California FY 2017

Preventive Health and Health Services Block Grant

Work Plan

Original Work Plan for Fiscal Year 2017 – D5

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Executive Summary

This is California's Preventive Health and Health Services Block Grant (PHHSBG) Work Plan for Federal Fiscal Year (FFY) 2017. California plans to expend these funds in State Fiscal Year (SFY) 17/18 (July 1, 2017–June 30, 2018).

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 and selected their top five Funding Criteria, which CDPH considered when allocating funding to programs.

PHHSBG funds will be used to address "Healthy People 2020" objectives and emerging health issues; provide leadership in developing and implementing Emergency Medical Systems throughout California; and optimize the health and well-being of the people in California.

California continues to adhere to federal requirements that the PHHSBG Advisory Committee (AC) review and approve all state Work Plans. The AC voted to approve the 2017 plan on May 10, 2017, during the 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 April 26, 2017, Public Hearing and/or submit written comments.

Funding Assumptions: The FFY 2017 State Plan is based on CDC's total award of $10,600,069. The Rape Set-Aside Program (RPSA) receives $832,969 of the total award, which leaves a balance of $9,767,100 (Base Award). PHHSBG Administrative Costs will not exceed 10% (or $976,710) of the remaining balance, in accordance with federal and state statute, regulations, and policies; $9,767,100 will be distributed between CDPH and the Emergency Medical Services Authority (EMSA), with CDPH receiving 70% and EMSA receiving 30% of the base award. The 70/30 funding split is based on the historical categorical distribution.

Of note: PHHSBG management and oversight are a direct expense, per CDC guidance and CDPH's policy. As such, costs associated with grant management and oversight are not included in the Administrative Cost calculation.

CDPH's administrative costs relate to the general management of the grantee, such as accounting, budgeting, personnel, procurement, and legal services.

Statutory and Budget Information

Budget Detail for CA 2017 V0 R2	
Total Award (1+6)	$10,600,069
A. Current Year Annual Basic	
1. Annual Basic Amount	$9,767,100
2. Annual Basic Admin Cost	($976,710)
3. Direct Assistance	$0
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$8,790,390
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$832,969
7. Sex Offense Admin Cost	$0
(8.) Sub-Total Sex Offense Set Aside	$832,969
(9.) Total Current Year Available Amount (5+8)	$9,623,359
C. Prior Year Dollars	
10. Annual Basic	$8,552,610
11. Sex Offense Set Aside (HO 15-35)	$832,969
(12.) Total Prior Year	$9,385,579
13. Total Available for Allocation (5+8+12)	$19,008,938

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$8,790,390
Sex Offense Set Aside	$832,969
Available Current Year PHHSBG Dollars	$9,623,359
B. PHHSBG $'s Prior Year:	
Annual Basic	$8,552,610
Sex Offense Set Aside	$832,969
Available Prior Year PHHSBG Dollars	$9,385,579
C. Total Funds Available for Allocation	$19,008,938

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
California Behavioral Risk Factor Surveillance System Program	PHI-7 National Data for Healthy People 2020 Objectives	$400,000	$0	$400,000
Sub-Total		**$400,000**	**$0**	**$400,000**
California Wellness Plan Implementation	PHI-15 Health Improvement Plans	$440,000	$330,000	$770,000
Sub-Total		**$440,000**	**$330,000**	**$770,000**
Cardiovascular Disease Prevention Program	HDS-2 Coronary Heart Disease Deaths	$424,654	$524,819	$949,473
Sub-Total		**$424,654**	**$524,819**	**$949,473**
Commodity-Specific Surveillance: Food and Drug Program	FS-2 Outbreak-Associated Infections Associated with Food Commodity Groups	$200,000	$200,000	$400,000
Sub-Total		**$200,000**	**$200,000**	**$400,000**
Ecosystem of Data Sharing/CDPH Interoperability Initiative	HC/HIT-11 Users of Health Information Technology	$214,291	$0	$214,291
Sub-Total		**$214,291**	**$0**	**$214,291**
Emergency Medical Dispatch Program/EMS Communications	AHS-8 Rapid Prehospital Emergency Care (EMS)	$102,452	$90,711	$181,422
Sub-Total		**$102,452**	**$90,711**	**$181,422**
EMS for Children	AHS-8 Rapid Prehospital Emergency Care (EMS)	$135,541	$123,800	$247,600
Sub-Total		**$135,541**	**$123,800**	**$247,600**
EMS Health Information Exchange	AHS-8 Rapid Prehospital Emergency Care (EMS)	$401,321	$389,580	$779,160
Sub-Total		**$401,321**	**$389,580**	**$779,160**
EMS Partnership for Injury Prevention and Public Education	AHS-8 Rapid Prehospital Emergency Care (EMS)	$90,256	$78,515	$157,030
Sub-Total		**$90,256**	**$78,515**	**$157,030**
EMS Poison Control System	IVP-9 Poisoning Deaths	$120,432	$108,691	$217,382
Sub-Total		**$120,432**	**$108,691**	**$217,382**
EMS Prehospital Data and Information Services and Quality Improvement Program	AHS-8 Rapid Prehospital Emergency Care (EMS)	$662,996	$651,256	$1,302,512
Sub-Total		**$662,996**	**$651,256**	**$1,302,512**
EMS STEMI and Stroke Systems	AHS-8 Rapid Prehospital Emergency Care (EMS)	$340,918	$269,178	$598,356
Sub-Total		**$340,918**	**$269,178**	**$598,356**
EMS Systems Planning and Development	AHS-8 Rapid Prehospital Emergency Care (EMS)	$662,938	$651,198	$1,302,396
Sub-Total		**$662,938**	**$651,198**	**$1,302,396**
EMS Trauma Care Systems	AHS-8 Rapid Prehospital Emergency Care (EMS)	$210,276	$258,536	$457,072
Sub-Total		**$210,276**	**$258,536**	**$457,072**

Program Title	Health Objective	Current Year PHHSBG $s	Prior Year PHHSBG $s	TOTAL Year PHHSBG $s
Health in All Policies	PA-15 Built Environment Policies	$592,748	$592,748	$1,185,496
Sub-Total		**$592,748**	**$592,748**	**$1,185,496**
Healthy People 2020 Program	PHI-16 Public Health Agency Quality Improvement Program	$667,000	$870,000	$1,537,000
Sub-Total		**$667,000**	**$870,000**	**$1,537,000**
Intentional and Unintentional Injury Prevention	IVP-1 Total Injury	$884,629	$0	$884,629
Sub-Total		**$884,629**	**$0**	**$884,629**
Obesity Prevention for Californians	NWS-10 Obesity in Children and Adolescents	$300,000	$300,000	$600,000
Sub-Total		**$300,000**	**$300,000**	**$600,000**
Partnering to Reduce Preventable Nonfatal Work-Related Injuries	OSH-2 Nonfatal Work-Related Injuries	$170,000	$0	$170,000
Sub-Total		**$170,000**	**$0**	**$170,000**
Preventive Medicine Residency Program	PHI-1 Competencies for Public Health Professionals	$565,278	$565,278	$1,130,556
Sub-Total		**$565,278**	**$565,278**	**$1,130,556**
Public Health 2035 Capacity-Building Activities	PHI-15 Health Improvement Plans	$776,370	$870,000	$1,646,370
Sub-Total		**$776,370**	**$870,000**	**$1,646,370**
Public Health Accreditation	PHI-17 Accredited Public Health Agencies	$30,000	$0	$30,000
Sub-Total		**$30,000**	**$0**	**$30,000**
Rape Prevention Program	IVP-40 Sexual Violence (Rape Prevention)	$832,969	$0	$832,969
Sub-Total		**$832,969**	**$0**	**$832,969**
Receptor Binding Assay for Paralytic Shellfish Poisoning Control	EH-22 Monitoring Diseases Caused by Exposure to Environmental Hazards	$275,000	$275,000	$550,000
Sub-Total		**$275,000**	**$275,000**	**$550,000**
TB Free California	IID-29 TB	$600,000	$0	$600,000
Sub-Total		**$600,000**	**$0**	**$600,000**
Using HIV Surveillance Data to Prevent HIV Transmission	HIV-1 HIV Diagnoses	$500,000	$500,000	$1,000,000
Sub-Total		**$500,000**	**$500,000**	**$1,000,000**
Grand Total		**$10,600,069**	**$7,649,310**	**$18,249,379**

Programs and Health Objectives

California Behavioral Risk Factor Surveillance System Program

State Program Strategy:

Goal: ***Optimize the knowledge and use of health information of the adult population of California through the collection of high-quality data and its dissemination in a timely manner.*** Through use of a technologically advanced survey research call center that utilizes state-of-the-art equipment, high-efficiency software, and highly specialized interviewers and research staff, the California Behavioral Risk Factor Surveillance System (CA BRFSS) shall: (1) maintain and expand surveillance of behaviors of the general population that contribute to the occurrence or prevention of current and emerging diseases, injuries, and other public health issues; (2) collect, analyze, and share data in a timely manner with state programs and external partners to assess trends, direct program planning, evaluate programs, establish priorities, develop policy, and target relevant population groups; and (3) strengthen capacity to enhance the value of public health surveys

Health Priority: ***Improve the health of individuals, families, and communities in California.*** Personal health behaviors play a major role in premature morbidity and mortality. Since 1984, CA BRFSS has provided state-level data to the national BRFSS program, housed within the Centers for Disease Control and Prevention (CDC). CA BRFSS is an ongoing surveillance system that identifies and collects information on health topics, including obesity, immunization, AIDS, tobacco use, diabetes, physical activity, diet, handgun safety, cancer screening, and emerging health issues that significantly impact society.

BRFSS data is the main source of data for at least half of the Leading Health Indicators (LHIs) established as a result of the *Healthy People 2020* Objectives and for State Health Objectives.

Role of Block Grant Funds: Preventive Health and Health Services Block Grant (PHHSBG) funding would:

- Ensure stable funding for the CA BRFSS program;
- Allow for the hiring of interviewers for the Public Health Survey Research Program (PHSRP), California State University, Sacramento (CSUS).
- Allow for increased analytic capability, including small-area analyses, to meet future needs, and
- Allow for the per-question cost to remain stable.

Without this funding, California will no longer be able to conduct BRFSS.

Primary Strategic Partnerships:

Internal
- California Tobacco Control Program
- Safe and Active Communities Branch
- Department of Health Care Services
- Comprehensive Cancer Control Program
- Childhood Lead Poisoning Prevention Branch

External
- American Cancer Society
- California Conference of Local Health Officers
- Alzheimer's Association

Evaluation Methodology: To determine the effectiveness of the CA BRFSS Survey Program in monitoring the prevalence of health risk behaviors that are associated with chronic health problems, CA BRFSS Program staff will: (1) convene quarterly BRFSS user meetings; and (2) track the number of programs adding questions, completed surveys, data requests, publications, reports, and fact sheets.

State Program Setting:
- Local health department
- State health department

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Total Number of Positions Funded: 0
Total FTEs Funded: 0

National Health Objective:
HO PHI-7: Data and Information Systems

State Health Objective:
Between 10/2016 and 09/2017, CA BRFSS Program will increase the number of internal and external public health programs that support the BRFSS survey by means of adding program-specific questions from an average of 13 programs to **14**. Data from BRFSS supports core public health programs and services representing all foundational areas of CDPH. BRFSS data are used for directing program planning, evaluating programs, establishing program priorities, developing interventions and policies, assessing trends, and targeting relevant population groups utilizing guidance from CDPH's *Public Health 2035 Initiative.*

Baseline: *BRFSS is the main source of baseline data for at least half of the LHIs established as a result of Healthy People 2020 Objectives. The CA BRFSS Program collects data and provides analytic support to programs that will use BRFSS data as a source of baseline data for achieving a state health objective.*

Process measure: Increase support for CA BRFSS from internal and external public health programs.

A. *Meet and exceed CDC requirement of 2,500 completed surveys to **3,000** per version of the survey (2015).*
B. *Increase the number of sampling strata from two to **six** for the BRFSS survey to provide data more representative of the diverse racial and ethnic population in rural and urban communities of California (2016).*

Baseline Data Source: California Behavioral Risk Factor Surveillance System (BRFSS) SAS Dataset Documentation and Technical Report: 1984–2015. Public Health; Survey Research Program, California State University, Sacramento, 2015

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 adult population of approximately 29 million people (**target population**). For the survey, the **target and disparate populations** are the same.

Health Burden Data Source:

Xu F, Mawokomatnada T, Flegal D, et al. *Surveillance for Certain Health Behaviors Among States and Selected Local Areas—Behavioral Risk Factor Surveillance System, United States, 2011*. MMWR 2014; 63(9):1–150

Target Population:

Number: 29,932,446
Infrastructure Group

- Disease Surveillance—High Risk

Disparate Population:

Number: 29,932,446
Infrastructure Group

- Disease Surveillance—High Risk

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:	$400,000
Total Prior Year Funds Allocated to Health Objective:	$0
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:
Maintain statewide collection and analysis of BRFSS data.
Between 10/2016 and 09/2017, PHSRP staff will conduct **one** California Behavioral Risk Factor survey to obtain 3,000 completed surveys. The 2018 BRFSS survey data will be used by public health programs for program planning, evaluating programs, establishing program priorities, developing interventions and policies, assessing trends, and targeting population groups.

Effectiveness is measured by achieving the targeted number of completed surveys and use of the data by the 13 participating public health programs.

Annual Activities:

1. **Collect BRFSS data.**
   Between 10/2016 and 09/2017, Sandy Kwong, State Coordinator for the California Behavioral Risk Factor Survey, will work with **one** contractor to collect CA BRFSS data that meets or exceeds CDC guidelines. High-quality data for research will optimize the knowledge and use of health information of the adult population of California. The collection of high-quality data will be monitored by CA BRFSS Program staff reviewing CDC reports on data collected by PHSRP.

2. **Provide data sets to BRFSS users.**
   Between 10/2016 and 09/2017, CA BRFSS Program staff will: (1) provide **one** data sets to **13** BRFSS users for analysis, program planning, evaluation, and resource-allocation activities; and (2) monitor collection of high-quality data and its dissemination in a timely manner by PHSRP through **biweekly** meetings on progress for data collections, **quarterly** submissions to CDC, and preparation of **one** data set for California state programs.

3. **Analyze BRFSS data.**
   Between 10/2016 and 09/2017, CA BRFSS Program staff will develop a method to create **58** county-level estimates for California, using an SAS software program developed for small-area estimation. County-level estimates will allow for public health programs to use BRFSS data for program planning, evaluating programs, establishing program priorities, developing specific interventions and policies, assessing trends, and targeting relevant population groups at the county-specific level.

4. **Conduct quarterly BRFSS users' meetings.**
   Between 10/2016 and 09/2017, CA BRFSS Program staff will hold **quarterly** meetings to inform **13** program partners of changes to survey or methods, data

collection progress, and data management, and planning and development of a 2018 questionnaire. Meetings will be monitored with an agenda, attendance list, and meeting minutes.

California Wellness Plan Implementation

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, administered through the California Department of Public Health (CDPH) California Wellness Plan Implementation (CWPI) Program. 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***. 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 trainings, meetings/conferences, and development and dissemination of reports and publications to advance chronic-disease prevention.

The estimated hire date for the vacant Research Scientist III position is May 2017.

Primary Strategic Partnerships:

Internal

- Department of Health Care Services
- Covered California
- Office of Statewide Health Planning and Development
- Office of Aging
- 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 Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Vacant
Position Title: Research Scientist III
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 Objectives:
Between July 2016 and December 2020, CWPI staff will:
1. Increase the number of California local public health departments (LHDs) nationally accredited from seven to **eight**. Accredited public health departments demonstrate a commitment to continuous quality improvement (QI) and measurement of health objectives to be strategic and efficient in their implementation of preventive services.
2. Decrease the rate of preventable hospitalizations from 1,109 per 100,000 California adults in 2015 to **727 per 100,000**.

Baseline:
1. ***Seven*** *LHDs in California are nationally accredited by the Public Health Accreditation Board (2016).*
2. *In 2015, the rate of preventable hospitalizations was **1,109 per 100,000** California adults.*

Data Source: Office of Statewide Planning and Development (OSHPD) Patient Discharge Data, 2015

State Health Problem:
Health Burden: Chronic diseases and unintentional injury are the leading causes of death, disability, and diminished quality of life in California. Some populations are affected more than others, resulting in significant inequities in health outcomes and quality of life within California's population (**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 Californians).

