- American Heart Association
- California Chronic Care Coalition
- California Conference of Local Health Officers
- County Health Executives Association of California
- The California Endowment

**Evaluation Methodology:** CWPI staff will evaluate progress toward reaching CWP goals with *process evaluation* (input and feedback from partners and stakeholders via in-person meetings, online surveys, calls, and e-mails) and *performance evaluation* (monitoring selected CWP objectives in collaboration with state partners).

**State Program Setting:**

Business, corporation or industry, Community based organization, Faith based organization, Local health department, Medical or clinical site, Parks or playgrounds, Schools or school district, Senior residence or center, State health department, Tribal nation or area, University or college, Work site

**FTEs (Full Time Equivalent):**

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

**Position Name:** Jessica Nuñez-de Ybarra

**Position Title:** Public Health Medical Officer III(T)

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Total Number of Positions Funded:** 1

**Total FTEs Funded:** 1.00

**National Health Objective: HO PHI-15 Health Improvement Plans**

**State Health Objective(s):**

Between 10/2015 and 12/2016,

1. Increase the number of California local public health departments nationally accredited from zero to **six** (by 2018).

2. Improve the following measures as long-term population health outcomes:
  - A. Increase the percentage of adults who report their overall health status to be good, very good, or excellent from baseline of 79.3% to **85%**.
  - B. Increase the percentage of 24- to 64-year-old adults in good or better health from baseline of 79.3% to **85%**.
  - C. Increase the percentage of adults 65 years and older in good or better health from baseline of 72.1% to **78%**.
  - D. Decrease percentage of adults in fair or poor health from baseline of 20.4% to **18%** for African Americans.
  - E. Decrease percentage of adults in fair or poor health from baseline of 28.5% to **25%** for Hispanics.

**Baseline:**

*Number of local public health departments in California nationally accredited by the Public Health Accreditation Board (2013): **zero***

1. In 2014, **79.3%** of adults reported their overall health status to be good, very good, or excellent.
2. In 2014, **79.3%** of 24- to 64-year-old adults reported to be in good or better health.
3. In 2014, **72.1%** of adults 65 years and older reported to be in good or better health.
4. In 2014, **20.4%** of African-American adults reported to be in fair or poor health.
5. In 2014, **28.5%** of Hispanic adults reported to be in fair or poor health.

**Data Source:**

Behavioral Risk Factor Surveillance System (BRFSS) 2014

**State Health Problem:**

**Health Burden:**

***Chronic diseases and unintentional injury are the leading causes of death, disability, and diminished quality of life in California.*** These conditions affect some populations more than others, resulting in significant inequities in health outcomes and quality of life within California's population of approximately 39 million people (**target population**). An estimated 14 million Californians live with at least one chronic condition; more than half of this group have multiple chronic conditions (**disparate population**: low-income elderly).

**Target Population:**

Number: 38,801,063

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions

**Disparate Population:**

Number: 5,054,168

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions

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

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

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

Total Current Year Funds Allocated to Health Objective: \$330,000

Total Prior Year Funds Allocated to Health Objective: \$391,400

Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Improve chronic-disease surveillance.**

Between 10/2015 and 09/2016, CWPI staff will conduct **one** conceptual framework for improved statewide chronic-disease surveillance beyond stroke and cancer registries, starting with a pilot on the burden of diabetes in California.

### **Annual Activities:**

#### **1. Convene stakeholders to develop conceptual framework.**

Between 10/2015 and 09/2016, CWPI staff will convene **one** statewide CWP Goal-3 Work Group of partners in **at least four** meetings to ensure “Accessible and Usable Health Information” by developing the strategic and conceptual framework for improved chronic-disease surveillance in California via electronic health-record data.

#### **2. Collaborate on pre-diabetes and diabetes pilot project.**

Between 10/2015 and 09/2016, CWPI staff will collaborate with Quest Diagnostic Laboratories, Inc., to develop **one** pilot proof-of-concept proposal to assess the frequency, distribution, and quality of care of patients with diabetes and those at risk of diabetes (i.e., pre-diabetics) by evaluating Quest hemoglobin A1c laboratory results.

### **Objective 2:**

#### **Maintain Chronic-Disease Prevention Coalition.**

Between 10/2015 and 09/2016, CWPI staff will conduct **four** meetings and attend partner meetings to promote CWPI in collaboration with partners committed to utilizing evidence-based chronic-disease–prevention practices that have a measurable impact on population health, patient experience, and health care cost.

### **Annual Activities:**

#### **1. Plan and convene statewide conference.**

Between 10/2015 and 09/2016, CWPI staff will, in partnership with internal and external stakeholders, host **one** statewide chronic-disease–prevention meeting to share successes and promote best practices for implementing chronic-disease prevention and health promotion in alignment with Let's Get Healthy California (LGHC) goals and California Wellness Plan (CWP) objectives to make California the healthiest state in the nation by 2022.

#### **2. Convene Work Group.**

Between 10/2015 and 09/2016, CWPI staff will engage internal and external partners and stakeholders to prevent, diagnose, treat, and control chronic disease by promoting **seven** interventions: (1) Asthma In-Home Services for Children/ California Breathing; (2) Standard Tobacco Cessation Benefit/ California Tobacco Control; (3) National Diabetes Prevention Program Benefit/ Heart Disease and Diabetes Prevention; (4) Colorectal Cancer Screening using Fecal Immunochemical Test Preferred Policy/ California Colon Cancer Control Program; (5) Perinatal Home Visiting Benefit/ California Home Visiting; (6) Breastfeeding-Friendly Hospital Preferred Policy/ Maternal, Child and Adolescent Health; and (7) Comprehensive Medication Management/ California Wellness Plan Implementation and Prevention First.

#### **3. Promote best practices, training, and collaboration.**

Between 10/2015 and 09/2016, CWPI staff will maintain **two** mechanisms for communication (e.g., listserv, website) of CWPI progress and opportunities for internal and external collaboration to promote and utilize best practices to prevent, treat, and control chronic disease, and promote use of measures such as return on investment and cost of prevention.

**4. Participate in partner conferences and meetings.**

Between 10/2015 and 09/2016, CWPI staff will provide guidance in CWPI to partners attending **six** conferences/meetings, to ensure collective impact in prevention, diagnosis, treatment, and control of chronic disease.

**Objective 3:**

**Monitor California Wellness Plan Implementation.**

Between 10/2015 and 09/2016, CWPI staff will maintain **one** process for providing progress on CWP Goals, including all 266 CWP Objectives, to inform partner chronic-disease–prevention priorities and planning efforts.

**Annual Activities:**

**1. Maintain Online CWP Data Reference Guide.**

Between 10/2015 and 09/2016, CWPI staff will maintain **one** CWP Data Reference Guide on the California Health and Human Services Open Data Portal by ensuring that data is accurate and current every year.

**2. Disseminate CWP progress report.**

Between 10/2015 and 09/2016, CWPI staff will disseminate **one** CWP progress report to a statewide audience of partners and stakeholders, to provide state-level updates on CWP health objectives to inform partner chronic-disease–prevention priorities and planning efforts.

**3. Track, monitor, and evaluate CMM update statewide.**

Between 10/2015 and 09/2016, CWPI staff will collaborate with partners and stakeholders to develop **one** article of recommendations to track, monitor, and evaluate comprehensive medication management uptake statewide, to provide evidence of impact and effectiveness of team-based care approach for high-risk patients.

**State Program Title: California Wellness Plan Implementation, Program B**

**State Program Strategy:**

**Goal:** *Identify methods and tools for conducting economic evaluation of public health interventions.*

**Health Priority:** *Prevent and reduce chronic disease in California.* An estimated 14 million Californians live with at least one chronic condition; more than half of this group has multiple chronic conditions. Chronic disease and injury not only cause the majority of deaths, but also contribute to poor quality of life, disability, and premature death. In 2010, approximately \$98 billion was the estimated cost of treating arthritis, asthma, cardiovascular disease, diabetes, cancer, and depression in California.

**Role of Block Grant Funds:** PHHSBG funds support staff salaries, state-level monitoring, communication, policy, and coordination capacity, including health economic analysis, analysis of survey results, and disseminating reports to advance chronic disease prevention.

**Primary Strategic Partnerships:**

**Internal:**

California Department of Public Health

**External:**

California Department of Health Care Services

California Health and Human Services Agency

California Health Benefits Review Program

Department of Finance

**Evaluation Methodology:** The California Department of Public Health (CDPH) Fusion Center will evaluate progress toward goals with *process evaluation* (input and feedback from partners and stakeholders via in-person meetings, online surveys, calls, and e-mails) and *performance evaluation* (monitoring selected Fusion Center Program objectives).

**State Program Setting:**

State health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Vacant

**Position Title:** Contractor

State-Level: 75% Local: 0% Other: 0% Total: 75%

**Position Name:** Vacant

**Position Title:** Graduate Student Assistant

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Total Number of Positions Funded:** 2

**Total FTEs Funded:** 1.00

**National Health Objective: HO PHI-14 Public Health System Assessment**

**State Health Objective(s):**

Between 01/2015 and 12/2016, *Increase the capacity for economic public health system assessment* at CDPH.

**Baseline:**

CDPH has **zero** health economists on staff. The capacity of other staff not in a designated health economist role within the Department that provide some kind of economic analysis of public health interventions in their job function is an unknown quantity.

**Data Source:**

State of California Civil Service Pay Scale - by Class Title, Pay Scales/CalHR Net: Updated 3/8/2016, [http://www.calhr.ca.gov/Pay%20Scales%20Library/PS\\_Sec\\_15.pdf](http://www.calhr.ca.gov/Pay%20Scales%20Library/PS_Sec_15.pdf)

**State Health Problem:**

**Health Burden:**

(1) Six common chronic conditions represent approximately 42% of all health care expenditures in the State. (2) If adult body mass index (BMI) was reduced by 5%, California could save \$81.7 billion in obesity-related health care costs by 2030.

The **target** and **disparate populations** are the same: the total population of California.

**Target Population:**

Number: 38,000,000

Infrastructure Groups: State and Local Health Departments

**Disparate Population:**

Number: 38,000,000

Infrastructure Groups: State and Local Health Departments

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

Other: CDC Public Health Economics Methods and Tools: Economic tools used to evaluate costs and burden of health problems and the effectiveness and efficiency of health programs.

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

Total Current Year Funds Allocated to Health Objective: \$112,500

Total Prior Year Funds Allocated to Health Objective: \$112,500

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Start-up

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Increase capacity for economic analysis of public health interventions.**

Between 10/2015 and 09/2016, Fusion Center staff, contractor, or graduate student, in partnership with Lets' Get Healthy California Goal team members, will analyze **three** centers or programs within CDPH to develop a summary of staffing resources, including the level of readiness to utilize and incorporate economic analysis, and build capacity within the centers to support economic-analysis activities.

**Annual Activities:**

**1. Evaluate or survey programs for economic-analysis capability.**

Between 10/2015 and 09/2016, a contractor, graduate student assistant, and/or Fusion Center staff, in partnership with Lets' Get Healthy California Goal team members, will follow up with **three** centers or programs, after reviewing the results of an environmental scan, to conduct key information interviews, that will provide robust baseline data and information to develop a strategy for increasing economic-analysis capacity within the department.

**2. Research public health economic-analysis tools.**

Between 10/2015 and 09/2016, a contractor, graduate student assistant, and/or Fusion Center staff will, in partnership with Lets' Get Healthy California Goal team members, conduct research on **at least two** public health economic-analysis tools developed by CDC, NACCHO, and ASTHO, to develop a strategy for increasing economic-analysis capacity within the department.

**3. Develop list of economic-analysis resources and tools.**

Between 10/2015 and 09/2016, a contractor, graduate student assistant, and/or Fusion Center staff will, in partnership with Lets' Get Healthy California Goal team members, develop **one** list of recommended tools and instructions in how to use them to increase economic-analysis capacity within the department.

**State Program Title: Cardiovascular Disease Prevention Program**

**State Program Strategy:**

**Goal:** *Reduce death and disability from heart disease, the leading cause of death in California.*

Approximately 24% of all deaths in California are due to heart disease, which in 2014 was almost 58,000 deaths (CDPH, Death Records, 2014).

**Health Priority:** *Control and prevent cardiovascular disease (CVD), with an emphasis on hypertension*, employing *primary* (education about healthy nutrition habits, including sodium reduction) and *secondary* (promoting regular hypertension screening) *prevention strategies* in fulfilling objectives. For example, the California Cardiovascular Disease Prevention Program (CDPP) will (1) provide leadership to reduce sodium intake, improve blood pressure control, and decrease the prevalence of CVD in California; (2) through strategic partnerships, statewide workgroups, identification of interventions and best practices, and data collection and analysis, maximize the impact of PHHSBG funds.

**Role of Block Grant Funds:** Funds will support CDPP staff positions, a statewide conference, and staff training; the anticipated start date for the Research Scientist III position is July 1, 2016.

**Primary Strategic Partnerships**

**Internal**

- California Department of Health Care Services
- Chronic Disease Control Branch: Heart Disease and Diabetes Prevention Unit
- Nutrition Education and Obesity Prevention Branch
- California Department of Education
- California Tobacco Control Program

**External**

- American Heart Association
- Right Care Initiative
- Million Hearts
- National Sodium Reduction Initiative
- Chronic Care Coalition

**Evaluation Methodology:** Project-activity evaluation will be based on progress of annual objectives toward the Work Plan. Evaluation methods will include (1) pre–post evaluation of trainings/webinars, (2) evaluation surveys of conferences, and (3) annual satisfaction surveys of workgroup members.

**State Program Setting:**

Community based organization, Local health department, Medical or clinical site, Schools or school district, State health department, Work site

**FTEs (Full Time Equivalent):**

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

**Position Name:** Thea Perrino

**Position Title:** Health Program Specialist II

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Alexandria Simpson

**Position Title:** Health Program Specialist II

State-Level: 50% Local: 0% Other: 0% Total: 50%

**Position Name:** Vacant

**Position Title:** Research Scientist III

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** LeeAnn Velasquez

**Position Title:** Associate Governmental Program Analyst

State-Level: 10% Local: 0% Other: 0% Total: 10%

Total Number of Positions Funded: 4  
Total FTEs Funded: 2.60

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

### **State Health Objective(s):**

Between 10/2000 and 09/2020, (1) **Reduce coronary heart disease deaths** from 92.6 to **90.0 per 100,000** population (HDS-2); (2) **Reduce hospitalizations of older adults with congestive heart failure** as the principal diagnosis from 10.5 per 1,000 in 2014 to **9.9 per 1,000** population aged 65 and above (HDS-24); (3) **Reduce the proportion of persons in the population with hypertension** from 27.2% in 2013–14 to **26.2%** in 2016–17 (HDS-5); (4) **Increase the crude rate of adults with hypertension who are taking the prescribed medications to lower their blood pressure** from 69.2% in 2013–14 to **70.2%** in 2016–17 (HDS-11).

### **Baseline:**

*In 2014, (1) the age-adjusted coronary heart disease mortality rate was **92.6 per 100,000** population; (2) the age-adjusted congestive heart failure hospitalization rate was **10.5 per 1,000** population aged 65 and above.*

*In 2013–14, (1) **27.2%** of adults reported a diagnosis of high blood pressure; (2) among Californians who had been given a diagnosis of high blood pressure by a clinician, the crude rate of those who were taking medications to control high blood pressure was **69.2%**.*

### **Data Source:**

(1) CDPH, Death Statistical Master File, 2014; (2) Office of Statewide Health Planning and Development, Patient Discharge Data, 2014; (3) California Health Interview Survey (CHIS), 2013–14

### **State Health Problem:**

#### **Health Burden:**

The **target population** for program interventions includes about 29 million (2013) California adults aged 18 years and over, both genders, all racial and ethnic groups, and all geographic regions of the State. The **target** and **disparate populations** are the same.

*Mortality:* In 2013, the age-adjusted rate of coronary heart disease deaths was **101.0 per 100,000** population, and the heart failure age-adjusted rate was **13.6 per 100,000** population.

*Morbidity:* In 2013, the age-adjusted hospitalization rate for discharges with a principal diagnosis of coronary heart disease was **11.7 per 1,000** population aged 65 and above; congestive heart failure hospitalization rate as a principal diagnosis was **11.2 per 1,000** population aged 65 and above.

#### **Target Population:**

Number: 29,294,003

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

#### **Disparate Population:**

Number: 29,294,003

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No  
Location: Entire state  
Target and Disparate Data Sources: California Department of Finance, 2016

**Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**  
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Other: (1) 2015–20 Dietary Guidelines for Americans; (2) Right Care Initiative University of Best Practices

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

Total Current Year Funds Allocated to Health Objective: \$524,819  
Total Prior Year Funds Allocated to Health Objective: \$524,819  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Analyze CVD and economic data.**

Between 10/2015 and 09/2016, CDPP staff will conduct **three** data analyses to measure CVD burden, risk factors associated with CVD, and return on investment of public health interventions. These measures will determine the success of interventions and inform program and policy decisions of CDPP and the Chronic Disease Control Branch (CDCB).

**Annual Activities:**

**1. Train on economic and statistical techniques.**

Between 10/2015 and 09/2016, CDPP staff will present **at least two** trainings to managers and staff on health economics (e.g., conducting cost studies, health impact assessments) to identify the cost and effect of public health programs aimed at reducing CVD.

**2. Collect and analyze data on sodium awareness.**

Between 10/2015 and 09/2016, CDPP staff will: (1) analyze 2015 data from **one** California Behavioral Risk Factor Surveillance System (BRFSS) module question to measure awareness of reducing sodium intake, to help prevent and control hypertension; (2) produce **one** fact sheet on sodium awareness, highlighting the 2015 BRFSS data; (3) purchase the same question for the 2017 BRFSS survey, to track trends over time that may help inform goals and objectives regarding sodium reduction.

**3. Develop policy recommendation.**

Between 10/2015 and 09/2016, CDPP staff will (1) lead **at least two** peer-reviewed health-economic studies to quantify the fiscal burden of CVD, (2) provide **at least two** estimates of county-level health care costs for treating the most common chronic conditions, including CVD, and (3) develop **at least two** policy recommendations for CDCB and the Health Economic Advisory Committee, to inform policy and/or program decisions that may impact staff efforts in CVD prevention.

**Objective 2:**

**Establish and support a statewide heart-disease alliance.**

Between 10/2015 and 09/2016, CDPP staff will conduct **12** Healthy Hearts California meetings and support Healthy Hearts California, a dynamic, diverse statewide alliance of individuals and organizations working to reduce the burden of heart disease and stroke in California by creating synergy between alliance members that will maximize the impact of each member's contribution to reducing coronary heart disease.

**Annual Activities:**

**1. Implement statewide heart disease alliance.**

Between 10/2015 and 09/2016, CDPP staff will (1) develop **one** steering committee composed of state and local heart disease leaders and experts; (2) in conjunction with American Heart Association partners, lead the steering committee in developing a framework—including a Vision, Mission, Goals, Guiding Principles, and Objectives—to be rolled out through a statewide alliance. Healthy Hearts California alliance members will share information and increase the ability to leverage resources and the visibility for heart disease prevention and control, to maximize public health impact.

**2. Organize statewide Conference.**

Between 10/2015 and 09/2016, CDPP staff will plan, organize, facilitate, and host **one** statewide Healthy Hearts California Conference and invite heart disease and stroke prevention and control leaders to promote, discuss, and create synergy toward national, state, and local efforts relating to heart disease and stroke, bringing together Healthy Hearts stakeholders to set goals and objectives and monitor progress toward reducing heart disease and stroke.

**3. Implement heart-disease awareness campaign.**

Between 10/2015 and 09/2016, CDPP staff will implement **one** heart-disease awareness campaign to be promoted by members of the Healthy Hearts California alliance. Heart-disease prevention and control concepts and materials will be developed and published online and in print and marketed to create awareness of heart disease risks and designed to shape behavior toward positive health outcomes.

**4. Distribute provider toolkits.**

Between 10/2015 and 09/2016, CDPP staff will develop and distribute **100** provider toolkits to targeted clinical providers throughout California. Toolkits will include quality-improvement tools and resources to improve health care delivery through health information technology, and tools to increase the engagement of non-physician team-members (e.g., nurses, pharmacists, and community health workers). Materials will include evidence-based protocols and algorithms from the Million Hearts Initiative, the American Heart Association, and the Right Care Initiative.

**Objective 3:**

**Maintain and expand partnerships to prevent CVD.**

Between 10/2015 and 09/2016, CDPP staff will maintain **ten** partnerships with key national, statewide, and local stakeholders that support cardiovascular risk reduction, with an emphasis on high blood pressure, leading to implementation of evidence-based guidelines and public health best practices.

**Annual Activities:**

**1. Participate in partner meetings and conferences.**

Between 10/2015 and 09/2016, CDPP staff will maintain and expand **at least ten** partnerships by participating in meetings and conferences hosted by partner programs working to reduce CVD in California. Staff will provide requested presentations at conferences, webinars, and events hosted by partner programs, and sign letters of support.

**Objective 4:**

**Maintain the Sodium Awareness Leadership Team (SALT) taskforce.**

Between 10/2015 and 09/2016, CDPP staff will conduct **12** monthly SALT taskforce meetings to strategize on taskforce objectives and monitor and track progress toward SALT taskforce goals. Evaluation of this activity will be through taskforce agendas and meeting minutes.

**Annual Activities:**

### **1. Implement sodium-reduction awareness campaign.**

Between 10/2015 and 09/2016, CDPP staff will implement **one** sodium-reduction awareness campaign that will: (1) distribute sodium-related information to parents at K–12 schools; (2) educate state employees on the risks of excess sodium consumption at the CDPH Public Health Showcase; (3) distribute nutrition and sodium-related materials to partners, including Healthy Hearts California, the Chronic Care Coalition, Lifetime of Wellness, Sodium Reduction in Communities grantees, and WISEWOMAN clinics; (4) add a sodium-awareness message to CDPH employee paystubs; (5) include sodium-awareness messages on social media sites. Measures will be taken to increase awareness of the dangers of consuming too much sodium and designed to shape behavior toward positive health outcomes.

### **2. Implement policies on nutrition and sodium reduction.**

Between 10/2015 and 09/2016, CDPP staff will apply policies related to **one** sodium-reduction campaign that will promote lower-sodium menu options at the CDPH office buildings in the East End Complex in Sacramento, which includes the Sports Grill, coffee bars, and snack shops. Campaign activities will also include surveying local area restaurants to collect and analyze data on the sodium content of menu items.

### **Objective 5:**

#### **Participate in the CWP: CMM Implementation Work Group.**

Between 10/2015 and 09/2016, CDPP staff will provide information and resources to **20** individuals working on Comprehensive Medication Management (CMM), to engage pharmacists to provide services resulting in medication adherence and improved health outcomes.

