Summary of Court Reporter Minutes – D3
Preventive Health and Health Services Block Grant (PHHSBG)
Advisory Committee Teleconference
Monday, September 12, 2016, 1:00–5:00 p.m.
Kings River Conference Room, Sacramento, CA 95814

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

AC members not present:
Dwight McCurdy

California Department of Public Health (CDPH) Attendees Present
Anita Butler, Block Grant Coordinator
Claudia Crist, Chief Deputy of Policy Programs
Susan Fanelli, Assistant Director
Monica Morales, Fusion Center Deputy
Brandon Nuñes, Chief Deputy Director of Operations
Karen L. Smith, Director
Mark Starr, CDPH
Monica Morales, CDPH Fusion Center
Greg Oliva, CDPH
Gordon Sloss, CDPH
Kimberly Knifong, OHE
Jessie Gouck, NEOPB
Dana E. Moore, CDPH FC
Sheila Chinn, NEOPB
Kama Brockman, CDCB OA
Mary Rodgers, CDCB
Nancy Bagnato, SACB
Stacy Alamo Mixson, SACB
Shirley Shelton, CDCB
Jami Chan, PDS
Esther Jones, CDCB
Leslie Stribling, OQPA
Bessie Leyble, OQPA
Rosanna Jackson, OHP
Deborah Holmes, EPO
Carolyn Kurtz, NEOPB
Hector Garcia, CDCB

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Additional Attendees
Diane Cassidy, UC Davis
Dan Smiley, EMSA
Christina Hildebrand, A Voice for Choice

The meeting opened at 1:00 p.m.

Welcome and Introductions
Block Grant Coordinator Anita Butler welcomed participants to the PHHS Block Grant Advisory Committee (AC) meeting and introduced Committee Co-chair Dr. Wes Alles.

Advisory Committee Updates
After Dr. Alles reported that Manal Aboelata had resigned from the PHHSBG Advisory Committee and that Rebekah Kharrazi, a colleague of Aboelata's at the Prevention Institute, was appointed to take Aboelata's place, and that Diane Cassidy sat in for Dr. Stephen McCurdy who was unable to attend, he called the AC roll.

Purpose of Meeting
Co-Chair Dr. Alles: The primary purpose of this AC meeting is to hear presentations by CDPH Director Karen Smith, Assistant Director Susan Fanelli, Chief Deputy Director of Operations, Brandon Nuñes, and Chief Deputy of Policy and Programs, Claudia Crist; ask questions; and provide informed input, to listen, question, and advise.

Dr. Alles commented on the transparency of Committee proceedings. Minutes derived from court reporter notes will be made public, the meetings are open to the public, and information is available on the CDPH website.

CDPH Vision: "Public Health 2035"
Co-Chair Dr. Peck recognized the work of the Director's Office and introduced Dr. Karen Smith.

Dr. Smith reflected on Department activities. She came to CDPH as a customer—as a deputy health officer in Santa Clara County, then as a Health Officer in Napa County—resulting in ideas of how CDPH could better work with Local Health Departments (LHDs). Although there is a lot more to CDPH than work with LHDs, she remains firm in her belief that CDPH's most important stakeholders are probably the LHDs, because they are the boots on the ground for public health and that CDPH will rapidly become anachronistic if it doesn't keep up with rapid changes taking place in public health.

Dr. Smith then touched on some of the drivers of change in the world of public health:

1. In addition to providing safety-net services and immunizations, as we've learned more about the ultimate determinants of health, we are expected to take into consideration—and where we can intervene in—things like poverty, homelessness, poor educational attainment—the social determinants of health that are arguably the strongest determinants of ultimate health outcome—especially true in the world of chronic diseases.

2. Our population is changing and growing: more people, a more diverse and an older population. In addition to creating a need for change, these changes reflect the fact that change isn't going to stop happening. Within CDPH, we need to become able to change, to evolve over time, so that's part of what we are doing.

3. Increase focus on the community as the level where intervention to improve health and upstream determinants can be most effective in engaging and empowering those communities (discussion to be continued later).

4. Health care reform hasn't just impacted the health care system—it has impacted public health substantially. Physicians, clinics, and hospitals are being directed to work more within their communities and take more responsibility for the health of the population. Things that were traditionally public health are now also of interest to the health care system. Taking advantage of that to redirect energy to upstream areas is an opportunity not to be missed.

5. More data sources are available. Does public health have the skill sets, people and tech, to take advantage of that? There is tremendous promise and significant challenges, and we're not making maximal use of the available data. At the local level, rolling out an education campaign to an entire diverse community is very different and probably less effective than targeting a communications campaign to a neighborhood or two in which you are already working. So there's opportunity to be had with our limited categorical funding to be more effective.

6. One of the biggest barriers to change is that our limited funding is categorical—very disease specific—which gets in the way of finding new ways to approach broader, less-specific things like social determinants. But that challenge also has its opportunities.

With Public Health (PH) 2035, we are talking about creating a strategic plan—put all these amazing CDPH people's minds to work on:

- "What is public health?"
- "What is the Department?"
- "What is the Department going to have to look like?"
- "What kind of people are we going to have working for us?"
- "What tools are we going to have available?"
- "What kind of work will we actually be doing that far into the future?"