Target Population:
Number: 39,250,017
Infrastructure Groups:
- State and Local Health Departments
- Boards, Coalitions, Task Forces, Community Planning, Policy Maker
- Disease Surveillance—High Risk
- Community-Based Organizations
- Health Care Systems
- Research and Educational Institutions

Disparate Population:
Number: 6,280,002
Infrastructure Groups:
- State and Local Health Departments
- Boards, Coalitions, Task Forces, Community Planning, Policy Makers
- Disease Surveillance—High Risk
- Community-Based Organization
- Health Care Systems
- Research and Educational Institutions

Health Burden Data Sources:
- U.S. Department of Commerce. Population: Estimates and Projections. Washington, DC: U.S. Census Bureau, 2016.
- Lui C, Wallace S. Chronic Conditions of Californians: California Health Interview Survey (CHIS). Oakland: California Health Care Foundation, 2010 (There is no more recent review of all chronic conditions.)

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 (CDC)

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

Total Current Year Funds Allocated to Health Objective:	$440,000
Total Prior Year Funds Allocated to Health Objective:	$330,000
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Improve chronic-disease surveillance beyond stroke and cancer registries.
Between 10/2016 and 09/2017, CWPI staff will conduct **four** meetings and attend partner meetings to: (1) promote CWPI in collaboration with partners committed to improving chronic disease surveillance; (2) discuss best practices; and (3) convene a work group for pilot projects.

Annual Activities:

1. **Update *The Burden of Chronic Disease and Injury–California* Report.**
   Between 10/2016 and 09/2017, CWPI staff will update **one** report. *The Burden of Chronic Disease and Injury–California*: (1) provides a holistic view of chronic disease and its effect on California's population; (2) will identify disparities, including the disparate low-income population; and (3) will be used by partners and stakeholders to focus chronic disease–prevention activities, with an emphasis on equity in health and well-being for all community members.

2. **Convene statewide work group to conduct pilot studies for diabetes surveillance.**
   Between 10/2016 and 09/2017, CWPI staff will collaborate with partners to obtain and analyze laboratory and electronic health-record data to develop and implement **one** pilot proof-of-concept project to assess the frequency, distribution, and quality of care of patients with diabetes and those at risk of diabetes (pre-diabetics) by evaluating Quest Diagnostics hemoglobin A1c laboratory results.

3. **Assist with coordination of the CDPH Epidemiology Steering Committee.**
   Between 10/2016 and 09/2017, CWPI staff will plan **quarterly** steering committee meetings and the **quarterly** Epidemiologists' Forum. The steering committee was established to build epidemiological capacity, enhance data sharing, and serve as epidemiological advisors for health policy within CDPH.

Impact Objective 2:

Maintain Chronic Disease Prevention Coalition.
Between 10/2016 and 09/2017, 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. **Convene CWP Goal 2: Optimal Health Systems Linked with Community Prevention Work Group.**
   Between 10/2016 and 09/2017, CWPI staff will engage **more than ten** internal and external partners and stakeholders to take steps 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.

2. **Promote best practices, training, and collaboration.**
   Between 10/2016 and 09/2017, 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.

3. **Participate in partner conferences and meetings.**
   Between 10/2016 and 09/2017, 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.

Impact Objective 3:

Monitor California Wellness Plan Implementation.

Between 10/2016 and 09/2017, 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 with a focus on health equity and well-being. This data will be utilized by local health departments (LHDs) and will inform local processes for data collection.

The development and maintenance of data for QI is a vital part of the accreditation process for LHDs.

Annual Activities:

1. **Update and maintain online CWP Data Reference Guide.**
   Between 10/2016 and 09/2017, 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. Data in this guide will continually inform partners and LHDs of rates of the burden of chronic diseases within their communities and within the State as a whole.

Cardiovascular Disease Prevention Program

State Program Strategy:

Goal: ***Reduce death and disability from cardiovascular disease (CVD), a leading cause of death in California.*** Cardiovascular Disease Prevention Program (CDPP) goals support *Healthy People 2020* Objectives:

1. Heart Disease and Stroke (HDS)-2: reduce coronary heart disease deaths, and
2. HDS-5.1: reduce the proportion of adults with hypertension.

In addition, CDPP health priorities align with state goals and indicators, including California's *Let's Get Healthy California* and the *Public Health 2035 Initiative*.

Health Priority:

1. ***Control and prevention of heart disease, with an emphasis on hypertension,*** employing primary and secondary prevention strategies to fulfill objectives;
2. ***Provide leadership via a statewide cardiovascular disease alliance: Healthy Hearts California (HHC).*** HHC coordinates statewide heart disease control and prevention efforts by:
   a. decreasing silos,
   b. increasing efficiency and effectiveness,
   c. decreasing health disparities, and
   d. addressing factors that contribute to heart disease.

   HHC members include state and local health departments; private and non-profit organizations; health, medical, and business communities; academic institutions; researchers; survivors; and caregivers.

Role of Block Grant Funds: CDPP funds will support salaries of two staff members.

Primary Strategic Partnerships:

Internal

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

External

- American Heart Association
- Right Care Initiative, University of Best Practices
- Million Hearts Initiative
- California Chronic Care Coalition
- CA4Health

Evaluation Methodology: CDPP staff implementing Annual Activities will evaluate progress/outcomes on a yearly basis, including: (1) post-evaluation of quarterly webinars; (2) annual evaluation tracking partnerships, coordination, and synergy among HHC membership.

State Program Setting:

- Community health center
- Local health department
- Medical or clinical site
- State health department
- Work site

FTEs (Full Time Equivalents):

Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Catrina Chambers-Taylor
Position Title: Research Scientist III
State-Level: 70%; Local: 0%; Other: 0%; Total: 70%

Position Name: Alexandria Simpson
Position Title: Health Program Specialist II
State-Level: 50%; Local: 0%; Other: 0%; Total: 50%

Total Number of Positions Funded: 2
Total FTEs Funded: 1.20

National Health Objective:

HO HDS-2: Coronary Heart Disease Deaths

State Health Objectives:

Between 10/2016 and 09/2017:
Heart Disease: Reduce coronary heart disease deaths from 92.6 per 100,000 population in 2014 to **90.0 per 100,000 population** in 2016–17. (HDS-2)

Heart Failure: Reduce hospitalizations of older adults with congestive heart failure as the principal diagnosis from 11.3 per 1,000 population in 2014 to **9.9 per 1,000 population** aged 65 and above. (HDS-24)

Blood Pressure:

1. Reduce the proportion of persons in the population with hypertension from 28.8% in 2014 to **26.2%** in 2016–17. (HDS-5)
2. Increase the crude rate of adults with hypertension who are taking the prescribed medications to lower their blood pressure from 68% in 2014 to **70.2%** in 2017–18. (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 **11.3 per 1,000 population** aged 65 and above.*

*Data from 2014 showed that: (1) **28.8%** 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 **68%.***

Data Sources:
1. California Department of Public Health, Death Statistical Master File, 2014;
2. Office of Statewide Health Planning and Development, Patient Discharge Data, 2014;
3. CHIS, 2014

State Health Problem:
Health Burden:
Mortality: In 2014, the age-adjusted rate of coronary heart disease deaths was 92.6 per 100,000 population. In that same year, the heart failure age-adjusted mortality rate was 11.3 per 100,000 population.

Morbidity: In 2014, the congestive heart failure hospitalization rate as a principal diagnosis was 10.5 per 1,000 population aged 65 and above.

Risk: 2013–2014 data showed that 27.2% of Californians had been told by a clinician that they had high blood pressure, including 36.5% of African Americans, 35.5% of American Indian/Alaska Natives, and 30.9% of Native Hawaiian/Pacific Islanders. In those same years, 69.2% of California adults with high blood pressure were taking medication to control their blood pressure.

The **target population** for program interventions includes approximately 29 million (2014) 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.

Health Burden Data Sources:
1. California Department of Public Health, Death Statistical Master File, 2014
2. Office of Statewide Health Planning and Development, Patient Discharge Data, 2014
3. CHIS, 2013–2014

Target Population:
Number: 29,932,446
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 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: 29,932,446
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 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: CA Department of Finance (2017)

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
(1) Guide to Community Preventive Services (Task Force on Community Preventive Services); (2) *Other:* 2015–2020 Dietary Guidelines for Americans

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

Total Current Year Funds Allocated to Health Objective:	$320,122
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 and 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 subject-matter expertise and guidance relating to CVD.
Between 10/2016 and 09/2017, CDPP staff will provide webinars to **at least 20** HHC members (e.g., state and local governments; private and nonprofit organizations; health, medical, and business communities; academic institutions; researchers; survivors; caregivers; and advocates). Webinars will provide information on emerging public health issues.

Annual Activities:

1. **Maintain statewide CVD alliance.**
   Between 10/2016 and 09/2017, FDB and CDPP staff will maintain **one** HHC alliance, created to coordinate statewide stroke and heart disease control and prevention efforts. HHC provides support, technical assistance, resources, best practices, and a statewide forum for discussion relating to undiagnosed

hypertension, hypertension, prediabetes, diabetes self-management, obesity, nutrition, and physical activity. Through this effort, staff will actively support the California Accountable Communities for Health Initiative (CACHI) by including them in the HHC Alliance.

2. **Host quarterly HHC Meetings.**
   Between 10/2016 and 09/2017, CDPP staff will host and facilitate **quarterly** meetings via HHC. Meetings/webinars will provide support and information on emerging public health issues, such as the implementation of health systems interventions to improve the delivery and use of clinical and other preventive services through implementation of quality-improvement processes through electronic health records, health information exchange, team-based care, and strategic use of health systems quality measure data, resulting in improved health outcomes.

3. **Conduct HHC annual evaluation and report.**
   Between 10/2016 and 09/2017, CDPP staff will conduct **one** evaluation per year to track statewide and local activities, partnerships, coordination, and synergy among HHC membership. Evaluation results will be published in an annual report.

4. **Collect and analyze data on sodium awareness.**
   Between 10/2016 and 09/2017, CDPP staff will purchase **one** question from California BRFSS to measure awareness of reducing sodium intake, to help prevent and control hypertension.

Commodity-Specific Surveillance: Food and 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 support salaries and operational costs of personnel conducting field work, such as sampling and removal of adulterated foods, and conducting 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 equivalent positions that are funded with PHHSBG funds:

Position Name: Chunye Lu
Position Title: Research Scientist II
State-Level: 60%; Local: 0%; Other: 0%; Total: 60%

Position Name: Christian Bond
Position Title: Environmental Scientist
State-Level: 19%; Local: 0%; Other: 0%; Total: 19%

Position Name: Evan Robinson
Position Title: Environmental Scientist
State-Level: 19%; Local: 0%; Other: 0%; Total: 19%

Position Name: Samantha Ahio
Position Title: Environmental Scientist
State-Level: 19%; Local: 0%; Other: 0%; Total: 19%

Position Name: Mary Diarbekirian
Position Title: Environmental Scientist
State-Level: 19%; Local: 0%; Other: 0%; Total: 19%

Total Number of Positions Funded: 5
Total FTEs Funded: 1.36

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

State Health Objective:
Between 10/2016 and 09/2017, Food and Drug Branch and Food (FDB) and Food and Drug Laboratory Branch (FDLB) staff will reduce by **1%** 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, once identified, from commerce.

Baseline: *Baseline data prior to 2015 does not exist. In the 2015–2016 state fiscal year (SFY), FDB collected **over 600** samples of high-risk food for microbial testing with PHHSBG funding. This sampling resulted in **two** retail samples of sliced mushrooms testing positive for "Listeria monocytogenes." These findings resulted in significant corrective activities at a mushroom harvesting and slicing operation in California.*

*The 2016–2017 surveillance sampling project (also funded by PHHSBG) resulted in the collection of approximately **340** samples, all with "negative" results for pathogens.*

Data Source: Prior to 2015, FDB collected samples of high-risk food commodities during for-cause investigations when some indication of possible adulteration was suspected. Commodity-specific surveillance sampling for high-risk foods was started during the 2015–2016 SFY.

State Health Problem:
Health Burden: Each year roughly one in six Americans (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.

Health Burden Data Source: CDC food-borne illness estimates, 2016; available online at: http://www.cdc.gov/foodborneburden/index.html

Target Population:
Number: 39,000,000
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: 39,000,000
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: CDC, Food-borne illness estimates, 2016: 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:	$200,000
Total Prior Year Funds Allocated to Health Objective:	$200,000
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Increase analysis of food commodities for microbial contamination.

Between 10/2016 and 09/2017, FDB and FDLB staff will collect **850** samples of high-risk food commodities known to be susceptible to microbial contamination. Staff will investigate the distribution of adulterated foods and take the necessary 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 10/2016 and 09/2017, FDB and FDLB staff will collect and analyze **approximately 850** samples of food commodities for microbial contamination. Microbial analysis will be conducted to isolate and serotype pathogens. Pulsed field Gel Electrophoresis (PFGE) and/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 10/2016 and 09/2017, FDB 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.

   Records of distribution and handling will be evaluated to determine product distribution, and processing and growing practices will be evaluated, as appropriate, to determine the source of the contaminant or the failure in the processing system that allowed the contaminant to proliferate.

Ecosystem of Data Sharing/CDPH Interoperability Initiative

State Program Strategy:
Goal: ***Use health communication strategies and health information technology to improve population health outcomes and health-care quality, and to achieve health equity*** is a *Healthy People 2020* goal in direct alignment with specific objectives of the California Department of Public Health (CDPH) Ecosystem Of Data Sharing (EODS) initiative.

These EODS objectives align with *HP 2020* National Health Objective HC/HIT-10: Increase the proportion of medical practices that use electronic health records.

Health Priority: ***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. Specific EODS initiative objectives align with objective #3 of CWP program goals: Accessible and Usable Health Information.

Role of Block Grant Funds: PHHSBG funds support staff salary, trainings, meetings/conferences, and development and dissemination of reports and publications to advance health care information exchange**.**

The anticipated start date of the vacant position is July 1, 2017.

Primary Strategic Partnerships:

Internal
- Information Technology Services Division
- Center for Infectious Disease
- Center for Environmental Health
- Center for Family Health
- Center for Chronic Disease Prevention and Health Promotion

External
- California Department of Health Care Services
- University of California, Davis, Health System
- California Office of Statewide Health Planning and Development

Evaluation Methodology: The objectives and progress of the program have been established and are being tracked and evaluated using SMART goal-management principles, based on the EODS Strategic Roadmap that is updated annually and approved by the EODS Governance Steering Committee. Two EODS objectives to be tracked against these goals are:
- Goal 5.1.1: Design and develop service-oriented architecture (SOA)-compliant messaging interface for EODS;
- Goal 5.1.2: Develop Data Virtualization strategy and technical approach.

EODS SMART Goals will be evaluated based on post-implementation utilization. Key Performance Indicators (KPIs) will be integrated into basic design for both goals, and methods to maintain statistical information on usage and performance will be defined.

State Program Setting:
- State health department

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Vacant
Position Title: Software Specialist III
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

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

National Health Objective:
HO HC/HIT-11: Increase the proportion of meaningful users of health information technology.

State Health Objective:
Between 10/2016 and 09/2017, Center for Health Statistics and Informatics staff will create **one** infrastructure for more easily accessible and usable health information exchange, in alignment with a principle goal of CWP. The EODS initiative is directed at significantly improving exchange of, and access to, health care data.

Baseline: *EODS is a new system complement, supporting new data-exchange capabilities and technologies; therefore, baseline data is not available.*

Baseline Data Source: No historical data available for this new system complement.

State Health Problem:
Health Burden: Lack of accurate and comprehensive health care information on individuals and communities represents significant gaps in health care service delivery capabilities. Although the overall target of EODS is to enhance health care information delivery for all Californians **(target population)**, by virtue of California Health and Human Services Agency support of state and federally sponsored Medi-Cal program activities, many CDPH programs serve, and emphasize service to, disparate and vulnerable population groups. Approximately 11 million California resident adults are enrolled in the Medi-Cal program (**disparate population**).

Health Burden Data Source: California Department of Health Care Services, Medi-Cal Managed Care Enrollment Report, December 2016.