### **Annual Activities:**

#### **1. Support CWP: CMM Work Group.**

Between 10/2015 and 09/2016, CDPP staff will (1) attend **monthly** meetings, conferences, and activities in support of the CWP: CMM Work Group. The CMM model engages pharmacists to provide services resulting in medication adherence and creating better health outcomes, and (2) share information and resources provided during CWP: CMM Work Group meetings with local health departments and Healthy Hearts California alliance members.

**State Program Title: Commodity-Specific Surveillance: Food & Drug Program**

**State Program Strategy:**

**Goal:** *Prevent consumer exposure to and reduce the incidence of food-borne illness.* The California Department of Public Health (CDPH) Commodity-Specific Surveillance (CSS) Program (1) collects surveillance samples of high-risk food products known to be susceptible to microbial contamination, (2) evaluates samples for microbial contamination, and (3) initiates interdiction efforts to remove products determined to be adulterated from the marketplace.

**Health Priority:** *Identification and removal of foods contaminated with pathogenic bacteria from the food supply* to prevent and reduce the incidence of food-borne illness, injury, and death of consumers.

**Role of Block Grant Funds:** PHHSBG funds will support salaries and operational costs of personnel conducting field work, such as sampling and removal of adulterated foods, and conducting the microbial analyses of the samples collected.

**Primary Strategic Partnerships**

**Internal**

- Division of Communicable Disease Control
- Infectious Disease Branch

**External**

- Industry trade associations
- Food and Drug Administration
- Centers for Disease Control and Prevention

**Evaluation Methodology:** Progress will be measured based on the number of samples collected and evaluated and the effectiveness of interdiction activities in removing adulterated foods from the marketplace once identified.

**State Program Setting:**

State health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Vacant

**Position Title:** Environmental Scientist

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Position Name:** Samantha Pastrana

**Position Title:** Environmental Scientist

State-Level: 15% Local: 0% Other: 0% Total: 15%

**Position Name:** Mary Diarbekirian

**Position Title:** Environmental Scientist

State-Level: 15% Local: 0% Other: 0% Total: 15%

**Position Name:** Travis You

**Position Title:** Environmental Scientist

State-Level: 15% Local: 0% Other: 0% Total: 15%

**Position Name:** Chunye Lu

**Position Title:** Research Scientist II

State-Level: 68% Local: 0% Other: 0% Total: 68%

**Total Number of Positions Funded:** 5

**Total FTEs Funded:** 1.38

**National Health Objective: HO FS-2 Outbreak-Associated Infections Associated with Food Commodity Groups**

**State Health Objective(s):**

Between 10/2015 and 09/2016, reduce the incidence of illness caused by *Escherichia coli* O157, *Listeria monocytogenes*, and *Salmonella* species pathogens from ingestion of contaminated food, through effective surveillance of high-risk food commodities and prompt interdiction to remove contaminated foods from commerce, once identified.

**Baseline:**

*Baseline data prior to 2015 does not exist. In federal fiscal year (FFY) 2015, Food and Drug Branch (FDB) staff will collect approximately 600 samples of high-risk food for microbial testing. To date, this sampling has resulted in two retail samples of sliced mushrooms testing positive for Listeria monocytogenes. These findings have resulted in significant sanitation and remediation activities at a mushroom harvesting and slicing operation in California.*

**Data Source:**

Before commodity-specific surveillance sampling for high-risk foods was started during FFY 2015, FDB collected samples of high-risk food commodities during for-cause investigations when some indication of possible adulteration was suspected.

**State Health Problem:**

**Health Burden:**

CDC estimates that each year roughly one in six Americans (or 48 million people) get sick, 128,000 are hospitalized, and 3,000 die of food-borne diseases. Based on these national statistics, California's proportionate burden of food-borne illness would result in 5.86 million getting sick, 15,600 being hospitalized, and 366 dying each year. The **target** and **disparate populations** are the same: the total population of California.

**Target Population:**

Number: 38,800,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 38,800,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: CDC, Food-borne illness estimates, 2011:

<http://www.cdc.gov/foodborneburden/index.html>

**Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**  
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

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

Total Current Year Funds Allocated to Health Objective: \$160,000

Total Prior Year Funds Allocated to Health Objective: \$140,000

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Increase analysis of food commodities for microbial contamination.**

Between 10/2015 and 09/2016, FDB and Food and Drug Laboratory Branch (FDLB) staff will collect **600** samples of high-risk food commodities that are known to be susceptible to microbial contamination. Staff will investigate the distribution of adulterated foods and take steps to ensure removal from commerce to decrease consumer exposure to contaminated foods and reduce the risk of contracting food-borne illness.

**Annual Activities:**

**1. Collect and evaluate high-risk food commodities for microbial contamination.**

Between 10/2015 and 09/2016, FDB and FDLB staff will analyze **approximately 600** samples of food commodities for microbial contamination. Microbial analysis will be conducted to isolate and serotype pathogens. Pulsed-field Gel Electrophoresis (PFGE) or Whole Genome Sequencing (WGS) may also be conducted on isolates to determine if they are linked to any reported illnesses.

**2. Investigate processors to determine source and distribution of contaminated foods.**

Between 10/2015 and 09/2016, FDB and FDLB staff will investigate **all** firms involved in the manufacture and distribution of foods identified with bacterial contamination to determine the likely source of the contaminant and the distribution of the contaminated food(s) to ensure removal from commerce. Distribution and handling records will be evaluated to determine product distribution, and processing and growing practices will be evaluated to determine the source of the contaminant or the failure in the processing system that allowed the contaminant to proliferate.

**State Program Title: Community Water Fluoridation Implementation Project**

**State Program Strategy:**

**Goal:** *Reduce the epidemic of dental decay in California’s children by fluoridating California’s public drinking water systems.*

**Health Priority:** (1) *Reach the Healthy People 2020 (HP 2020) goal of 79.6% of the population of California having access to fluoridated drinking water,* and (2) *Maintain fluoridation efforts for at least eight communities currently fluoridating.*

The California Water Fluoridation Initiative (CWFI), through the California Department of Public Health (CDPH) Oral Health Department (OHP) promotes community water fluoridation (CWF), the safest, most effective, and most economical public health intervention for reducing dental caries. Drinking water with the right amount of fluoride keeps the tooth surface strong and solid and prevents about 25% of cavities during a person’s lifetime. CWF is also the least-expensive way to deliver the benefits of fluoride to all residents of a community, regardless of age, income, education, or socioeconomic status. Income and ability to get routine dental care are not barriers since all residents can enjoy fluoride's protective benefits just by drinking tap water.

For communities of more than 20,000 people, it costs about 50 cents per person to fluoridate the water. Every \$1.00 invested in this preventive measure saves \$38 in dental treatment costs, saving millions of dollars to Denti-Cal (California’s Medi-Cal dental program provider).

**Role of Block Grant Funds:** PHHSBG funds support one FTE position; a contract for subject-matter expertise; and technical assistance to local health departments, public water systems, the general public, dental professionals, and City/County Boards of Supervisors regarding the benefits, safety, and efficacy of fluoridation.

**Primary Strategic Partnerships**

**Internal**

- Division of Drinking Water
- Chronic Disease Control Branch
- Maternal Child Adolescent Health

**External**

- University of California, San Francisco, School of Dentistry
- California Dental Association
- Fluoridation Advisory Council
- Centers for Disease Control and Prevention
- Local health departments

**Evaluation Methodology:** Published water fluoridation data from the “Morbidity and Mortality Weekly Report” and the Water Fluoridation Reporting System, and data from the State Water Resources Control Board, Division of Drinking Water Programs (DWP), regarding water systems adding fluoride will be used to determine the increase in the percentage of the population receiving fluoridated water from public water systems in California.

The percent differential will be used to determine if California is either maintaining or increasing the percentage of the population receiving fluoridated water. *Process and performance evaluation* (by monitoring CWFI objectives) will be used to determine overall progress toward meeting objectives.

**State Program Setting:**

Business, corporation or industry, Community health center, Local health department, State health department, Other: Regional Drinking Water District Offices, and City/County public water systems

**FTEs (Full Time Equivalent):**

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

**Position Name:** Rosanna Jackson

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

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

**National Health Objective: HO OH-13 Community Water Fluoridation**

**State Health Objective(s):**

Between 10/2015 and 09/2016, OHP staff and partners will *increase the proportion of the population in California served by fluoridated community water systems* from 63.7 to 64%.

**Baseline:**

**63.7%** (2012) of Californians had access to fluoridated drinking water.

**Data Source:**

CDC, 2012; "Community Water Fluoridation: 2012 Water Fluoridation Statistics"; available at <http://www.cdc.gov/fluoridation/statistics/2012stats.htm>

**State Health Problem:**

**Health Burden:**

Tooth decay (dental caries) affects 50% of all school-aged children and 96% of adults aged 18 years or older. Tooth decay is five times more common in children than asthma. According to the 2004–05 California Smile Survey, 54% of the kindergartners and 71% of third-grade children screened had a history of tooth decay. Twenty-eight percent of kindergartners and third graders had untreated tooth decay. Twenty-two percent of children needed non-urgent dental care, and an additional 4% needed urgent dental care because of pain or infection.

California children miss approximately 874,000 days of school each year due to dental problems, putting them at risk of lagging behind their peers. Seventeen percent of kindergartners and 5.5% of third graders had never been to a dentist, putting them at greater risk of having untreated tooth decay. Latino children and poor children in California experience more tooth decay and untreated tooth decay than other children. In addition, low-income, high-risk children rarely have dental insurance, and children of color are more likely to be from low-income families.

Oral disease can cause malnutrition, depression, poor self-esteem, and inability to concentrate. Left untreated, pain and infection can result in problems with eating, speaking, and learning. Poor oral health can have a detrimental effect on quality of life, performance at school, and success in life.

African-American adults in California have a higher prevalence of tooth extraction due to decay or gum disease, and higher mortality from oral cancers than adults of other racial/ethnic groups.

Fewer than half of pregnant women in California receive dental care during their pregnancies; women whose providers recommend a dental visit during their pregnancy are nearly twice as likely to have dental care as women who did not receive a recommendation from their provider.

There is a strong link between smoking and oral disease; however, only one in ten smokers report being advised to quit by their dental providers.

An additional benefit to the senior population is gained because fluoridated water also reduces the occurrence of root caries in seniors; fluoridation prevents approximately 25% of cavities during a person's lifetime. The **target population** includes all Californians. Although adults benefit from CWF, most benefits are noticed by children in the tooth-forming years in urban areas, up to the age of 16 years (**disparate population**).

**Target Population:**

Number: 38,340,074

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 10,210,827

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: California Department of Finance (2014)

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

Other: • "Surgeon General's Report on Oral Health" (2000) (Seminal report on oral health; cites fluoridation as a best practice)

• U.S. Community Preventive Services Task Force Systematic Review of Community Water Fluoridation (2013)

• CDC, Achievements in Public Health, 1990–1999: Fluoridation of Drinking Water to Prevent Dental Caries. MMWR, 1999;48(41):933–940 (CWF identified as a best practice and one of the top ten achievements in public health of the 20th Century)

• The California "Smile Survey" (Dental Health Foundation, 2006) (This is the most recent basic screening survey data that indicates the status of children's oral health in California.)

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

Total Current Year Funds Allocated to Health Objective: \$263,813

Total Prior Year Funds Allocated to Health Objective: \$260,560

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Provide leadership, technical assistance, and training.**

Between 10/2015 and 09/2016, OHP staff will provide ongoing leadership and guidance to **a minimum of two** communities, local health departments, or water systems interested in fluoridating their water or maintaining their fluoridation efforts.

**Annual Activities:**

**1. Identify priorities, challenges, and opportunities.**

Between 10/2015 and 09/2016, OHP staff will meet **quarterly** with the Fluoridation Advisory Council to identify priorities, gaps, and progress of fluoridation efforts, as well as opportunities, challenges, and resources for fluoridation and to problem solve and determine where to provide technical assistance to implement or maintain water fluoridation in strategic areas.

**2. Track fluoridated water systems.**

Between 10/2015 and 09/2016, OHP staff will collaborate with DWP to identify **at least 57** optimally fluoridated water systems that are fluoridating to provide information to health providers and the public. This information will inform providers regarding the efficacy of prescribing fluoride supplements.

**3. Provide technical assistance.**

Between 10/2015 and 09/2016, OHP staff and contractor will provide (1) technical assistance to **at least three** local health departments, water systems, or communities (e.g., to provide scientific expertise and testimony regarding the safety and efficacy of water fluoridation, interpret fluoridation studies and technical reports, identify educational materials, list of resources), and (2) information to rebut anti-fluoridation information to **at least four** local communities (such as San Jose, Sonoma County, Woodland, and Davis) interested in implementing or maintaining fluoridation, and to stop rollback efforts, and (3) information to DWP regarding the public health benefits, safety, cost effectiveness, and efficacy of community water fluoridation.

**4. Identify new fluoridation formula.**

Between 10/2015 and 09/2016, OHP staff, DWP, CDC National Fluoridation Engineer, and contractor will identify **one** new methodology to determine the fluoridation status of the population receiving fluoridated water from public water systems in California. An appropriate numerator and denominator will be identified to better reflect the number of people served by fluoridated water systems. This will help to align the methodology with other states and provide a more accurate fluoridation status.

**5. Promote CDC water-fluoridation course.**

Between 10/2015 and 09/2016, OHP staff and DWP will identify and recruit **two to five** water engineers and/or operators to attend **one** national water fluoridation training course.

**State Program Title: Emergency Medical Dispatch Program/EMS Communications**

**State Program Strategy:**

**Goal 1: *Improve statewide pre-hospital training standards*** and provide uniformity through guidelines by (1) California Emergency Medical Dispatch (EMD) program staff assessing statewide EMS training standards that encourage use of medical pre-arrival instructions by dispatchers at Public Safety Answering Points (PSAPs); (2) EMD program staff working in conjunction with the California 9-1-1 Emergency Communications Office staff, who have technical and fiscal oversight of the PSAPS.

**Goal 2: *Improve public care and maximize efficiency of 9-1-1 systems*** by encouraging PSAPs that use EMD guidelines to reach minimum national certification standards for dispatchers and dispatch centers.

**Health Priority: *Improve interoperability communications among EMS agencies and public safety responders*** so that critical communication links are available during major events and timely access to comprehensive, quality emergency health care services is ensured.

**Role of Block Grant Funds:** Funded positions (1) coordinate state and local agencies that implement statewide standardized program guidelines for emergency medical dispatch; (2) improve interoperability communications among EMS agencies and public-safety responders to ensure timely access to comprehensive, quality emergency health care services. The vacant position is expected to be filled by August 1, 2016.

**Primary Strategic Partnerships**

**Internal**

- Office of Emergency Services, 9-1-1 Emergency Communications Office
- Office of Emergency Services, 9-1-1 Advisory Board
- EMS Authority Disaster Management
- California Highway Patrol

**External**

- California State Association of Counties
- California Fire Chiefs Association
- California Ambulance Association
- California Chapter of Emergency Numbers Association
- California Association of Public Safety Communications Officers

**Evaluation Methodology:** (1) Monitor local EMS systems plans related to EMD and 9-1-1 communications components to ensure statewide disaster frequency coordination. (2) Analyze development of resource manual.

**State Program Setting:**

Community based organization, Local health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Teri Harness

**Position Title:** Staff Service Manager I

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Kathy Kay Spencer

**Position Title:** Associate Governmental Program Analyst

State-Level: 10% Local: 0% Other: 0% Total: 10%

**Position Name:** Vacant

**Position Title:** Associate Governmental Program Analyst

State-Level: 80% Local: 0% Other: 0% Total: 80%

**Position Name:** Lori O'Brien  
**Position Title:** Office Technician  
State-Level: 11% Local: 0% Other: 0% Total: 11%  
**Position Name:** Heidi Wilkening  
**Position Title:** Associate Governmental Program Analyst  
State-Level: 25% Local: 0% Other: 0% Total: 25%

**Total Number of Positions Funded:** 6  
**Total FTEs Funded:** 1.46

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

**State Health Objective(s):**

Between 10/2015 and 09/2016, *improve prehospital care in California* by providing technical assistance to **100%** of the local EMS agencies (LEMSAs) in the operations and development of local EMD and 9-1-1 communications system service programs.

**Baseline:**

*Emergency response communications, historically lacking interoperability and communication coordination, is a critical component for the public to receive efficient, rapid, and quality pre-hospital care.*

**Data Source:**

Public Safety and Wireless Communication Interoperability, February 2013

**State Health Problem:**

**Health Burden:**

- Public safety agencies throughout the State follow inconsistent EMD training standards and protocols.
- Public safety agencies also face significant challenges in establishing radio interoperability at communications centers and field first-responder levels. This is particularly problematic in disaster situations, where personnel may be dispatched from other areas.

The **target** and **disparate populations** are the same: the total population of California.

**Target Population:**

Number: 39,144,818  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No

**Disparate Population:**

Number: 39,144,818  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau (2015)

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Other: • International Academies of Emergency Dispatch  
• National Emergency Number Association (NENA)  
• Statewide EMD guidelines, based on U.S. Department of Transportation and Office of Traffic Safety evidence.

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

Total Current Year Funds Allocated to Health Objective: \$90,711

Total Prior Year Funds Allocated to Health Objective: \$90,711

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Maintain active partnerships with key EMS communication stakeholder groups.**

Between 10/2015 and 09/2016, EMSA staff will increase the percent of participation in key EMS communications stakeholder association groups that represent EMSA in California EMS communications operations from 30% to **50%**.

### **Annual Activities:**

#### **1. Attend 9-1-1 Advisory Board meetings.**

Between 10/2015 and 09/2016, EMSA staff will participate in **at least four** 9-1-1 Advisory Board meetings to (1) develop relationships with key EMS communication stakeholders, (2) receive up-to-date 9-1-1 service information, and (3) to ensure statewide coordination of efficient pre-hospital medical responses.

#### **2. Attend NAPCO meetings**

Between 10/2015 and 09/2016, EMSA staff will attend **at least three** NAPCO meetings to develop relations with key communication stakeholders and provide EMS related information in NAPCO activities.

### **Objective 2:**

#### **Review EMS manual.**

Between 10/2015 and 09/2016, EMSA staff will review **one** "Statewide EMS Operations and Communications Resource Manual" to determine the need for addition/deletion of information. Revisions will improve interoperability communications among EMS agencies and public-safety responders.

### **Annual Activities:**

#### **1. Update manual.**

Between 10/2015 and 09/2016, EMSA staff will revise **one** "Statewide EMS Operations and Communications Resource Manual" by implementing suggested addition/deletion of content, to improve access to information that enables interoperability of communications systems among responders to crash sites.

#### **2. Establish Communication Technical Advisory Committee.**

Between 10/2015 and 09/2016, EMSA staff will identify **six to ten** stakeholders and communicate with all

appropriate agencies to get current information for revision of the resource manual.

**State Program Title: EMS for Children**

**State Program Strategy:**

- **Goal 1: *Implement fully institutionalized Emergency Medical Services for Children (EMSC) in California*** by continuing to incorporate statewide compliance with national EMSC performance measures and the collection of statewide EMS data.
- **Goal 2: *Continue development of a comprehensive model for the integration of family-centered care for children*** into California's EMS system.

**Health Priority: *Improve access to rapid, specialized pre-hospital EMS services for children statewide***, to reduce the morbidity and mortality rates of patients in California.

**Role of Block Grant Funds:** PHHSBG dollars support EMSC staff salaries. EMSA staff work with local emergency medical services agencies (LEMSAs) to develop and improve EMSC throughout California.

**Primary Strategic Partnerships**

**Internal**

- California Children Services
- California Department of Public Health
- Commission on EMS
- Office of Traffic Safety
- Department of Social Services

**External**

- EMSC Technical Advisory Committee
- EMSC Coordinators Group
- American Academy of Pediatrics
- Maternal and Child Health Bureau
- Emergency Nurses Association

**Evaluation Methodology:** Outcome- and goal-based methodologies will be used to evaluate progress toward institutionalizing EMSC in California's EMS system. Using state CEMISIS data to establish quality-improvement (QI) measures, coupled with goal-based outcomes of these objectives, EMSA will evaluate additional needs for LEMSAs to enhance their EMSC programs.

**State Program Setting:**

Community based organization, Local health department, Medical or clinical site, State health department

**FTEs (Full Time Equivalent):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Terri Harness

**Position Title:** Staff Services Manager I

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Lori O'Brien

**Position Title:** Office Technician

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Kathy Kay Spencer

**Position Title:** Associate Governmental Program Analyst

State-Level: 10% Local: 0% Other: 0% Total: 10%

**Position Name:** Farid Nasr

**Position Title:** Health Program Specialist II

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Total Number of Positions Funded:** 5

**Total FTEs Funded:** 0.66

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

### **State Health Objective(s):**

Between 10/2015 and 09/2016, EMSA staff will **develop and maintain EMSC programs** by providing technical assistance to **100%** of the LEMSAs that request assistance.

### **Baseline:**

*100% of the LEMSAs participate in some level of EMSC programs; however, the types of EMSC programs being implemented are not known. Data collected from completed program objectives will be used to create a statewide report that identifies the status of each LEMSAs programs and their needs.*

### **Data Source:**

EMS Authority, 2015

### **State Health Problem:**

#### **Health Burden:**

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.

All 33 LEMSAs have implemented portions of EMSC into their EMS systems. Continued development of these programs to a standardized and optimum level of care across California is needed. The pediatric **target and disparate populations** (23.1% of the State's population) includes all California children below 18 years of age, regardless of their race or socioeconomic background.

#### **Target Population:**

Number: 9,042,452

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

#### **Disparate Population:**

Number: 9,042,452

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau (2015)

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Other: American Academy of Pediatrics: Policy Statement--Equipment for Ambulances, 2013

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

Total Current Year Funds Allocated to Health Objective: \$123,800  
Total Prior Year Funds Allocated to Health Objective: \$123,800  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

## OBJECTIVES – ANNUAL ACTIVITIES

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

### **Objective 1:**

#### **Develop EMSC regulations.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** set of draft regulations for the EMSC program. EMSC regulations are being drafted to provide the LEMSAs and other local facilities with minimum requirements to establish and maintain EMSC program(s).

### **Annual Activities:**

#### **1. Coordinate Work Group meetings.**

Between 10/2015 and 09/2016, EMSA staff will schedule **at least two** meetings and **two** conference calls with the EMSC Regulations Work Group to discuss draft regulations and come to an agreement on regulatory language.