Some key principles that came out of that conversation are the need to be more collaborative, transformative, and transparent in the way we work, the work we do, and the outcomes we have. One of our most important missions is to increase health equity, which by its very nature means working on those upstream determinants. The challenge is, How do we do that? Who do we partner with? What resources do we use? What interventions work? It's a brave new world, but the single most important thing that we have to do. The best way we can do that is to work on building healthy communities, and that's really at the heart of what public health has always tried to do. It's incumbent on us to start moving in that direction.

Our services, whatever they will be in 2035, will be data driven, will have to focus on outcomes, and we have to articulate the values of those services. We have to be collaborative.

By its very nature, public health—governmental public health in particular—cannot do the work alone. We need to bring that leading-edge, science-based practice to bear in the communities empowered to decide their priorities, and then move toward becoming healthier.

Ultimately, we want to decrease dependence on the health care system, which is expensive, not just in cost but in human suffering. The better we do our job, the less people need the health care system.

Our tools at the state level will continue to be public health policy; that's not going to change. Issuing guidelines, providing technical assistance, and helping communities find funding opportunities to pay for the cutting-edge work that we hope we'll be doing—those are some of our challenges.

One approach to becoming a change-oriented organization is to—not upend everything and do things differently from day one—but find current business practices amenable to change and changing them.

For example, the process by which a state department asks for money is called a "budget change proposal." We had a process that was program specific, where programs looked at their programs, said "we need X, Y, and Z," and those things were written up in a particular form and thrown on the table, then the executive team figured out what to do. Instead of that, what we are now doing is to collaborate and work differently—ask the department to look across programs and across centers, to really look for opportunities to take advantage of the collaborative nature of the work we do, and rather than trying to fix programs in small increments.

Another place we identified early on was looking at how we use what flexible funding we do have—the Block Grant is one of few such flexible funding sources. Knowing that we are getting our money's worth out of Block Grant work is really important. We wanted to use those kinds of approaches looking at collaborative work, focusing on foundational public health issues.

We need to retain those basic public health functions that no one else does: communicable disease control; chronic disease prevention and control; environmental health. There are foundational public health capabilities, so we build those back where we've lost ground, but also make sure the foundation is strong before we build new, exciting opportunities on top of that. So, being strategic about how we use funding is at the heart of all of it.

Finally, we are trying to align and share goals across our agency and with other partners. We are using the "Let's Get Healthy California" (LGHC) plan as a set of shared priorities to align around, which helps us identify common priorities. The 200-plus Department programs are figuring out how what they do fits, what they are speaking to, where they are moving the dialogue. That kind of alignment helps to articulate what public health does. Using a common language helps people understand what we do and why it's important.

This does not detract from our other plans, for example, "Portrait of Promise," California's strategic plan for achieving health and mental health equity, and the Wellness Plan. We still

have disease-specific strategic plans created with our partners, overarching chronic disease and health equity plans. But they all roll up under the umbrella of Let's Get Healthy.

To create a brave new world of public health, we'll talk systems of prevention—as opposed to just prevention—a set of overlapping and mutually reinforcing levelers of prevention that will ultimately drive down rates of chronic disease and deal with many other challenges.

Tobacco control is an example of how individual, community, and high-level policy interventions can reinforce each other. Working toward systems of prevention, that's a language we are taking on intentionally—within the department and in our external communications.

The California Accountable Communities for Health Initiative (ACH), a model of bringing communities together, is funded by six of our foundation partners. ACH is giving the community the information it needs to understand where health is coming from and the challenges for setting priorities, and sharing those priorities across sectors and creating plans to address them from this systematic point of view. We're looking forward to seeing how this promising new practice rolls out over the next three years. It's a model getting attention across the country, but the California goal is to see what the return is for a community as a whole from work across sectors, taking account of not just savings in the health care world, but savings in correctional facilities, better education, etc.—benefits gained from a collective focus on shared priorities and improved health.

We're looking forward to this conversation with the AC about the Block Grant. We've had a conversation for a year with the Department about taking a different approach to where the funding goes. That doesn't necessarily mean where the funding goes will change. We'll start at the beginning, look back at the intent of the funding, but also what's best for the Department and the people of California.

An important structural change we've made in the Department because of PH 2035 is creation of the Fusion Center, within Susan Fanelli's scope, so she'll talk specifically about that.

CDPH Fusion Center

Ms. Fanelli continued discussion of PH 2035. She sees the Fusion Center as kick-starting changes intended to bring people together across the 200-plus CDPH programs with distinct and categorical funding—to look at doing business differently: Where are opportunities to better collaborate? People come to public health with all kinds of backgrounds—how do we teach those models and approaches to public health? How do we look at things like systems of prevention, social determinants of health, and return on investment as more than just savings in the health care delivery system? How do we build that culture of health and move the whole Department in that direction? How do we understand the State's and our partners' roles in local public health or in communities? And so how do we align public health with health care and community-based organizations? How does cross-program work we do align with that effort?

How do we strengthen internal collaborations? Much Fusion Center work has to start internally, although examples of our internal and external work will be given.