Target Population:
Number: 39,250,017
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: 11,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 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: DHCS, Medi-Cal Enrollment Report, 2016

Evidence-Based Guidelines and Best Practices Followed in Developing Interventions:
Other: *Healthy People 2020* Program, Goal: Use health communication strategies and health information technology to improve population health outcomes and health care quality, and to achieve health equity (U.S. Department of Health and Human Services)

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

Total Current Year Funds Allocated to Health Objective:	$214,291
Total Prior Year Funds Allocated to Health Objective:	$0
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

Impact Objective 1:
Manage EODS system development and implementation activities.
Between 10/2016 and 09/2017, EODS staff will develop **one** SOA-compliant messaging interface for the EODS initiative. EODS staff will also manage the research and evaluation of data virtualization technologies for adoption by the EODS initiative and CDPH.

Annual Activities:
1. **Manage EODS system support and administrative functions.**
   Between 10/2016 and 09/2017, EODS staff will provide managerial oversight of **at least eight** EODS-related system-development activities, including vendor management, technical requirements definition, system-configuration definition, service-level establishment, coordination with the Information Technology

Services Division, and coordination with EODS program and project managers. This state oversight is required for the successful coordination and delivery of complex EODS service capabilities to the health-care community.

Emergency Medical Dispatch Program/EMS Communications

State Program Strategy:

Goal 1: ***Improve statewide training standards and provide uniformity through guidelines*** by California Emergency Medical Dispatch (EMD) program staff (1) assessing statewide EMS training standards that encourage use of medical pre-arrival instructions by dispatchers at Public Safety Answering Points (PSAPs); and (2) 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.

California is dedicated to employing strong interoperable communications governance, training, and outreach to provide first responders and the wider public-safety community the tools, training, and support needed to ensure the safety and security of the citizens of California.

Role of Block Grant Funds: Funded positions: (1) coordinate state and local agencies that implement statewide standardized program guidelines for EMD; (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 September 1, 2017.

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; and (2) Analyze development of resource manual.

State Program Setting:

- Community-based organization
- Local health department

FTEs (Full-Time Equivalents):

Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Tom McGinnis
Position Title: Health Program Manager II
State-Level: 9%; Local: 0%; Other: 0%; Total: 9%

Position Name: Angela Wise
Position Title: Staff Services Manager I
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Lori O'Brien
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: Tiffany Pierce
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%

Position Name: Nancy Marker
Position Title: Research Program Analyst I
State-Level: 20%; Local: 0%; Other: 0%; Total: 20%

Total Number of Positions Funded: 7
Total FTEs Funded: 1.66

National Health Objective:

HO AHS-8: Rapid Prehospital Emergency Care (EMS)

State Health Objective:

Between 10/2016 and 09/2017, ***improve prehospital care in California*** by providing technical assistance (TA) 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: *Within the 33 LEMSAs are approximately **391** primary PSAPs, which include approximately **88** dispatch centers that utilize EMD guidelines.*

Data Source: California Statewide Communication Interoperability Plan (CalSCIP) May 2016, EMS Authority, 2016

State Health Problem:

Health Burden: Public safety agencies throughout the State:

- Follow inconsistent EMD training standards and protocols.
- 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: 39,250,017
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: 39,250,017
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:

- 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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Continue review of EMS Communications Manual.

Between 10/2016 and 09/2017, 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 of communications among EMS agencies and public-safety responders.

Annual Activities:

1. **Update manual.**
   Between 10/2016 and 09/2017, 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.

Impact Objective 2:

Maintain active partnerships with key EMS communication stakeholder groups.

Between 10/2016 and 09/2017, 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 **70%**.

Annual Activities:

1. **Attend 9-1-1 Advisory Board meetings.**
   Between 10/2016 and 09/2017, EMSA staff will participate in **at least three** 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) ensure statewide coordination of efficient pre-hospital medical responses.

2. **Attend NAPCO meetings.**
   Between 10/2016 and 09/2017, EMSA staff will attend **two** Northern California Chapter of the Association of Public-Safety Communications Officials (NAPCO) meetings, to develop relationships with key communication stakeholders and provide EMS-related information in NAPCO activities.

Impact Objective 3:

Respond to frequency-use requests.

Between 10/2016 and 09/2017, EMSA staff will review **100%** of medical-frequency requests, to ensure the requester is an appropriate entity to use a medical frequency, and that the frequency is consistent with EMS bandwidth use and medical in nature (such as MedNet and Hospital Administrative Radio), to verify whether a support letter should be provided.

Annual Activities:

1. **Write frequency-use letters.**
   Between 10/2016 and 09/2017, EMSA staff will review and respond to **100%** of the requests for frequency use to ensure use is appropriate and related to emergency medical services.

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 California EMS Data Information System (CEMSIS) 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 Equivalents):

Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Tom McGinnis
Position Title: Health Program Manager II
State-Level: 9%; Local: 0%; Other: 0%; Total: 9%

Position Name: Angela Wise
Position Title: Staff Services Manager I
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Tiffany Pierce
Position Title: Office Technician
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Lori O'Brien
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:
Between 10/2016 and 09/2017, EMSA staff will ***develop and maintain EMSC programs*** by providing TA to **100%** of the LEMSAs that request assistance. LEMSAs contact EMSA staff to request guidance on EMSC programs. EMSA staff provides ongoing assistance, which results in continued improvement by providing EMSC website updates, and interpretation of EMSC guidance documents.

Baseline: ***21*** *of the 33 California LEMSAs (**64%**) have EMSC programs in place.*

Data Source: EMS Authority, 2016 (Statewide Specialty Care Systems document)

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.

Twenty-one 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** (23.3% of the State's population) include all California children below 18 years of age, regardless of their race or socioeconomic background.

Target Population:
Number: 9,145,254
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: 9,145,254
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 (2016)

Evidence-Based Guidelines and Best Practices Followed in Developing Interventions:
Other: American Academy of Pediatrics: Policy Statement—Equipment for Ambulances, 2013 (This is the most recent source.)

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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Continue development of EMSC regulations.

Between 10/2016 and 09/2017, EMSA staff will develop **one** set of draft regulations for the EMSC program to the Office of Administrative Law (OAL) to initiate the rulemaking process. EMSC regulations have been drafted to provide the LEMSAs and other local facilities with minimum requirements to establish and maintain EMSC program(s). The draft regulations are under EMSA management review. Upon management approval, the next steps in initiating the rulemaking process will be taken.

Annual Activities:

1. **Submit one Rulemaking File for EMSC regulations.**
   Between 10/2016 and 09/2017, EMSA staff will submit: (1) **one** Std 400, Notice of Proposed Rulemaking; (2) **one** Initial Statement of Reasons (ISOR); and (3) **one** draft regulation to OAL. The ISOR is the primary rulemaking document that satisfies the necessity standard in the rulemaking process.

2. **Obtain approval of draft EMSC regulations.**
   Between 10/2016 and 09/2017, EMSC staff will present for approval **one** set of final draft regulations to: (1) the Emergency Medical Services Administrators' Association of California; and (2) the Commission on EMS.

Impact Objective 2:

Establish EMSC TAC subcommittees.

Between 10/2016 and 09/2017, EMSA staff will develop **six** subcommittees to oversee essential EMSC tasks, such as: (1) reviewing and restructuring the EMSC technical advisory committee (TAC) and mission statement; (2) updating EMSC guidelines; and (3) determining the most appropriate treatment options for pediatric patients in the field.

Annual Activities:

1. **Coordinate Work Group meetings.**
   Between 10/2016 and 09/2017, EMSA staff will schedule **at least two** conference calls with each newly identified EMSC subcommittee to discuss necessary activities for implementation.

   Conference calls will identify tasks and requirements for each established subcommittee. The newly established subcommittees will ensure that California's EMSC stays in the forefront of pediatric care.

EMS Health Information Exchange

State Program Strategy:
Goal: ***Improve access to rapid, specialized pre-hospital Emergency Medical Services (EMS) 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 EMS program by facilitating access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, and 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 share best practices and continue plans for bi-directional exchange of statewide patient medical-record information exchanges.

Role of Block Grant Funds: PHHSBG dollars support EMSA staff in implementing HIE in California by: (1) administering an effective system of coordinated emergency medical care, injury prevention, and disaster medical response; and (2) providing assistance to LEMSAs via e-mail and telephone to help implement HIE in their counties.

The vacant position is expected to be filled by September 1, 2017.

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: (1) the Office of the National Coordinator for Health Information Technology; (2) EMSA program staff activities; and (3) EMSA HIE program outcomes.

EMSA staff will monitor LEMSA HIE progress via: (1) facilitation of stakeholder teleconferences; (2) oversight of LEMSA HIE program grant-funded projects; and (3) 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 equivalent positions that are funded with PHHSBG funds:

Position Name: Tom McGinnis
Position Title: Health Program Manager II
State-Level: 9%; Local: 0%; Other: 0%; Total: 9%

Position Name: Angela Wise
Position Title: Staff Services Manager I
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Lori O'Brien
Position Title: Associate Governmental Program Analyst
State-Level: 10%; Local: 0%; Other: 0%; Total: 10%

Position Name: Tiffany Pierce
Position Title: Office Technician
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Vacant
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:

Between 10/2016 and 09/2017, EMSA staff will ***encourage utilization of patient-care record technology by EMS practitioners, to ensure quality patient care*** 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 (2016 survey responses are pending.)

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: 39,250,017
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: 39,250,017
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: Lumetra Healthcare Solutions, Health Information Exchange Report, 2013 (2016 survey responses are pending.)

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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Provide leadership and coordination of HIE.

Between 10/2016 and 09/2017, EMSA staff will provide TA and support to **100%** of LEMSAs that request assistance in areas associated with HIE system developments and operations, to improve statewide EMS patient care.

Annual Activities:

1. **Participate in teleconferences.**
   Between 10/2016 and 09/2017, 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 10/2016 and 09/2017, 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.

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 EMS*** 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.

The vacant position is expected to be filled by September 1, 2017.

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 Equivalents):

Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Tom McGinnis
Position Title: Health Program Manager II
State-Level: 9%; Local: 0%; Other: 0%; Total: 9%

Position Name: Angela Wise
Position Title: Staff Services Manager I
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Lori O'Brien
Position Title: Associate Governmental Program Analyst
State-Level: 20%; Local: 0%; Other: 0%; Total: 20%

Position Name: Vacant
Position Title: Health Program Specialist II
State-Level: 20%; Local: 0%; Other: 0%; Total: 20%

Position Name: Tiffany Pierce
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:
Between 10/2016 and 09/2017, EMSA staff will provide technical assistance (TA) to **100%** of the LEMSAs that request assistance with local injury-prevention programs. EMSA staff will provide requested guidance and promote ongoing collaboration with LEMSAs and other stakeholders who create EMS-related injury-prevention policies, ensuring that policies are created using the most up-to-date injury-prevention strategies.

Baseline: *California had the highest number of injury deaths (**18,152**) in the country. California also had the highest number of unintentional injury deaths (**11,804**).*

*Although the numbers remain high throughout the country and for our state, California ranked among the lowest in the country in terms of rate of fatalities. California had the third-lowest rate of all injury intents (**44.9 per 100,000**).*

Data Sources:
- State-level Lifetime Medical and Work-Loss Costs of Fatal injuries—United States, 2014. Centers for Disease Control and Prevention (CDC);
- MMWR (Morbidity and Mortality Weekly Report); January 13, 2017.

State Health Problem:

Health Burden: 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.

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

Health Burden Data Sources: (1) Trauma Managers Association of California; (2) California Department of Public Health; and (3) CDC, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention

Target Population:

Number: 39,250,017
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: 39,250,017
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: The American College of Surgeons report, "Resources for Optimal Care of the Injured Patient: 2014" and Clarification Document, updated 2016

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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:
Continue to maintain EMSA injury- and illness-prevention web page.
Between 10/2016 and 09/2017, EMSA staff will provide ongoing maintenance to **one** injury- and illness-prevention web page on the EMSA website on a **quarterly** basis. The web page links: (1) provide sources for education and for EMS partners and (2) promote injury prevention in the EMS community.

1. **Verify functionality of website links.**
   Between 10/2016 and 09/2017, EMSA staff will check **55** web links for connectivity and correct links in need of updating, to ensure access to and accuracy of injury- and illness-prevention data.

Impact Objective 2:
Continue to maintain trauma system public-information web page.
Between 10/2016 and 09/2017, EMSA staff will provide ongoing maintenance on **one** trauma-system public-information page on the EMSA website, to make sure injury prevention–related information is available and current.

Annual Activities:

1. **Update trauma system public-information web page.**
   Between 10/2016 and 09/2017, EMSA staff will review **one** EMSA trauma-system public-information web page on a **quarterly** basis and update information, to maximize accuracy and usability of web-page content.

EMS Poison Control System

State Program Strategy:

Goal: ***Provide poison-control services.*** California Poison Control System (CPCS) is one of the largest single providers of poison-control services in the United States and the sole provider of poison-control services for California.

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: PHHSBG dollars support Emergency Medical Dispatch (EMD) staff and the University of California, San Francisco, in providing rapid, prehospital, poison-related medical advice; prevention; and educational information, to reduce the morbidity and mortality rates of people exposed to poisons.

Primary Strategic Partnerships:

Internal

- Health and Human Services Agency
- Department of Health Care Services
- 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 (Fresno/Madera)
- Office of Emergency Services

Evaluation Methodology: Quarterly progress reports are required to: (1) evaluate and monitor CPCS operations; and (2) 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 equivalent positions that are funded with PHHSBG funds:

Position Name: Tom McGinnis
Position Title: Health Program Manager II
State-Level: 9%; Local: 0%; Other: 0%; Total: 9%

Position Name: Angela Wise
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: Tiffany Pierce
Position Title: Office Technician
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Lori O'Brien
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:
Between 10/2016 and 09/2017, EMSA staff will ***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 **300,000** calls annually, according to the CPCS 2015/16 "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 223,389 cases in state fiscal year 2015–16; about 71% of the cases (159,557) were managed on site. Cases involving children age 5 and under accounted for 45% 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 29**%** of poisoning cases (63,832) could result in emergency department visits.

Using a moderate estimate of $610 per emergency department visit, CPCS saves the State an estimated $39 million annually in health-care costs. 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: 39,250,017
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: 39,250,017
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 data

Evidence-Based Guidelines and Best Practices Followed in Developing Interventions:
Other: National Academies Press (U.S.) "Forging a Poison Prevention and Control System" (2004) (No newer source of this data exists.)

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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:
Provide program oversight.
Between 10/2016 and 09/2017, EMSA staff will provide oversight to **one** poison-control system provider, the California Poison Control System (CPCS), to promote rapid and effective telephone emergency advice service to **300,000** Californians exposed to poisons.

Annual Activities:

1. **Review quarterly activity reports.**
   Between 10/2016 and 09/2017, EMS staff will review **four** activity reports per **quarter** from **one** poison control service provider, CPCS, to verify that the work performed is consistent with the contractual scope of work.

2. **Develop a Request for Information.**
   Between 10/2016 and 09/2017, EMS staff will develop **one** Request for Information, to identify potential service providers interested in serving as the provider of poison control services for the entire State of California.

3 **Develop a Request for Offer.**
   Between 10/2016 and 09/2017, EMS staff will develop **one** Request for Offer, to identify **one** California Multiple Award Schedules contractor interested in performing a comprehensive program and fiscal evaluation of the CPCS provider.

4. **Conduct site visits.**
   Between 10/2016 and 09/2017, EMS staff will conduct **two** site visits at **two** poison control centers within California, to verify that the work performed is consistent with regulations and the contractual scope of work**.**

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; and (2) ***Quality Improvement (QI) Program: Improve pre-hospital EMS services and public health systems statewide*** by providing measurable EMS 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.

The vacant position is expected to be filled by September 1, 2017.

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 Equivalents):

Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Tom McGinnis
Position Title: Health Program Manager II
State-Level: 9%; Local: 0%; Other: 0%; Total: 9%

Position Name: Angela Wise
Position Title: Staff Services Manager I
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Nancy Marker
Position Title: Research Program Specialist I
State-Level: 47%; Local: 0%; Other: 0%; Total: 47%

Position Name: Lori O'Brien
Position Title: Associate Governmental Program Analyst
State-Level: 10%; Local: 0%; Other: 0%; Total: 10%

Position Name: Vacant
Position Title: Staff Services Manager 1
State-Level: 50%; Local: 0%; Other: 0%; Total: 50%

Position Name: Tiffany Pierce
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%

Total Number of Positions Funded: 7
Total FTEs Funded: 1.88

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

State Health Objective:
Between 10/2016 and 09/2017, EMSA staff will ***provide TA to at least three LEMSAs in areas of QI measuring and patient-care assessments,*** based on their EMS QI plan and EMS pre-hospital data submissions to EMSA.