#### **2. Draft EMSC regulations.**

Between 10/2015 and 09/2016, EMSA staff will (1) provide **one** final draft of regulations for EMSC Work Group review and feedback, (2) revise the draft regulations based on Work Group comments, and (3) circulate draft regulations to internal EMSA management for approval.

#### **3. Obtain approval of the draft EMSC regulations.**

Between 10/2015 and 09/2016, EMSC staff will present for approval **one** set of final draft regulations to (1) the EMSC Regulation Work Group, (2) the Emergency Medical Services Administrators' Association of California (EMSAAC); and (3) the Commission on EMS, to satisfy required regulation standards.

#### **4. Develop one Rulemaking File for EMSC regulations.**

Between 10/2015 and 09/2016, EMSA staff will (1) complete **one** Notice of Publication form (Std 400) to begin the review process with the California Office of Administrative Law (OAL); (2) develop **one** Notice of Proposed Rulemaking, announcing the proposed rulemaking to the regulated public (required by California law); (3) submit **one** Std 400, Notice of Proposed Rulemaking, the Initial Statement of Reason Statement (ISORS), and **one** draft regulations to OAL. The ISOR is the primary rulemaking document that satisfies the necessity standard in the rulemaking process.

**State Program Title: EMS Health Information Exchange**

**State Program Strategy:**

**Goal:** *Improve access to rapid, specialized pre-hospital EMS services statewide*, to improve patient outcomes and reduce the morbidity and mortality rates of patients in California.

**Health Priority:** *Improve the statewide development of Health Information Exchange (HIE)* (electronic movement of health-related information among organizations) in California's Emergency Medical Services (EMS) program by facilitating access to and retrieval of clinical data to provide safer, timelier, efficient, effective, equitable, patient-centered care.

Emergency Medical Dispatch (EMD) staff evaluate options for HIE between field EMS providers, using electronic prehospital care records (ePCRs), and hospital electronic health records (EHRs). EMSA staff will develop plans to improve data with two local emergency medical services agencies (LEMSAs) in the use of ePCR data exchange to (1) share best practices, and (2) continue plans for bi-directional exchange of statewide patient medical-record information exchanges.

**Role of Block Grant Funds:** PHHSBG dollars support EMSA staff in the implementation of HIE in California, including (1) administering an effective system of coordinated emergency medical care, injury prevention, and disaster medical response; and (2) providing local assistance grants to LEMSAs for implementing HIE in their counties.

**Primary Strategic Partnerships**

**Internal**

- California Health and Human Services Agency
- California Department of Public Health
- Chronic Disease Control Branch

**External**

- California Office of Health Information Integrity
- California Hospital Association
- California EMS Commission
- Emergency Medical Services Administrators' Association of California
- California Ambulance Association

**Evaluation Methodology:** Track California EMS data from the Office of the National Coordinator for Health Information Technology, EMSA program staff activities, and EMSA HIE program outcomes. EMSA staff will monitor LEMSA HIE progress via the facilitation of stakeholder teleconferences, oversight of LEMSA HIE program grant-funded projects, and the collection of EMS data and core-measure developments.

**State Program Setting:**

Community based organization, Local health department, Medical or clinical site, State health department, Other: Local EMS Agencies

**FTEs (Full Time Equivalents):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Teri Harness

**Position Title:** Staff Services Manager I

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Kathy Kay Spencer

**Position Title:** Associate Governmental Program Analyst

State-Level: 10% Local: 0% Other: 0% Total: 10%

**Position Name:** Lori O'Brien  
**Position Title:** Office Technician  
State-Level: 11% Local: 0% Other: 0% Total: 11%  
**Position Name:** Kathy Bissell  
**Position Title:** Staff Services Manager I  
State-Level: 50% Local: 0% Other: 0% Total: 50%

**Total Number of Positions Funded:** 5  
**Total FTEs Funded:** 0.91

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

**State Health Objective(s):**

Between 10/2015 and 09/2016, *optimize patient care during medical emergencies* by providing technical support to **100%** of the LEMSAs that request assistance.

**Baseline:**

*(1) 29% of providers within LEMSAs are using paper ePCRs; (2) 37% of providers within LEMSAs are unable to electronically submit patient-care data to the hospital.*

**Data Source:**

Lumetra Healthcare Solutions, Health Information Exchange Readiness Assessment/Survey, 2013

**State Health Problem:**

**Health Burden:**

EMS providers lack access to pre-existing patient information when providing pre-hospital patient care in the field, resulting from the lack of HIE between the field provider and the hospital. Providing access to pre-existing patient information could improve the quality, safety, and efficiency of patient care. The lack of coordination between EMS and hospitals can result in delays that may compromise patient care. Not all LEMSAs are using ePCRs. Without electronic means to transmit data, HIE cannot be implemented. For some LEMSAs, the implementation of ePCRs is cost prohibitive. The 33 LEMSAs work with many providers. A majority of the EMS providers have no system compatibility to communicate with each other. The **target** and **disparate populations** are the same: the total population of California.

**Target Population:**

Number: 39,144,818  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No

**Disparate Population:**

Number: 39,144,818  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male

Geography: Rural and Urban  
Primarily Low Income: No  
Location: Entire state  
Target and Disparate Data Sources: U.S. Census Bureau (2015)

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Other: Lumetra Healthcare Solutions, Health Information Exchange Report, 2013

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

Total Current Year Funds Allocated to Health Objective: \$389,580  
Total Prior Year Funds Allocated to Health Objective: \$389,580  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Provide funding to LEMSAs for HIE programs.**

Between 10/2015 and 09/2016, EMSA staff will implement **at least one** EMSA-approved, LEMSA-proposed HIE project, to enhance patient medical information exchange services.

### **Annual Activities:**

#### **1. Develop contracts.**

Between 10/2015 and 09/2016, EMSA staff will develop **at least one** contractual agreement with a LEMSA to receive PHHSBG funds, to ensure that their HIE-related pilot projects adhere to the approved proposal scope of work.

#### **2. Coordinate quarterly project reports.**

Between 10/2015 and 09/2016, EMSA staff will coordinate **quarterly** project reports from the LEMSAs, to ensure that scope-of-work and project objectives are being met.

#### **3. Coordinate final project report.**

Between 10/2015 and 09/2016, EMSA staff will coordinate the receipt of **one** final project report from the LEMSA, to ensure completion of the HIE project as described in the contract.

### **Objective 2:**

#### **Provide leadership and coordination of HIE.**

Between 10/2015 and 09/2016, EMSA staff will provide technical assistance and support to **100%** of LEMSAs that request assistance in areas associated with health information exchange system developments and operations to improve statewide EMS patient care.

### **Annual Activities:**

#### **1. Participate in teleconferences.**

Between 10/2015 and 09/2016, EMSA staff will attend **at least six** teleconference calls with the Office of the National Coordinator for Health IT (ONC), the California Association of Health Information Exchanges, the California Office of Health Information Integrity, and/or other participating EMS entities. These teleconferences provide a forum for discussion of HIE designs and sharing of successes and program implementation issues for states that are operating HIE programs under an ONC grant.

**2. Participate in HIE workshop.**

Between 10/2015 and 09/2016, EMSA staff will organize and host **at least one** event to share LEMSA HIE successes to (1) inform EMS partners how best to use HIE to improve patient care, and (2) measure that improved care.

**State Program Title: EMS Partnership for Injury Prevention and Public Education**

**State Program Strategy:**

**Goal:** *Maintain continuous emergency medical services (EMS) participation* in statewide injury-prevention and public-education initiatives, programs, and policies by collaborating with local EMS agencies (LEMSAs) and stakeholders in the development and continued maintenance of EMS-related injury-prevention strategies.

**Health Priorities:** *Increase access to and effectiveness of rapid prehospital emergency medical services* by developing statewide injury-prevention training standards and initiatives with local EMS providers and stakeholders.

**Role of Block Grant Funds:** PHHSBG dollars support EMS staff participation in statewide prevention and public-education activities by covering a percentage of personnel costs and associated operating expenses related to these activities.

**Primary Strategic Partnerships**

**Internal**

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

**External**

- American College of Surgeons
- California Chapter of the American College of Emergency Physicians
- Centers for Disease Control and Prevention
- EMS Administrators Association of California
- EMS Medical Directors Association of California

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

**State Program Setting:**

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

**FTEs (Full Time Equivalent):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Teri Harness

**Position Title:** Staff Services Manager I

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Kathy Kay Spencer

**Position Title:** Associate Governmental Program Analyst

State-Level: 20% Local: 0% Other: 0% Total: 20%

**Position Name:** Bonnie Sinz, R.N.

**Position Title:** Health Program Specialist II

State-Level: 20% Local: 0% Other: 0% Total: 20%

**Position Name:** Lori O'Brien

**Position Title:** Office Technician

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Total Number of Positions Funded:** 5

**Total FTEs Funded:** 0.71

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

### **State Health Objective(s):**

Between 10/2015 and 09/2016, provide technical support to **100%** of the LEMSAs that request assistance with local injury-prevention programs, and EMSA staff will support these efforts by providing requested data.

### **Baseline:**

*California has reduced the age-adjusted death rate for unintentional injuries to **no more than 36.0 per 100,000** deaths. There were **17,417** unintentional deaths in California as a result of all types of injuries during 2013.*

### **Data Source:**

(1) California Department of Public Health, Vital Statistics Death Statistical Master Files; (2) EPIC Data Report 2015 (2013 data)

### **State Health Problem:**

#### **Health Burden:**

In 2013, unintentional injuries accounted for the highest number of the 17,417 injury deaths in California (most current EPIC Data Reports) due to all types of injuries (**target population:** potentially the total population of California). The highest concentration of deaths (5,915) occurred among 45–64 year olds (**disparate population**).

Rapid and effective response to patient injuries by emergency first responders can reduce injury-related deaths. EMTs and paramedics, first on the scene of traumatic injuries, have witnessed the need for reducing preventable injuries.

EMS providers in California collect comprehensive injury data from patient-care reports to develop effective injury-prevention programs, including obtaining funding to implement programs.

#### **Target Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

#### **Disparate Population:**

Number: 29,750,061

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau (2015)

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Other: The American College of Surgeons report, "Resources for Optimal Care of the Injured Patient: 2014"

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

Total Current Year Funds Allocated to Health Objective: \$78,515

Total Prior Year Funds Allocated to Health Objective: \$78,515

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Create trauma system public-information web page.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** public-information page on the EMSA website for the trauma system to make injury-prevention information available.

### **Annual Activities:**

#### **1. Review public information pages from other states.**

Between 10/2015 and 09/2016, EMSA staff will review **at least five** trauma-related websites that provide public information that may be used for California.

#### **2. Draft public-information web page.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** draft web page providing public information on state and local trauma programs to provide injury-prevention information.

#### **3. Distribute draft public-information web page.**

Between 10/2015 and 09/2016, EMSA staff will review the draft web page with **at least four** LEMSAs and **four** trauma centers through regional meetings or e-mail. Review of draft public information by essential stakeholders is essential for statewide uniformity and transparency.

#### **4. Obtain approval of trauma public-information web page.**

Between 10/2015 and 09/2016, EMSA staff will review and make necessary revisions to **one** web page based on administrative comments, to maximize accuracy and usability of web-page content.

#### **5. Go live with trauma public-information web page.**

Between 10/2015 and 09/2016, EMSA staff will activate **one** public-information web page and inform all trauma partners that it is live, to disseminate injury-prevention information.

### **Objective 2:**

#### **Develop an injury-report template.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** template for reporting injury data to requesting entities. A standardized reporting process will assist the State of California in completing a state report on injuries seen at trauma centers.

### **Annual Activities:**

**1. Collaborate on injury-report template development.**

Between 10/2015 and 09/2016, EMSA staff will meet **at least three** times with CDPH staff to draft **one** injury-report template, taking into consideration available data in EpiCenter and CEMISIS.

**2. Generate data reports for each selected population.**

Between 10/2015 and 09/2016, EMSA staff will generate **at least two** EpiCenter and CEMISIS data reports on select demographics, location, age, and gender (at a minimum) to determine the best categories for the template.

**3. Draft injury-report template.**

Between 10/2015 and 09/2016, EMSA staff will review **one** draft injury-report template with trauma regions and Trauma Managers Association of California for suggested revisions.

**4. Complete injury-report template.**

Between 10/2015 and 09/2016, EMSA staff will provide electronic access to **one** injury-report template on the EMSA website that has the ability to electronically complete a local report.

**Objective 3:**

**Update the EMSA injury- and illness-prevention website.**

Between 10/2015 and 09/2016, EMSA staff will update **four** EMSA injury- and illness-prevention website links, at least quarterly. Updating the website links provides education for EMS partners and promotes injury prevention in the EMS community.

**Annual Activities:**

**1. Verify functionality of website links.**

Between 10/2015 and 09/2016, EMSA staff will check **63** links for connectivity and correct links as needed to ensure access to and accuracy of injury- and illness-prevention data.

**2. Inquire with trauma partner organizations.**

Between 10/2015 and 09/2016, EMSA staff will collaborate with **one** Trauma Managers Association, **five** California Trauma Regions. and the **27** LEMSAs that have trauma centers, to add any new programs to the website as information becomes available.

**State Program Title: EMS Poison Control System**

**State Program Strategy:**

**Goals: *Provide poison-control services.*** California Poison Control System (CPCS) is one of the largest single providers of poison-control services in the United States. CPCS receives approximately 398,000 calls a year and has saved California over \$70 million in health care costs by averting an estimated 61,000 emergency department visits annually.

**Health Priorities: *Provide immediate, uninterrupted, high-quality emergency telephone advice for poison exposures,*** to (1) reduce morbidity and mortality rates of poison-related medical emergencies, and (2) reduce health care costs.

**Role of Block Grant Funds:** PHHS dollars support Emergency Medical Dispatch (EMD) staff and the University of California, San Francisco, in providing rapid, pre-hospital, poison-related medical advice, prevention, and educational information to reduce the morbidity and mortality rates of people exposed to poisons.

**Primary Strategic Partnerships**

**Internal**

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

**External**

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

**Evaluation Methodology:** Quarterly progress reports are required to evaluate and monitor CPCS operations and to ensure compliance with state standards for poison-control services and contractual scopes of work.

**State Program Setting:**

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

**FTEs (Full Time Equivalents):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Teri Harness

**Position Title:** Staff Services Manager I

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Lisa Galindo

**Position Title:** Health Program Specialist I

State-Level: 20% Local: 0% Other: 0% Total: 20%

**Position Name:** Lori O'Brien

**Position Title:** Office Technician

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Kathy Kay Spencer

**Position Title:** Associate Governmental Program Analyst

State-Level: 10% Local: 0% Other: 0% Total: 10%

**Total Number of Positions Funded: 5**

Total FTEs Funded: 0.61

**National Health Objective: HO IVP-9 Poisoning Deaths**

**State Health Objective(s):**

Between 10/2015 and 09/2016, **reduce morbidity and mortality rates associated with poison-related medical emergencies, and reduce health care costs** by providing oversight to **one** contracted poison-control service provider, the California Poison Control System (CPCS).

**Baseline:**

*(1) CPCS received **398,000** calls annually, according to the CPCS 2014/15 "Poison Control Call Statistic Report." (2) Approximately **61,000** emergency department visits are averted annually and over **\$70 million** saved in health care costs.*

**Data Source:**

California Poison Control System, 2016

**State Health Problem:**

**Health Burden:**

CPCS managed 271,158 cases; about 72% of the cases were managed on site. Cases involving children age 5 and under accounted for 48% of the on-site managed cases. Poison centers reduce health care expenditures by preventing unnecessary ambulance transports and emergency department visits. Without CPCS services, approximately 28% of poisoning cases (75,924) could result in emergency department visits.

Using a moderate estimate of \$610 per emergency department visit, CPCS saves the State an estimated \$46 million annually in health care costs. In addition, increased 9-1-1 transport costs could be incurred without CPCS intervention. The **target** and **disparate populations** are the same: the total population of California, plus an unknown number of visitors.

**Target Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau, 2015 data

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

Other: Institute of Medicine's "Forging a Poison Prevention and Control System" (2004)

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

Total Current Year Funds Allocated to Health Objective: \$108,691

Total Prior Year Funds Allocated to Health Objective: \$108,691

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Provide program oversight.**

Between 10/2015 and 09/2016, EMSA staff will provide oversight to CPCS to promote rapid and effective telephone emergency advise service to **398,000** Californians exposed to poisons.

**Annual Activities:**

**1. Submit reports.**

Between 10/2015 and 09/2016, EMS staff will coordinate with the CPCS Business Operations Director to ensure timely report submissions following each reporting quarter.

**2. Review quarterly activity reports.**

Between 10/2015 and 09/2016, review the quarterly reports submitted by CPCS to verify that the work performed is consistent with the contractual scope of work.

**State Program Title: EMS Prehospital Data and Information Services and Quality Improvement Program**

**State Program Strategy:**

**Goals:** (1) **Data and Information: Increase specialized pre-hospital EMS data submissions** by local EMS agencies (LEMSAs) into the EMS Authority's (EMSA's) state EMS database system and unite components under a single data warehouse, fostering analyses on patient-care outcomes, public health system services, and compliance with California state and federal EMS service laws. (2) **Quality Improvement Program: Improve pre-hospital EMS services and public health systems statewide** by providing measurable EMS Quality Improvement (QI) oversight, resources, and technical assistance (TA) to LEMSAs.

**Health Priority: Improve access to rapid, specialized pre-hospital EMS services statewide** to reduce the morbidity and mortality rates of patients in California. Increased participation by LEMSAs in the submission of EMS pre-hospital data will establish EMS service baselines and metrics, key components of QI.

**Role of Block Grant Funds:** PHHSBG dollars support (1) development of a state QI program, (2) implementation of QI activities, and (3) operating expenses and program personnel costs.

**Primary Strategic Partnerships**

**Internal**

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

**External**

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

**Evaluation Methodology:** Statewide QI/QA (quality-assurance) activities, including annual review and revision of state QI/QA indicators (CA EMS Core Quality Measures) reported by LEMSAs (e.g., scene time for trauma, percentage of direct transports). This will provide evidence-based decision-making information available for EMSA and statewide EMS stakeholders to improve delivery of EMS care throughout California.

**State Program Setting:**

Community based organization, State health department

**FTEs (Full Time Equivalent):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Teri Harness

**Position Title:** Health Program Manager I

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Kathy Kay Spencer

**Position Title:** Associate Governmental Program Analyst

State-Level: 10% Local: 0% Other: 0% Total: 10%

**Position Name:** Kathy Bissell

**Position Title:** Health Program Manager

State-Level: 50% Local: 0% Other: 0% Total: 50%

**Position Name:** Lori O'Brien

**Position Title:** Office Technician  
State-Level: 11% Local: 0% Other: 0% Total: 11%  
**Position Name:** Adam Davis  
**Position Title:** Associate Governmental Program Analyst  
State-Level: 50% Local: 0% Other: 0% Total: 50%  
**Position Name:** Nancy Marker  
**Position Title:** Research Program Specialist I  
State-Level: 100% Local: 0% Other: 0% Total: 100%

**Total Number of Positions Funded:** 7  
**Total FTEs Funded:** 2.41

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

#### **State Health Objective(s):**

Between 10/2010 and 09/2016, provide TA to **at least three** LEMSAs in areas of QI measuring and patient-care assessments, based upon their EMS QI plan and EMS pre-hospital data submissions to EMSA.

#### **Baseline:**

*Twenty-one of 33 LEMSAs actively participate in the State's electronic data program, an increased participation of 64% in the past fiscal year. The EMSA Data/QI Coordinator anticipates participation by at least two additional LEMSAs during the grant period. All 33 LEMSAs are required to submit EMS QI plans to EMSA.*

#### **Data Source:**

California EMS Data Information System (CEMSIS), 2015

#### **State Health Problem:**

##### **Health Burden:**

Determining morbidity and mortality rates is complicated by the State's data-collection system. The best use of morbidity and mortality 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 assessable manner; however, this is not the case in California because California does not have an enforceable mandate for the electronic collection or submissions of patient-care information by local agencies to EMSA. 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, California EMS Information System (CEMSIS). Although data reflecting these incidents 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.

The **target** and **disparate populations** are the same, the total population of California.

##### **Target Population:**

Number: 39,141,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No

**Disparate Population:**

Number: 39,141,818  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No  
Location: Entire state  
Target and Disparate Data Sources: U.S. Census Bureau (2015)

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

Other: American College of Surgeons (ACS)/National Trauma Data Bank

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

Total Current Year Funds Allocated to Health Objective: \$651,256  
Total Prior Year Funds Allocated to Health Objective: \$595,573  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Fund LEMSA local QI or data-related programs.**

Between 10/2015 and 09/2016, EMSA staff will provide PHHS funds to **at least one** LEMSA, to support the implementation of their local QI or data-related pilot. Pilot projects will include efforts to more clearly define clinical performance measure data in the EMSA Core Measures Report and conduct periodic testing to ensure the data collected in NEMSIS 3.4 provide the information needed for the future Core Measures performance data.

**Annual Activities:**

**1. Develop contracts.**

Between 10/2015 and 09/2016, EMSA staff will develop **at least one** contractual agreement with a LEMSA receiving PHHSBG funds, to ensure that their QI or data-related pilot project adheres to the approved proposal scope of work during this federal fiscal year.

**2. Coordinate reports.**

Between 10/2015 and 09/2016, EMSA staff will coordinate **quarterly and final** LEMSA project reports, to ensure that scope-of-work and project objectives are met. Providing contract oversight presents a mechanism for EMSA to ensure that local areas are improving data quality and program operations that

emanate from those data. It is important that the EMSA staff stay informed and aware of the scope and progress of the contracts by reviewing the data quarterly.

### **3. Coordinate final project reports.**

Between 10/2015 and 09/2016, EMSA staff will coordinate the receipt of **at least two** final project reports from the LEMSAs, to ensure completion of the project as described in the contract.

### **Objective 2:**

#### **Increase the quality and availability of EMS data.**

Between 10/2015 and 09/2016, EMSA staff will develop **at least three** EMS annual and Trauma data reports that show frequencies for specific data elements (e.g., cause of injury, type of service) specific to a particular area or county, (e.g., number of calls and proportion that are 9-1-1 calls). Data, to be published on the EMSA website, will help develop a state baseline and track what data are successfully moving from the LEMSAs to CEMSIS.

### **Annual Activities:**

#### **1. Analyze CEMSIS database data.**

Between 10/2015 and 09/2016, EMSA staff will analyze **100%** of a selected data set submitted by LEMSAs to the CEMSIS database, to ensure accurate and efficient evaluation of critical data submitted for successful QI and QA data reporting.

#### **2. Publish EMS data reports.**

Between 10/2015 and 09/2016, EMSA staff will publish **at least three** EMS data reports for distribution via the EMSA website, to make the data available to promote public trust and quality patient care.