Our biggest asset is our people. How do we: ensure the training, background, and skills needed for the public health department of the future? use resources and talent from one program across the Department? find funding mechanisms to do that or discover flexibility in current funding sources? Then, how do we include health equity in all of our programs?

Key functions: We tend to be conveners, bringing diverse sectors or diverse parts of CDPH together to focus on new issues or issues that need highlighting or external partner participation. How do we increase our natural collaboration across the Department? How do we make sure we know everybody who's touching a certain population—all the data we may have on that particular subject—start to bring that together across our programs?

How do we promote innovation, look for new, more collaborative approaches to work we're already doing?

How do we start to look at health economics? There's not a lot of work done in that area, but how do we evaluate programs in a different way, and what are those more difficult-to-quantify benefits of some of the things we are interested in doing?

Then how do we build that into our internal knowledge and have a process where knowledge transfer happens?

At the Fusion Center, we are implementing the first steps of the PH 2035 framework. We manage the LGHC goal teams that are led and made up of people across the Department. We try our best to represent the program and administrative sides.

The Innovation Challenge is a way to collect from the community and LHDs the things they are most proud of—that are moving the dial on the public's health. We got about 100 last year; the innovations that came in were very cross-sector based. They were doing amazing work at the local level, and this gave them an opportunity to share it. Innovation Challenge 2.0, to be released this week, will focus on social determinants of health, not just the LGHC goal areas. But how do you tie it to work being done to move the work upstream?

The letsgethealthy.ca.gov website is innovative in trying to have two-way communications, not only with LHDs, but broader than that. We need to reach out beyond public health into the health care community and essential services. How do we have a platform where that information comes together?

Emerging issues, such as opioid overdose prevention and violence prevention, are of key focus right now, bringing together subject-matter experts from across the department, and sometimes across government and the private sector.

Health care reform: Dana Moore has been building public health and health care integration, more collaboration with our sister department and the medical program, trying to understand their world. The only way we are going to make real teams is to understand the world in which our partners live when we come to the table with them to make change.

We mentioned ACH in terms of what the future may look like for that model, but what does that evaluation component look like, and how do we use that evaluation methodology to not only look at the six ACH pilot projects, but as a model for future projects?

The California Reducing Disparities Project has an equal evaluation component. How do we bring those together to really understand what to look at to evaluate our programs?

Looking at econometrics, we are building that better model. Six Fusion Center staff, some Block Grant–funded, work on a variety of projects. On the org chart you'll see dotted lines where we take a creative look at how to portion people's time, how we use Department resources.

We are just bringing on our Block-Grant funded econometric person; then we have our LGHC dashboard and website, then ACH staff.

Co-Chair Alles announced that there would be a question and answer session after the next two speakers.

FFY 2013–FFY 2016 PHHSBG Funding History

Brandon Nuñes provided a project history of the Block Grant: recent history, organizational changes within CDC, and funding history.

In FFY 2014 the Block Grant doubled in size; it had steadily declined since 2002, and 2013 was its lowest level, at about $75 million, which doubled in 2014 to about $140 million. This brings us back to about the 2002 funding level.

Until 2014, the Block Grant was a separate line item within the federal budget; it is now part of the Prevention and Public Health Fund, a portfolio of about 16 federal grants and programs totaling ~$950 million. Our $160 million from the Block Grant is one of those allocations.

The Block Grant moved within CDC from the Center for Chronic Disease to the Office for State, Tribal, Local, and Territorial Support (OSTLTS), an office that reports directly to CDC's director, so more visibility at the federal level.

California's allocation in FFY 2013, the lowest point in a decade, was $5 million. It doubled in 2014, and we've remained at around $10.5 million since then. And while the federal budget is not in place, we are anticipating $10.5 million in FFY 2017.

The Block Grant is provided annually, but because of the way the federal budget rolls out, we have two years to spend that funding. We only actually have one year to spend the funds; the budget typically is passed late, which delays our allocation being received. Once CDC receives its preliminary Block Grant award they determine what each state will get, which can further delay when we receive our award.

Typically the notice of grant award isn't awarded until nine months after the federal budget is passed, hence we really only have a year to spend the funds.

We anticipate getting the 2017 award sometime in spring 2017, and getting the actual grant award around August, when we submit our state plan. We will base our expectations on these historical time frames and adjust as necessary. The fact that 2017 is an election year could cause further delays to passage of the federal budget.

The Block Grant is one of the few flexible funding sources we have. CDPH has about 4 percent general funds; the rest comes from specific, restrictive federal or state funding sources. Even our general fund has restrictions.

Historically, the Block Grant has funded chronic disease prevention. That changed in 2014, the year the award doubled—the first year we funded program areas outside the Center for Chronic Disease.

CDPH received a $10.5 million award after the $800,000 rape prevention set aside and 9 percent for administration (we usually send around 9 percent of the 10 percent allocated).

The remaining funding is split roughly 70–30 between CDPH and the Emergency Medical Services Authority (EMSA). Based on that split, which we've maintained since around 1981, 19 CDPH programs receive Block Grant funding. About half of our $6 million, around $3.1 million, goes to the Center for Chronic Disease; the rest is split among four areas, including environmental health, infectious disease, and emergency preparedness. The remaining 30 percent funds nine EMSA programs.