Baseline: ***23*** *of 33 LEMSAs actively participate in the State's electronic data program, an increased participation of* ***16.5%*** *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), 2016

State Health Problem:

Health Burden: Determining morbidity and mortality rates is complicated by the State's data-collection system. The best use of mortality and morbidity rates is to provide a meaningful tool to support infrastructure development, such as roads, schools, hospitals, and power and water utilities. Optimally, data from local areas would be available in a timely and easily assessable manner; however, 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, 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.

Health Burden Data Source: EMSA

Target Population:
Number: 39,250,017
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: 39,250,017
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: American College of Surgeons/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:	$651,256
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:
Continue to increase the quality and availability of EMS data.
Between 10/2016 and 09/2017, EMSA staff will develop **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; 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 10/2016 and 09/2017, EMSA staff will analyze **100%** of a selected data set submitted by LEMSAs to the CEMSIS database, to ensure accurate, efficient evaluation of critical data submitted for successful QI and QA data reporting.

2. **Publish EMS data reports.**
   Between 10/2016 and 09/2017, 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.

Impact Objective 2:
Continue to lead and coordinate Core Measure reporting.
Between 10/2016 and 09/2017, EMSA staff will provide TA to **100%** of the LEMSAs that request assistance with Core Measure reporting, to ensure effective use of data used to prepare Core Measure reports regarding selected clinical measures.

Annual Activities:

1. **Facilitate Core Measure Taskforce.**
   Between 10/2016 and 09/2017, 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 10/2016 and 09/2017, 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 10/2016 and 09/2017, 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 for obtaining statewide data on 17 clinical measures because the CEMSIS data system is limited by a variety of data systems, ranging from differing electronic systems to pen-and-paper systems.

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

Impact Objective 3:

Coordinate EMS plan QI submissions.

Between 10/2016 and 09/2017, EMSA staff will provide TA to **100%** of LEMSAs that submit their EMS plans, to ensure that QI compliance requirements are met.

Annual Activities:

1. **Coordinate QI Plan submissions.**
   Between 10/2016 and 09/2017, 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 10/2016 and 09/2017, 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. **Maintain activity log for QI plan submissions.**
   Between 10/2016 and 09/2017, EMSA staff will maintain **one** administrative QI Plan activity log, identifying submission and approval dates.

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 (ST-segment Elevation Myocardial Infarction) Critical-Care System and Stroke Critical-Care System regulations for submission to the Office of Administrative Law (OAL), to initiate the required regulatory approval process; and (2) providing leadership and oversight of STEMI and Stroke Critical-Care System services.

Role of Block Grant Funds: PHHSBG dollars support EMSA staff, who establish a specialized and timely STEMI and Stroke Critical-Care System within prehospital emergency medical services.

Primary Strategic Partnerships:

Internal

- California Department of Public Health
- California Emergency Management Agency
- California Highway Patrol
- State Office of Rural Health
- 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 outlined in the Work Plan Objectives and Activities.

State Program Setting:

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

FTEs (Full-Time Equivalents):

Full-time equivalent positions that are funded with PHHSBG 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: Angela Wise
Position Title: Staff Services Manager I
State-Level: 12%; Local: 0%; Other: 0%; Total: 12%

Position Name: Tiffany Pierce
Position Title: Office Technician
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Lori O'Brien
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:
Between 10/2000 and 09/2020, ***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 Critical-Care Systems for their regions.*

Data Source: Emergency Medical Services Authority, 2016

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;
- 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: 39,250,017
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: 39,250,017
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) 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:	$329,178
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Continue development of STEMI and Stroke Critical-Care System regulations.

Between 10/2016 and 09/2017, EMSA staff will develop **two** sets of draft regulations, one for the Stroke Critical-Care System and one for the STEMI Critical-Care System, to provide LEMSAs and other local facilities with minimum requirements to establish and maintain STEMI and Stroke Critical-Care Systems throughout California. Draft regulations were initially submitted to OAL in December 2016 (rulemaking is a 12-month process).

Annual Activities:

1. **Resubmit STEMI Critical-Care System regulations.**
   Between 10/2016 and 09/2017, EMSA staff will: (1) provide **one** final draft of the STEMI Critical-Care System regulations to the STEMI Regulations Work Group; and (2) make the necessary revisions to the draft regulations before *resubmission* to OAL.

2. **Resubmit Stroke Critical-Care System regulations.**
   Between 10/2016 and 09/2017, EMSA staff will: (1) provide **one** final draft of the Stroke Critical-Care System regulations to the Stroke Regulations Work Group for review; and (2) make the necessary revisions to the draft regulations before *resubmission* to OAL.

Impact Objective 2:

Develop STEMI TAC.

Between 10/2016 and 09/2017, 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 STEMI TAC.**
   Between 10/2016 and 09/2017, EMSA staff will: (1) mail a letter of request for volunteers to serve on STEMI TAC to **11** STEMI program constituents, requesting a letter of interest and CV if interested in serving on the TAC; (2) review letters of interest and CVs; and (3) choose STEMI TAC members based on subject-matter knowledge and experience.

2. **Plan and facilitate STEMI TAC meetings.**
   Between 10/2016 and 09/2017, EMSA staff will: (1) develop a schedule of **at least two** meetings at the EMSA HQ; (2) facilitate discussions of the TAC's mission, purpose, parameters, and meeting rules; and (3) facilitate vision and work plan/issues for the TAC to focus on.

Impact Objective 3:

Develop Stroke TAC.

Between 10/2016 and 09/2017, 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 Stroke Program TAC.**
   Between 10/2016 and 09/2017, EMSA staff will: (1) mail a letter of request for volunteers to serve on Stroke TAC to **ten** Stroke program constituents, requesting a letter of interest and CV if interested in serving on the TAC; (2) review letters of interest and CVs; and (3) choose Stroke TAC members based on subject-matter knowledge and experience.

2. **Plan and facilitate Stroke TAC meetings.**
   Between 10/2016 and 09/2017, EMSA staff will: (1) schedule **at least two** meetings or conference calls at EMSA HQ; (2) facilitate discussions of the TAC's mission, purpose, parameters, and meeting rules; and (3) facilitate vision and work plan/issues for the TAC to focus on.

Impact Objective 4:

Host State STEMI and Stroke Critical-Care Systems Forums.

Between 10/2016 and 09/2017, EMSA staff will conduct **two** one-day Forums, one in Northern California and one in Southern California, to provide education on clinical and system aspects of STEMI and Stroke care, and to improve and implement STEMI and Stroke Critical-Care Systems in California.

Annual Activities:

1. **Develop pre-Forum documents.**
   Between 10/2016 and 09/2017, EMSA staff will create **two** "save the date" postcards, one for each STEMI and Stroke Critical-Care Systems Forum, to be distributed to LEMSAs, hospitals, and physicians in California. Postcards will also be posted to the EMSA website.

2. **Create an online registration portal for each STEMI and Stroke Forum.**
   Between 10/2016 and 09/2017, EMSA staff will create **one** Eventbrite registration portal, to include the ability to register and pay for sponsorship online.

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 Emergency Medical Services (EMS) 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 Priority: ***Administer an effective statewide 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 September 1, 2017.

Primary Strategic Partnerships:

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

External
- Department of Forestry and Fire Protection
- Emergency Medical Directors Association
- Local EMS Agencies

Evaluation Methodology: The LEMSAs are statutorily required to submit an annual EMS Plan. In addition, multi-county agencies submit quarterly progress reports. Statue requires EMSA to review and approve EMS Plans submitted by the LEMSAs. The EMS Plan information is 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 equivalent positions that are funded with PHHSBG funds:

Position Name: Tom McGinnis
Position Title: Health Program Manager II
State-Level: 9%; Local: 0%; Other: 0%; Total: 9%

Position Name: Angela Wise
Position Title: Staff Services Manager I
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Nancy Steiner-Keyson
Position Title: Health Program Manager II (RA)
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: Lori O'Brien
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: Tiffany Pierce
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:
Between 10/2016 and 09/2017, EMSA staff will ***provide oversight and technical assistance (TA) 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: 39,255,883
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: Specific Counties: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Fresno, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Modoc, Mono, Nevada, Placer, Plumas, San Bernardino, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Yuba

Target and Disparate Data Sources: CA Department of Finance Estimates (2016)

Evidence-Based Guidelines and Best Practices Followed in Developing Interventions:
Other: California Health and 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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:
Provide oversight and TA to counties.
Between 10/2016 and 09/2017, EMSA staff will provide oversight and TA to **100%** of the counties required to submit Maddy EMS Fund Reports, assisting with adherence to California EMS statutes for optimum EMS patient care.

Annual Activities:

1. **Coordinate Maddy EMS Fund report submissions.**
   Between 10/2016 and 09/2017, EMSA staff will coordinate submission of Maddy EMS Fund reports for **a minimum of six** counties. Coordination will be directed to county directors, supporting timely report submissions.

Impact Objective 2:
Provide oversight and TA to LEMSAs with transportation plans.
Between 10/2016 and 09/2017, EMSA staff will provide oversight and TA to **100%** of EMS providers regarding transportation services assistance associated with the LEMSAs' EMS Plans.

Annual Activities:

1. **Review LEMSA transportation service request for proposal.**
   Between 10/2016 and 09/2017, EMSA staff will review and assist in the development of **at least two** LEMSA requests 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 National Guard rescue helicopter medical supplies.**
   Between 10/2016 and 09/2017, EMSA staff will coordinate the inspection of **one** bag of Advanced Life Support auxiliary helicopter medical equipment, to ensure compliance with state and local standards. California National Guard helicopter medical equipment is located at Mather Field in Sacramento, California. Aircraft medical supply inspections support successful EMS transportation services within California.

2. **Assess LEMSA EMS Transportation Plan appeal hearing documentation.**
   Between 10/2016 and 09/2017, EMSA staff will research transportation documents, history of EMS exclusive and non-exclusive operating zones, provider company sales, and EMS plans in preparation for appeal hearings filed with the Office of Administrative Hearings.

Impact Objective 3:

Provide oversight and TA to LEMSAs.

Between 10/2016 and 09/2017, EMSA staff will provide oversight and TA 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 10/2016 and 09/2017, 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 10/2016 and 09/2017, 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 10/2016 and 09/2017, 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 promotes high-quality patient care across California.

4. **Review quarterly activity reports.**
   Between 10/2016 and 09/2017, EMSA staff will review **four** quarterly reports per quarter from each of the **six** multi-county EMS agencies, to verify that the work performed is consistent with the contractual scope of work.

5. **Revise EMS Plan submission process.**
   Between 10/2016 and 09/2017, EMSA staff will revise the EMS Plan submission process and develop **one** automated system for the **33** LEMSAs to electronically submit their EMS Plans. Use of the automated system will enable LEMSA and EMSA staff to increase efficiencies, analyze and cross-reference data, and generate reports.

EMS Trauma Care Systems

State Program Strategy:
Goal: ***Reduce morbidity and mortality resulting from injury in California*** by providing continued oversight of the statewide Trauma System in accordance with the California Health and Safety Code and California Code of Regulations.

Health Priority: ***Provide timely access to optimal trauma care*** through the continued development, implementation, and review 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.

The vacant position is expected to be filled by September 1, 2017.

Primary Strategic Partnerships:

Internal
- California Department of Public Health
- Strategic Highway Safety Plan
- Office of Traffic Safety
- Commission on EMS
- 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 California EMS Data Information System (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 equivalent positions that are funded with PHHSBG funds:

Position Name: Tom McGinnis
Position Title: Health Program Manager II
State-Level: 9%; Local: 0%; Other: 0%; Total: 9%

Position Name: Angela Wise
Position Title: Staff Services Manager I
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Vacant
Position Title: Health Program Specialist II
State-Level: 80%; Local: 0%; Other: 0%; Total: 80%

Position Name: Tiffany Pierce
Position Title: Office Technician
State-Level: 11%; Local: 0%; Other: 0%; Total: 11%

Position Name: Lori O'Brien
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:
Between 10/2016 and 09/2017, EMSA staff will ***provide technical support to 100% of the LEMSAs*** that request assistance with local trauma programs, and EMSA staff will ***continue to develop 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 (40 counties) have designated trauma centers. California has **78** designated trauma centers.*

Data Sources: (1) EMS Authority, 2016; (www.emsa.ca.gov, listing of designated trauma centers); (2) American College of Surgeons, 2016; (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 **target** and **disparate populations** are the same; the total population of California**.**

Health Burden Data Source: CDC, Key Injury and Violence Data, https://www.cdc.gov/injury/wisqars/overview/key_data.html

Target Population:
Number: 39,250,017
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, 250,017
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) Division 2.5, California Health and Safety Code; (2) Resources for the Optimal Care of the Injured Patient, American College of Surgeons.2014 (6th Ed.); (3) 2011 Guidelines for Field Triage of Injured Patients," CDC, 2011 (These are the most current sources.)

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

Total Current Year Funds Allocated to Health Objective:	$198,536
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:
Restart revision of trauma regulations.
Between 10/2016 and 09/2017, EMSA staff will develop **one** draft revision of trauma regulations that incorporates suggestions for trauma system requirements in California.

Annual Activities:

1. **Establish Task Force to provide recommended revisions to trauma regulations.**
   Between 10/2016 and 09/2017, 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 10/2016 and 09/2017, 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 10/2016 and 09/2017, EMSA staff will review **all** suggested revisions from the Trauma Regulations Revision Committee and will provide **at least two** revised drafts to committee members.

4. **Review trauma regulation drafts.**
   Between 10/2016 and 09/2017, EMSA staff will: (1) review **at least two** revised trauma regulations with EMS Systems Division administration and Executive Division; and (2) make recommended revisions.

Health in All Policies

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 support staff salary, state-level monitoring, communication, policy, and coordination capacity, and disseminating reports to advance chronic-disease prevention.

The vacant position is anticipated to be filled by July 1, 2017.

Primary Strategic Partnerships:

Internal:
- Chronic Disease Control Branch
- Nutrition Education and Obesity Prevention Branch
- Safe and Active Communities Branch
- Environmental Health Investigations Branch
- 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: Track number of partner agency and internal departmental program practices integrating health and equity, using interviews and surveys.

State Program Setting:
- Local health department
- Parks or playgrounds
- Schools or school district
- State health department
- *Other:* Cities, Counties, Metropolitan Planning Organizations

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Meredith Lee
Position Title: Health Program Specialist II
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Dahir Nassir
Position Title: Health Program Specialist I
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Carol Gomez
Position Title: Associate Government Program Analyst
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Vacant
Position Title: Health Program Specialist I
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: Between 10/2016 and 09/2017, Office of Health Equity (OHE) staff will: (1) embed health and equity into **at least 10** 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; (2) partner with **at least 10** state-level departments and agencies to achieve this objective.

Baseline:
1. *In 2010, **73.8%** of California residents lived within one-half mile of a park, beach, open space, or coastline.*
2. *In 2012, **21.5%** of California residents used walking, biking, or public modes of transportation.*

Data Sources: (1) Healthy Community Data and Indicators project, HCI CALANDS [2012], U.S. Census Bureau [2010]; (2) 2012, California Household Travel Survey

No newer data measure statewide access to parks, beaches, open space, or the coastline, and percentage of residents walking, biking, or using public transportation.

State Health Problem

Health Burden: Significant portions of California's population lack access to physical-activity opportunities, which can contribute to poor health and health inequities. 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. 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%.

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% did not have a park, playground, or open space within walking distance; 9% had not been physically active in the past week; and 18% were overweight or obese (CHIS, 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 population** includes those considered “vulnerable”: women, racial and ethnic minorities; low-income individuals; individuals currently or previously incarcerated; individuals with disabilities; individuals with mental health conditions; children, youth and young adults; seniors; immigrants and refugees; individuals who are limited-English proficient (LEP); lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities; or combinations of these populations (Health and Safety Code Section 131019.5). The **disparate population** includes those who are the most vulnerable and likely experiencing the greatest inequities and therefore worse health outcomes.

The **disparate populations** are those most vulnerable and likely experiencing the greatest inequities and therefore worse health outcomes.