#### **3. Select and develop a minimum data set.**

Between 10/2015 and 09/2016, EMSA staff will, with appointed Executive Data Advisory Group members, develop **one** Minimum Data Set (MDS) for use with pre-hospital reports. The use of an MDS is intended to (1) streamline the data-collection process and lead to higher-quality data submissions to CEMSIS (an MDS is usually smaller than the initial data set, which reduces the time users must devote to becoming familiar with the data); and (2) reduce the data selections, which reduces EMS staff time devoted to data entry and is expected to reduce data-quality issues.

### **Objective 3:**

#### **Lead and coordinate Core Measure reporting.**

Between 10/2015 and 09/2016, EMSA staff will provide TA to **100%** of the LEMSAs that request assistance with Core Measure reporting, to ensure that data used to prepare Core Measure reports regarding selected clinical measures is used effectively.

### **Annual Activities:**

#### **1. Facilitate Core Measure Taskforce.**

Between 10/2015 and 09/2016, EMSA staff will facilitate **at least two** Core Measure Taskforce meetings to prepare the Core Measures book and review Core Measure reports, to ensure that measures are written accurately and appropriately by inclusion of EMS stakeholders and experts.

#### **2. Develop annual summary report.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** summary report of all LEMSA Core Measure data submitted and a map of **one** Core Measure of reported values, to provide data to the public and EMS stakeholders.

#### **3. Develop a multi-year Summary Report.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** summary report of all LEMSA Core Measure data submitted over a multi-year period. This report is the only available mechanism by which to obtain statewide data on 17 clinical measures because the CEMSIS data system is limited by a wide variety of data systems, ranging from differing electronic systems to pen-and-paper systems.

The Core Measures report allows the LEMSAs to focus on meaningful clinical measures that they can measure in whatever way their system supports, then provides the resulting data along with the specifics of how the data were run to provide a useful statewide data profile for the specific measures.

**Objective 4:**

**Lead and coordinate EMS plans.**

Between 10/2015 and 09/2016, EMSA staff will provide TA to **100%** of LEMSAs that submit their EMS plans, to ensure that compliance requirements are met.

**Annual Activities:**

**1. Coordinate QI Plan submissions.**

Between 10/2015 and 09/2016, EMSA staff will contact **each of the 33** LEMSA administrators, either by electronic or telephone communication, to request their QI plan submittal **at least three months prior** to their Plan due date, to support timely Plan submission and evaluation.

**2. Review LEMSA QI Plans.**

Between 10/2015 and 09/2016, EMSA staff will review **at least five** submitted QI Plans from the LEMSAs, to assist them in meeting the compliance requirements of California EMS regulations, standards, and guidelines.

**3. Develop an activity log.**

Between 10/2015 and 09/2016, EMSA staff will maintain and continue to develop **one** administrative QI Plan activity log, to standardize and streamline the administrative review processes within EMSA.

**State Program Title: EMS STEMI and Stroke Systems**

**State Program Strategy:**

**Goal:** *Reduce premature deaths and disabilities from heart disease and stroke* through improved cardiovascular health detection and treatment during medical emergencies.

**Health Priority:** *Support optimum patient outcomes during medical emergencies* by (1) drafting California STEMI System (ST-segment Elevation Myocardial Infarction) and Stroke System Regulations for submission to the Office of Administrative Law (OAL), to initiate the required regulatory approval process, and (2) providing leadership to and oversight of STEMI and Stroke System services.

**Role of Block Grant Funds:** PHHSBG dollars support EMSA staff, who establish specialized and timely STEMI and Stroke emergency medical systems within prehospital emergency medical services.

**Primary Strategic Partnerships**

**Internal**

- California Department of Public Health
- California Emergency Management Agency
- California Highway Patrol
- California State Office of Rural Health
- California Cardiovascular Disease Prevention Program

**External**

- American Heart Association
- American College of Cardiology
- California Hospital Association
- California Chapter of the American College of Emergency Physicians
- California Stroke Registry

**Evaluation Methodology:** EMSA staff will monitor the progress of the regulations through checks and balances outlined within OAL processes/requirements. Through the creation of two Technical Advisory Committees (TACs), STEMI and Stroke Programs will be evaluated by the completion of the steps that are outlined in the Work Plan objectives and activities.

**State Program Setting:**

Local health department, Medical or clinical site, State health department

**FTEs (Full Time Equivalent):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Farid Nasr, MD

**Position Title:** Health Program Specialist II

State-Level: 75% Local: 0% Other: 0% Total: 75%

**Position Name:** Teri Harness

**Position Title:** Staff Services Manager I

State-Level: 12% Local: 0% Other: 0% Total: 12%

**Position Name:** Lori O'Brien

**Position Title:** Office Technician

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Kathy Kay Spencer

**Position Title:** Associate Governmental Program Analyst

State-Level: 10% Local: 0% Other: 0% Total: 10%

**Total Number of Positions Funded:** 5

**Total FTEs Funded:** 1.17

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

### **State Health Objective(s):**

Between 10/2015 and 09/2016, To **increase the cardiovascular health of Californians**, EMSA will assist **100%** of the LEMSAs that request support in developing STEMI and Stroke programs.

### **Baseline:**

*Within the 33 local Emergency Services Agencies in California, **28** have a STEMI system; **17** have Stroke systems for their regions.*

### **Data Source:**

Emergency Medical Services Authority 2015

### **State Health Problem:**

#### **Health Burden:**

Heart disease is the leading cause of death and long-term disability in adults. The chance of stroke is doubled each decade after the age of 55, and three-quarters of all heart attacks occur in people over 65. In California, heart disease accounts for approximately 291 deaths per 100,000 population. Heart disease and stroke account for 35% of deaths in California and are leading causes of long-term disability. The **target** and **disparate populations** are the same: the total population of California.

#### **Target Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

#### **Disparate Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau (2015)

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Other: (1) U.S. Department of Health and Human Services, (2) CDPH, (3) California EMS Authority, (4) American Heart and Stroke Association, (5) American College of Cardiology, (6) National Institute of Neurological Disorders and Stroke, and (7) American College of Emergency Physicians

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

Total Current Year Funds Allocated to Health Objective: \$269,178  
Total Prior Year Funds Allocated to Health Objective: \$269,178  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

## OBJECTIVES – ANNUAL ACTIVITIES

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

### **Objective 1:**

#### **Develop stroke and STEMI program regulations.**

Between 10/2015 and 09/2016, EMSA staff will develop **two** sets of draft regulations for the Stroke and STEMI Programs to provide the LEMSAs and other local facilities with minimum requirements to establish and maintain STEMI and Stroke Programs throughout California.

### **Annual Activities:**

#### **1. Coordinate STEMI/Stroke Programs Regulations Work Group Meetings.**

Between 10/2015 and 09/2016, EMSA staff will (1) schedule **at least two** meetings and **two** conference calls with the Stroke and STEMI Work Group, and (2) discuss **one** set of draft regulations with the Work Group, and come to an agreement on the regulatory language.

#### **2. Draft STEMI/Stroke Regulations.**

Between 10/2015 and 09/2016, EMSA staff will (1) provide **one** final draft of the STEMI/Stroke Regulations to the Stroke and STEMI Work Group for their review and feedback, and (2) make the necessary revisions to the draft regulations based on Work Group comments.

#### **3. Approve STEMI/Stroke Regulations.**

Between 10/2015 and 09/2016, EMSA staff will present **one** final draft regulations for review and feedback from **three** recipients: (1) the Stroke and STEMI Regulations Work Group, (2) EMSAAC, and (3) the Commission on EMS for approval.

#### **4. Develop Rulemaking File for the Stroke and STEMI Programs.**

Between 10/2015 and 09/2016, EMSA staff will: (1) Complete **one** Notice of Publication form (Std 400) to OAL; (2) Develop **one** Notice of Proposed Rulemaking; and (3) Submit **one** Std 400, **one** Notice of Proposed Rulemaking, ISORS, and **one** draft regulations to OAL to complete the rulemaking process.

### **Objective 2:**

#### **Develop Stroke Program TAC.**

Between 10/2015 and 09/2016, EMSA staff will establish **one** TAC to serve as subject-matter experts to advise EMSA on identifying and meeting the program goal of supporting optimum patient outcomes during medical emergencies.

### **Annual Activities:**

#### **1. Develop a Stroke Program TAC.**

Between 10/2015 and 09/2016, EMSA staff will: (1) develop **one** list of Stroke Program constituents; (2) develop **one** letter requesting volunteers to serve on the Stroke TAC; (3) mail the letter to **all** Stroke Program constituents, and request **one** letter of interest and CV if they would like to serve on the TAC; (4) review letters of interest and CVs; and (5) choose Stroke TAC members based on subject-matter knowledge and experience.

#### **2. Plan and facilitate Stroke TAC meetings.**

Between 10/2015 and 09/2016, EMSA staff will: (1) develop a schedule of **at least two** meetings at the

EMSA HQ; (2) facilitate discussions of the TACs mission, purpose, parameters, and meeting rules; and (3) facilitate vision and workplan/issues for the TAC to focus on.

**Objective 3:**

**Develop TAC for the STEMI Program.**

Between 10/2015 and 09/2016, EMSA staff will establish **one** TAC to serve as advisory subject-matter experts to EMSA to help identify and meet program goals of supporting optimum patient outcomes during medical emergencies.

**Annual Activities:**

**1. Develop a STEMI TAC.**

Between 10/2015 and 09/2016, EMSA staff will: (1) develop **one** list of STEMI program constituents; (2) develop **one** letter requesting volunteers to serve on the STEMI TAC; (3) mail the letter to **all** STEMI constituents, and request **one** letter of interest and CV if they would like to serve on the TAC; (4) review letters of interest and CVs; (5) choose STEMI TAC members based on subject-matter knowledge and experience.

**2. Plan and facilitate STEMI TAC meetings.**

Between 10/2015 and 09/2016, EMSA staff will: (1) schedule **at least two** meetings at the EMSA HQ; (2) facilitate discussions of the TACs mission, purpose, parameters, and meeting rules; (3) facilitate vision and workplan/issues for TAC to focus on.

**State Program Title: EMS Systems Planning and Development**

**State Program Strategy:**

**Goal:** *Increase quality patient care outcomes* through 33 local Emergency Medical Services agencies (LEMSAs), comprised of six multi-county EMS systems composed of 30 counties, one regional agency composed of two counties, and 26 single-county agencies that administer all local EMS systems. Multi-county agencies are usually small and rural; single-county agencies are usually larger and more urban. **Health Priorities:** *Administer an effective statewide Emergency Medical Service (EMS) system* of coordinated emergency care, injury prevention, and disaster medical response to ensure quality patient care.

**Role of Block Grant Funds:** PHHSBG dollars support EMSA staff positions and activities that promote quality EMS patient care across California. The vacant position is expected to be filled by August 1, 2016.

**Primary Strategic Partnerships**

**Internal**

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

**External**

- California Department of Forestry and Fire Protection
- Emergency Medical Directors Association
- LEMSAs

**Evaluation Methodology:** The LEMSAs are required to submit an annual EMS Plan. In addition, multi-county agencies submit quarterly progress reports. The local plans are used to evaluate progress toward the goal of statewide coordination, including planning, development, and implementation of local EMS systems.

**State Program Setting:**

Community based organization, Local health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Teri Harness

**Position Title:** Staff Services Manager I

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Nancy Steiner

**Position Title:** Health Program Manager II

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Craig Stevenson

**Position Title:** Legal Counsel

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Lisa Galindo

**Position Title:** Health Program Specialist I

State-Level: 80% Local: 0% Other: 0% Total: 80%

**Position Name:** Laura Little

**Position Title:** Health Program Specialist I

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Kathy Kay Spencer  
**Position Title:** Associate Governmental Program Analyst  
State-Level: 10% Local: 0% Other: 0% Total: 10%  
**Position Name:** Adam Davis  
**Position Title:** Associate Governmental Program Analyst  
State-Level: 50% Local: 0% Other: 0% Total: 50%  
**Position Name:** Vacant  
**Position Title:** Associate Governmental Program Analyst  
State-Level: 20% Local: 0% Other: 0% Total: 20%  
**Position Name:** Lori O'Brien  
**Position Title:** Office Technician  
State-Level: 11% Local: 0% Other: 0% Total: 11%

**Total Number of Positions Funded:** 10  
**Total FTEs Funded:** 4.91

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

**State Health Objective(s):**

Between 10/2000 and 09/2020, EMSA staff will *provide oversight and assistance to 33 LEMSAs* regarding EMS planning and development.

**Baseline:**

*Thirty-three LEMSAs serve all California's residents. This includes six multi-county agencies that service over two-thirds of the State's geographic region.*

**Data Source:**  
EMS Authority

**State Health Problem:**

**Health Burden:**

California's emergency care continues to be fragmented; emergency departments (EDs) and trauma centers are not effectively coordinated, resulting in unmanaged patient flow. Training and certification of emergency medical technicians (EMTs) do not consistently conform to national and state standards, resulting in various levels of trained and qualified personnel working the front lines of EMS. Critical-care specialists are often unavailable to provide emergency and trauma care; the emergency-care system is not fully prepared to handle a major disaster; and not all EDs are equipped to handle pediatric care. Multi-county agencies are often served by multiple 9-1-1 call centers, and often EMS providers operate on different radio frequencies; therefore they do not effectively communicate with each other.

The **target population** is the number of persons that may require 9-1-1 emergency calls for medical care annually, potentially the entire population of the State, and an unknown number of visitors to the State. The **disparate population** is the number of persons making 9-1-1 calls in rural counties. The six multi-county agencies that serve rural counties cover over two-thirds of the State's geography. These agencies provide service to 30 of the State's 58 counties.

**Target Population:**

Number: 39,144,818  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male

Geography: Rural and Urban  
Primarily Low Income: No

**Disparate Population:**

Number: 6,670,759  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural  
Primarily Low Income: No  
Location: Entire state  
Target and Disparate Data Sources: U.S. Census Bureau (2015)

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

Other: California Health & Safety Code, Division 2.5

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

Total Current Year Funds Allocated to Health Objective: \$651,198  
Total Prior Year Funds Allocated to Health Objective: \$651,198  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Provide oversight and assistance to LEMSAs with transportation plans.**

Between 10/2015 and 09/2016, EMSA staff will provide oversight and technical assistance to **100%** of EMS providers regarding transportation services assistance associated with the LEMSA's EMS Plan.

**Annual Activities:**

**1. Review LEMSA transportation service request for proposal.**

Between 10/2015 and 09/2016, EMSA staff will review and develop **at least one** LEMSA request for proposal for emergency ambulance services regarding prospective exclusive operating areas. Collaboration promotes successful, competitive bidding for local emergency ambulance services that ensure ideal patient care during an emergency.

**2. Inspect California Highway Patrol rescue helicopters.**

Between 10/2015 and 09/2016, EMSA staff will coordinate the inspection of **11** advanced life support auxiliary rescue helicopters to ensure compliance with state and local standards. California Highway Patrol helicopters are maintained and located within seven California locations. Aircraft inspections support successful EMS transportation services within California.

**Objective 2:**

**Provide oversight and technical assistance to LEMSAs.**

Between 10/2015 and 09/2016, EMSA staff will provide oversight and technical assistance to **100%** of the LEMSAs required to submit EMS Plans or Annual Plan updates, assisting with adherence to California EMS statutes and EMSA guidelines for optimum EMS patient care.

**Annual Activities:**

**1. Coordinate EMS Plan submissions**

Between 10/2015 and 09/2016, EMSA staff will coordinate submission of EMS Plans for **a minimum of six** LEMSAs. Coordination will be directed to LEMSA administrators, supporting timely plan submissions.

**2. Record EMS Plan submissions and collaborate with EMSA staff.**

Between 10/2015 and 09/2016, EMSA staff will update **one** internal tracking log to show receipt of EMS Plans or Updates and all collaboration with other EMSA staff, to ensure effective oversight of the Plan-review process for timely, comprehensive Plan development and plan approvals.

**3. Update EMSA website.**

Between 10/2015 and 09/2016, EMSA staff will post fully reviewed EMS Plans and Plan Updates to **one** EMSA EMS Systems Planning website. Posting promotes effective injury-prevention EMS strategies, ensures public trust, and provides high-quality patient care across California.

**4. Review quarterly activity reports.**

Between 10/2015 and 09/2016, EMSA staff will contact the **six** contracted LEMSAs **one month prior** to each **quarterly** report due date to promote comprehensive and timely reporting. Activity reports are reviewed to verify that the work performed is consistent with the contractual scope of work.

**State Program Title: EMS Trauma Care Systems**

**State Program Strategy:**

**Goal:** *Reduce morbidity and mortality resulting from injury in California* by continuing implementation of the statewide Trauma System in accordance with the *State Trauma Plan*, to be approved by the Commission on Emergency Medical Services (EMS) by June 30, 2017.

**Health Priority:** *Provide timely access to optimal trauma care* through the development and implementation of local trauma systems.

**Role of Block Grant Funds:** PHHSBG dollars support EMSA staff who coordinate state and local trauma services and assist in ongoing improvements to trauma-related patient-care programs across the State.

**Primary Strategic Partnerships**

**Internal**

- California Department of Public Health
- California Strategic Highway Safety Plan
- California Office of Traffic Safety
- Commission on EMS
- California Health and Human Services Agency:  
Office of Statewide Health Planning and  
Development

**External**

- American College of Surgeons
- California Ambulance Association
- California Chapter of the American College of  
Emergency Physicians
- California Hospital Association
- EMS Administrators Association of California

**Evaluation Methodology:** 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 in the development of statewide regulations.

**State Program Setting:**

Community based organization, Medical or clinical site

**FTEs (Full Time Equivalents):**

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

**Position Name:** Tom McGinnis

**Position Title:** Health Program Manager II

State-Level: 9% Local: 0% Other: 0% Total: 9%

**Position Name:** Teri Harness

**Position Title:** Staff Services Manager I

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Bonnie Sinz, RN

**Position Title:** Health Program Specialist II

State-Level: 80% Local: 0% Other: 0% Total: 80%

**Position Name:** Lori O'Brien

**Position Title:** Office Technician

State-Level: 11% Local: 0% Other: 0% Total: 11%

**Position Name:** Kathy Kay Spencer

**Position Title:** Associate Governmental Program Analyst

State-Level: 10% Local: 0% Other: 0% Total: 10%

**Total Number of Positions Funded: 5**

Total FTEs Funded: 1.21

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

**State Health Objective(s):**

Between 10/2015 and 09/2016, provide technical support to **100%** of the LEMSAs that request assistance with local trauma programs, and EMSA staff will continue the development of the State Trauma System.

**Baseline:**

*Each LEMSA has approved trauma plans for their EMS county/region. Although the majority of LEMSAs have trauma care plans, only 27 LEMSAs (38 counties) have designated trauma centers. California has 78 designated trauma centers.*

**Data Source:**

(1) EMS Authority, 2016; ([www.emsa.ca.gov](http://www.emsa.ca.gov), listing of designated trauma centers); (2) American College of Surgeons, 2016; ([www.facs.org](http://www.facs.org), listing of verified trauma centers)

**State Health Problem:**

**Health Burden:**

In California, the 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 **disparate** and **target populations** are the same; the total population of California.

**Target Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 39,144,818

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: U.S. Census Bureau 2015

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

Other: (1) Division 2.5, California Health and Safety Code; (2) "Optimal Hospital Resources Care of the

Injured Patient" (American College of Surgeons, Committee on Trauma, 1976, pre-publication 2014); (3)  
"2011 Guidelines for Field Triage of Injured Patients," CDC, 2011

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

Total Current Year Funds Allocated to Health Objective: \$258,536

Total Prior Year Funds Allocated to Health Objective: \$258,536

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Draft final State Performance Improvement and Patient Safety Plan.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** final version of the State Performance Improvement and Patient Safety (PIPS) Plan, with revisions based on comments from the Executive Division of EMSA and the public. The PIPS Plan will be used by EMSA and the PIPS Subgroup to ensure the delivery of quality trauma care to Californians.

**Annual Activities:**

**1. Review EMSA comments.**

Between 10/2015 and 09/2016, EMSA staff will review **100%** of comments received from the EMSA Executive Division on the draft PIPS Plan and revise.

**2. Release draft PIPS Plan for public comment.**

Between 10/2015 and 09/2016, EMSA staff will provide an electronic copy of the draft PIPS Plan to **33** LEMSAs for review, and post updates on the EMSA website.

**3. Review public comments, and revise PIPS Plan.**

Between 10/2015 and 09/2016, EMSA staff will review **100%** of comments received on **one** draft PIPS Plan and revise based on comments received.

**4. Submit PIPS Plan for approval.**

Between 10/2015 and 09/2016, EMSA staff will send **one** electronic version of the final draft of the PIPS Plan to the Commission on EMS and **one** issue memo requesting approval, and attend **one** Commission on EMS meeting to address any questions and obtain final approval.

**Objective 2:**

**Draft revised trauma regulations.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** draft revision of the trauma regulations that incorporate suggestions for trauma system requirements in California.

**Annual Activities:**

**1. Establish committee to revise trauma regulations.**

Between 10/2015 and 09/2016, EMSA staff will contact **at least 33** LEMSAs and **78** trauma centers to select Trauma Regulations Revision Committee members to draft trauma system requirements.

**2. Schedule meetings and conference calls.**

Between 10/2015 and 09/2016, EMSA staff will (1) determine availability of Trauma Regulations Revision Committee members to attend **at least two** meetings and **two** conference calls, and (2) create a **one-**

year calendar.

**3. Draft revised trauma regulations.**

Between 10/2015 and 09/2016, EMSA staff will review each suggested revision from the Trauma Regulations Revision Committee and will provide at least two revised drafts to committee members.

**4. Review trauma regulation drafts.**

Between 10/2015 and 09/2016, EMSA staff will review at least two revised trauma regulations with EMS Systems Division administration and Executive Division and will make recommended revisions.

**Objective 3:**

**Host annual State Trauma Summit.**

Between 10/2015 and 09/2016, EMSA staff will conduct one State Trauma Summit to educate on clinical and system aspects of trauma care, to improve trauma care in California.

**Annual Activities:**

**1. Develop pre-Trauma Summit documents.**

Between 10/2015 and 09/2016, EMSA staff will create one "save the date" postcard for the *State Trauma System Summit*, including agenda for 9 hours of sessions; will distribute to 33 LEMSAs; and will post on EMSA website.

**2. Create an online portal for State Trauma Summit registration.**

Between 10/2015 and 09/2016, EMSA staff will create one Eventbrite registration portal, to include ability to register and pay for sponsorship online.