PHHSBG Highlights and Connection to PH 2035

Ms. Crist: CDC funds many projects in the area of chronic disease, the leading cause of preventable deaths (7 of 10 deaths, according to CDC). Chronic disease accounts for 86 percent of our annual health care cost.

Health inequities in chronic disease are dependent on place as well as social determinants of health; successful public health interventions can reduce the burden of chronic disease on individuals.

Flexible Block Grant funds allow for addressing emerging health issues as well as gaps; decrease premature death and disabilities from preventable risk factors; focus on health equity; eliminate health disparities by addressing social determinants of health; support local programs; achieve healthy communities; and establish data and surveillance systems.

California has autonomy to decide its funding priorities, taking into consideration particular needs and addressing core public health issues. These priorities must align with one of the 1,200 or so "Healthy People 2020" objectives.

CDC OSTLTS staff conducted a site visit in May, looking at everything California does related to the Block Grant—how we handle money, accounting, controls, programs—and making sure the money is used according to Block Grant criteria. CDC's feedback was that California exceeds the goals and objectives for the Block Grant, that we deliver high-level work, including the state projects and evaluations; have robust stakeholder engagement; use the funds in flexible and

creative ways that allow pivoting when budgets and priorities change; and have solid internal fiscal controls.

They did recommend that we need to perform an annual audit. Implementation plans are already in place, so we should be fine there.

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

I want to highlight a few Block Grant–funded projects that underscore the breadth of how the funding is being used:

- Accountable Communities for Health: We've prepared a comparative analysis and crosswalk for the initiative, and a crosswalk and analysis of the federal ACH grant;
- Let's Get Healthy California and a lot of work through the Fusion Center;
- California Wellness Plan: several objectives outlined in the plan we've provided work for (e.g., publishing fact sheets, tools, and information; two trainings on economic evaluation; etc.
- Enhance laboratory capacity to identify valley fever through development of Block Grant–funded real-time PCR assay reference laboratory services;
- Providing public health accreditation to 55 local public health agencies, arranged an Accreditation Readiness Conference, and convened two trainings specific to tribal public health accreditation;
- Workforce development: Training residents through the Preventive Medicine Residency Program (PMRP) is key. Of 111 graduates, 66 percent are working in California public health agencies, institutes, community clinics, or universities. Three health officers are graduates of the PMRP program.
- The California Epidemiologic Investigation Service (Cal EIS) has trained 13 fellows. This program provides graduates with hands-on experience working with a preceptor at local or state health departments.

During their California site visit, CDC indicated that the Block Grant's value to the public is the opportunity to innovate, address emerging issues, plug gaps in some issues, build partnerships, integrate across systems, implement evidence-based practice, increase reach, build public health infrastructure, and be a "force multiplier."

PHHSBG AC Opportunity to Ask Questions

Co-Chair Alles thanked the four speakers and commented on the alignment within their four presentations, showing lots of planning to bring focus to PH 2035, recognizing such things as social determinants and the importance of collaboration and flexible funding. He then opened the meeting to AC questions.

Dr. Glassman: Dr. Smith, how will looking at crosscutting measures, focusing more on communities and determinants, be balanced with the need to continue foundational activities at the core of public health?

Dr. Smith: We have a broad strategy of looking at where capacity can be built to serve multiple purposes, such as epidemiology. CDPH has epidemiologists in almost every one of our Centers, where they focus on their particular programs or branches. We have begun to bring them together. They still have their primary affiliation but have the opportunity to talk to each other, which has already elicited novel approaches. Their skill sets are different. The next time we hire an epidemiologist, rather than having to create a new program or make decisions around community-based epidemiology, we can actively look for skill sets that enhance our capacity where we don't currently have it.

Another approach is how to grade funding. This is challenging because most of the department doesn't have systems to track project costing. For example, coding project activities in 15-minute increments allows for bringing together multiple funding streams to support an individual or a project and be 100 percent able to document accountability to each funding stream.

Right up front in our work now is improving business processes; unless we are a really high-performing business entity, we can't do any of our real work. Our back-office functions have to be impeccable.

We are spending a lot of resources addressing all audit findings so that when we do something new, organizations funding us will be able to trust the information they are getting back and that the funding is being used as intended.

During the recession, we lost a lot of capacity across California in communicable disease control, in particular diseases without specific funding sources. TB, immunization, preventable diseases, vaccines for preventable diseases, all have funding sources. With no funding sources for sexually transmitted diseases, capacity vanished. With about the delay you would predict, around five years, rates increased dramatically. We have to articulate what it takes, in the absence of something like Zika or Ebola, to keep communicable diseases from recurring.

We must, in any possible way, support basic communicable disease control. If you fund an epidemiologist, they can do STD control, TB control, but if you are smart, you hire one either ready to train or who already has skills, such as to map outbreaks relating to many other community health issues.

There's not likely to be a magical new source of funding for public health. We have to make the case that you can take a tiny sliver from something such as diabetes control and get a whole lot of prevention out of it. This is not new, but we are trying to do it in a way that says we are open to having a conversation about doing business in public health differently.