Health Burden Data Sources: (1) BRFSS Behavioral Risk Factor Surveillance System: Prevalence and Trend Data—Physical Activity, U.S. Physical Activity Trends by State; (2) CHIS, 2012

Target Population:
Number: 6,900,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
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: 5,900,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
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: CHIS, 2015

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:	$592,748
Total Prior Year Funds Allocated to Health Objective:	$592,748
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 and 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:
Build public health capacity to promote and implement health equity.
Between 10/2016 and 09/2017, OHE staff will conduct **eight** meetings, trainings, or one-on-one technical assistance (TA) sessions with CDPH programs or local health departments (LHDs) to increase the capacity of public health staff to promote health equity, implement health in all policies activities, and understand and address the social determinants of health, including the built and social environment.

Annual Activities:

1. **Build CDPH capacity to promote health and racial equity.**
   Between 10/2016 and 09/2017, OHE staff will provide trainings or consultations to **at least five** CDPH programs or offices to: (1) build CDPH staffs' capacity to understand and promote health and racial equity; (2) implement a health in all policies approach; and (3) understand and address the social determinants of health, including the built and social environment.

2. **Build LHD capacity to promote health and racial equity.**
   Between 10/2016 and 09/2017, OHE staff will provide trainings or TA to **at least three** LHDs to: (1) build LHDs' capacity to understand and promote health and racial equity; (2) implement a health in all policies approach; and (3) increase understanding of and address the social determinants of health, including the built and social environment.

Objective 2:

Conduct a public health and equity consultation.

Between 10/2016 and 09/2017, OHE staff will conduct **ten** health and equity consultations to non-health agencies and departments to increase the capacity of staff from non-health agencies to understand the social determinants of health and health equity, including the built environment, and how their work can impact health equity.

Annual Activities:

1. **Conduct health and equity consultations.**
   Between 10/2016 and 09/2017, OHE staff, as health-equity experts, will work with staff from **at least 10** non-health agencies to help inform them about the social determinants of health, including the built and social environment and health equity.

Objective 3:

Increase collaboration and integration of health and equity considerations.

Between 10/2016 and 09/2017, OHE staff will implement **ten** health and equity considerations into non-health department policies, programs, or practices to impact the social determinants of health, including the built environment.

Annual Activities:

1. **Increase health and equity considerations in non-health department grants.**
   Between 10/2016 and 09/2017, through the Health in All Policies Task Force, OHE staff will partner with **at least ten** non-health agencies and departments to integrate health and equity consideration in **at least four** grants, such as the Caltrans' Active Transportation Program Grant, the Strategic Growth Council's (SGC's) Affordable Housing and Sustainable Communities Grant program, the SGC's Transformative Climate Communities Grants, and the Natural Resources Urban Greening Grant Program.

2. **Increase health and equity considerations in non-health department guidance.**
   Between 10/2016 and 09/2017, OHE staff, through the Health in All Policies Task Force, will partner with **at least five** non-health agencies and departments to integrate health and equity considerations in **at least three** guidance documents (such as the Department of Education's Title V Guidelines, the Office of Planning and Research's General Plan Guidelines), and other guidance documents that impact the social determinants of health, including the built environment.

3. **Develop Health in All Policies Action Plans**
   Between 10/2016 and 09/2017, OHE staff, in partnership with the Health in All Policies Task Force, will develop **three** new multi-agency action plans that include commitments for **more than ten** departments, agencies, and offices to engage in cross-sectoral actions.

   In addition to the outcomes from the activities identified in the action plans, Task Force members will increase collaboration and coordination. These action plans will improve the built and social environments, including green space and active transportation infrastructure, to promote physical activity.

Healthy People 2020 Program

State Program Strategy

Goal: *The California Department of Public Health (CDPH) will* ***enhance the accountability and transparency of the Preventive Health and Health Services Block Grant (PHHSBG)*** *through the Healthy People 2020 Program (HP 2020) by measuring progress and impact of funded programs, as well as communicating current accomplishments.*

Health Priority HP 2020 objectives align with the CDPH *Public Health 2035* and *Strategic Map* as they ***strengthen CDPH as an organization and make continuous quality improvement (QI) a way of life in the Department.*** A QI process for PHHSBG programs will strengthen public health infrastructure to improve public health outcomes, decrease health disparities, premature death, and disabilities, and improve health equity.

Role of Block Grant Funds: Funds will support salaries of staff responsible for overarching PHHSBG activities: evaluation; QI process; stakeholder relationships; communication of program outcomes; and program, fiscal and grant management.

The vacant position is anticipated to be filled by September 1, 2017.

Primary Strategic Partnerships

Internal

- Center for Health Statistics and Informatics
- Center for Environmental Health
- Center for Chronic Disease Prevention and Health Promotion
- Center for Infectious Diseases
- Fusion Center

External

- Emergency Medical Services Authority

Evaluation Methodology: Program goals and objectives are in line with congressional mandate, Centers for Disease Control and Prevention (CDC) State, Tribal, Local, and Territorial Subcommittee recommendations, and the CDC PHHSBG evaluation initiative. The State Health Objectives are monitored and evaluated twice yearly. Monitoring tools include a program work plan, program procedures, monthly fiscal reports, twice-yearly fiscal analyses, once-yearly program outcome reports, twice-yearly public hearings and Advisory Committee meetings, and yearly program audit.

State Program Setting

- State health department

FTEs (Full-Time Equivalents)
Full-time equivalent positions that are funded with PHHSBG funds

Position Name: Becca Parks
Position Title: Staff Services Manager I
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Anita Butler
Position Title: Staff Services Manager II
State-Level: 50%; Local: 0%; Other: 0%; Total: 50%

Position Name: Hector Garcia
Position Title: Health Program Specialist I
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Matthew Herreid
Position Title: Associate Governmental Program Analyst
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: 5
Total FTEs Funded: 4.50

National Health Objective:
HO PHI-16: Public health agency quality improvement program

State Health Objective(s):
Between 10/2016 and 09/2017, HP 2020 staff will develop **one** QI process, using the CDC evaluation framework and the Plan Do Study Act (PDSA) or other QI model, to increase efficiency and effectiveness of PHHSBG-funded programs.

Baseline: *No QI process for PHHSBG-funded programs exists.*

Data Source: CDPH PHHSBG Annual Outcomes Report

State Health Problem:
Health Burden: Funding for public health in California is low. Annual per-capita state funding for public health is $57.16, and annual per-capita CDC funding for public health is $19.61 (Trust for America's Health). Consequently, there is a need to use public health dollars wisely. California has the opportunity to use the PHHSBG for state priorities, developed in conjunction with stakeholders. Once the funds have been allocated to critical public health programs, service, and activities, it is imperative that program outcomes are tracked and evaluated to assure that the funds are used in the

most efficient and effective way possible. If there is a lack of progress or impact, the decision makers should be alerted, and funds can be allocated elsewhere.

The PHHSBG program does not have an evaluation or QI process. Using the CDC evaluation framework and a QI model, HP 2020 will institute a quality-improvement process for the PHHSBG programs.

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

Target Population:
Number: 39,250,217
Infrastructure Group
- State and Local Health Departments

Disparate Population:
Number: 39,250,217
Infrastructure Group
- State and Local Health Departments

Evidence-Based Guidelines and Best Practices Followed in Developing Interventions
- *Healthy People 2020*
- Public Health Accreditation Board: Standards and Measures
- Agency for Healthcare Research and Quality: Public Health Performance Improvement Toolkit
- Public Health Foundation Public Health Quality Improvement Handbook

Funds Allocated and Block Grant Role in Addressing this Health Objective

Total Current Year Funds Allocated to Health Objective:	$667,000
Total Prior Year Funds Allocated to Health Objective:	$870,000
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1
Communicate Program Outcomes.
Between 10/2016 and 09/2017, HP 2020 staff will implement **two** communication strategies, to highlight the success of the PHHSBG-funded programs.

Annual Activities

1. **Publish Program Outcomes Report online.**
   Between 10/2016 and 09/2017, HP 2020 staff will publish **one** Program Outcomes Report on the CDPH website, to disseminate information to the public.

2. **Distribute Program Outcomes Report to stakeholders.**
   Between 10/2016 and 09/2017, HP 2020 staff will distribute the Program Outcomes Report to **at least ten** stakeholders to disseminate information directly to stakeholders.

3. **Publish Program Success Stories online.**
   Between 10/2016 and 09/2017, HP 2020 staff will publish **at least ten** success stories on the CDPH website, to disseminate information to the public.

Impact Objective 2

Develop and institute a QI process to improve PHHSBG Program Outcomes.
Between 10/2016 and 09/2017, HP 2020 staff will develop one QI process, to contribute to PHHSBG program evaluation.

Annual Activities

1. **Develop QI process.**
   Between 10/2016 and 09/2017, HP 2020 staff will: (1) review **at least two** QI methodology models and best practices, and (2) develop **one** QI process with procedures and timeline, to contribute to PHHSBG program evaluation.

2. **Perform QI analysis of PHHSBG Program.**
   Between 10/2016 and 09/2017, HP 2020 staff will analyze **one** Program Outcomes Report. For programs that did not achieve objectives, **at least one** will be identified for a QI analysis, using the developed QI process to contribute to PHHSBG program evaluation and summarize the QI analysis.

3. **Assist PHHSBG program staff on QI process.**
   Between 10/2016 and 09/2017, HP 2020 staff will: (1) provide **at least one** TTA to PHHSBG program staff via e-mail, phone, or other communications, as appropriate; and (2) conduct **at least one** QI meeting to ensure QI process is understood.

Impact Objective 3

Track and report PHHSBG Program Outcomes to document progress and impact.
Between 10/2016 and 09/2017, HP 2020 staff will develop **one** report on Program Outcomes, to support PHHSBG program evaluation through analysis of met and unmet deliverables.

Annual Activities

1. **Collect Outcomes information from PHHSBG programs.**
   Between 10/2016 and 09/2017, HP 2020 staff will collect and document PHHSBG program outcomes **once** from all **26** funded programs, to assemble data for QI analyses.

2. **Develop a report on program outcomes.**
   Between 10/2016 and 09/2017, HP 2020 staff will write **one** comprehensive summary report, to document progress and impact.

3. **Provide TTA to staff submitting program outcomes information.**
   Between 10/2016 and 09/2017, HP 2020 staff will: (1) provide **at least four** ad hoc TTA to PHHSBG program staff via e-mail, phone, and other communications as appropriate; and (2) conduct **at least one** TTA meeting for **no less than 25%** of PHHSBG-funded programs, to ensure continuous QI for PHHSBG programs.

Intentional and Unintentional Injury Prevention

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

Health Priorities: ***Increase accessible and usable health information and expand access to comprehensive statewide data,*** a goal consistent with the California Wellness Plan (CWP). Other CWP objectives for injury and violence prevention include ***decreasing the annual incidence rate of unintentional injury deaths in California*** from 27 in 2011 to 20 per 100,000, and ***decreasing the annual incidence rate for homicides*** from five in 2011 to four per 100,000.

Role of Block Grant Funds: PHHSBG funds will be used by the California Department of Public Health (CDPH) Safe and Active Communities Branch (SACB) to: (1) pay staff salaries; (2) provide information, data, training, technical assistance (TA); and funding to support policies and programs at state and local levels for the prevention of: (a) unintentional childhood injuries, (b) older-adult falls, (c) traffic-related injuries, and (d) Adverse Childhood Experiences (ACEs); and (3) support data enhancements of the Web-based data query system EpiCenter: California Injury Data Online.

It is anticipated that the vacant position will be filled by May 1, 2017.

Primary Strategic Partnerships:

Internal:
- Chronic Disease Control Branch
- Office of Health Equity
- Maternal, Child, and Adolescent Health Branch
- Home Visitation Program
- Health in All Policies Program

External:
- Local public health departments
- California Department of Education
- California Safe Kids Coalition
- California State Falls Coalition
- Children Now

Evaluation Methodology:
- Injury numbers/rates overall and for specific injury types will be tracked using data from EpiCenter.
- *Process evaluation* will focus on measuring whether objectives are met (e.g., number of trainings/participants).
- *Impact evaluation* will assess immediate and intermediate outcomes of activities using multiple measures (e.g., surveys, evaluations, EpiCenter website hits).

State Program Setting:
- Community-based organization
- Community health center
- Local health department
- Medical or clinical site
- Senior residence or center
- State health department

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Pam Shipley
Position Title: Staff Services Manager 1
State-Level: 25%; Local: 0%; Other: 0%; Total: 25%

Position Name: Steve Wirtz, PhD
Position Title: Research Scientist Supervisor I
State-Level: 25%; Local: 0%; Other: 0%; Total: 25%

Position Name: Nancy Bagnato, MPH
Position Title: Health Program Manager II
State-Level: 25%; Local: 0%; Other: 0%; Total: 25%

Position Name: Kate Bernacki, MPH
Position Title: Health Education Consultant III, Specialist
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Claudia Angel, MPH
Position Title: Staff Services Analyst
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Vacant
Position Title: Health Education Consultant III, Specialist
State-Level: 50%; Local: 0%; Other: 0%; Total: 50%

Position Name: Karissa Anderson
Position Title: Health Program Specialist 1
State-Level: 75%; Local: 0%; Other: 0%; Total: 75%

Position Name: Ravi Dasu
Position Title: Research Scientist III
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%

Position Name: Jaynia Anderson
Position Title: Research Scientist II
State-Level: 3%; Local: 0%; Other: 0%; Total: 3%

Position Name: Mary (Kit) Lackey
Position Title: Health Program Specialist I
State-Level: 3%; Local: 0%; Other: 0%; Total: 3%

Total Number of Positions Funded: 11
Total FTEs Funded: 4.12

National Health Objective:
HO IVP-1: Reduce Fatal and Nonfatal Injuries

State Health Objective:
Between 10/2016 and 09/2017, SACB staff will maintain the rate of total, unintentional, and intentional injury deaths in California at their 2013 levels of **45.6, 28.7, and 15.2 per 100,000**, respectively.

Baseline:
Rate of injury deaths in California in 2013 for three indicators:
- *Total =* ***45.6 per 100,000***
- *Unintentional =* ***28.7 per 100,000***
- *Intentional =* ***15.2 per 100,000***

Baseline Data Source: EpiCenter: California Injury Data Online, available online at: http://epicenter.cdph.ca.gov, accessed March 2017

State Health Problem:
Health Burden: Injuries: (1) are the leading cause of death, hospitalization, and disability for Californians ages 1–44 years; and (2) have substantial impacts and consequences for the economy, communities, and the well-being of the State's population.

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

Each year, injuries in California lead to: (1) over 17,000 deaths; (2) 250,000 hospital visits; and (3) 2.5 million visits to emergency departments.

The estimated cost of intentional and unintentional injuries, based on medical and work-lost costs only (not including quality-of-life measures) is $58.9 billion annually.

Health Burden Data Sources:
- EpiCenter–California Injury Data Online: http://epicenter.cdph.ca.gov, based on CHSI 2013 death files, and Office of Statewide Planning and Development 2014 hospital and ED data files, accessed Nov. 7, 2016
- CDC, Data and Statistics (WISQARS): Cost of Injury Reports. Retrieved Nov. 6, 2016, from https://wisqars.cdc.gov:8443/costT

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. March, 2017. California Department of Public Health

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

- Consensus Recommendations For Injury Surveillance in State Health Departments https://c.ymcdn.com/sites/www.cste.org/resource/resmgr/Injury/isw1.pdf
- Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health Pediatrics, Jan. 2012, 129(1); from the American Academy of Pediatrics Policy Statement
- Stopping Elderly Accidents, Deaths, and Injuries (STEADI), CDC; https://www.cdc.gov/steadi/index.html

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

Total Current Year Funds Allocated to Health Objective:	$884,629
Total Prior Year Funds Allocated to Health Objective:	$0
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Increase availability of data on the spectrum of injuries and violence in California.
Between 10/2016 and 09/2017, SACB Crash Medical Outcomes Data Project staff will provide updated injury and violence surveillance data and TA to **100** state and local injury-prevention partners, the media, and the general public, to inform prevention policies and practices.

Annual Activities:

1. **Update and maintain California injury and violence data on EpiCenter.**
   Between 10/2016 and 09/2017, SACB staff will update and maintain California injury and violence data to **one** EpiCenter online query-based website, using the most recent emergency department, hospital discharge, and death data available, to ensure 24/7 access to injury data.

2. **Conduct EpiCenter TA consultations.**
   Between 10/2016 and 09/2017, SACB staff will conduct **50** direct TA consultations regarding the use of EpiCenter and general injury and violence surveillance to injury-prevention partners, media, and the general public, to demonstrate the value of EpiCenter data for local planning and activities.