**3. Organize Trauma Summit.**

Between 10/2015 and 09/2016, EMSA staff will contact at least four sponsors/vendors for the summit, and complete a minimum of 150 information packets for registrants, to include an agenda, list of speakers with bios, objectives, evaluation forms, and post-test.

**4. Host annual Trauma Summit.**

Between 10/2015 and 09/2016, EMSA staff will host one State Trauma Summit in May or June 2017, to provide education covering clinical and system aspects of trauma care, to improve trauma care in California.

**5. Provide continuing education credits.**

Between 10/2015 and 09/2016, EMSA staff will distribute a minimum of 50 continuing education certificates to eligible State Trauma Summit participants.

**Objective 4:**

**Implement the State Trauma Plan.**

Between 10/2015 and 09/2016, EMSA staff will develop one timeline for short-term goals and objectives for improving trauma care in California (to be completed in one year) listed under the responsibility of the EMS Authority.

**Annual Activities:**

**1. Determine short-term trauma system objectives.**

Between 10/2015 and 09/2016, EMSA staff will determine a minimum of ten short-term objectives for improving trauma care in California by utilizing the eight Health Resources and Services Administration benchmarks and the State Trauma Plan.

**2. Review selection of trauma care goals and objectives.**

Between 10/2015 and 09/2016, EMSA staff will host one meeting with the State Trauma Advisory Committee to review short-term objectives for improving trauma care in California.

**3. Revise short-term trauma care objectives.**

Between 10/2015 and 09/2016, EMSA staff will revise the **ten** short-term objectives for improving trauma care in California, based on discussion with State Trauma Advisory Committee members.

**4. Create timeline for short-term trauma care objectives.**

Between 10/2015 and 09/2016, EMSA staff will create **one** electronic timeline designed to allow for updating activities for improving trauma care in California and that can be shared with trauma-system partners.

**Objective 5:**

**Prepare Regional Network/Re-Triage Guidance document.**

Between 10/2015 and 09/2016, EMSA staff will develop **one** final draft of the Regional Network/Re-Triage Guidance document, including revisions, from public comment period(s). The document will assist LEMSAs, trauma centers, and non-trauma facilities in improving time to definitive care for critically injured patients.

**Annual Activities:**

**1. Review EMS System Division administration comments.**

Between 10/2015 and 09/2016, EMSA staff will review **all** Division comments received, and revise for review by the PIPS Subgroup, incorporating language for statewide QI activities in support of improving the care of critically injured patients.

**2. Host a conference call to review comments.**

Between 10/2015 and 09/2016, EMSA staff will review **all** comments from EMS System Division administration with the PIPS Subgroup and will revise the guidance document to incorporate suggestions to measure improvement in the care of critically injured trauma patients.

**3. Schedule comment period(s).**

Between 10/2015 and 09/2016, EMSA staff will schedule **at least one** comment period, and will provide access to the electronic version of the Regional Network/Re-Triage Guidance through the EMSA website, to disseminate recommendations to LEMSAs, trauma centers, and other facilities that care for injured patients, to improve the timeliness of trauma care.

**4. Review comments.**

Between 10/2015 and 09/2016, EMSA staff will review **all** comments received, and revise **one** Regional Network/Re-Triage Guidance document to incorporate recommendations for improved state trauma care.

**5. Review final draft of the guidance document.**

Between 10/2015 and 09/2016, EMSA staff will review **one** final version of the Regional Network/Re-Triage Guidance document in preparation for submission to the Commission on EMS for final approval of recommendations, to improve timeliness of trauma care in California.

**State Program Title: Let's Get Healthy California Dashboard and Website**

**State Program Strategy:**

**Goal:** *Become the healthiest state in the nation by 2022* by (1) implementing Let's Get Healthy California (LGHC), the state health improvement plan, and (2) tracking the progress of 39 selected LGHC health-outcome indicators (<https://letsgethealthy.ca.gov/progress/>).

**Health Priorities:** *Reduce health disparities and improve health outcomes on 39 chosen indicators.* The California Department of Public Health (CDPH) Fusion Center staff will maintain, update, and enhance the newly launched LGHC informational website (<http://www.chhs.ca.gov/pages/LGHCTF.aspx>), whose educational resources promote implementation of a community-engagement plan that will draw in key state and local audiences to advance the LGHC Initiative's health-promotion goals.

**Role of Block Grant Funds:** PHHSBG funds support staff salaries, communications, coordination capacity, facilitated meetings with partners, training, and capacity-building activities. The projected date for filling the AISA position is July 2017.

**Primary Strategic Partnerships**

**Internal**

- Office of Quality Performance and Accreditation
- Center for Health Statistics and Informatics
- Office of Health Equity
- Information Technology Services Division

**External**

- California Health and Human Services Agency
- California Conference of Local Health Officers
- County Health Executives Association of California
- Office of Statewide Healthcare Planning and Development
- California Department of Health Care Services (Medicaid Program)

**Evaluation Methodology:** Fusion Center staff will evaluate progress through *process evaluation* (e.g., number of innovations submitted, number of community events, number of innovation challenges). The level of participation and use of the dashboard website platform will be monitored via Google Analytics reports.

**State Program Setting:**

Business, corporation or industry, Community based organization, Local health department, State health department, Other: State Health and Human Services Agency; Civic technologist community (e.g., CityLab, Hackerlab)

**FTEs (Full Time Equivalents):**

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

**Position Name:** Vacant

**Position Title:** Associate Information Systems Analyst

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Latesa Slone

**Position Title:** Associate Governmental Program Analyst

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Tamara Srzentic

**Position Title:** Analyst VI (UC Davis)

State-Level: 50% Local: 0% Other: 0% Total: 50%

**Total Number of Positions Funded:** 3

Total FTEs Funded: 2.50

**National Health Objective: HO PHI-14 Public Health System Assessment**

**State Health Objective(s):**

Between 10/2015 and 09/2016, *make California the healthiest state in the nation by 2022* by improving the health of all Californians, controlling health care costs, promoting personal responsibility of individual health, and advancing health equity. Targets should be achieved without additional government spending, and recommendations should be made for standards for measuring improvement over 10 years.

**Baseline:**

*The first version of the LGHC website and dashboard, presenting statewide health and cost-indicator data, was launched in January 2016. The 2015 data results on the dashboard show that 41% of indicators when compared with the 2012 report baseline are classified as “yellow: no significant movement” and 17% are classified as “red: movement away from goal.” The stagnant or declining indicator progress demonstrates the need and opportunity for targeted and coordinated effort to achieve multiple improvements in health-indicator outcomes.*

**Data Source:**

California Health and Human Services Agency: (1) Let's Get Healthy California Task Force Report, 2012; (2) Let's Get Healthy California Dashboard. 2016 ([www.letsgethealthy.ca.gov](http://www.letsgethealthy.ca.gov))

**State Health Problem:**

**Health Burden:**

*Chronic conditions and aging population:* alarmingly high rates of obesity and resulting conditions, such as diabetes, may reverse the progress in increasing life expectancy made over the last 100 years. This generation of children may be the first to not live as long as their parents.

*Significant health disparities:* California is the most populous and diverse U.S. state. Significant health disparities exist by race/ethnicity, income, educational attainment, geography, sexual orientation and gender identity, and occupation. These disparities relate to differences in social, economic, and environmental conditions, as well as within the health care system itself.

The **target** and **disparate populations** are the same: 61 local health jurisdictions that serve the State's entire population. The key audience for this information includes state and local policy makers and health and general media. Key messaging will identify where California is doing well, where improvements are needed, and where disparities exist. The information can be used to target limited resources and serve as a starting point for drilling down further.

**Target Population:**

Number: 38,800,000

Infrastructure Groups: State and Local Health Departments

**Disparate Population:**

Number: 38,800,000

Infrastructure Groups: State and Local Health Departments

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

Other: Live Well San Diego is an initiative and website for a region that is Building Better Health, Living

Safely and Thriving through four strategic approaches: Building a Better Delivery System, Supporting Positive Choices, Pursuing Policy and Environmental Changes, and Improving the culture within government.

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

Total Current Year Funds Allocated to Health Objective: \$300,000

Total Prior Year Funds Allocated to Health Objective: \$280,000

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Implement a community engagement plan.**

Between 10/2015 and 09/2016, Fusion Center staff will implement **one** community engagement plan to (1) promote and track local- and state-level innovation and collective impact activities to reduce disparities and improve health outcomes; and (2) promote application of the LGHC framework through communications and outreach, data analytics, and fostering collaborative state and local innovation to improve health outcomes in targeted priority areas.

**Annual Activities:**

**1. Implement a communications and outreach plan.**

Between 10/2015 and 09/2016, Fusion Center staff, in collaboration with Public Affairs staff, will implement **one** communications and outreach campaign to increase awareness and engagement of state and local audiences with the LGHC dashboard website. The communication plan will include **at least four** sub-campaigns: (1) building awareness of the recently launched website and soliciting user feedback; (2) building active participation and encouraging users to submit stories of activities “moving the dial” on indicator outcomes; (3–4) promoting each of the **two** major content releases on the website (see Objective #1), highlighting priority focus areas that represent key opportunities for collective action and disparities reduction.

**2. Facilitate Innovation Challenge 2.0.**

Between 10/2015 and 09/2016, Fusion Center staff will coordinate the next iteration of this open innovation activity, *Innovation 2.0*. This targeted challenge will focus on specific LGHC priorities. Challenge and selection criteria will be framed and promoted to target audiences. **Two** facilitated workshops will expose state and local audiences to user-centered design. Submissions will be evaluated, and selected innovations will be showcased on the LGHC website as well as at a Statewide Innovation Conference in January 2017.

**3. Collaborate around indicator priorities.**

Between 10/2015 and 09/2016, Fusion Center staff will implement **at least one** collaborative project to effectively link programs within CDPH. This cross-cutting collaboration will be supported by “goal teams” of staff from programs organized around common objectives, and will be implemented by aligning efforts between CDPH and a local health department partner.

**Objective 2:**

**Maintain, update, and enhance the newly launched website.**

Between 10/2015 and 09/2016, Fusion Center staff will maintain **one** statewide LGHC dashboard and website; manage technical maintenance, facilitate regular content and data updates, and implement

design and feature enhancements to improve the functionality and utility of the LGHC website and dashboard.

**Annual Activities:**

**1. Conduct ongoing maintenance and updates.**

Between 10/2015 and 09/2016, Fusion Center staff will support the ongoing technical maintenance for **one** LGHC website and dashboard. This includes responding to user feedback, conducting regular performance testing and content review, and facilitating the review and inclusion of user-generated content to maintain the dynamic and participatory aspects of the website (such as submissions to the site inbox, additions to the listserv, and “share your story” features).

**2. Conduct data indicator updates.**

Between 10/2015 and 09/2016, Fusion Center staff will collaborate with the LGHC Data Analytics Workgroup to post updated indicator data for 2016 for **39** selected indicators. Indicator data pages, visualizations, and dashboard progress will be updated on a rolling basis as the updated results from each data source are made available.

**3. Release content.**

Between 10/2015 and 09/2016, Fusion Center staff will, in addition to regular content updates, plan, organize, collect, and publish **two** major content releases on highlighted focus areas (sub-themes that represent opportunities for collective action and disparities reduction) to include enhanced data presentation, stories of local- and state-level activities, and opportunities for community engagement.

These major releases will be coordinated with communications campaigns and community engagement activities (see Objective #2), to bring users to the site to connect with, learn from, and participate in collective impact opportunities around the highlighted focus areas.

**4. Enhance website.**

Between 10/2015 and 09/2016, Fusion Center staff will assess feedback from user surveys and partner feedback and identify **two** opportunities to improve the user experience and functionality of the website. The team will test options to enhance the staging environment. When new features are rolled out to the production site, additional user feedback will be solicited to evaluate their effectiveness.

**State Program Title: Microbial Diseases Laboratory Branch/Select Agent and Biosafety**

**State Program Strategy:**

**Goal:** *Provide essential public health laboratory services in California* to assist in the diagnosis, treatment, and prevention of bacterial, mycobacterial, fungal, and parasitic diseases in humans, food, water, and other environmental sources.

**Health Priority:** *Strengthen the capacity of the Microbial Diseases Laboratory (MDL) to comply with Select Agents and Toxins Tier-1 regulations and ensure timely responses to all events triggered by suspect bio-threat agents.* MDL, an integral component of California's infrastructure for emergency response against bioweapons or "select agents" threats, consists of 34 local public health laboratories. MDL is California's only public health repository of high-priority bio-threat agents (Tier-1 select agents and toxins).

**Role of Block Grant Funds:** PHHSBG funds cover one Public Health Microbiologist Specialist hired to strengthen lab capacity to comply with Tier-1 select agent and toxins regulations.

**Primary Strategic Partnerships:**

**Internal**

- Emergency Preparedness Office
- Center for Environmental Health
- Office of the State Laboratory Director
- Communicable Diseases Emergency Response Program
- Infant Botulism Treatment and Prevention Program

**External**

- 34 local public health laboratories
- Federal Bureau of Investigation
- U.S. Health and Human Services Agency Division of Select Agents and Toxins
- U.S. Department of Agriculture
- U.S. Department of Homeland Security

**Evaluation Methodology:** Projects will be evaluated using quantitative and outcome measures, such as the number of laboratory manuals, handbooks, and informational sheets finalized; and training events and preparedness exercises completed.

**State Program Setting:**

State health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Mahtab Shahkarami

**Position Title:** Public Health Microbiologist Specialist

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Total Number of Positions Funded:** 1

**Total FTEs Funded:** 1.00

**National Health Objective: HO PHI-11 Public Health Agencies Laboratory Services**

**State Health Objective(s):**

Between 10/2014 and 09/2017, *increase the proportion of tribal and state public health agencies that provide or assure comprehensive laboratory services* in support of emergency response to the HP 2020 goal of **76%** of "State public health agencies that provide or assure comprehensive laboratory

services for emergency response."

**Baseline:**

*CDPH MDL is the only public health facility in California with Tier-1 status for handling, processing, and storage of select agents and toxins (Bacillus anthracis, Burkholderia mallei, Burkholderia pseudomallei, Botulinum neurotoxins, Botulinum neurotoxin-producing species of Clostridium, and Francisella tularensis). MDL urgently needs additional resources to comply with recently enacted enhanced regulatory requirements. The baseline staff strength stands at zero.*

**Data Source:**

(1) Comprehensive Laboratory Services Survey; (2) Association of Public Health Laboratories; (3) Federal Select Agent Program [cited 2016 April 7] <http://www.selectagents.gov/regulations.html>

**State Health Problem:**

**Health Burden:**

Screening for and confirming potential agents of bioterrorism (bio-threat or select agents) have been facilitated by considerable federal investment in infrastructure, including public health laboratories across California. CDC licenses testing facilities under rigorous regulations for the handling of bio-threat agents.

The CDPH high-level select-agent and toxins program serves as a reference laboratory for local public health laboratories and performs critical activities, enabling the State to quickly detect, characterize, and communicate confirmed infections or releases of bio-threat agents. Sustaining these resources reduces the time needed to respond to exposure and contain the spread of any one of these high-consequence agents, protecting the 39 million people in California (**target and disparate populations**).

**Target Population:**

Number: 39,144,818

Infrastructure Groups: State and Local Health Departments, Disease Surveillance - High Risk

**Disparate Population:**

Number: 39,144,818

Infrastructure Groups: State and Local Health Departments, Disease Surveillance - High Risk

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

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Association of Public Health Laboratories, 2016

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

Total Current Year Funds Allocated to Health Objective: \$150,000

Total Prior Year Funds Allocated to Health Objective: \$150,000

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

50-74% - Significant source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Finalize biosafety and biosecurity policies.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will implement **one** Tier-1 select agents and toxins program to maintain the ability to perform critical activities in detecting and preventing the spread of bio-threat agents in California.

**Annual Activities:**

**1. Conduct compliance review.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will complete **one** review of laboratory procedures and inventory, to ensure adherence to compliance requirements.

**2. Complete facility review.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will inspect **one** High-Risk Pathogens Section laboratory and its equipment, to ensure adherence to compliance standards.

**Objective 2:**

**Implement biosafety and biosecurity outreach.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will conduct **eight** outreach activities with internal and external partners, to establish and refine emergency communication channels.

**Annual Activities:**

**1. Increase coordination between EPO and CDER.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will establish close contacts with **at least two** parties in the EPO and CDER offices, to ensure coordination in response to a bio-threat event.

**2. Increase external coordination.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will reach out to **14** California Laboratory Response Network (LRN)-B laboratories. **Two** webinars and **two** mailings will be undertaken, to engage laboratories in: (1) performance of MDL Tier-1 duties in reference testing of *Bacillus anthracis*, *Burkholderia mallei*, *Burkholderia pseudomallei*, *botulinum* neurotoxins, *botulinum* neurotoxin-producing species of *Clostridium*, and *Francisella tularensis*, and (2) sharing of resources to increase capacity for such testing in the LRN-B laboratories.

**3. Increase preparedness.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will send **one** state-of-preparedness document to **at least 35** contacts in local and state police, FBI, local and state fire departments, and the U.S. Postal Service, to serve as a ready reference. MDL staff will follow up with an **annual** on-site meet-and-greet event, to familiarize principals likely to be involved in responding to an actual bio-threat event.

**Objective 3:**

**Improve biosafety and biosecurity practices.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will develop **at least two** detailed procedures binders, to prescribe handling, processing, storage, and shipment of select agents.

**Annual Activities:**

**1. Provide annual biosafety training.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will provide **annual** training in biosafety, security, and incident response to **approximately 12** MDL staff members. This training is mandated by federal select-agent regulations.

**2. Respond to mock and real security incidents.**

Between 10/2015 and 09/2016, the MDL Public Health Microbiologist Specialist will perform **one** mock security incident exercise, to test the level of preparedness of MDL staff and obtain hands-on experience

for actual breach events.

**State Program Title: Microbial Diseases Laboratory Branch/Valley Fever**

**State Program Strategy:**

**Goal:** *Provide reference, diagnostic, and applied research activities for the detection, epidemiological investigation, control, and prevention of bacterial, mycobacterial, fungal, and parasitic diseases in humans, food, water, and other environmental sources.* Microbial Diseases Laboratory (MDL) is the reference laboratory for California's public health infrastructure, which includes 34 local laboratories and approximately 50 academic and referral medical facilities.

**Health Priority:** *Improve laboratory and epidemiology support to assist state epidemiologists and local public health departments in the surveillance, prevention, and control of Valley Fever* by setting up an accredited laboratory and developing a dedicated team of laboratorians at MDL for the identification, characterization, and genotyping of *Coccidioides* species. Valley Fever (coccidioidomycosis) is a disease with high morbidity and mortality in California. Public health infrastructure dedicated to detecting and conducting surveillance for Valley Fever is limited.

**Role of Block Grant Funds:** Three laboratory positions will help build lab capacity for diagnosing fungal infections, especially Valley Fever. The anticipated fill date for the vacant position is July 1, 2016. The specialist laboratorians will partner with epidemiologists and local public health laboratories for characterization and genotyping of *Coccidioides* species, the causal agents of Valley Fever.

**Primary Strategic Partnerships**

**Internal**

- Center for Chronic Disease Prevention and Health Promotion, Division of Environmental and Occupational Disease Control, Occupational Health Branch
- Center for Infectious Diseases, Division of Communicable Disease Control, Infectious Diseases Branch

**External**

- 34 Local Public Health Laboratories in California
- Referral hospitals for Valley Fever: Kern Medical Center, UC Davis Medical Center, UCSF-Fresno Medical Center, UC San Diego, UCLA, Santa Clara Valley
- Local public health departments especially those in endemic counties: Fresno, Kings, Kern, Madera, San Luis Obispo, Tulare
- University of California, San Francisco and Davis

**Evaluation Methodology:** Laboratory activities will be evaluated using quantitative outcome measures, including the number of *Coccidioides* isolates tested and confirmed, incidences of outbreaks and clusters investigated, and the fungal whole-genome sequencing of outbreak isolates.

**State Program Setting:**

State health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Linlin Li

**Position Title:** Research Scientist III

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Kara Pham

**Position Title:** Public Health Microbiologist II

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Vacant

**Position Title:** Public Health Research Technician I

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Total Number of Positions Funded:** 3

**Total FTEs Funded:** 3.00

**National Health Objective: HO PHI-11 Public Health Agencies Laboratory Services**

**State Health Objective(s):**

Between 10/2015 and 09/2016, ***CDPH will establish public health infrastructure with strong fungal disease diagnosis capacity and provide comprehensive laboratory services that support specialized and reference fungal testing and disease outbreak investigations.*** These specialized laboratory diagnostic services are not available in California public health laboratories. California has one of the highest incidences of coccidioidomycosis, or Valley Fever, a fungal disease endemic in the San Joaquin Valley. Diagnosis and outbreak investigations are challenging. Thus, the availability of high-quality laboratory services would greatly enhance the ability to meet the State and National Health Objectives.

**Baseline:**

*Since 2000, reported cases of coccidioidomycosis in California have **increased five-fold; more than 4,000 cases** were reported in 2012. Most experts agree that these case numbers under-represent the true incidence of the disease. Unfortunately, the capacity for the diagnosis of mycotic diseases is limited in California. Accurate numbers for laboratory tests performed in public health laboratories are not available.*

**Data Source:**

(1) CDC; (2) CDPH Centers for Environmental Health and Infectious Diseases; (3) California Association of Public Health Laboratory Directors (CAPHLD). These organizations/associations have resources and material to assist in collection of baseline data.

**State Health Problem:**

**Health Burden:**

The most important mycotic disease affecting Californians is Valley Fever (coccidioidomycosis). The etiologic agents are two soil fungi, *Coccidioides immitis* and *C. posadasii*, endemic in California, especially in the Central Valley. In 2012 there were 4,049 reported Valley Fever cases, a 67% increase from 2009. The highest rates of 200 cases per 100,000 population are found in Kern and Kings Counties in the Central Valley. Although many Valley Fever infections are mild or unapparent, severe illness such as meningitis or disseminated disease may cause long-term disability, lifelong treatment, or even death. Despite California's strong public health infrastructure, mycotic diagnostic capacity is inadequate in all laboratories, including MDL, which only offers a GenProbe test for *Coccidioides* species. Although coccidioidomycosis is a reportable disease in California, the laboratories are not required to report it. As a result, the true burden of coccidioidomycosis in California is likely underestimated. The **target population** includes racial/ethnic minorities in Kern, Kings, and Tulare Counties as they are at higher risk for Valley Fever. All age groups and both sexes are at high risk for this infection. The **disparate population** includes disproportionately large numbers of African Americans and Hispanics.