Ms. Kharrazi: Thank you for seeing the department move toward upstream social determinants of health initiatives. In envisioning 2035, this Block Grant may not be here. What does it look like to move all we are doing with the Block Grant, should it go away? Should it continue, what

efforts are being made to move infrastructure needs more and more away from the Block Grant? Third, taking the innovative Block-Grant efforts and make them into more infrastructure.

Dr. Smith: I don't think governmental public health will do most of this work. If we do our job right, the only way we can make sustainable changes is when we empower communities to really take it on, own it, and then provide technical assistance. I hope we won't be the only entities doing it. I see a smaller, more focused governmental public health role, where one thing we can do that almost no one else can is bring in money from the federal government. But state-level policy will also have two pieces, as advocates external to the government, but internal to the government as well. I'm a big believer in the power of policy to affect change, so that role will always be there.

We will be better able to do what we do when we have better data systems, so that's another area to improve. Spending less human hours generating analyses from multiple databases, which can take months, is another way of saving costs.

The way we currently do public health is not necessarily sustainable. If we don't get better at prevention, nothing in health or health care is sustainable. I am optimistic about the power of the models coming out now to do that. The Block Grant is an important source of funding because it allows for innovation. There are ways to gain from innovation in all Department areas.

Judy Monroe, director of OSTLTS, told me the Block Grant was moved explicitly to recognize that chronic disease has always been in the forefront with innovating because there was never any infrastructure. There didn't need to be one until we started living the way we do now. They recognized that all areas of public health need to innovate; the whole function of that program, as its name indicates, is to support state and local governments. That's CDC's recognition that they are less able to do innovation and cutting-edge work. The closer you get to the community, the more able you are to do that. A key principle is facilitating LHD work, getting out of their way, making funding as flexible as possible.

I see the Block Grant being used wherever it will get the biggest bang for the buck; I'm also cautiously optimistic about foundational public health capabilities and activities. Post-recession, people again realize the need for things like environmental health. People outside public health are drawing connections to issues of climate change and sustainability.

Twenty years is going to show a big change, unless there's a big economic meltdown, in which case we'll go back to the way we were. I hope to see the Block Grant doing what it's intended to do—stimulate innovation and different ways of doing things, not just filling holes.

Ms. Wooten: Dr. Smith, what are your thoughts on how PHHSBGs can support public health accreditation, particularly for very small and smaller jurisdictions?

Dr. Smith: Accreditation can be incredibly valuable to a health department, especially in business practice areas.

Ms. Wooten: 11 and 12, administrative and governmental.

Dr. Smith: They are critical to your ability to do anything else. We are governmental public health; we have responsibility to be good fiscal stewards. So I'm supportive of accreditation. I don't want to say it should happen in the Block Grant, because I'm committed to accreditation being a collaborative process.

We're looking forward to the recommendations of the AC, and that those, along with overarching guiding principles, will reflect the will of the people—people charged to think seriously about where the Block Grant can do California the most good, and us internally in the Department, program people closer to the strengths and challenges of the individual programs.

Dr. Alles: Is there a timeline for beginning to see results of the different orientation and processes that support it?

Dr. Smith: We've already started. We have changed the way we make funding decisions. We've increased resources in key administrative divisions, to become more administratively adept. The Fusion Center exists, and is actively working on significant work. Several multi-departmental and cross-sectoral initiatives are being undertaken. These changes may not be visible from outside, but we now have a process where we will evaluate an issue from the perspective of what we are already doing, look for gaps in what we are doing, decide whether to put more energy or resources toward this issue. If so, what does that look like? Which was not in place before; it worked extremely well in addressing questions and challenges in terms of violence prevention as a public health issue.

There are a lot of moving pieces in the Department. We have many registries: cancer registries, immunization registries, scattered about the Department, functioning in different ways. Only Vital Records resides in our Center for Statistics and Informatics. Claudia will be taking the lead on bringing the registries together this month.

On the radar is developing a coherent, explainable, supportable approach to chronic disease. Those from outside the world of chronic disease don't take anything for granted, so that conversation will start with the Center for Chronic Disease. When the right person if found to fill the Director position, someone looking to the future, we'll have a better sense of where we want the Center to go.

We are also looking at laboratories: I challenged the California Association of Public Health Laboratory Directors to describe what the public health laboratory system in California should look like in 20 years. They will answer back next month. We will do the same with all of our laboratories. It's a systematic, not necessarily longitudinal, approach.

Dr. Alles: To follow up, I'd like to raise the issue of metrics that demonstrate income as rates or percents of whole numbers. For so many years those metrics have been the determination of success. A change as you've described will, in the beginning, take a lot more conversation to get to the collaboration, a lot more adjusting of what a lab system should look like, and while transformation is happening, traditional metrics could suffer. You've already given an example, the issue of violence, and I think you referenced rape as another issue.

Public health people are really good people; my guess is they will sign on with this and think of it as an exciting journey, an improvement to what we've had since we began in public health. It will take time to get new metrics. How optimistic are you that you'll have time to get there?