3. **Convert data to the ICD-10-CM coding system.**
   Between 10/2016 and 09/2017, SACB staff will convert **two years** of data for non-fatal injury surveillance causes and other variables to the ICD-10-CM coding system for data received on or after October 1, 2015, to ensure accuracy of injury data and identify and explain (dis)continuities.

Impact Objective 2:

Increase available data and information on ACEs.
Between 10/2016 and 09/2017, SACB staff will publish **one** fact sheet on ACEs, based on data from the 2015 Behavioral Risk Factor Surveillance System (BRFSS) ACEs module, to make available updated ACEs data for state and local policy and program actions.

Annual Activities:

1. **Fund ACEs questions.**
   Between 10/2016 and 09/2017, SACB staff will fund a set of **eight** questions on ACEs on the FY 17/18 BRFSS questionnaire, to create ongoing trend lines for ACEs composite scores across time and space.

2. **Clean and prepare the 2015 BRFSS ACEs module data.**
   Between 10/2016 and 09/2017, SACB staff will clean and prepare **one** 2015 BRFSS ACEs module data set, and conduct descriptive and multivariate analyses, to prepare the data for translation into actionable information.

3. **Develop a fact sheet.**
   Between 10/2016 and 09/2017, SACB staff will develop **one** fact sheet based on data from the 2015 BRFSS ACEs module, to make available to partners and the general public updated ACEs data for state and local policy and program actions.

Impact Objective 3:

Increase capacity to implement evidence-based, older-adult, fall-prevention programs.

Between 10/2016 and 09/2017, SACB staff will conduct **five** planning and TA activities (e.g., in-person meetings and program consultations) for health care organizations and local entities, to support implementation of evidence-based, older-adult, fall-prevention programs.

Annual Activities:

1. **Develop an action plan to integrate STEADI into a health care system.**
   Between 10/2016 and 09/2017, SACB Older-Adult Fall-Prevention staff will develop **one** action plan to integrate STEADI screenings into **one** health care system's work-flow procedures and increase its practice of fall risk assessment.

2. **Contribute expertise to California State Falls Coalition meetings.**
   Between 10/2016 and 09/2017, SACB staff will contribute expertise to **three** meetings of the California State Falls Coalition, whose mission is to prevent falls in older adults by reducing fall risk, injuries, and hospitalizations associated with falls.

3. **Conduct TA on fall-prevention programs and resources.**
   Between 10/2016 and 09/2017, SACB staff will conduct **20** TA consultations to advise LHDs, community agencies, health care professionals, or members of the public, via telephone or e-mail, on availability of fall-prevention programs and resources.

4. **Support local or regional informational activities.**
   Between 10/2016 and 09/2017, SACB staff will fund **one** local or regional activity that provides information on fall-prevention best practices, programs, and resources to LHDs, community agencies, or health care professionals.

5. **Research ongoing grants and funding partnerships.**
   Between 10/2016 and 09/2017, SACB staff will research **two** funding opportunities, including grants and funding partnerships, to support local agencies in implementing evidence-based fall-prevention programs (e.g., Stepping On and Tai Chi: Moving for Better Balance).

Impact Objective 4:

Increase capacity to implement unintentional childhood injury-prevention programs.

Between 10/2016 and 09/2017, SACB staff will conduct **five** TA and training activities (e.g., webinars, quarterly e-mails), to build the capacity of Kids' Plates Program grantees and local entities to implement and evaluate evidence-based unintentional childhood injury-prevention programs.

Annual Activities:

1. **Conduct webinars on unintentional childhood injury-prevention topics.**
   Between 10/2016 and 09/2017, SACB staff will conduct **five** webinars on unintentional childhood injury-prevention topics, to educate Kids' Plates grantees, injury-prevention coalitions, local health departments (LHDs), and advocates on the risks to the public and intervention strategies to address these risks.

2. **Develop and distribute quarterly e-mail updates.**
   Between 10/2016 and 09/2017, SACB staff will develop and distribute **quarterly** e-mail updates on unintentional childhood injury-prevention topics to Kids' Plates Program grantees and interested parties, to provide information on research, resources, and educational opportunities.

3. **Develop and maintain a web page on the CDPH website.**
   Between 10/2016 and 09/2017, SACB staff will develop and maintain **one** web page on the CDPH website on unintentional childhood injury-prevention topics and resources, for use by Kids' Plates Program grantees and other interested parties.

4. **Conduct regional meetings.**
   Between 10/2016 and 09/2017, SACB staff will conduct **two** regional meetings with Kids' Plates Program grantees and interested parties to share best practices and resources on the implementation of their local programs, to increase effectiveness of unintentional childhood injury-prevention, evidence-based programs.

5. **Conduct TA consultations.**
   Between 10/2016 and 09/2017, SACB staff will conduct **50** TA consultations with Kids' Plates Program grantees and interested parties, via telephone or e-mail, on available unintentional childhood injury-prevention best practices, evidence-based programs, and resources, to increase program effectiveness at the local level.

Impact Objective 5:

Increase data capacity of LHDs or other traffic-safety partners.

Between 10/2016 and 09/2017, SACB Crash Medical Outcomes Data Project staff will conduct **at least six** TA and training activities to build the capacity of LHDs and other

traffic-safety partners to expand data-centric efforts to reduce traffic crashes and injuries.

Annual Activities:

1. **Conduct trainings or webinars.**
   Between 10/2016 and 09/2017, SACB staff will conduct **two** trainings or webinars on increasing availability and use of actionable traffic-safety data for LHDs or traffic-safety partners.

2. **Conduct TA for LHDs.**
   Between 10/2016 and 09/2017, SACB staff will conduct **two** in-depth TA and data-support consultations for LHDs on traffic-injury problems and prevention approaches.

3. **Conduct TA for traffic-safety partners.**
   Between 10/2016 and 09/2017, SACB staff will conduct **two** in-depth TA and data-support consultations for traffic-safety partners (e.g., Emergency Medical Services Authority), to improve data quality, completeness, and timeliness.

Obesity Prevention for Californians

State Program Strategy:

Goal: ***Promote healthy eating, physical activity, and food security, emphasizing communities with the greatest health disparities*** through statewide, regional, and local partnerships. 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 Priority: ***Although California adults and adolescents meet the Healthy People 2020 (HP 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 PHHSBG 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
- Safe and Active Communities Branch
- Chronic Disease Control Branch
- Health in All Policies Taskforce

External:

- Nutrition Policy Institute, University of California—Office of the President
- California local health departments
- California Local School Wellness Collaborative
- California Action for Healthy Kids
- Kaiser Permanente

Evaluation Methodology: Obesity-prevention projects will be evaluated using a combination of process measures (including number of trainings, trainees, and partnerships), 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.

State Program Setting:

- Child care center
- Community-based organization
- Faith-based organization
- Local health department
- Schools or school district
- State health department
- University or college
- Work site

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Linda Lee Gutierrez
Position Title: Health Program Specialist II
State-Level: 25%; Local: 0%; Other: 0%; Total: 25%

Position Name: Sophia Mercado
Position Title: Health Program Specialist I
State-Level: 25%; Local: 0%; Other: 0%; Total: 25%

Position Name: Monet Parham-Lee
Position Title: Health Education Consultant III (Specialist)
State-Level: 10%; Local: 0%; Other: 0%; Total: 10%

Position Name: Katharina Streng
Position Title: Health Program Specialist I
State-Level: 10%; Local: 0%; Other: 0%; Total: 10%

Position Name: Sheila Chinn
Position Title: Associate Government Program Analyst
State-Level: 10%; Local: 0%; Other: 0%; Total: 10%

Position Name: Jessie Gouck
Position Title: Health Program Specialist II
State-Level: 7% Local: 0%; Other: 0%; Total: 7%

Position Name: Celeste Doerr
Position Title: Research Scientist III
State-Level: 3% Local: 0%; Other: 0%; Total: 3%

Total Number of Positions Funded: 7
Total FTEs Funded: 0.9

National Health Objective:
HO NWS-10: Obesity in Children and Adolescents

State Health Objective:
Between 10/2016 and 09/2017, NEOPB staff will ***decrease the incidence of overweight or obesity in children (aged 2–17) and/or adults*** 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:
- ***791,560 (14%)** of California children aged 2–11 are estimated to be overweight for their age.*
- ***974,820 (33%)** of California children aged 12–17 are estimated to be overweight and obese for their age.*

Adults:
- ***18,322,290 (63%)** of California adults are estimated to be overweight/obese.*
- ***6,821,270 (67%)** of California adults less than 185% federal poverty level [FPL] are estimated to be overweight/obese.*
- ***7,852,410 (27%)** of California adults are estimated to be obese.*
- ***3,257,920 (32%)** of California adults less than 185% FPL are estimated to be obese.*

Data Source:
California Health Interview Survey, 2011–2015

State Health Problem:
Health Burden: Obesity represents a public health challenge of equal magnitude to that of tobacco. Obese children are more likely to become obese adults, and 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, and high blood pressure; type 2 diabetes; some cancers; and respiratory problems.

Although many factors contribute to weight gain and ultimately to obesity, inactivity, unhealthy diets, and eating behaviors are the risk factors most amenable to prevention (Obesity in California: The Weight of the State, 2000–2014, CDPH, 2016).

Obesity in Children and Teens: In 2011–2015, 33% of children and teens aged 12–17 years were considered overweight and obese. The *HP 2020* target is 9.6%.

Obesity Prevalence:
- Adults: 27%,
- Low-income adults (less than or equal to 185% of the FPL): 32%.
- The breakdown based on Race/Ethnicity (less than 185% of FPL):
  - Hispanic: 55.3%,
  - White: 25.0%,
  - Asian: 9.7%,
  - African-American: 7.2%,
  - American Indian/Alaska Native: 0.5%,
  - Native Hawaiian/Other Pacific Islander: 0.3%,
  - Multiracial: 1.7%,
  - Unknown: 0.1%.

The **target population** is all children (aged 0–17 years); the **disparate population** is primarily low-income, minority children.

Target Population:
Number: 6,483,000
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: 4,617,000
Ethnicity: Hispanic
Race: African American or Black, 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: CHIS, 2011–2015

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, 2016; (2) Accelerating Progress in Obesity Prevention: Solving the Weight on the Nation, Institute of Medicine of the National Academies, 2012

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:	$300,000
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 and 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 10/2016 and 09/2017, NEOPB staff will maintain **at least ten** educational opportunities, resources, and TA on evidence-based and evidence-informed strategies to **at least ten** partners statewide to support the advancement of nutrition education and obesity-prevention policy, systems and environmental (PSE) changes to reduce the incidence of obesity and chronic disease in California.

Annual Activities:

1. **Develop policy-inventory infrastructure.**
   Between 10/2016 and 09/2017, NEOPB staff will create **one** online infrastructure of existing organizational and legislative policies related to obesity prevention, nutrition, and physical activity among local California jurisdictions.

   The policy inventory will be built in partnership with CDPH and other state agencies, as well as the University of California, Davis, and the California Tobacco Control Program. This infrastructure will help increase state and local programs' capacity to identify and pursue strong and impactful public health policies that support community-change goals.

2. **Collect and analyze statewide data for policy recommendations.**
   Between 10/2016 and 09/2017, NEOPB staff will purchase **more than 70** assessment/survey questions to focus on sugar-sweetened beverage consumption, school health, and the California Fit Business Kit.

   Assessment results will help inform and support statewide activities for the LHDs and partners. NEOPB will leverage and partner with SNAP-Ed and CDC prevention-funded projects to expand and enhance reach and capacity.

Objective 2:

Coordinate healthy eating, physical activity, and food-security activities with partners.

Between 10/2016 and 09/2017, NEOPB staff will maintain **at least five** partnerships with internal and external partners to coordinate state and local efforts in the priority focus areas of food and beverages, physical activity, and food security, to reduce the prevalence of obesity in California.

Annual Activities:

1. **Develop relationships with nontraditional partners.**
   Between 10/2016 and 09/2017, NEOPB staff will work with **one** partner, Google Government Division, to identify social media influencers/celebrities that have adopted key messages related to obesity prevention, including: (1) limiting unhealthy foods and beverages; (2) promoting healthy eating; and (3) promoting physical activity.

Efforts will build on SNAP-Ed statewide advertising campaign but include more directed and targeted messages not permitted with USDA funding. NEOPB will specifically target populations: (1) with high prevalence of obesity and overweight; and (2) who are high users of mobile technology.

2. **Promote physical activity in early childhood and school settings.**
   Between 10/2016 and 09/2017, NEOPB staff will: (1) provide policy-related and programmatic technical assistance (TA) on physical-activity promotion efforts to **five to ten** early childhood, school, and after-school settings. This will include adults within the context of supporting youth activity; and (2) provide TA, best practices, and guidance in safe and active transportation through PSE change strategies.

3. **Plan the Childhood Obesity Conference.**
   Between 10/2016 and 09/2017, NEOPB staff will continue to plan and coordinate **one** biennial conference with long-standing partners: The California Endowment, Kaiser Permanente, University of California Nutrition Policy Institute, and the California Department of Education, to implement this highly visible, nationally recognized conference.

   NEOPB's role includes: (1) serving on the Conference Executive Committee; (2) convening the Executive Committee, which is responsible for implementing the Conference; (3) providing subject-matter expertise to support Conference content development; and (4) providing staff support for the Conference.

   Through the Executive Committee, the Conference agenda and associated content will prioritize evidence-based and evidence-informed resources and best practices that will enhance the capacity of attendees to advance PSE change for childhood-obesity prevention.

Partnering to Reduce Preventable Nonfatal Work-Related Injuries

State Program Strategy:
Goal: ***Reduce serious nonfatal work-related injuries in high-risk industries*** by investigating and identifying hazards and promoting prevention recommendations through expanded partnerships.

Health Priority: In Year One, maintain and, over subsequent years, ***decrease the annual incidence rate of nonfatal work-related injuries in selected high-risk industries*** (i.e., those industries with lost-time injury rates at least 50% greater than the overall 2015 rate of 2.2 injuries per 100 full-time equivalents (FTEs) employed for all industries, based on Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses {BLS SOII, 2015]). This priority will be accomplished by increasing access to prevention information through expanded partnerships with organizations representing affected employers and workers.

Role of Block Grant Funds: PHHSBG funds will support one FTE position salary (anticipated hire date 08/01/2017) and operating expenses, including travel to conduct worksite investigations, stakeholder relationship building, and educational activities.

Primary Strategic Partnerships:

Internal
- Safe and Active Communities Branch
- Office of Health Equity

External
- Trade associations representing employers in high injury risk industries
- State Compensation Insurance Fund
- Department of Industrial Relations, Division of Occupational Safety and Health (Cal/OSHA) and Division
- California Labor Federation
- Worksafe

Evaluation Methodology: OHB will evaluate progress toward injury-rate reduction with *process evaluation* (input and feedback from partners and stakeholders; number of investigations and new partnerships, number of educational activities and participants reached), and *outcome evaluation* (changes in knowledge, attitudes, and behaviors among participants in educational activities; decrease in injury rate).

State Program Setting:
- Business, corporation, or industry
- State health department
- Work site

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Vacant
Position Title: Associate Industrial Hygienist
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

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

National Health Objective:
HO OSH-2: Nonfatal Work-Related Injuries

State Health Objective:
Between 10/2016 and 09/2017, Occupational Health Branch (OHB) staff will maintain the baseline annual incidence rate of nonfatal work-related injuries in **up to 5** selected high-risk industries, i.e., those industries with lost-time injury rates at least 50% greater than the overall 2015 rate of 2.2 injuries per 100 FTEs employed for all industries based on the U.S. Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses (BLS SOII, 2015).

This objective will be accomplished by increasing access to prevention information through expanded partnerships with organizations representing affected employers and workers.

Baseline: *The high-risk industries selected for Year-One focus will have a 2015 baseline injury rate of **at least 3.3 per 100** FTEs employed, as compared to the nonfatal work-related injury incidence rate for all industries (private + state/local government) of 2.2 per 100 FTEs employed.*

Baseline Data Source: U.S. Bureau of Labor Statistics Survey of Occupational Injuries and Illnesses, 2015.

State Health Problem:
Health Burden: In 2015, there were over 470,000 work-related injuries and illnesses reported by employers in California, resulting in direct workers' compensation costs of over $12 billion, with additional employer costs for lost productivity, as well as the social and economic costs borne by injured and/or disabled workers and their families.