**Target Population:**

Number: 3,523,483

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions

**Disparate Population:**

Number: 1,018,130

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care

Systems, Research and Educational Institutions, Business and Merchants

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Other: Guidelines from the Clinical and Laboratory Standards Institute, Mycotic Diseases Branch, Center for Disease Control and Prevention, the American Society for Microbiology for the utilization of microbiology and molecular biology tests for the identification of *Coccidioides* species.

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

Total Current Year Funds Allocated to Health Objective: \$340,800

Total Prior Year Funds Allocated to Health Objective: \$319,500

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Conduct diagnostic reference services for *Coccidioides* species.**

Between 10/2015 and 09/2016, MDL Program/Valley Fever staff will analyze **400** clinical specimens for diagnostic reference services for the isolation of pathogenic fungi from clinical specimens and identification of *Coccidioides* species isolates submitted to state and local public health laboratories.

### **Annual Activities:**

#### **1. Provide fungal laboratory reference services.**

Between 10/2015 and 09/2016, MDL Program staff will (1) complete mycology laboratory proficiency testing from the College of American Pathologists and meet the licensing requirements for a comprehensive mycology laboratory; (2) process **400** specimens and isolates for reference testing. This activity will ensure that California patients receive reference services for fungal infections, including coccidioidomycosis.

#### **2. Foster internal and external partnerships.**

Between 10/2015 and 09/2016, MDL Program staff will (1) reach out to **34** local public health laboratories and academic centers involved with Valley Fever; (2) collaborate with epidemiologists at CDPH to have **six** conference calls, **two** webinars, and **three** mailings. These activities will introduce specialized *Coccidioides* tests in the regular work flow of local public health laboratories.

### **Objective 2:**

#### **Develop fungal genotyping by whole-genome sequencing.**

Between 10/2015 and 09/2016, MDL Program/Valley Fever staff will analyze **25** isolates of *Coccidioides* species from clinical specimens and environmental samples from suspected Valley Fever outbreaks. These will be genotyped by multi-locus sequencing typing and whole-genome sequence typing. The results will improve surveillance of *Coccidioides* in California, eventually helping to remediate the "hotspots" of coccidioidomycosis in the Central Valley.

### **Annual Activities:**

#### **1. Support prevention, control, and surveillance of coccidioidomycosis.**

Between 10/2015 and 09/2016, MDL Program/Valley Fever staff will validate multi-locus sequence typing and whole-genome sequence typing of *Coccidioides* species. **Two** next-generation sequencing platforms will be employed to seek the optimal sequencing solution, leading to standardized genotyping methods

and real-time genomic data for **up to 25** *Coccidioides* isolates obtained from outbreak investigations in California.

## **2. Support public health policy development.**

Between 10/2015 and 09/2016, MDL Program staff will collaborate with CDPH and **34** local public health laboratories to establish guidelines for utilization of *Coccidioides* species genotyping data during an outbreak investigation, to standardize the application of whole-genome sequencing platforms in public health laboratories, such that uniform results are obtained for outbreak investigations.

## **3. Support public health-related investigations.**

Between 10/2015 and 09/2016, MDL Program/Valley Fever staff will use **25** *Coccidioides* species outbreak isolates to compare multi-locus sequence typing and whole-genome sequence typing from various outbreaks to find the best laboratory method for the outbreak investigation. The genotyping results will enhance surveillance activities aimed at disease control and prevention.

### **Objective 3:**

#### **Identify *Coccidioides* species by rapid real-time PCR.**

Between 10/2015 and 09/2016, MDL Program/Valley Fever staff will identify **100** clinical isolates of *Coccidioides* species by two rapid DNA tests. The first test uses DNA sequencing to identify fungal species. The second test employs more-sensitive DNA probes to identify two pathogens of Valley Fever, *Coccidioides immitis* and *C. posadasii*.

### **Annual Activities:**

#### **1. Provide specialized and reference fungal tests.**

Between 10/2015 and 09/2016, MDL Program staff will introduce the **two** validated rapid molecular tests, the real-time PCR assays for the differentiation of *Coccidioides immitis* and *C. posadasii*, and internal transcribed spacer sequencing for fungal identification, to partner public health laboratories, to promote rapid and accurate diagnosis of pathogenic fungi, especially *Coccidioides* species, in clinical specimens and ensure better clinical management of coccidioidomycosis patients.

#### **2. Support validation of new assays.**

Between 10/2015 and 09/2016, MDL Program/Valley Fever staff will identify and diagnose *Coccidioides* in **100** clinical specimens from California public health laboratories and publish the validation and improvement of the testing methods. This activity will contribute to the knowledge of *Coccidioides* in the public health and academic communities.

**State Program Title: Nutrition Education and Obesity Prevention Branch**

**State Program Strategy:**

**Goal:** *Promote healthy eating, physical activity, and food security, emphasizing communities with the greatest health disparities.* The Nutrition Education and Obesity Prevention Branch (NEOPB) works directly with local health departments (LHDs) on the obesity epidemic. The LDH model provides an equitable distribution of funds and resources and facilitates statewide representation. NEOPB also partners with state departments, universities, schools, and community and faith-based organizations.

**Health Priorities:** *Although California adults and adolescents meet the Healthy People 2020 targets for obesity, rates among low-income children exceed the targets. The prevalence rates double when overweight and obesity are combined for adults and adolescents.*

**Role of Block Grant Funds:** The PHHS Block Grant funds staff that provide leadership, oversight, and administrative support for program activities that focus on healthy eating, physical activity, and food security.

**Primary Strategic Partnerships**

**Internal**

- SNAP–Ed–funded programs
- Prevention First–funded programs
- Office of Health Equity
- California Tobacco Control Program
- Safe and Active Communities Branch

**External**

- California Department of Education
- Kaiser Permanente
- California local health departments
- Child Care Food Program Roundtable
- California Food Policy Advocates

**Evaluation Methodology:** Projects will be evaluated using a combination of process measures, along with the required project success story. Annual CHIS data will be consulted to assess decreases in the prevalence of overweight and/or obesity in children and adolescents. These data will be complemented with information from the NEOPB LHD Evaluation.

**State Program Setting:**

Child care center, Community based organization, Faith based organization, Local health department, Schools or school district, State health department

**FTEs (Full Time Equivalent):**

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

**Position Name:** Linda Lee Gutierrez

**Position Title:** Health Program Specialist II

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Sheila Chinn

**Position Title:** Staff Services Analyst

State-Level: 45% Local: 0% Other: 0% Total: 45%

**Position Name:** Monet Parham-Lee

**Position Title:** Health Education Consultant III (Spec)

State-Level: 15% Local: 0% Other: 0% Total: 15%

**Position Name:** Katharina Streng

**Position Title:** Health Program Specialist I

State-Level: 5% Local: 10% Other: 0% Total: 15%

**Position Name:** Vacant

**Position Title:** Health Program Specialist I

State-Level: 50% Local: 0% Other: 0% Total: 50%

Total Number of Positions Funded: 5

Total FTEs Funded: 2.25

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

**State Health Objective(s):**

Between 10/2015 and 09/2016, **decrease the incidence of overweight or obesity in children (aged 6–11) and/or adolescents** by maintaining California's child and adolescent obesity rates, which are below the *HP 2020* targets, or improving these rates by **0.005%**.

**Baseline:**

*Children:* (1) **15.2%** of California children aged 6-11 are overweight for their age; (2) For California children aged 6-11 that are 0-185% of the federal poverty level (FPL), the rate of overweight for age is **19.6%**; (3) For California children aged 6-11 that are 0-199% of the FPL, the rate of overweight for age is **20.1%**.

*Adolescents:* (1) **14.5%** of California children adolescents aged 12–14 are obese; (2) For California adolescents aged 12–17 that are 0–185% of the FPL, the rate of obesity rises to **18.2%**; (3) For California adolescents aged 12–17 that are 0–199 of FPL, the rate of obesity is **17.7%**.

**Adults:** **25.9%** of California adults are obese.

**Data Source:**

California Health Interview Survey (CHIS) 2013-2014

**State Health Problem:**

**Health Burden:**

Obesity represents a public health challenge of equal magnitude to that of tobacco. Overweight children and adolescents are developing serious health problems and are more likely to become obese adults; obesity increases the risk of many health conditions and contributes to some of the leading causes of preventable death, posing a major public health challenge.

Health conditions associated with obesity include coronary heart disease, stroke, high blood pressure; type 2 diabetes; some cancers; and respiratory problems. Although many factors contribute to weight gain and obesity, inactivity and unhealthy diets are risk factors most amenable to prevention.

The prevalence of obesity among California adolescents in 2013–14 was just below the *Healthy People 2020* target (16.1%). But similar to adults, the prevalence of obesity among adolescents 12–17 years old increased from 2003 (12.4%) through 2013–14 (14.5%).

In 2013–14, the prevalence of obesity among low-income children (19.6%, age 2–11) exceeded the *Healthy People 2020* targets for every age group; the obesity rate in preschool-age children (11.3%) was over the *Healthy People 2020* target of 9.6%.

**Target population:** all children and adolescents aged 5–17 years; **disparate population:** primarily low-income, minority (non-White) children and adolescents under age 1 and 5–17 years.

**Target Population:**

Number: 6,567,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 4 - 11 years, 12 - 19 years

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 3,001,000  
Ethnicity: Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander  
Age: 1 - 3 years, 4 - 11 years, 12 - 19 years  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: Yes  
Location: Entire state  
Target and Disparate Data Sources: California Health Interview Survey (CHIS 2013-2014)

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Other: (1) Supplemental Nutrition Assistance Program Education (SNAP-Ed) Obesity Prevention Toolkit, USDA Food and Nutrition Services and the National Collaborative on Obesity Research, 2014; (2) Accelerating Progress in Obesity Prevention: Solving the Weight on the Nation, 2012

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

Total Current Year Funds Allocated to Health Objective: \$468,039  
Total Prior Year Funds Allocated to Health Objective: \$468,039  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: Supplemental Funding  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
10-49% - Partial source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Advance education and prevention policy.**

Between 10/2015 and 09/2016, NEOPB staff will maintain **35** educational opportunities, resources, and technical assistance on evidence-based and evidenced-informed strategies to partners statewide to support the advancement of nutrition education and obesity prevention on policy, systems, and environmental (PSE) changes to reduce the incidence of obesity and chronic disease in California.

### **Annual Activities:**

#### **1. Implement Childhood Obesity Conference.**

Between 10/2015 and 09/2016, NEOPB staff will (1) collaborate with **four** partners: The California Endowment, Kaiser Permanente, University of California Nutrition Policy Institute, and the California Department of Education, to implement this nationally recognized conference; (2) convene the conference Executive Committee, responsible for implementing the conference and providing subject-matter expertise and content development; (3) through the Executive Committee, the agenda and associated content, prioritize evidence-based and evidence-informed resources and best practices to advance PSE changes for childhood obesity prevention.

#### **2. Promote physical activity in early childhood and school settings.**

Between 10/2015 and 09/2016, NEOPB staff will (1) provide policy-related and programmatic technical assistance on physical-activity promotion efforts to **five to ten** early childhood, school, and after-school settings; (2) provide technical assistance, best practices, and guidance in the area of safe and active transportation through education and PSE change strategies.

### **Objective 2:**

**Coordinate healthy eating, physical activity, and food security activities.**

Between 10/2015 and 09/2016, NEOPB staff will maintain **25** partnerships with internal and external partners to coordinate state and local efforts in the priority focus areas of food and beverage, physical activity, and food security to reduce the prevalence of obesity in California.

**Annual Activities:**

**1. Implement NEOPB's three-year Strategic Framework.**

Between 10/2015 and 09/2016, NEOPB staff will distribute and implement **one** completed NEOPB three-year Strategic Framework that will include strategies and strategic directions in the priority focus areas of food and beverage, food security, and physical activity. It will also include recommendations, including barriers and challenges. The Strategic Framework will be shared with **more than 100** internal and external partners, including LHDs, that will use the Framework as a tool for their three-year work plans.

**2. Advance education and prevention policy.**

Between 10/2015 and 09/2016, NEOPB staff will (1) actively initiate, foster, pursue, and engage in **10–15** strategic partnerships across multiple sectors, especially among low-income populations and ethnic communities; (2) continue to develop and maintain partnerships with agencies and programs regarding food and beverage, physical activity, and food security. These partnerships include statewide public and private organizations in areas of retail, health care, faith-based organizations, government, education, and agriculture; and (3) cultivate and maintain relationships with traditional and nontraditional partners.

**Objective 3:**

**Support obesity-prevention interventions.**

Between 10/2015 and 09/2016, NEOPB staff will conduct **ten** obesity-prevention trainings and ongoing technical assistance to at least 20 local jurisdictions statewide to support obesity-prevention interventions and promote healthy community changes that foster healthy and active California communities.

**Annual Activities:**

**1. Provide training, technical assistance, and resources to LHDs.**

Between 10/2015 and 09/2016, NEOPB staff will help **10–15** LHDs achieve sustainable, healthy community change that supports obesity prevention, targeting youth and adults. PHHSBG funds will leverage SNAP-Ed promotion funding with technical assistance on policy-driven change with PSE consultation and multiple trainings.

**State Program Title: Office of AIDS: Re-engagement in HIV Care and Partner Services Using HIV Surveillance Data**

**State Program Strategy:**

**Goals:** (1) *Reduce the number of people infected with the human immunodeficiency virus (HIV);* (2) *Increase access to care and improve health outcomes for people living with HIV;* and (3) *Reduce HIV-related health inequities.* The California Department of Public Health (CDPH) Office of AIDS (OA) is responsible for meeting these President's National HIV/AIDS Strategy goals in California.

**Health Priority:** *Increase California's HIV viral-suppression rate.* California's rate is higher than the national average of 25% but needs to be significantly higher to decrease new HIV infections in California. Although deaths from HIV have declined, the rate of new infections has remained stable as the epidemic continues among populations heavily impacted by health inequities, such as African Americans, Latinos, and men who have sex with men (MSM), especially young MSM African Americans.

**Role of Block Grant Funds:** PHHSBG funds will be used to increase the number of HIV-positive African-American and Latino MSM engaged in HIV care and partner services in Alameda, Orange, and San Diego Counties.

**Primary Strategic Partnerships**

**Internal**

- Sexually Transmitted Disease (STD) Control Branch, Division of Communicable Disease Control

**External**

- County of San Diego; Public Health Services; HIV, STD, and Hepatitis Branch
- Alameda County Public Health Department, Office of AIDS Administration
- Orange County Health Care Agency, HIV Planning and Coordination

**Evaluation Methodology:** HIV surveillance data will be used in the funded counties to determine the proportion of people living with HIV not in health care and its change over the funding period. The increase in those newly identified as HIV-positive by partner services will be measured by the Local Evaluation Online database managed by the OA Prevention Research and Evaluation Branch and STD surveillance data available from the STD Control Branch.

**State Program Setting:**

Local health department, Medical or clinical site, State health department

**FTEs (Full Time Equivalents):**

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

**Total Number of Positions Funded:** 0

**Total FTEs Funded:** 0.00

**National Health Objective: HO HIV-1 HIV Diagnoses**

**State Health Objective(s):**

Between 10/2015 and 09/2020, *increase the proportion of people living with HIV/AIDS who are in continuous care* from 74% to **80%**, based on California's goals in response to the National HIV/AIDS Strategy.

**Baseline:**

*The number of people with HIV classified as out-of-care as of December 31, 2013, in Alameda, Orange, and San Diego counties is **11,568**. This is based on OA HIV surveillance data of those diagnosed with HIV as of December 31, 2012, and living with HIV on December 31, 2013 (most current data available).*

**Data Source:**

OA HIV Surveillance Case Registry

**State Health Problem:**

**Health Burden:**

California ranks second in the nation for cumulative AIDS cases; as of December 2013, approximately 137,000 Californians were living with HIV. The rate of new infections has remained stable as the epidemic continues among populations heavily impacted by health inequities.

The **target population** is all people with HIV in Alameda, Orange, and San Diego Counties. The **disparate population** is all people of color with HIV in these counties.

**Target Population:**

Number: 11,568

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 4,966

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

Location: Specific Counties

Target and Disparate Data Sources: OA HIV Surveillance Case Registry

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

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: California HIV surveillance data from April 2015.

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

Total Current Year Funds Allocated to Health Objective: \$375,000

Total Prior Year Funds Allocated to Health Objective: \$375,000

Funds Allocated to Disparate Populations: \$375,000

Funds to Local Entities: \$375,000

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

### **Analyze Orange County Linkage to HIV Care and Partner Services Activities.**

Between 10/2015 and 09/2016, the Orange OA contractor will analyze **two** linkages to HIV care (LTC) and/or partner services policies, protocols, or work flows, and suggest improvements to the Division Manager of Disease Control and Epidemiology in Orange County.

#### **Annual Activities:**

##### **1. Investigate LTC and partner-services processes.**

Between 10/2015 and 09/2016, the Orange OA contractor will develop **two** improvements to LTC and/or partner-services policies, protocols, or work flows and present them to the Division Manager of Disease Control and Epidemiology in Orange County.

##### **2. Improve LTC/partner-services activities.**

Between 10/2015 and 09/2016, the Orange OA contractor will interview **75%** of Orange County staff currently providing LTC and partner services to determine processes, protocols, or work flows to improve.

#### **Objective 2:**

##### **Develop Alameda County-specific database of people with HIV.**

Between 10/2015 and 09/2016, the Alameda County contractor will develop **one** database to assist in determining people with HIV who are not in HIV care or not virally suppressed, and/or have become co-infected with syphilis or gonorrhea (GC).

#### **Annual Activities:**

##### **1. Evaluate available data sources.**

Between 10/2015 and 09/2016, the Alameda OA contractor will assess **100%** of available sources and, if appropriate, include them in the database.

##### **2. Develop protocol for usage of database information.**

Between 10/2015 and 09/2016, the Alameda OA contractor will develop **one** protocol for HIV LTC and partner services staff to use information from the database to provide services to people who need them.

#### **Objective 3:**

##### **Link HIV care and partner services in San Diego.**

Between 10/2015 and 09/2016, the San Diego OA contractor will conduct **250** interviews with people co-infected with non-virally suppressed HIV and GC to provide linkage to HIV care, ascertain appropriate GC treatment, and elicit information about sex or needle sharing partners.

People with HIV and GC co-infection must receive appropriate GC treatment to decrease the possibility of developing drug-resistant GC. It is also important to find the partners of people with HIV and GC co-infection because if the partner has GC it may make them more likely to have become infected with HIV. Finding and testing partners is critical to decreasing HIV transmission.

#### **Annual Activities:**

##### **1. Identify those co-infected with HIV and GC.**

Between 10/2015 and 09/2016, the San Diego contractor will use laboratory and Enhanced HIV/AIDS Reporting System (eHARS) data to identify **325** people recently diagnosed with GC who are also HIV positive.

##### **2. Interview identified patients.**

Between 10/2015 and 09/2016, the San Diego contractor will (1) contact **all** identified patients and determine if they are currently in HIV care and have received appropriate GC treatment and (2) elicit identifying information about their sex and/or needle-sharing partners that can allow for anonymous third-party notification.

**State Program Title: Office of Health Equity**

**State Program Strategy:**

**Goal:** *Achieve the highest level of physical and mental health for all people*, especially vulnerable communities that have experienced socioeconomic disadvantage, historical injustices, and systematic discrimination.

**Health Priorities:** *Incorporate health, equity, and sustainability considerations* that enhance access to and availability of physical activity opportunities *into decision-making* across sectors and policy areas.

**Role of Block Grant Funds:** PHHSBG funds are used for four FTE positions; the anticipated fill date for the vacant position is August 1, 2016.

**Primary Strategic Partnerships**

**Internal**

- Chronic Disease Control Branch
- Nutrition Education and Obesity Prevention Branch
- Environmental Health Investigations Branch
- California Department of Public Health Public Health Executive Management Team
- Let's Get Healthy California, Director's Office

**External**

- Health in All Policies Task Force
- Governor's Strategic Growth Council
- California Conference of Local Health Officers
- California Pan-Ethnic Health Network
- University of California, Berkeley

**Evaluation Methodology:** Use interviews and surveys to track the number of partner agency practices integrating health and equity.

**State Program Setting:**

Community based organization, Community health center, Faith based organization, Local health department, Parks or playgrounds, Schools or school district, State health department, Tribal nation or area, University or college

**FTEs (Full Time Equivalents):**

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

**Position Name:** Carol Gomez

**Position Title:** Associate Governmental Program Analyst

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Meredith Lee

**Position Title:** Health Program Specialist I

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Dahir Nasser

**Position Title:** Health Program Specialist I

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Vacant

**Position Title:** Health Program Specialist II

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Total Number of Positions Funded:** 4

**Total FTEs Funded:** 4.00

**National Health Objective: HO PA-15 Built Environment Policies**

### **State Health Objective(s):**

Between 10/2015 and 09/2016, OHE staff will, in partnership with state-level departments and agencies, **embed physical-activity-related health and equity components into California programs, policies, and processes that impact the social determinants of health**, including land use, active transportation, transit-oriented affordable housing development, school facility siting and design, and access to parks and green spaces.

### **Baseline:**

(1) *In 2010, 73.8% California residents lived within one-half mile of park, beach, open space, or coastline;*  
(2) *In 2012, 21.5% of California residents used walking, biking, or public modes of transportation.*

### **Data Source:**

(1) 2014, Healthy Community Data and Indicators project, HCI CALANDS [2012], U.S. Census Bureau [2010]; (2) 2012, California Household Travel Survey (CHTS). No newer data exists for measuring statewide access to parks, beaches, open space, or coastline, and percentage of residents walking, biking, or using public modes of transportation.

### **State Health Problem:**

#### **Health Burden:**

Significant portions of California's population lack access to physical-activity opportunities, which contributes to poor health and health inequities. For example, in 2012, 2.3 million California adults reported having been diagnosed with diabetes, and one in five California adults reported that during the past month, they had not participated in any physical activity (BRFSS, 2010). Community design that prioritizes active transportation and increases proximity and access to schools, economic opportunities, housing, parks and open space, and health-supportive services have been shown to increase physical activity.

The Integrated Transport and Health Impacts Model (I-THIM), developed by CDPH, found that in the San Francisco Bay Area an increase in daily walking and biking per capita from 4 to 22 minutes would reduce cardiovascular disease and diabetes by 14%.

Additional evidence from the San Joaquin Valley, an area of California facing high rates of health disparities, shows that 29.8% of teenagers did not go to a park, playground, or open space in the past month, 18.3% do not have a park, playground, or open space within walking distance, 9% have not been physically active in the past week, and 18% are overweight or obese (California Health Interview Survey, 2011–2012).

OHE targets California's community-design resources to populations most in need of opportunities for physical activity as a strategy to improve health and reduce inequities. The **target** and **disparate populations** are the same: all low-income, nonwhite racial and ethnic groups.