Dr. Smith: Performance appearing to deteriorate as you make change is one reason we are making evolutionary, not revolutionary change, and the other reason we are focusing on business practices. Providing better service, in terms of ultimate effective policy and lots of communication, that's one area where we've increased resources to LHDs and communities that we work with in our stakeholder groups.

If we don't message things well, some advocacy groups will feel left out. I'm optimistic though. ACH is an interesting invention, not just because it will make real, sustainable change, but because you have to measure it differently. If governmental public health focuses on "did your disease rates go down?" that's a lose–lose situation, because nothing you do will ever make that rate of TB go down. You are always extrapolating to effect.

We in public health need to learn from the arena of social services, not government, but social science. We look at numbers, of disease, of individuals, case rates, morbidity rates, etc., things we have little ability to effect. We don't tend to quantify the real differences we can make when we collaborate well. We haven't taken advantage of ways to measure that.

I have colleagues who can measure the value of what we do, which is different than impact. Impact implies numbers, especially when talking to the general public or to legislatures. They want to know why they should be paying for your service, and they don't want to know why in terms of, for example, there will be 14 less cases of syphilis this year. They want to know what the value is to them. It's a different way of talking about what we do from the very strict science base, so we have a challenge with people pulling in a different direction.

I'm a scientist—we do numbers, life cycles, and hard science. On the other hand, issues like poverty, the more subtle mental health issues, addiction, you can't measure in the same way, and you can't measure a community's satisfaction with your services in the same way.

We won't stop giving funders the data they need or tracking disease rates, that sort of thing. Part of the challenge is to add information to the conversation, as opposed to data; that's actually persuasive to people who need to understand what we do and why they should care, and that's the general public as well as the people that have the power to fund what we do.

Ms. Crist: We need to connect with the world of health care, and health care needs to connect with public health. Having spent time on both sides, I can tell you that neither side understands the other. My personal mission is to help facilitate bringing those two worlds together.

The measurements on the health care side are very different than what we measure in public health and what we need to measure in the future. It's even more complex now that we have to figure out how to connect worlds that have really different ways of measuring success and different focus, for very good reasons.

Co-Chair Alles: Another paradigm shift mentioned is changing from a disease mindset to a health mindset, and measuring what would demonstrate that we were becoming a healthier nation. Through that you talked about structure and function—that by thinking about becoming healthier instead of becoming sicker, that will resonate with a lot of constituencies, and that will be exciting to communities as stakeholders and even for individuals and medical scientists to become engaged in the work of public health.

Dr. Glassman: You are talking about using metrics to look at bigger, social-determinant issues. From my experience, it is extraordinarily difficult to get data from the Department of Health Care Services (DHCS) that would help measure outcomes of public health programs, even though that data does reside in DHCS databases. The Oral Health Program at CDPH has done extraordinary work trying to set up a way to query DHCS database to give up some information. This is a ripe opportunity for departmental cooperation that would help enhance stability of public health programs to get at existing data and be able to demonstrate value and some of the interventions that are taking place.

Ms. Crist: Dr. Jay Kumar, our state dental officer, resides within CDHP, specifically within this Center for Chronic Disease Prevention and Health Promotion. Not only have we been able to negotiate, but he is, in part, funded by DHCS. Dr. Kumar has great connections with DHCS, specifically Renee Mollow, on the dental side at DHCS, but also with the team as a whole. We have an interagency agreement we can take advantage of to share data. Sometimes it is a lot harder than it needs to be, not just with DHCS, but in general, to get data out of our systems, and we feel we have a good partnership there now; I'm hoping for a better path forward.

Ms. Fanelli: Jim Green, the information person from our health and statistics group, is meeting with the data person from Medi-Cal and really looking at streamlining data requests, making them more understandable and easier.

Mr. Nuñes: Our agency recently finalized a data-sharing agreement among all departments to ease information sharing between departments. You don't have to start from the beginning with a data-sharing agreement. You can start three or four steps down the path, make the process faster and more efficient, standardize among all departments.

Ms. Fanelli: It comes down to how we use our vast resources and become more creative about how we use those resources. The way we will make changes is not by getting new dollars, but taking advantage of opportunities like the Block Grant to innovate, to look at doing business differently—and braided funding, that's the other opportunity.

We are working on finding a better, easier way to get dollars out the door with less restriction; understanding dollars have to be used according to what's allowable—easier ways like allocations or grants versus cooperative agreements versus contract vehicles.

The more we can free up time for program work, the better off we'll be. How do we get there with what we have? It's really being creative with the resources we have.

Mr. Smiley: One benefit from having nine EMSA programs funded by the Block Grant is our role as systems integrator. As Dr. Smith said, there's an element of the Block Grant that serves as a force multiplier. Much of what we do in EMS, like so much of public health, is coordinate multiple autonomous, functionally independent organizations. Where we come across best is when we empower local EMS agencies, private and public EMS providers, hospitals, to collaborate, to achieve some of those metrics.