Work-related injuries are underreported by as much as 50%. California's overall rate of lost-time injuries (involving days away from work, restriction, or job transfer) is 2.2 per 100 FTEs employed for all industries. Several industries with lost-time injury rates much greater than average are low-wage with high proportions of Hispanic workers (e.g., agriculture [3.7/100 FTEs], animal processing [4.7/100 FTEs], framing contractors [6.2/100 FTEs], and landscaping [3.4/100 FTEs]).

The **target population** is all employed Californians; the **disparate population** is Hispanic workers. We will focus program activities specifically on those workers

employed in selected high-risk industries and their employers, without regard to race/ethnicity.

Health Burden Data Source:
Xu F, Mawokomatnada T, Flegal D, et al. *Surveillance for Certain Health Behaviors Among States and Selected Local Areas—Behavioral Risk Factor Surveillance System, United States, 2011*. MMWR 2014; 63(9):1–150.

Target Population:
Number: 19,195,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 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: 6,899,000
Ethnicity: Hispanic
Race: Other
Age: 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 Source: CA Employment Development Dept., 2017

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

- MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
- *Other*: California Division of Occupational Safety and Health Injury and Illness Prevention Program - e Tool (http://www.dir.ca.gov/dosh/etools/09-031/)

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

Total Current Year Funds Allocated to Health Objective:	$170,000
Total Prior Year Funds Allocated to Health Objective:	$0
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: 75–99%: Primary source of funding

Impact Objective 1:

Identify hazards in industries at high risk of serious work-related injuries.

Between 10/2016 and 09/2017, OHB staff will identify **five** industries and perform worksite investigations to assess injury hazards and make recommendations for prevention that can be disseminated to employers and employees to prevent similar incidents.

Annual Activities:

1. **Review and select industries for investigation.**
   Between 10/2016 and 09/2017, OHB staff will use the BLS SOII and other data sources (such as workers-compensation claims data), to select **five** industries with high rates and/or numbers of cases of lost-time work-related injuries for targeting worksite investigations.

2. **Conduct worksite investigations.**
   Between 10/2016 and 09/2017, OHB staff will conduct **five** worksite investigations (one per selected high-risk industry) that involve meeting at the worksite with employers, workers, witnesses, and health and safety professionals where injuries have occurred; assessing workplace injury hazards and control measures, reviewing written safety and training materials; obtaining related documents on equipment design; and producing an investigation report containing **at least three** prevention recommendations per investigation that will be shared with employers and employees.

Impact Objective 2:

Implement interventions to reduce injuries in selected high-risk industries.

Between 10/2016 and 09/2017, OHB staff will implement **five** industry-specific educational interventions aimed at reducing serious work-related injuries by working with partners to develop and disseminate best practices and prevention recommendations.

1. **Identify partner organizations for each selected high-risk industry.**
   Between 10/2016 and 09/2017, OHB staff will identify **at least five** trade associations, labor unions, worker advocacy organizations, government agencies, and others with access to and/or knowledge of the selected high-risk industries willing to partner on development and implementation of interventions aimed at reducing injuries.

2. **Convene industry stakeholders.**
   Between 10/2016 and 09/2017, OHB staff will convene **at least five** meetings and/or phone calls with industry partners/stakeholders, to obtain technical input and review of prevention recommendations, share industry best practices and recommendations for prevention, and plan for educational interventions in selected high-risk industries.

3. **Provide educational webinars and trainings.**
   Between 10/2016 and 09/2017, OHB staff will work with partners to host **five** injury-prevention webinars designed for employers in the selected high-risk industries and will provide **five** on-site trainings for workers at the worksites where injury investigations were conducted. Educational activities will share case studies of injury incidents and preventable risk factors, industry best practices, and practical and feasible methods for preventing future incidents.

4. **Participate in industry meetings and other educational venues.**
   Between 10/2016 and 09/2017, OHB staff will participate in **up to five** industry meetings and other educational venues, as available, to continue to provide technical consultation and scientific expertise on best practices to prevent serious work-related injuries within selected high-risk industries.

Preventive Medicine Residency Program/Cal-EIS

State Program Strategy:

Goal: The California Department of Public Health (CDPH) will ***support public health professional training*** through the Preventive Medicine Residency Program (PMRP) and the California Epidemiologic Investigation Service Fellowship Program (Cal-EIS).

Residents will enter PMRP in Post-Graduate Year (PGY)-2, complete graduate-level coursework, and/or receive a Masters of Public Health (MPH) degree. Residents will receive requisite exposure to epidemiology, biostatistics, social and behavioral aspects of public health, environmental health, health services administration, clinical preventive services, and risk communication.

Cal-EIS post-MPH trainees will receive real-world experience in the practice of epidemiology, public health, surveillance, and evaluation projects at a local or state health department.

Health Priority: PMRP and Cal-EIS Fellowship objectives align with *Public Health 2035* and the CDPH Strategic Map as they ***strengthen CDPH as an organization through developing the workforce***; trained physicians and epidemiologists gain the competencies needed to become public health professionals to support and facilitate the work of state health departments and local health departments (LHDs).

Role of Block Grant Funds: Funds will: (1) support trainees' stipends, as well as salaries for three staff who recruit, place, and monitor the Residents/Fellows; (2) leverage state and local funding for stipends; and (3) assure continued accreditation of the Residency Program, including program revisions to meet 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
- City of Berkeley, Department of Public Health
- Contra Costa County, Public Health
- Solano County Department of Public Health

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 a Program Evaluation Committee.

State Program Setting:

- Community health center
- Local health department
- Medical or clinical site
- State health department
- University or college

FTEs (Full-Time Equivalents):

Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Esther Jones
Position Title: PMRP Program Coordinator, Health Program Specialist I
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Jami Chan
Position Title: Cal-EIS Program Coordinator (Health Program Specialist I)
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Andra Riley
Position Title: PMRP/Cal-EIS Administrative Coordinator (Staff Services 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:

Between 10/2016 and 09/2017, PMRP/Cal-EIS staff will ***increase the public health workforce*** by graduating **at least 14** trainees from PMRP or Cal-EIS, to become qualified public health physicians and epidemiologists who contribute to and/or lead the maintenance and improvement of the health of Californians.

Baseline: ***Eight*** *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 Sources: PMRP and Cal-EIS records, including 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 and concerns: (1) As older public health leaders retire, there is a need to replace them with well-trained professionals; (2) New leaders offer novel perspectives and insights into methods of meeting the challenges of public health.

Shortages of public health physicians and other health professionals continue. A 2014 ASTHO report indicated a 5% decrease in the public health workforce (5,500 FTE) nationwide since 2010. 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 influenza, Zika, West Nile Virus, *Escherichia coli* O157:H7, Ebola, measles, drought, 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 same: the total population of California.

Target Population:
Number: 39,250,217
Infrastructure Groups:
- State and Local Health Departments
- Boards, Coalitions, Task Forces, Community Planning, Policy Makers
- Disease Surveillance—High Risk
- Health Care Systems
- Research and Educational Institutions
- Safety Organizations

Disparate Population:
Number: 39, 250,217
Infrastructure Groups:
- State and Local Health Departments
- Boards, Coalitions, Task Forces, Community Planning, Policy Makers
- Disease Surveillance—High Risk
- 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)
- 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:	$565,278
Total Prior Year Funds Allocated to Health Objective:	$565,278
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: 75–99%: Primary source of funding

OBJECTIVES—ANNUAL ACTIVITIES

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

Impact Objective 1:
Increase number of trainees who gain Preventive Medicine and Applied Epidemiology competencies.
Between 10/2016 and 09/2017, PMRP/Cal-EIS 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 114 Residents and 157 Fellows to **118 Residents and 169 Fellows**.

Annual Activities:

1. **Recruit and interview applicants for PMRP and Cal-EIS.**
   Between 10/2016 and 09/2017, PMRP/Cal-EIS staff will recruit and interview **at least eight** 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 LHDs; and posting on various websites, such as FREIDA Online, Electronic Residency Application Service (ERAS), and Public Health Employment 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 10/2016 and 09/2017, PMRP/Cal-EIS staff will train **at least 16** individuals (**at least 12** Cal-EIS trainees to achieve CSTE competencies and **at least four** 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 10/2016 and 09/2017, 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.

Public Health 2035 Capacity-Building Activities

State Program Strategy:

Goal: ***Create an environment that fosters the development and retention of an efficient and well-trained public health workforce*** to advance California's adopted health improvement plan, *Let's Get Healthy California* (*LGHC*). Public health has entered a new era—one that acknowledges the need for cross-sector collaboration and data-driven innovations to address emerging issues, health-system transformation, and health equity. Yet, much of the public health workforce is unsure how to embrace this emerging role of public health.

With 62% of staff reaching retirement eligibility within the next five years, it is imperative that the California Department of Public Health (CDPH) actively address the changing role of public health by developing tools, resources, and professional-development opportunities to ensure an innovative, agile workforce.

Health Priorities: ***Make California the healthiest state in the nation by 2022*** by training and fostering a workforce prepared for shifting public health approaches and priorities. *LGHC* monitors indicators toward CDPH ten-year targets, promoting community innovations, informing and convening cross-center and sector collaborations.

LGHC guides CDPH in addressing complex challenges, including those pertaining to collaboration, alignment, and daily operations to maximize impact and value. By aligning activities with the *LGHC* State Health Improvement Plan (SHIP), the Fusion Center (FC) facilitates innovative approaches to public health and will focus on: (1) cross-cutting initiatives; (2) health-economic evaluation; and (3) emerging issues.

In harmony, these activities will help CDPH catalyze *Public Health 2035* (*PH 2035*) trajectories to enhance staff knowledge, exposure, and skills necessary to meet the changing role of public health.

Role of Block Grant Funds: PHHSBG funds support salaries of staff and contractors who: (1) coordinate and facilitate meetings with partners and stakeholders; (2) conduct policy analysis; (3) pilot innovative ways to support local agencies; (4) prepare and disseminate reports, data, and tools; and (5) deliver workforce trainings and workshops.

Ultimately, these activities: (1) Ensure an agile and nimble workforce; and (2) Increase innovative approaches to addressing the priorities in the SHIP.

Primary Strategic Partnerships:

Internal:
- Center for Health Systems Information
- Information and Technology Services
- Office of Public Affairs
- Center for Maternal, Child, and Adolescent Health
- Office of Health Equity

External:
- Health in All Policies Task Force
- Governor's Strategic Growth Council
- AHEAD Advocates for Health
- Alzheimer's Association of California
- American Cancer Society

Evaluation Methodology: FC staff will evaluate progress toward reaching program goals with process-evaluation tracking tools, including informal stakeholder input; online surveys; and web analytic tools, such as Google analytics.

Each Impact Objective has an evaluation plan that tracks the status of project activities, deliverables, and evaluation indicators and methods.

State Program Setting:
- Local health department
- State health department

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Amanda Lawrence
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: Latesa Slone
Position Title: Associate Government Program Analyst
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-15: Community Based Primary Prevention Services

State Health Objective:
Between 10/2016 and 09/17, FC staff will coordinate and facilitate **four** staff engagement and educational initiatives in alignment with California's SHIP by

addressing workforce capacity pertaining to horizontal leadership, economic evaluation, and strategic partnerships to improve daily department operations.

Through FC's cross-center/program and cross-sector coordination and facilitation, CDPH will lead the nation in innovative government-agency approaches to solving pressing public health issues and designing a health system that addresses clinical and prevention measures as well as social determinants of health.

Baseline: *(1)* ***51%*** *of program managers are very or extremely familiar with LGHC; (2)* ***29%*** *are very or extremely knowledgeable about the PH 2035 Framework.*

Program managers found data and communications/culture to be a top contributor to collaborative projects, whereas "strict roles/responsibilities" is a major barrier to collaboration.

These data describe the need to further engage staff around LGHC, but most importantly, to coordinate and facilitate activities that: (1) engage and educate staff; (2) break down silos; and (3) encourage collaboration.

Data Source: CDPH Program Scan survey, September 2016.

State Health Problem:

Health Burden:

- California's health uninsurance rate has decreased by 6.1% since 2009;
- The percentage of those who receive health care in an integrated system has increased by 9% since 2013.

Despite these accomplishments, (1) the percentage of adults reporting “good,” “very good,” or “excellent” health has decreased from 81.6% to 78%; (2) adult obesity has increased from 22.7% to 28%; (3) diabetes prevalence has held steady at 9%; and (4) serious health disparities among race, class, and education levels persist or, in some cases, have been exacerbated.

Thus, there is a need to do business differently in public health, and it starts with training and engaging staff around new and innovative program design and administrative public health practices.

The FC’s **target population** is CDPH staff, whose activities potentially impact all California residents; its **disparate population** is at least five local health departments and community-based organizations, whose activities potentially affect all residents of the communities in which they operate. FC will transform the way CDPH does business with an agile workforce that fosters productive collaborations and the implementation of new approaches to: (1) community-based health-system interventions; (2) emerging issues; (3) data gaps; (4) data sharing; and (5) social determinants of health.

Target Population:
Number: 39,250,017
Infrastructure Groups:
- State health department

Disparate Population:
Number: 200,000
Infrastructure Groups:
- Community-based organizations
- Local Health Departments

Evidence-Based Guidelines and Best Practices Followed in Developing Interventions:
(1) Public Health Accreditation Board's Standards and Measures, v 1.5; (2) CDC Public Health Economics Methods and Tools: Economic tools used to evaluate the costs and burden of various health problems and the effectiveness and efficiency of health programs. The tools were created by CDC and its partners.

Funds Allocated and Block Grant Role in Addressing this Health Objective

Total Current Year Funds Allocated to Health Objective:	$776,370
Total Prior Year Funds Allocated to Health Objective:	$870,000
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:
Build capacity within CDPH to conduct health-economic evaluations.
Between 10/2016 and 09/2017, Dr. Michael Samuel, the FC Senior Data Scientist, will develop **one** CDPH Economic-Analysis Plan that includes: (1) purpose/background section; (2) prioritization process for conducting CDPH Economic Analyses; and (3) resource tool kit.

The Health-Economics Evaluation Initiative will continue to increase workforce capacity for economic public health system assessment across CDPH programs, providing a framework for identifying and using economic and epidemiological evidence and other objective-based metrics to inform policy and program decision-making. Effectiveness will be measured through: (1) staff engagement in The Think Tank (see Annual Activity

#1 below); (2) successfully meeting deadlines; (3) Web application utilization; and (4) implementation of the framework within **at least one** program by year's end.

1. **Convene the Health-Economics Think Tank.**
   Between 10/2016 and 09/2017, Dr. Samuel will continue to convene the **bimonthly** Health-Economics Think Tank, founded in September 2016, to maximize expertise and resources within CDPH with an overarching goal of innovating the measures by which CDPH traditionally evaluates public health and health care systems. The Think Tank will identify internal capacity and resources, and catalogue best practices and methods.

   Dr. Samuel will conduct **one** economic evaluation of the State's maternal, child, and adolescent health and home visitation program.

2. **Develop economic-evaluation best practices and supporting tools.**
   Between 10/2016 and 09/2017, Dr. Samuel will collaborate with the Health-Economics Think Tank to identify and develop best-practice tools and data for public health economic analyses, including the use of epidemiological data and population health outcomes and measures of health equity, social determinants, and other health and non-health related factors.

   Identification of tools and data will include assessment of and focus on "place-based" programs and impact. The tools will include **one** readiness assessment and **one** comprehensive literature review—an interactive web application that can monitor the cost of indicators.

3. **Develop a Public Health Economic-Analysis Framework for CDPH.**
   Between 10/2016 and 09/2017, Dr. Samuel will collaborate with the Think Tank to design **one** Public Health Economic-Analysis Framework/Plan, to ensure that economic evaluation becomes a valued tool throughout CDPH, to be used systematically in policy and program decision-making and resource allocation. This framework will be used by staff specializing in economic analysis to conduct economic evaluations (e.g., cost benefit, return on investment, cost utility) on a wide range of CDPH interventions and programs.

Impact Objective 2:
Establish proactive leadership on emerging issues.
Between 10/2016 and 09/2017, FC staff will develop **one** "Emerging Issues" Toolkit for statewide implementation. No framework to guide health departments through the process of swiftly and proactively addressing emerging issues exists. A proactive, rather than reactive, approach can prevent future harm and financial waste.

The Toolkit will: (1) be based on the experience of two emerging-issue pilot projects implemented within the department (opioid overdose prevention and violence prevention); (2) outline the steps in the CDPH Emerging Issue Process, including

frameworks, templates, and resources to support each step; and (3) be tested through an internal pilot process.