#### **Target Population:**

Number: 15,800,022

Ethnicity: Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: Yes

#### **Disparate Population:**

Number: 15,800,022

Ethnicity: Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: Yes  
Location: Entire state  
Target and Disparate Data Sources: Behavioral Risk Factor Survey 2012

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

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

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

Total Current Year Funds Allocated to Health Objective: \$491,689  
Total Prior Year Funds Allocated to Health Objective: \$491,688  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Coordinate stakeholder engagement initiatives focused on improving health equity.**

Between 10/2015 and 09/2016, OHE staff will develop **at least three** opportunities to embed physical-activity–promoting health and equity components into state-issued land-use and transportation grants, guidelines, programs, data collection, or processes to support efforts to build healthy and equitable communities.

### **Annual Activities:**

#### **1. Expand relationships with state non-health departments.**

Between 10/2015 and 09/2016, OHE staff will, in response to input from agency partners, facilitate **four** multi-agency forums with **at least 15** state departments, agencies, and offices through the Health in All Policies (HiAP) Task Force to assess capacity for non-health departments to consider physical-activity-related health and health-equity components; identify and lift up successes, creating a venue for sharing and troubleshooting; and identify gaps where further training and tools are needed when developing grant applications and guidance documents.

#### **2. Increase collaboration and coordination with local health departments.**

Between 10/2015 and 09/2016, OHE staff will gather input from **at least two** local health department leaders through the California Conference of Local Health Officers to ensure that their needs are incorporated in policies of the California Departments of Education and Transportation to promote physical-activity–related health and equity components in state policies, programs, and processes related to active transportation and school facilities siting.

#### **3. Increase collaboration and coordination with CDPH.**

Between 10/2015 and 09/2016, OHE staff will provide technical assistance and partnership to **at least two** branches within CDPH to support coordination of healthy-community and health-equity initiatives such as Let's Get Healthy California through activities that convene staff and align physical-activity–related program planning and implementation, and communications efforts to create organizational efficiency and increase CDPH's collective impact toward improving the health of Californians.

### **Objective 2:**

**Develop healthy public policy.**

Between 10/2015 and 09/2016, OHE staff will develop **at least three** OHE staff will develop at least three opportunities to embed physical-activity–related health and equity components into state-issued land-use and transportation grants, guidelines, programs, data collection, or processes to support efforts to build healthy and equitable communities.

**Annual Activities:**

**1. Promote sustainable, equitable land-use planning and development.**

Between 10/2015 and 09/2016, OHE staff will partner with **one** HiAP Task Force by providing guidance and technical input to the Departments of Education and Transportation on including equity and health promotion considerations in school facilities siting guidelines and practices and active-transportation projects. These policy areas promote sustainable, equitable land-use planning and development supportive of regular daily physical activity and other behaviors that will lead to improved health outcomes.

**2. Promote greater equity in CDPH policies, programs, and processes.**

Between 10/2015 and 09/2016, OHE staff will build on **at least two** existing organizational relationships by partnering with the Government Alliance on Race and Equity to assess CDPH policies, programs, and processes that present barriers to racial equity and develop a plan for CDPH to address institutional racism. Reasons OHE is focusing on racism include that government institutions and employees must be aware of their role in promoting proportionate health and well-being outcomes across populations, and prioritizing efforts targeted to populations with the greatest need, particularly those historically and currently disadvantaged, including in built-environment policies that affect access to physical-activity opportunities.

**State Program Title: Office of Quality Performance and Accreditation**

**State Program Strategy:**

**Goal:** *Ensure optimal services and outcomes for the 39 million people in California who receive public health services* from 61 local and 32 tribally controlled health departments. A systemic review and evaluation of health department systems and processes is needed to ensure optimal services and outcomes.

**Health Priorities:** *Maintain California Department of Public Health (CDPH) Public Health Accreditation Board (PHAB) accreditation*, awarded on December 9, 2014. Accreditation indicated that CDPH's performance meets a set of nationally recognized, practice-focused, and evidence-based standards.

The CDPH Office of Quality Performance and Accreditation (OQPA) facilitates and supports CDPH as a quality performing organization, which includes coordinating the department's efforts to achieve and maintain National Public Health Accreditation. To maintain the department's accreditation status, PHAB's Standards and Measures require CDPH to make technical assistance (TA) services available to local health departments (LHDs) and tribal public health partners to support their accreditation-related activities.

**Role of Block Grant Funds:** PHHSBG funds facilitate personnel support and provision of accreditation-readiness TA and consultation services to California's local and tribal public health agencies.

**Primary Strategic Partnerships**

**Internal**

- California Conference of Local Health Officers
- Fusion Center
- Office of Health Equity

**External**

- California Rural Indian Health Board
- Centers for Disease and Control and Prevention
- County Health Executives Association of California (CHEAC)
- Public Health Accreditation Board
- Public Health Institute

**Evaluation Methodology:** OQPA will use a deliverable-based approach to monitor grant activities. Success will be the expenditure of all grant funds and completion of all objectives by June 30, 2017.

**State Program Setting:**

Local health department, State health department, Tribal nation or area

**FTEs (Full Time Equivalent):**

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

**Position Name:** Leslie Stribling

**Position Title:** Health Program Specialist I

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Martha Reyes

**Position Title:** Health Program Specialist II

State-Level: 5% Local: 0% Other: 0% Total: 5%

**Position Name:** Sandra Fasolette

**Position Title:** Health Program Specialist II

State-Level: 5% Local: 0% Other: 0% Total: 5%

**Total Number of Positions Funded: 3**

Total FTEs Funded: 1.10

## **National Health Objective: HO PHI-17 Accredited Public Health Agencies**

### **State Health Objective(s):**

Between 10/2015 and 09/2016,

(1) Increase the percentage of local/tribal public health agencies that have registered (statement of intent) to apply for national public health accreditation by **10%**; (2) Increase the percentage of local and tribal public health agencies that have submitted an application to PHAB by **10%**. (3) Provide accreditation readiness (preparation) TA to **at least three** local public health agencies; (4) Provide financial assistance to increase accreditation readiness and capacity to **at least one** local and/or tribal public health agency.

### **Baseline:**

1. In 2015, CHEAC surveyed 61 LHDs to assess level of accreditation readiness. Of the 52 respondents, one is accredited, **ten** registered (potential applicants), and **nine** submitted an application to PHAB. **Six** LHDs completed documentation submission and **16** started the documentation selection process. As of March 8, 2016, **two** additional LHDs became accredited; totaling **three** in California. The following represents LHD plans completed: Community Health Assessment (CHA): **35% (18)**; Community Health Improvement Plan (CHIP): **25% (13)**; Strategic Plan (SP): **27% (14)**; Quality Improvement (QI): **17% (9)**; Performance Management (PM): **19% (10)**.

2. CRIHB conducted a 2015 assessment of tribal accreditation readiness; results indicated **none** of the 20 respondents registered or applied to PHAB. The following represents tribal plans completed: CHA: **30% (6)**; CHIP: **15% (3)**; SP: **15% (3)**; QI: **35% (7)**; PM: **10% (2)**.

### **Data Source:**

(1) CHEAC, October 2015, Local Health Department Public Health Accreditation Status Survey;  
(2) California Rural Indian Health Board, November 2015, Tribal Public Health Accreditation Readiness Assessment

### **State Health Problem:**

#### **Health Burden:**

Only three California LHDs have achieved public health accreditation. The remaining local and tribal public health agencies are in various stages of accreditation readiness and many do not have the in-house technical expertise and/or resources to facilitate, lead, direct, or coordinate accreditation readiness activities. There are 61 California LHDs, one from 58 counties and three cities: Berkeley, Long Beach, and Pasadena. Additionally, 32 tribally controlled health departments serve 109 federally recognized tribes.

Preparing for accreditation is complex and introspective process that highlights areas of strength and reveals opportunities for improvement that may directly impact patient care and outcomes. A public health department that does not apply for public health accreditation because it lacks the appropriate resources is missing an opportunity to critically evaluate its services and make adjustments to improve services and outcomes.

PHHSBG funds are needed to ensure LHDs and tribal health partners have knowledge, resources, and capacity to pursue public health accreditation through extensive coaching and TA services. If all LHD and tribal public health partners applied for and obtained national public health accreditation, the provision of public health services throughout California would meet a national standard, and the overall public health for approximately 39 million residents (**target** and **disparate populations**) would be optimized.

#### **Target Population:**

Number: 39,144,818

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Health Care Systems

**Disparate Population:**

Number: 39,144,818

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Health Care Systems

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

- Other:
- Association of State and Territorial Health Officials, 2011–2015
  - Accreditation Coordinators Learning Community, 2013
  - Michigan Quality Improvement Guidebook, 2008
  - National Association of County and City Health Officials, 2010–2015

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

Total Current Year Funds Allocated to Health Objective: \$193,483

Total Prior Year Funds Allocated to Health Objective: \$187,500

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Assess needs.**

Between 10/2015 and 09/2016, OQPA, in collaboration with CHEAC and California Rural Indian Health Board, will develop **two** assessments of accreditation readiness, for one local and one tribal public health agency, to determine which resources are available and which are lacking.

**Annual Activities:**

**1. Evaluate needs assessment data.**

Between 10/2015 and 09/2016, OQPA staff will evaluate the information gathered to determine the TA areas to address with **at least two** local and/or tribal public health agencies.

**Objective 2:**

**Maintain internal personnel capacity.**

Between 10/2015 and 09/2016, OQPA staff will maintain **three** staff positions to provide accreditation-readiness TA to local and/or tribal public health agencies.

**Annual Activities:**

**1. Provide infrastructure and personnel support.**

Between 10/2015 and 09/2016, OQPA staff will provide TA services, including documentation selection and submission, site-visit preparation, strategic planning, QI, and performance management to **at least two** local and/or tribal public health agencies, to augment and facilitate their accreditation planning activities.

**Objective 3:**

**Provide financial assistance.**

Between 10/2015 and 09/2016, OQPA staff will provide financial assistance to increase accreditation readiness to **at least one** local and/or tribal public health agency to improve the capacity to apply for national public health accreditation.

**Annual Activities:**

**1. Establish mini-grant program.**

Between 10/2015 and 09/2016, OQPA staff will establish an accreditation readiness mini-grant program for **at least two** local and/or tribal public health agencies to apply for financial assistance. Mini-grants may be used to fund the PHAB application fee when applying for accreditation or support the development of accreditation-related activities such as workforce development, QI, and performance management. The allocation of financial assistance will increase the capacity of **at least one** local and/or tribal public health agency that has demonstrated limited economic resources to pursue and apply for public health accreditation.

**Objective 4:**

**Support interventions.**

Between 10/2015 and 09/2016, OQPA staff will provide accreditation-readiness TA to **at least three** local and/or tribal public health agencies, to address identified accreditation needs and increase agency capacity to apply for and achieve national public health accreditation.

**Annual Activities:**

**1. Provide TA.**

Between 10/2015 and 09/2016, OQPA staff will provide **at least two** webinars, educational seminars, and conference calls that provide guidance on the national public health–accreditation process to local and/or tribal public health agencies.

**2. Provide accessible accreditation resources.**

Between 10/2015 and 09/2016, OQPA staff will utilize the information provided by **at least two** needs assessments to identify materials and tools to support local and/or tribal public health agency accreditation-related activities. These resources will be posted on the California Performance Improvement Management Network's website.

**State Program Title: Prescription Drug Overdose Surveillance Project**

**State Program Strategy:**

**Goal:** *Decrease prescription drug misuse, abuse, and overdose in California* by increasing the availability of useful surveillance data and the capacity of state and local partners to implement and monitor data-informed strategies.

**Health Priority:** Two California Wellness Plan objectives consistent with the Prescription Drug Overdose Surveillance (PDOS) project are: (1) **reduce opiate-related morbidity and mortality**, and (2) **decrease by 2020 the annual incidence rate of unintentional injury deaths** in California from 27 to 20 per 100,000.

In 2014, the California Department of Public Health (CDPH) launched the Prescription Opioid Misuse and Overdose Prevention Workgroup and developed collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in response to the Association of State and Territorial Health Officers (ASTHO) President's Challenge.

**Role of Block Grant Funds:** PHHSBG funds will (1) pay staff salaries; (2) develop and disseminate data on prescription-drug-related deaths, hospitalizations, and emergency department visits; (3) provide technical assistance (TA) to state and local stakeholders on using the *EpiCenter—California Injury Data Online* query system; (4) lead the evaluation team for the CDC Prescription Drug Overdose Prevention for States grant; and, (5) provide TA to the Prescription Opioid Misuse and Overdose Prevention Workgroup.

**Primary Strategic Partnerships**

**Internal**

- CDPH Office of the Director
- Safe and Active Communities Branch
- Office of AIDS
- Center for Health Care Quality
- Center for Health Statistics and Informatics

**External**

- California Department of Health Care Services
- California Department of Justice
- California HealthCare Foundation
- Drug Enforcement Administration
- California Consumer Affairs

**Evaluation Methodology:** *Process evaluation* will measure the extent to which project objectives are met. *Impact evaluation* will assess immediate and intermediate outcomes using multiple measures, including reported use of data and the quality and usefulness of TA. Ultimate outcomes of decreased poisonings are dependent on the impact of data-informed actions taken by project partners.

**State Program Setting:**

Local health department, State health department, University or college

**FTEs (Full Time Equivalent):**

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

**Position Name:** Nancy Bagnato

**Position Title:** Health Program Manager II

State-Level: 5% Local: 0% Other: 0% Total: 5%

**Position Name:** John Pugliese

**Position Title:** Research Scientist III

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Total Number of Positions Funded:** 2

Total FTEs Funded: 1.05

**National Health Objective: HO IVP-11 Unintentional Injury Deaths**

**State Health Objective(s):**

Between 10/2015 and 09/2020, *decrease the rate of opioid-related deaths in California* by **5%**.

**Baseline:**

*Rate of 5.1 deaths per 100,000 in 2014.*

**Data Source:**

EpiCenter: California Injury Data Online, <http://epicenter.cdph.ca.gov>, accessed April 18, 2016.

**State Health Problem:**

**Health Burden:**

In 2013, there were 1,934 opioid-related deaths in California (rate of 5.1 per 100,000). The rate of pharmaceutical opioid related deaths was 3.7 per 100,000; the rate of heroin-related deaths was 1.3 per 100,000. In addition, non-fatal emergency department opioid-related visits increased dramatically from 5,753 cases in 2006 to 11,683 in 2014 (103% increase), for a rate of 30.3 per 100,000 in 2014. The **target** and **disparate populations** are the same: the total population of California.

**Target Population:**

Number: 38,548,204

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 38,548,204

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: <http://epicenter.cdph.ca.gov>. Accessed April 15, 2016

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

Other: (1) Brandeis University Prescription Drug Monitoring Program Center for Excellence; (2) From Epi to Policy: Prescription Drug Overdose; (3) CDC Guidelines <http://www.cdc.gov/drugoverdose/prescribing/guideline.html>

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

Total Current Year Funds Allocated to Health Objective: \$150,000

Total Prior Year Funds Allocated to Health Objective: \$140,000

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

10-49% - Partial source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Increase capacity for using surveillance data.**

Between 10/2015 and 09/2016, PDOS Project staff will analyze **quarterly** data reports to 25 state and local stakeholders to inform policy and program implementation.

### **Annual Activities:**

#### **1. Prepare and upload data on EpiCenter website.**

Between 10/2015 and 09/2016, PDOS Project staff will design and/or update **at least three** functionalities for EpiCenter, to capture data sources using International Classification of Diseases (ICD) coding and upload the most current data to increase availability for surveillance activities.

#### **2. Provide TA to EpiCenter users.**

Between 10/2015 and 09/2016, PDOS Project staff will provide TA to **at least ten** state or local partners on how to use data from the EpiCenter, to conduct surveillance activities to enhance planning and implementation of policies and programs.

### **Objective 2:**

#### **Support statewide workgroup.**

Between 10/2015 and 09/2016, PDOS Project staff will provide surveillance and programmatic technical assistance to **ten** state agency members of the Director's Prescription Opioid Drug Overdose Prevention Workgroup to promote policy and program planning, implementation, and evaluation at state and local levels.

### **Annual Activities:**

#### **1. Provide data support**

Between 10/2015 and 09/2016, PDOS Project staff will provide **four** regular reports on data sources and data-sharing activities to Workgroup members to support policy and program planning and implementation.

#### **2. Provide TA.**

Between 10/2015 and 09/2016, PDOS Project staff will provide data and programmatic TA to the Workgroup and its partners (e.g., Department of Health Care Services) to assist with program planning, implementation, and evaluation **at least 10** times annually.

### **Objective 3:**

#### **Translate data into useful information.**

Between 10/2015 and 09/2016, PDOS Project staff will distribute quarterly data reports to **25** state and local stakeholders, to inform policy and program implementation.

### **Annual Activities:**

#### **1. Prepare and analyze available data.**

Between 10/2015 and 09/2016, PDOS Project staff will, using **three** data sources, **annually** prepare and

analyze data on prescription-drug–related deaths, hospitalizations, and emergency department visits to be included in multiple dissemination platforms (e.g., websites, webinars, conferences, TA).

**2. Disseminate reports to stakeholders.**

Between 10/2015 and 09/2016, PDOS Project staff will produce and disseminate ten data reports to at least 100 state and local prevention/public health stakeholders to inform program planning and implementation.

**State Program Title: Preventive Medicine Residency Program**

**State Program Strategy:**

**Goal:** *Strengthen the California Department of Public Health (CDPH) as an organization through developing the workforce*, one of the three CDPH directorate-sponsored priorities.

**Health Priority:** *To maintain a competent, skilled public health workforce, CDPH supports public health professional training through the Preventive Medicine Residency Program (PMRP) and the California Epidemiologic Investigation Service (Cal EIS) Fellowship Program.* Residents enter PMRP in Post-Graduate Year (PGY)-2, complete graduate-level coursework and/or receive a Masters of Public Health (MPH) degree. Residents receive requisite exposure to subject areas, such as epidemiology, biostatistics, social and behavioral aspects of public health, and environmental health. Cal EIS post-MPH trainees receive real-world experience in the practice of epidemiology, public health, surveillance, and evaluation projects at a local or state health department.

**Role of Block Grant Funds:** PHHSBG funds support trainees' stipends, as well as salaries for three staff who recruit, place, and monitor the Residents/Fellows; leverage state and local funding for stipends; and assure continued accreditation of the Residency Program, including program revisions to meet new Accreditation Council of Graduate Medical Education (ACGME) requirements.

**Primary Strategic Partnerships**

**Internal**

- Chronic Disease Surveillance and Research Branch
- Environmental Health Investigations Branch
- Healthcare Associated Infections Program
- Office of Health Equity
- Safe and Active Communities Branch

**External**

- University of California, Davis, School of Medicine, Department of Public Health Sciences
- University of California, Berkeley, School of Public Health
- County of Los Angeles Department of Public Health
- Napa County Public Health
- Santa Cruz County Health Services Agency

**Evaluation Methodology:** Program goals and objectives in line with national organizational requirements and state health objectives are monitored and evaluated yearly. Monitoring tools include program policies/procedures; monthly/quarterly trainee reports, preceptor/trainee evaluations, site visits, and Evaluation Committee.

**State Program Setting:**

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

**FTEs (Full Time Equivalent):**

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

**Position Name:** Jami Chan

**Position Title:** Health Program Specialist I

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Esther Jones

**Position Title:** Health Program Specialist II

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Position Name:** Jennifer Bale

**Position Title:** Associate Government Program Analyst

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Total Number of Positions Funded: 3**

**Total FTEs Funded: 2.25**

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

**State Health Objective(s):**

Between 10/2015 and 09/2016, **increase the public health workforce** by graduating **at least eight** trainees from PMRP or Cal EIS, to become qualified public health physicians and epidemiologists who contribute to and/or lead in the maintenance and improvement of the health of Californians.

**Baseline:**

*Six graduates who achieved moderate to high skill levels in specific competencies developed by national organizations, by working in local or state public health agency programs.*

**Data Source:**

Competency/milestones charts, monthly/quarterly activity reports, preceptor/faculty evaluations, and program evaluations of trainee performance.

**State Health Problem:**

**Health Burden:**

To maintain a skilled professional workforce, public health agencies must train the next generation of public health experts and leaders. This need arises from two realities: (1) As older public health leaders retire, well-trained professionals need to replace them; (2) New leaders offer novel perspectives and insights into methods of meeting public health challenges.

Shortages of public health physicians and other health professionals continue (e.g., a 5% decrease in the public health workforce [5,500 FTEs] nationwide since 2010 [ASTHO 2014]). Larger states like California have the lowest number of FTEs per 100,000 population, at approximately 13 FTEs per 100,000, compared to other states that have over 100 FTEs per 100,000 population.

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

The **target** and **disparate populations** are the same: the total population of California.

**Target Population:**

Number: 39,144,818

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Safety Organizations

**Disparate Population:**

Number: 39,144,818

Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Safety Organizations

### **Evidence Based Guidelines and Best Practices Followed in Developing Interventions:**

Best Practice Initiative (U.S. Department of Health and Human Service)  
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)  
Guide to Community Preventive Services (Task Force on Community Preventive Services)  
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)  
Model Practices Database (National Association of County and City Health Officials)

Other: (1) ACGME Program Requirements for Graduate Medical Education in Preventive Medicine; (2) ACGME Milestones for Preventive Medicine Residents; (3) Council of State Territorial Epidemiologists (CSTE), Competencies for Applied Epidemiology

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

Total Current Year Funds Allocated to Health Objective: \$534,600  
Total Prior Year Funds Allocated to Health Objective: \$528,464  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: No other existing federal or state funds  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:  
100% - Total source of funding

## **OBJECTIVES – ANNUAL ACTIVITIES**

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

### **Objective 1:**

#### **Increase the number of trainees who gain Preventive Medicine and Applied Epidemiology competencies.**

Between 10/2015 and 09/2016, PMRP staff will increase the number of trainees who, over the course of their training period, have satisfactorily achieved moderate or high competency in American College of Preventive Medicine (ACPM)/ACGME or CSTE competencies, by working in local or state public health agency programs or community-based settings and/or completing academic coursework, from 111 Residents and 145 Fellows to **113 Residents and 155 Fellows**.

### **Annual Activities:**

#### **1. Recruit and interview applicants for PMRP and Cal EIS Fellowships.**

Between 10/2015 and 09/2016, PMRP/Cal-EIS staff will recruit and interview **at least seven** PMRP applicants and **26** Cal-EIS applicants. The competitive recruitment and selection process includes distributing PMRP and Cal-EIS information to schools of public health, residency programs, and local health departments, and posting on various websites, such as FREIDA Online, Electronic Residency Application Service (ERAS), and Public Health Connection. Applications from this pool will be reviewed by the PMRP and Cal-EIS Advisory Committees, and top candidates will be selected for interview.