As we move forward with metrics, a major EMS priority is to recognize that health information technology and health information exchange can serve as a sustainable direction to bring in multiple sources of information, in alignment with the presidential Precision Medicine Initiative. When health information technology is more mature, in 15 or 20 years, we can harvest that important information. Those are some things we are looking at from an EMS perspective in terms of integrating with other public health activities to reduce morbidity and mortality in the pre-health care setting.

Ms. Cassidy: I teach in the MPH program at UCD and can speak directly to the value that funding for the Cal-EIS program has made, not just to UCD graduates but graduates across the state, as well as the Preventive Medicine Residency Program. So I want to applaud the spirit of innovation Dr. Smith addressed. These young graduates really can make a tremendous contribution to the direction in which you are turning the department. Even as funds are limited, I encourage you to continue to invest in these programs.

Dr. Smith: In fact, we are centralizing our internship program—internship includes students, interns, residents, etc.—because we value it so much. When you don't have a lot of funding and you want energetic people, that's a great source.

Ms. Kharazzi: What will the health economics person be working on? How will it touch some of these concepts of highlighting values of moving upstream?

Ms. Fanelli: We brought on someone with an epidemiology and data background who will start with program evaluation. Starting with chronic disease programs: What are they looking at and are there some parameters that we could build upon that lead to that evaluation structure? To get to the next level, how do you get to that return on investment in a formula that has some science to it to say, How do we value relationship building? How do we value these softer kinds of things? We are starting with a scan of what we are already doing, looking at models that are out there. ASTHO has a model; a few models are trying to take return on investment into public health, not so much into health care delivery.

We are working with CDC and a couple of academic institutions. Health economists and health care economists are hard to come by. Students with master's degrees in economics are hired on the spot to go to work for health care. It's very hard in government to compete with that. We've brought in a few people to do some training, but we'll be looking at developing modules between our epidemiologist and our staff and looking at social services as well.

Ms. Fanelli introduced Monica Morales, Deputy for the Fusion Center, brought on board two months ago.

Dr. Smith excused herself to attend another meeting.

Future Use of PHHSBG Funding

Co-Chair Dr. Alles: An agenda item presents the AC's funding recommendations and the way funding is determined by the AC (Document 7).

Issues the AC considers: size of the problem; number of people involved; severity of condition; equity and health status; community concern; programs that engage community at the local level; cost of the condition; cost effectiveness of interventions; concordance with Healthy People objectives; other resources that are available (e.g., Prop 99 for smoking); ability to leverage funds, to find other groups or organizations to collaborate with in terms of bringing more funds in; and metrics.

Those have served us well for 15 years or so. We've brought this up every several years and again this year. Many of these seem to be useful; several in a new paradigm would already be accounted for. Equity and community concern would be good examples. The AC ought to take a look at the ASTHO recommendations; there's probably more consistency with the funding priorities that Dr. Smith and the other speakers presented. And CDPH has even had to change their way of thinking about how to adjust priorities to accommodate a plan that was presented. For the AC to do a good job reconsidering criteria, an in-service presentation that would extend the concepts in more detail would be helpful. If that's not possible, we'll do the best we can. But the more we understand the directions of the plan, the better we'll be able to help identify principles for allocation.

Ms. Wooten: Dr. Smith highlighted operational excellence. That's obviously not one of our criteria, and I think the criteria you just read off still stand in helping us determine funding priorities. Do we have criteria focused on evidence-based? That might be a way to link some factors Dr. Smith spoke about.

Co-Chair Alles: We do not.

Ms. Wooten: That might be a criterion to add in.

Co-Chair Alles: We do have something close to that: proven interventions. Shifting to a paradigm of measuring and improving health would rely more on evidence-based as opposed to proven intervention.

Ms. Wooten: Exactly

Co-Chair Dr. Peck: It says "innovation in areas for which there are few proven interventions," so I think the whole concept of evidence-based is missing.

Ms. Wooten: Yes, it is.

Co-Chair Alles: The concept of innovations could by itself stand in, in addition to evidence-based.

Ms. Wooten: I agree.

Ms. Kharazzi: At the Prevention Institute, we prefer it described as "evidence informed," recognizing that certain populations tend to be the ones that the evidence builds for; when you take something out of the neat box of a study, there are implications. So evidence informed gives more flexibility on being able to pull from community experience. That could be another way we might want to approach that.

I want to highlight criteria that relate to balancing infrastructure needs versus the opportunity for new, innovative pilots, for instance.

The ability to cross over multiple sectors and disciplines has been emphasized today as one of very few flexible-funding options, so there's not a lot of opportunity for this type of work otherwise. Clearly innovation falls under that, and from the perspective of the Prevention Institute, equity is always a top priority, so it's great to see that here, and the needs of the community. The thing I don't see explicitly is spending funds on the highest community needs.

Dr. Wong: Is there a way that the criteria are weighted to prioritize funding?

Co-Chair Dr. Alles: No, we haven't done it that way. We've asked AC members to keep these priorities at the forefront of their thinking; they needed to weigh and balance a variety of factors. Somebody would look at one thing with more weight than somebody else would. It's worked pretty well in recommending which programs were at the top of the priority list and whether those programs should receive more, less, or the same amount of funding. If the AC were all in a room together and looking at the list, we'd all create a different numeric value for each one.

Maybe we should have a conference call just of the AC to put everything on the table—it would all be scrambled at that point—and try to reassemble it. Your question gets to the issue of changes relative to what would be high-ranking versus low-ranking priorities.

Dr. Wong: I agree, the process has worked pretty well. There are pros and cons of having an objective scoring system; many grants these days, like NIH grants, get evaluated on a fairly objective rating system. I don't know if we should go in that direction, I just raise the question; it could influence how objectively these proposals get reviewed.

Co-Chair Dr. Alles: It would get more difficult when talking about collaboration as opposed to silos. Typically we looked project by project, and a number of times it came up today that there would be cross funding or that programs would be braided together, funding sources even would be braided together, and it feels like the paradigm is a big enough shift that we need to examine it almost from scratch. We have good criteria, so we don't have to go back further than that, but how do we put these together to demonstrate that our recommendation is supportive of PH 2035 and all the specific points that differentiate what was and what will be?

Co-Chair Dr. Peck: We haven't had an in-person AC meeting for a while; if we were able to pay for travel, do you think the AC would want to come together to discuss and really come up with a new numerical objective rating or whatever they want to do to help the department? This is a time of change with the Block Grant, and it may be worthwhile to collectively invest time and funds to allow the AC to do that.

Co-Chair Dr. Alles: Let's put that together then and figure out a good time to make it happen.

Public Comment
Co-Chair Alles asked for comments or questions from the public.

Christina Hildebrand from A Voice for Choice asked when the decision of where Block Grant funding would go would be made.

Co-Chair Dr. Peck: The purpose of this meeting was for the AC to hear the Director's vision on how to use the Block Grant. But we are open to recommendations from the general public. We will communicate recommendations to the director. After the AC, the public, and Department staff have given input, the Director will determine how best to use the money. At the next AC meeting, draft funding allocations and Department recommendations will be presented; the AC and the public will have an opportunity to weigh in again at that point.

Ms. Hildebrand: The Block Grant funding for this year that was determined two years ago was very specific—specific organizations or projects and how much money went to them. I heard more general suggestions today but no specifics. Is there a formal proposal or request for suggesting where money could go?

Co-Chair Dr. Peck: There is not a formal RFT process for use of this money. Traditionally it's been used internally through programs within the health department; it may then go out to communities for use. The Director will determine what process will be used this year, but it will be an internal determination. If you feel an area should be funded, you could talk about it now.

Ms. Hildebrand: An area where I would ask for funding, something that came up, is chronic disease, not only treatment, but looking for the reasons for the increase in chronic disease. We've seen huge increases, especially among children—one in 54 children has a chronic disease or disability. We obviously need to treat children and adults with chronic disease, but also look at what is causing it, because we've never seen numbers like we've seen now.

AC Review & Discussion of June 22, 2016, AC Meeting Minutes
Co-Chair Alles: Highlights from the June 22 minutes: We recognized the 70–30 split between CDPH and EMSA; approved the February 8 minutes; discussed FFY 2016 and 2017 funding; talked about the CDC visit, and you heard the positive comments from the executive staff; talked about whether objectives were met and asked that a form be developed. It's a very detailed form that did the work the AC was hoping it would do, and we'd like to see that kind of accountability in the future.

Summary of Court Reporter Minutes – D3
Preventive Health and Health Services Block Grant (PHHSBG)
Advisory Committee Teleconference
Monday, September 12, 2016, 1:00–5:00 p.m.
Kings River Conference Room, Sacramento, CA 95814

Approval of June 22, 2016, Minutes
A motion to approve the June 22 minutes was made by Mr. Speiss and seconded by Dr. Glassman. The motion was approved, with the exception of abstentions by Ms. Kharrazi, who was not on the AC at that time, and Dr. Stratton, who was not present at the meeting.

Further Discussion
Mr. Speiss: Will we be contacted regarding our evaluation criteria?

Co-Chair Dr. Alles: Yes, we just did that last year, but given the paradigm shift, it's probably warranted for us to see how we can synchronize our criteria with the Department's direction. Dr. Peck, are other states moving in the same way?

Co-Chair Dr. Peck: It's interesting how different the states are in what they choose to use this money for. That's one reason for bipartisan, bicameral support in Congress. California is often the leader, so if we move toward a different paradigm, other states may follow. I may put it up as a model approach.

Co-Chair Dr. Alles: How come we didn't see this coming, predict the flow of the current? It makes perfect sense, given the direction of the change, and it makes sense that a lot of changes will need to be made, and one of them would be the funding priorities we choose to recommend. Did anyone else get a sense like that?

Dr. Glassman: Something more along the lines of looking for opportunities to collaborate, looking across programs, not necessarily immediate revision of funding priorities.

Co-Chair Dr. Alles: Thank you that's kind of what I meant to say, that a new paradigm has been presented, and we can't use old measurements to be effective in our work.

Dr. Glassman: On the other hand, that didn't mean slowing the current processes and plans and starting from a blank slate, more of an evolutionary way of thinking.

Adjournment
Dr. Peck's motion to adjourn was seconded by Dr. Glassman and passed unanimously. The meeting adjourned at 3:28 p.m.