#### **2. Place trainees for a public health training experience.**

Between 10/2015 and 09/2016, PMRP staff will train **at least 12** individuals (**at least ten** Cal-EIS trainees to achieve CSTE competencies and **at least two** Residents to meet ACPM/ACGME competencies). Experienced preceptors mentor and guide trainees to meet competencies through applied state and local public health experiences, training required for the State's public health workforce.

#### **3. Develop and implement public health practice curriculum.**

Between 10/2015 and 09/2016, PMRP/Cal-EIS staff will conduct **at least 14** public health/preventive medicine (PM) seminars for PMRP and Cal-EIS trainees. These bimonthly PM seminars address ACPM/ACGME or CSTE competencies and provide trainees with insights and resources on public health practice, epidemiologic investigation procedures, and other processes that prepare trainees to enter the public health workforce.

**State Program Title: Rape Prevention Program**

**State Program Strategy:**

**Goal:** The Rape Prevention Program, within the California Department of Public Health (CDPH) Safe and Active Communities Branch (SACB), addresses the national *Healthy People 2020* focus area of Injury and Violence Prevention, which includes a goal of **reducing sexual violence**.

**Health Priorities:** **Stop first-time perpetration and victimization of sex offenses** by implementing evidence-informed sex-offense (rape) prevention strategies.

**Role of Block Grant Funds:** The PHHSBG Rape Set-Aside allocation funds (1) local rape crisis centers (RCCs) that directly serve victims, and potential victims and perpetrators, to deliver sex-offense (rape) prevention programs; and (2) RCC-implemented *MyStrength* Clubs for young men ages 14–18 to promote bystander involvement and attitude and behavior change.

**Primary Strategic Partnerships**

**Internal**

- Office of Health Equity
- Maternal, Child, and Adolescent Health

**External**

- California Coalition Against Sexual Assault
- California Office of Emergency Services
- California Partnership to End Domestic Violence
- California Department of Education

**Evaluation Methodology:** Behavioral Risk Factor Surveillance System (BRFSS) data will be used to evaluate progress toward ending sexual violence. *Process evaluation* will measure the extent to which objectives are met (e.g., number of organizational assessments conducted). *Impact evaluation* will assess immediate and intermediate outcomes using multiple measures, including evaluation instruments administered as part of trainings to determine knowledge and skills improvement.

**State Program Setting:**

Community based organization, Rape crisis center, Schools or school district, State health department, Tribal nation or area

**FTEs (Full Time Equivalent):**

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

**Position Name:** Vacant

**Position Title:** Health Program Manager III

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Position Name:** Stacy Alamo Mixson, MPH

**Position Title:** Health Program Manger II

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Total Number of Positions Funded:** 2

**Total FTEs Funded:** 0.50

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

**State Health Objective(s):**

Between 10/2015 and 09/2016, **reduce the rate of rape in California**, as measured by BRFSS, by **1%**.

**Baseline:**

*In 2013, the incidence of rape among women age 18 and over in California was **420 per 100,000**.*

**Data Source:**

California BRFSS, 2013.

**State Health Problem:**

**Health Burden:**

Rape victims often have long-term emotional and health consequences as a result of this adverse experience, such as chronic diseases, emotional and functional disabilities, harmful behaviors, and intimate relationship difficulties. The **target** and **disparate populations** are the same: females age 12 and over. Females are more often the victims of rape; the lifetime rate for females was 15% versus 3% for males.

**Target Population:**

Number: 16,210,327

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 16,210,327

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: State of California, Department of Finance, 2016

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

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Initial Guidance for Rape Prevention and Education CE14-1401, Centers for Disease Control and Prevention, Rape Prevention and Education Program, 2014.

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

Total Current Year Funds Allocated to Health Objective: \$832,969

Total Prior Year Funds Allocated to Health Objective: \$832,969

Funds Allocated to Disparate Populations: \$705,963

Funds to Local Entities: \$0

Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

50-74% - Significant source of funding

## OBJECTIVES – ANNUAL ACTIVITIES

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

### **Objective 1:**

#### **Increase delivery of evidence-informed rape-prevention programs.**

Between 10/2015 and 09/2016, SACB staff will increase the number of evidence-informed sexual-offense–prevention programs provided to victims, potential victims, and potential perpetrators, by promoting the use of the Nine Principles of Effective Prevention (Principles), from 10 to **20**.

### **Annual Activities:**

#### **1. Assess knowledge and application of Principles among RCCs.**

Between 10/2015 and 09/2016, SACB staff will conduct organizational assessments with **34** RCCs to determine to what extent they are implementing sexual-offense–prevention programs using *Principles*.

#### **2. Increase knowledge and skills of RCCs to use "Principles."**

Between 10/2015 and 09/2016, SACB staff will conduct **a minimum of four** *Principles*-based educational activities to contracted RCCs so they may conduct evidence-informed sexual-offense (rape)-prevention programs for potential victims and perpetrators, to change behaviors that lead to sexual offenses.

#### **3. Fund MyStrength Clubs.**

Between 10/2015 and 09/2016, SACB staff will fund **eight** local RCCs to conduct *MyStrength* Clubs with young men to change behaviors that have been shown to contribute to the perpetration of sexual offenses.

**State Program Title: Receptor Binding Assay for Paralytic Shellfish Poisoning Control**

**State Program Strategy:**

**Goal:** *Reduce the incidence of Paralytic Shellfish Poisoning (PSP) illness in consumers* by implementing more-sensitive PSP-detection monitoring at the Drinking Water and Radiation Laboratory Branch (DWRLB) within the California Department of Public Health (CDPH). DWRLB's PSP Surveillance Program could more effectively detect PSP toxins by replacing the standard mouse bioassay (MBA) in use at DWRLB with the more-sensitive receptor binding assay (RBA) (an assay that relies on a biological-receptor protein for specific detection of biologically active molecules) to monitor PSP toxins in shellfish from California shellfish-growing areas and coastal waters.

**Health Priority:** *Identify and remove shellfish contaminated with PSP toxins from the food supply,* and reduce the incidence of poisoning among shellfish consumers.

**Role of Block Grant Funds:** PHHSBG funds support operating costs and salaries for personnel involved in development, standardization, and validation of the RBA for use in surveillance of PSP toxins.

**Primary Strategic Partnerships**

**Internal**

- Environmental Management Branch, Preharvest Shellfish Program;
- Microbial Diseases Laboratory;
- Food and Drug Branch

**External**

- Pacific Coast Shellfish Growers Association;
- International Shellfish Sanitation Conference;
- National Shellfish Sanitation Program;
- U.S. Food and Drug Administration;
- California Department of Fish and Wildlife

**Evaluation Methodology:** Progress will be based on comparative testing between the RBA and the mouse bioassay. These two assays will be applied to shellfish samples collected from actual phytoplankton blooms (current and historic) in California waters and growing areas.

**State Program Setting:**

State health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Stephanie Abromaitis

**Position Title:** Research Scientist III (Micro)

State-Level: 25% Local: 0% Other: 0% Total: 25%

**Position Name:** Chad Crain

**Position Title:** Research Scientist III (Micro)

State-Level: 100% Local: 0% Other: 0% Total: 100%

**Total Number of Positions Funded:** 2

**Total FTEs Funded:** 1.25

**National Health Objective: HO EH-22 Monitoring Diseases Caused by Exposure to Environmental Hazards**

**State Health Objective(s):**

Between 10/2015 and 09/2016, conduct a feasibility study of the RBA for routine regulatory testing in

California; this study will compare performance of the RBA and the currently used testing method (MBA). The greater sensitivity and higher throughput of the RBA compared to the MBA has the potential to **reduce risk of illness due to food-borne intoxication**.

**Baseline:**

*There have been 542 reported illnesses and 39 deaths attributed to PSP-contaminated shellfish in California (existing shellfish testing data utilizing the MBA method) since 1927. Development of the RBA for use in California, along with its subsequent implementation, is anticipated to be an enhancement of PSP surveillance in terms of sensitivity and effectiveness for public health protection, and in terms of moving away from an assay based on use of live animals.*

**Data Source:**

Environmental Management Branch Preharvest Shellfish Program web page (<https://www.cdph.ca.gov/HealthInfo/environhealth/water/Pages/Shellfish.aspx>)

**State Health Problem:**

**Health Burden:**

PSP ingestion can result in a spectrum of illnesses, ranging from tingling of the lips and tongue, to loss of control of extremities, to severe muscle paralysis and death. The severity of the illness depends on the amount of PSP toxin consumed and characteristics of the consumer, such as body weight. The National Shellfish Sanitation Program originated in 1925, and the MBA has been in continuous use for 50 years. The annual sport-harvested mussel quarantine, combined with year-round CDPH surveillance, protects consumers from PSP illness. The level of protection can be increased with RBA. The RBA is desirable because it is more humane, more sensitive, less subject to matrix effects, and has a greater capacity than the MBA.

The **target population** includes all consumers of commercial and sport-caught shellfish from California growing areas and coastal waters. The **target** and **disparate populations** are the same.

**Target Population:**

Number: 26,000,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

**Disparate Population:**

Number: 26,000,000

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older

Gender: Female and Male

Geography: Rural and Urban

Primarily Low Income: No

Location: Entire state

Target and Disparate Data Sources: California Census Data (2015), adjusted for vegetarians, and assuming that 50-75% of the remainder consume shellfish

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

Other: (1) International Shellfish Sanitation Conference; (2) National Shellfish Sanitation Program; (3) U.S. Food and Drug Administration

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

Total Current Year Funds Allocated to Health Objective: \$206,250

Total Prior Year Funds Allocated to Health Objective: \$192,500

Funds Allocated to Disparate Populations: \$0

Funds to Local Entities: \$0

Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:

100% - Total source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Conduct a feasibility study of regulatory testing in California.**

Between 10/2015 and 09/2016, RBA for PSP Control staff will conduct one feasibility study of the RBA for routine regulatory testing in California. This study will compare performance of the RBA and the currently used testing method (MBA). The greater sensitivity and higher throughput of the RBA compared to the MBA has the potential to reduce risk of illness due to food-borne intoxication.

**Annual Activities:**

**1. Test all shellfish samples submitted to CDPH using the RBA.**

Between 10/2015 and 09/2016, RBA for PSP Control staff will analyze every shellfish sample received by CDPH for PSP toxin testing by the RBA and the MBA for one calendar year. It is necessary to test samples with both methods to (1) establish that the results generated from the two tests are similar; and (2) demonstrate that the RBA is as protective to public health as the MBA before considering changing methods.

This side-by-side testing needs to be done for a full year to adequately characterize method performance in varying environmental conditions. Samples will be pre-screened using a qualitative immuno-test (Scotia test); only positive samples will be tested by RBA and MBA. This testing will also establish whether the sample processing and data analysis time required for the RBA allow for timely results reporting (quick turnaround time is important for public safety and commercial interests).

**2. Validate commercial porcine membrane for use in the RBA.**

Between 10/2015 and 09/2016, RBA for PSP Control staff will validate use of one type of commercial porcine membrane for use in the RBA. Previous validation work for the RBA used a rat-brain homogenate as the source of PSP toxin binding sites. The rat homogenate is not commercially available and must be prepared in batches by the laboratory. Homogenate preparation is complex and labor intensive. A recently available commercially made porcine brain homogenate (1) uses tissue from animals slaughtered for other products, removing the need to slaughter animals solely for RBA-reagent preparation; and (2) is made in larger lots, reducing variability that can result from in-house homogenate preparation.

Staff will test the performance of the commercial porcine membrane through side-by-side comparison to sample testing with the in-house prepared homogenate. Validation of the porcine reagent's performance has the potential to streamline the RBA workflow and yield a more uniform assay reagent.

**3. Evaluate rapid toxin extraction method.**

Between 10/2015 and 09/2016, RBA for PSP Control staff will evaluate performance of **one** rapid toxin-extraction method. When the International Shellfish Sanitation Conference approved the RBA for testing mussels for PSP toxin, they approved it for use with a rapid small-scale toxin-extraction method.

Historically, toxin is extracted from shellfish by boiling 100 g of tissue with 100 mL of hydrochloric acid (HCl); the solution is then cooled, buffered, and clarified. The small-scale method uses 5 g of tissue and 5 mL of HCl. The smaller volume can be processed more quickly, allowing for high sample throughput.

Staff will perform a side-by-side comparison of the traditional (large-volume) and small-scale extraction methods for oyster tissue processing for the RBA. If the two extraction methods yield similar results in the validation study, staff will have data to support transitioning to the rapid method.

#### **4. Develop a laboratory information management system for use with the RBA.**

Between 10/2015 and 09/2016, RBA for PSP Control staff will develop **one** laboratory information management system (LIMS) for use by the Preharvest Shellfish Program and the DWRL.

The current LIMS used for shellfish samples is a commercial product; the portion of the LIMS for shellfish data entry will be discontinued due to system upgrades. A DWRL staff member will build a LIMS using Microsoft Access. The system will have fields for entering sample collection information, including environmental conditions at the time of sample collection, laboratory testing method, and laboratory results.

The LIMS will be searchable and have the ability to export data into Excel and Adobe Acrobat. By building a LIMS specific to RBA, staff will not be constrained by commercial product limitations and will be able to generate a system tailored to DWRL needs.

**State Program Title: Safe and Active Communities Branch**

**State Program Strategy:**

**Goal:** *Decreasing injuries in California* by supporting development of data-informed, evidence-based prevention policies, practices, and programs at state and local levels is the goal of the California Department of Public Health (CDPH) Safe and Active Communities Branch (SACB).

**Health Priorities:** SACB priorities consistent with the California Wellness Plan (the CDPH chronic disease prevention and health promotion program), include (1) **increasing accessible and usable health information**, (2) **expanding access to comprehensive statewide data**, and (3) **decreasing the annual incidence rate of unintentional injury deaths** in California from 27 to 20 per 100,000.

**Role of Block Grant Funds:** PHHSBG funds: (1) support SACB staff salaries; (2) support data enhancements of the SACB web-based data query system; (3) increase local access to data on traffic-related injuries; (4) increase access to child passenger safety seat misuse data; and (5) analyze the prevalence and impact of Adverse Childhood Experiences (ACEs).

**Primary Strategic Partnerships**

**Internal**

- Chronic Disease Control Branch
- Office of Health Equity
- Maternal, Child, Adolescent Health Program
- Home Visitation Program
- Health in All Policies Program

**External**

- Local public health departments
- Local public safety advocates, e.g., educators, fire and police departments
- California Wellness Foundation
- Injury Prevention Research Center, University of California, San Francisco
- Local Sheriff/Coroners/Medical Examiners

**Evaluation Methodology:** Although multiple factors influence statewide injury rates, injury numbers and rates will be tracked using data from EpiCenter (CDPH website for injury surveillance) to determine if changes have occurred. *Process evaluation* will measure the extent to which objectives are met. *Impact evaluation* will assess immediate and intermediate outcomes, including knowledge and skills, website hits, and reports of data use.

**State Program Setting:**

Community based organization, Local health department, State health department

**FTEs (Full Time Equivalents):**

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

**Position Name:** Pamela Shipley

**Position Title:** Staff Services Manager I

State-Level: 5% Local: 0% Other: 0% Total: 5%

**Position Name:** Steve Wirtz, PhD

**Position Title:** Research Scientist Supervisor I

State-Level: 3% Local: 0% Other: 0% Total: 3%

**Position Name:** Cathy Saiki

**Position Title:** Research Scientist II

State-Level: 3% Local: 0% Other: 0% Total: 3%

**Position Name:** Kate Bernacki

**Position Title:** Health Education Consultant III, Specialist

State-Level: 3% Local: 0% Other: 0% Total: 3%

**Position Name:** Claudia Angel  
**Position Title:** Staff Services Analyst  
State-Level: 3% Local: 0% Other: 0% Total: 3%  
**Position Name:** Ravi Dasu  
**Position Title:** Research Scientist III  
State-Level: 3% Local: 0% Other: 0% Total: 3%  
**Position Name:** Jaynia Anderson  
**Position Title:** Research Scientist II  
State-Level: 3% Local: 0% Other: 0% Total: 3%  
**Position Name:** Mary Lackey  
**Position Title:** Health Program Specialist I  
State-Level: 3% Local: 0% Other: 0% Total: 3%  
**Position Name:** Nana Tufuoh  
**Position Title:** Research Scientist II  
State-Level: 3% Local: 0% Other: 0% Total: 3%

**Total Number of Positions Funded:** 9  
**Total FTEs Funded:** 0.29

### **National Health Objective: HO IVP-11 Unintentional Injury Deaths**

#### **State Health Objective(s):**

Between 10/2015 and 09/2016, *maintain the rate of unintentional injury deaths in California* at its 2013 level of **28.7** per 100,000.

#### **Baseline:**

*Rate of unintentional injury deaths in 2013 = 28.7 per 100,000*

#### **Data Source:**

[EpiCenter: California Injury Data Online, http://epicenter.cdph.ca.gov](http://epicenter.cdph.ca.gov)

### **State Health Problem:**

#### **Health Burden:**

Unintentional injuries are: (1) the leading cause of death for those between 0 and 19 years; (2) the fifth-leading cause of death for those less than a year old; (3) the fifth-leading cause of death among persons of all ages, regardless of sex, race/ethnicity, or socioeconomic status; (4) the cause of more than 10,900 deaths, over 206,000 nonfatal hospitalizations, and more than 2.2 million emergency department visits annually.

The impact of injuries on public health is so great that health care reform will need to address injury prevention to help control waste of medical resources.

Injuries and their consequences account for more than 10% of annual medical spending. The medical and work-lost costs of California injuries in 2011 were estimated at \$48.6 billion. These costs affect the state's medical resources, and cost to government, insurers, businesses, and individuals.

The **target** and **disparate populations** are the same: the total population of California.

#### **Target Population:**

Number: 38,548,204

Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50

- 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No

**Disparate Population:**

Number: 38,548,204  
Ethnicity: Hispanic, Non-Hispanic  
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other  
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older  
Gender: Female and Male  
Geography: Rural and Urban  
Primarily Low Income: No  
Location: Entire state  
Target and Disparate Data Sources: EpiCenter: California Injury Data Online, <http://epicenter.cdph.ca.gov>, accessed April 15, 2016

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

Other: Guide to Community Preventive Services, CDC; Consensus Recommendations For Injury Surveillance in State Health Departments, Report from the Injury Surveillance Workgroup (ISW5) State and Territorial Injury Prevention Directors Association;

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

Total Current Year Funds Allocated to Health Objective: \$309,919  
Total Prior Year Funds Allocated to Health Objective: \$244,919  
Funds Allocated to Disparate Populations: \$0  
Funds to Local Entities: \$0  
Role of Block Grant Dollars: Supplemental Funding  
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO: 10-49% - Partial source of funding

**OBJECTIVES – ANNUAL ACTIVITIES**

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

**Objective 1:**

**Analyze the prevalence and impact of Adverse Childhood Experiences (ACEs).**

Between 10/2015 and 09/2016, SACB staff will analyze one ACEs module of questions to assess the prevalence and impact of ACEs on population health.

**Annual Activities:**

**1. Fund the ACEs module of questions.**

Between 10/2015 and 09/2016, SACB staff will fund one ACEs module of questions in the Behavioral Risk Factor Surveillance System (BRFSS) to document the impact of ACEs on population health.

**2. Analyze and report on ACEs data from BRFSS.**

Between 10/2015 and 09/2016, SACB staff will analyze and prepare one report on ACEs from BRFSS data to document the impact of ACEs on population health.

**Objective 2:**

### **Improve access to data on traffic-related injuries.**

Between 10/2015 and 09/2016, SACB staff will conduct **two** web-based trainings to at least 20 local health department (LHD) staff and stakeholders on locally identified data from the Crash Medical Outcomes Data Project.

#### **Annual Activities:**

##### **1. Assess training needs.**

Between 10/2015 and 09/2016, SACB staff will assess the needs of California's LHD staff and other partners to identify **at least two** data issues for web-based trainings.

##### **2. Conduct training webinars and provide technical assistance.**

Between 10/2015 and 09/2016, SACB staff will conduct **at least two** webinars and provide follow-up technical assistance consultations to participants to increase their ability to use traffic-injury surveillance data from the Crash Medical Outcomes Data Project.

#### **Objective 3:**

##### **Increase access to occupant-protection data.**

Between 10/2015 and 09/2016, SACB staff will develop **one** uniform process to collect standardized child passenger safety-seat misuse data to inform program, policy, and evaluation.

#### **Annual Activities:**

##### **1. Develop data collection system.**

Between 10/2015 and 09/2016, SACB staff will develop **one** data-collection instrument and system to obtain local child passenger safety-seat misuse data from local stakeholder organizations to increase access to occupant-protection data.

##### **2. Conduct pilot test of data-collection system.**

Between 10/2015 and 09/2016, SACB staff will conduct **one** pilot test of the data-collection instrument and system with **at least three** local stakeholder organizations to increase access to occupant-protection data.

##### **3. Disseminate findings at additional venues.**

Between 10/2015 and 09/2016, SACB staff will identify and utilize **at least two** additional venues to disseminate findings to state and national injury-prevention/public health community stakeholders to inform them about key findings on critical or emerging injury issues, such as participation on national expert panels, preparation of comprehensive reports and manuscripts for peer-reviewed journals, and presentations at state and national public health conferences.

#### **Objective 4:**

##### **Increase capacity for conducting injury surveillance.**

Between 10/2015 and 09/2016, SACB staff will publish **three** sets of data on the EpiCenter web-based query system, to provide information on California injury deaths (approx. 16,200 annually); non-fatal hospitalizations (approx. 256,000 annually); and, nonfatal emergency departments treatments/transfers (approx. 2,220,000 annually).

#### **Annual Activities:**

##### **1. Develop data for the EpiCenter website.**

Between 10/2015 and 09/2016, SACB staff will develop **at least two** data elements on injury deaths, non-fatal hospitalizations, and non-fatal emergency department treatments/transfers to post on the EpiCenter website to increase the availability of data for injury surveillance.

##### **2. Publish data on the EpiCenter website.**

Between 10/2015 and 09/2016, SACB staff will provide **at least two** of the most current fatal, emergency department, and nonfatal hospitalized injury-data elements on the EpiCenter's predefined and custom query systems to increase the availability of data for injury surveillance.

**3. Provide technical assistance to EpiCenter website users.**

Between 10/2015 and 09/2016, SACB staff will provide technical assistance to **at least 25** state and local policy makers, academicians, program advocates, health departments, and others to increase their ability to use data from the EpiCenter website for injury surveillance.