Once finalized, FC staff will host internal-development trainings on the Toolkit. Effectiveness will be measured: (1) via participant/stakeholder surveys; and (2) over subsequent years, through successful implementation of the Toolkit.

Annual Activities:

1. **Develop an Emerging Issues Toolkit.**
   Between 10/2016 and 09/2017, FC staff will collaborate with extenders in the Information Technology Services Division (ITSD) on design and configuration of **one** Toolkit as a digital resource accessible through the SharePoint platform.

   Developing this Toolkit will: (1) document lessons learned and provide a roadmap for **two** project teams addressing future topics; and (2) assemble useful tools to support expanded department engagement in proactively and effectively addressing emerging issues.

2. **Pilot the Emerging Issues Toolkit.**
   Between 10/2016 and 09/2017, FC staff will: (1) identify **one** internal project team to pilot the initial draft of the Toolkit on an identified issue; (2) work with the project team to apply **one** emerging-issue process using the Toolkit. Throughout implementation, and at the end of the initial assessment process, team members will be asked to provide feedback on the process steps and resources; and (3) document lessons learned from the pilot implementation and incorporate feedback into **one** revised Toolkit prior to wider dissemination.

3. **Provide training on the Toolkit.**
   Between 10/2016 and 09/2017, FC staff will provide **two** training sessions on the Emerging Issue Toolkit, one for internal CDPH audiences and one for local health-jurisdiction partners. General trainings may be provided via group meeting and/or webinar. Applied trainings and technical assistance (TA) may also be provided for project teams implementing the process for specific issues.

   All trainees will be asked to provide feedback on opportunities to improve the materials and format or add to the suite of resources available. By establishing the Toolkit in a digital format, continuous feedback can be used to increase the relevance and effectiveness of these tools for use by public health programs.

Impact Objective 3

Increase cross-sector and cross-center collaboration around shared priorities.
Between 10/2016 and 09/2017, FC staff will conduct **two** enhancement activities to support the *LGHC* initiative focused on the website and engagement plan to: (1) expand alignment with community needs and existing efforts; (2) increase engagement with stakeholders; and (3) continue sustainment over the next five years.

Activities will be evaluated through: (1) web analytic tools; (2) detailed work plans with milestones; and (3) partner feedback.

Annual Activities

1. **Maintain and update the *LGHC* website and dashboard.**
   Between 10/2016 and 09/2017, FC staff will: (1) continue to oversee the ongoing maintenance and hosting of **one** *LGHC* website and interactive dashboard, which serves as a dynamic repository of indicator data, change strategies, and success stories. Updates will include data and major content upgrades; and (2) include new data indicators and interactive tools.

   This work is driven by collaborations across teams comprised of subject-matter experts from state government, vendors, and nonprofit foundations/associations.

2. **Implement a strategic *LGHC* community-engagement plan.**
   Between 10/2016 and 09/2017, FC staff will: (1) develop and implement **one** community-engagement plan to promote and track local and state efforts highlighted within the *LGHC* framework; (2) incorporate feedback from partners, such as the *LGHC* Innovation Challenge applicants, the planning committee for the 2017 Innovation Conference; (3) identify priority indicators that could benefit from enhanced collaboration; and (4) find meaningful ways of interacting with internal and external audiences to advance *LGHC* and the *PH 2035* framework.

Impact Objective 4:

Prepare workforce for evolving role of public health.

Between 10/2016 and 09/2017, FC staff will implement **three** workforce-engagement strategies and TA to empower employees to embrace CDPH's *PH 2035* framework and the U.S. Department of Health and Human Services (DHHS) *Public Health 3.0* vision, which calls on public health departments to embrace their role as strategists and encourages leadership to create a center housed within the department dedicated specifically to: (1) external relations; (2) internal cross-sector collaboration; (3) strategic development; and (4) community engagement.

As an early adopter of this model, CDPH in 2015 created FC, which serves as an innovative hub to explore, research, and implement department-wide strategies to empower employees to embrace the evolving role of public health. FC staff will measure the effectiveness of these strategies by: (1) tracking how often resources are accessed via the CDPH Intranet; (2) participation in events; (3) staff surveys; and (4) direct input from program directors and external partners.

1. **Create a *PH 2035* communications and engagement plan.**
   Between 10/2016 and 09/2017, FC staff will develop **one** communications and engagement plan to align the FC workforce with the *LGHC* and *PH 2035* framework. The plan will target internal public health staff and encourage them to engage with *PH 2035* resources. These resources will encourage staff to adopt new, innovative approaches to business and program management.

2. **Develop *PH 2035* resources.**
   Between 10/2016 and 09/2017, FC staff will: (1) develop new modes of communicating and engaging with staff regarding the **four** pillars of *PH 2035*: evaluation, strategic partnerships, workforce, and leadership; and (2) create **quarterly** newsletters, podcasts, and learning sessions sharing real-world examples illustrative of *PH 2035* core principles.

   This communications platform will encourage staff to: (1) explore new ways of operating teams and programs; and (2) provide tools and resources.

3. **Coordinate town halls and podcasts with leadership.**
   Between 10/2016 and 09/2017, FC staff will facilitate **two** town halls and **two** podcasts with CDPH and California Health and Human Services Agency leadership to keep staff apprised of important Affordable Care Act legislative changes and activities that impact their personal and program-level work, allowing them to make the necessary policy, program, and budget decisions for projects and programs.

4. **Provide Accountable Communities for Health with TA.**
   Between 10/2016 and 09/2017, FC staff will provide TA, as needed, to **one** California Accountable Communities for Health Initiative (CACHI), such as evaluation and data-sharing guidance. CACHI is innovating the way community and clinical services can strengthen partnerships to address the social determinants of health.

   FC staff will meet **quarterly** with CACHI to provide input and feedback on the initiative and activities within pilot Accountable Communities for Health sites.

Public Health Accreditation

State Program Strategy:

Goal: As an accredited state public health department, the California Department of Public Health (CDPH) is required to provide accreditation readiness technical assistance (TA) to California's 61 local health departments (LHDs) and tribal public health partners. This TA is intended to ***increase California's local and tribal agency capacity to pursue, achieve, and sustain national public health accreditation***, thereby contributing to optimal public health services and outcomes for Californians.

Health Priority: Thirty-nine million people in California may receive public health services from local and tribal health departments. ***Accreditation serves as a mechanism to systematically review and evaluate health departments' systems and processes, along the continuum of Ten Essential Public Health Services.*** This evaluative process validates provision of quality services and may contribute to improving outcomes to communities served.

Role of Block Grant Funds: PHHSBG funds will support the establishment and administration of the CDPH Public Health Accreditation Mini-Grant Program by Office of Quality Performance and Accreditation (OQPA). This program will enable California's local and/or tribal public health agencies to apply for financial assistance to support accreditation-readiness activities.

Primary Strategic Partnerships:

Internal:

- California Conference of Local Health Officers
- Fusion Center
- Office of Health Equity

External:

- California Rural Indian Health Board (CRIHB)
- Centers for Disease Control and Prevention
- County Health Executives Association of California (CHEAC)
- Public Health Accreditation Board
- Public Health Institute

Evaluation Methodology: Participating agencies will be required to commit to the requirements of CDPH's Public Health Accreditation Mini-Grant Program. OQPA's Public Health Accreditation program staff will monitor participants' adherence to program guidelines, timelines, and achievement of deliverables during the project period.

State Program Setting:

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

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Total Number of Positions Funded:	0
Total FTEs Funded:	0

National Health Objective:
HO PHI-17: Accredited public health agencies.

State Health Objective
Between 10/2016 and 09/2017, OQPA Public Health Accreditation program staff will provide financial assistance to increase accreditation readiness and capacity to **at least one** local and/or tribal public health agency. Funding assistance will provide participating agencies an opportunity to develop, complete, and/or implement a process or project conforming to the Public Health Accreditation Board's (PHAB's) standards, thereby demonstrating increased readiness and capacity to apply for national public health accreditation.

Baseline: *In 2016, CHEAC surveyed 61 LHDs to assess status of accreditation readiness. Of the 53 respondents,* ***seven*** *are PHAB accredited, and* ***eight*** *submitted an accreditation application. Additionally,* ***40*** *LHDs are in varying stages of accreditation planning, and* ***six*** *have not started. The following represents LHD accreditation plans completed:*

- *Community Health Assessment:* ***22***
- *Community Health Improvement Plan:* ***11***
- *Performance Management:* ***8***
- *Quality Improvement:* ***8***
- *Strategic Plan:* ***11***
- *Workforce Development:* ***5***

CRIHB did not conduct a 2016 assessment of tribal accreditation readiness due to insufficient staffing to carry out this function; no current tribal data is available.

Data Source: CHEAC, Accreditation Status Survey, October 2016

State Health Problem
Health Burden: As of March 2017, CDPH and seven California LHDs are PHAB accredited. The remaining 54 LHDs and tribally controlled health departments may need support to plan for and achieve national public health accreditation.

PHAB accreditation preparation is complex, requiring a public health department to conduct a comprehensive review to evaluate the effectiveness of its services against a set of national quality standards. This process highlights areas of strength and opportunities for improvement that may directly impact community health. PHHSBG

funds will support OQPA's provision of accreditation-readiness financial assistance to build local and tribal capacity to pursue public health accreditation.

If each California local and tribal public health department applied for and obtained PHAB accreditation, the statewide provision of public health services would meet a national standard of excellence, and overall public health for over 39 million state residents would be optimized.

The **target** and **disparate populations** (39,400,000, the population of California) are the same.

Health Burden Data Source: CHEAC, Accreditation Status Survey, October 2016

Target Population:
Number: 39,400,000
Infrastructure Groups:
- State and Local Health Departments
- Boards, Coalitions, Task Forces, Community Planning, Policy Makers
- Disease Surveillance—High Risk
- Health Care Systems
- Research and Educational Institutions
- Safety Organizations

Disparate Population:
Number: 39,400,000
Infrastructure Groups:
- State and Local Health Departments
- Boards, Coalitions, Task Forces, Community Planning, Policy Makers
- Disease Surveillance—High Risk
- Health Care Systems
- Research and Educational Institutions
- Safety Organizations

Evidence-Based Guidelines and Best Practices Followed in Developing Interventions:
- Association of State and Territorial Health Officials, 2011–2015
- Michigan Quality Improvement Guidebook, Second Edition, 2012
- 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:	$30,000
Total Prior Year Funds Allocated to Health Objective:	$0
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Provide financial assistance.

Between 10/2016 and 09/2017, OQPA Public Health Accreditation program staff will provide financial assistance to increase accreditation readiness to **at least one** local and/or tribal public health agency, to improve capacity to prepare for national public health accreditation.

Annual Activities:

1. **Establish and administer a mini-grant program.**
   Between 10/2016 and 09/2017, OQPA Public Health Accreditation program staff will establish **one** CDPH Public Health Accreditation Mini-Grant Program for California's local and/or tribal public health agencies to apply for accreditation readiness financial assistance. A mini-grant may be used to support development of accreditation-related activities, such as community health assessment and improvement planning, workforce development, QI, strategic planning, and/or performance management.

   The allocation of financial assistance will increase capacity of **at least one** local and/or tribal public health agency that has demonstrated limited economic resources to prepare for public health accreditation. OQPA's Public Health Accreditation program staff will monitor participants' adherence to program guidelines, timelines, and achievement of deliverables during the project period.

Rape Prevention Program

State Program Strategy:
Goal: ***Stop first-time perpetration and victimization of sex offenses*** by implementing evidence-informed sex-offense (rape) prevention strategies.

Health Priorities: ***Reduce sexual violence*** (national *Healthy People 2020* focus area of Injury and Violence Prevention). In 2014, the incidence of rape reported to the criminal justice system among both men and women in California was 32.7 per 100,000 (California Department of Justice [CDOJ], 2014).

Role of Block Grant Funds: The PHHSBG Rape Set-Aside allocation will be used by the Safe and Active Communities Branch (SACB) to provide funding to local RCCs that directly serve victims, and potential victims and perpetrators, to deliver sex-offense (rape) prevention programs that promote positive social norms and change attitudes, behaviors, and social conditions that make sexual violence possible.

Primary Strategic Partnerships:

Internal:
- Office of Health Equity
- Maternal, Child, and Adolescent Health
- CDPH Health in All Policies
- CDPH Sexually Transmitted Diseases Control Branch

External:
- California Coalition Against Sexual Assault
- California Office of Emergency Services
- California Partnership to End Domestic Violence
- California Department of Education

Evaluation Methodology: Data from CDOJ will be used to evaluate progress toward ending sexual violence. This is a standardized data source that provides yearly updates on crime in California.

CDPH will assess and monitor progress through online reporting systems to collect data and narrative reports from funded contractors.

State Program Setting:
- Community-based organization
- Rape crisis center
- Schools or school district
- State health department
- Tribal nation or area

FTEs (Full-Time Equivalents):
Full-time equivalent positions that are funded with PHHSBG funds.

Position Name: Nancy Bagnato, MPH
Position Title: Health Program Manager II
State-Level: 30%; Local: 0%; Other: 0%; Total: 30%

Position Name: Pam Shipley
Position Title: Staff Services Manager I
State-Level: 30%; Local: 0%; Other: 0%; Total: 30%

Total Number of Positions Funded: 2
Total FTEs Funded: 0.60

National Health Objective:
HO IVP-40: Sexual Violence (Rape Prevention)

State Health Objective:
Between 10/2000 and 09/2020, reduce by **1%** the rate of rape in California, as measured by CDOJ data.

Baseline: *In 2015, the incidence of rape reported to criminal justice in California was **32.7 per 100,000**.*

Data Source: CDOJ, 2015 (No newer data exists.)

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 (MMWR, CDC, 2008).

Females are more often the victims of rape; nearly one in five females have been raped during their lifetimes versus one in 59 males.

The **target population** consists of the total population of California. The **target** and **disparate population** consists of African-American females.

Target Population:
Number: 39,589,144
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 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: 1,140,146
Ethnicity: Non-Hispanic
Race: African American or Black
Age: 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
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state

Target and Disparate Data Source: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010–2060. Sacramento, California, January 2013; retrieved March 2017 from http://epicenter.cdph.ca.gov

Evidence-Based Guidelines and Best Practices Followed in Developing Interventions:
Other: (1) Initial Guidance for RPE CE14-1401, CDC, 2014; (2) Resources for Sexual Violence Preventionists, NSVRC, 2012; (3) *Moving Forward by Looking Back: Reflecting on a Decade of CDC's Work in SV Prevention*, 2000-2010, J. of Women's Health, 2012; (4) *STOP SV: A Technical Package to Prevent Sexual Violence, CDC, 2016*

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:	$0
Funds to Local Entities:	$707,741

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.

Impact Objective 1:
Address the community and/or societal levels of the social-ecological model.
Between 10/2016 and 09/2017, SACB staff will increase by the number local rape crisis centers (RCCs) that provide sexual-offense prevention programs to victims, potential victims, and potential perpetrators that address the community and/or societal level of the social-ecological model (SEM) from **two** [RPE Annual Data Report, 2015–16] to **four**.

Annual Activities:

1. **Assess sexual-violence risk and protective factors that RCCs address.**
   Between 10/2016 and 09/2017, Rape Prevention staff will conduct assessments with **six** RCCs to determine to what extent they are implementing sexual-offense prevention programs addressing community- and/or societal-level risk and protective factors.

2. **Increase knowledge and skills of RCCs to utilize a public health approach.**
   Between 10/2016 and 09/2017, Rape Prevention staff will conduct **a minimum of four** educational activities to enhance the knowledge and skills of staff from **six** RCCs to conduct sexual-offense (rape) prevention programs that address the community and/or societal levels of the SEM.

3. **Fund sexual-offense prevention programs.**
   Between 10/2016 and 09/2017, Rape Prevention Program staff will fund **six** local RCCs to conduct sexual-offense prevention programs that address the community and/or societal levels of the SEM.

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 (e.g., saxitoxin [STX]) 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 will support salaries and operating costs for personnel involved in development, standardization, and validation of the RBA for use in surveillance of PSP toxins.

The anticipated fill date for the vacant position is April 30, 2017.

Primary Strategic Partnerships:

Internal:
- Environmental Management Branch, Preharvest Shellfish Program
- Microbial Diseases Laboratory
- Food and Drug Branch
- Pacific Coast Shellfish Growers Association

External:
- 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 determined by the generation of formalized Standard Operating Procedures (SOPs) describing the full scope of the RBA analysis, and good correlation between the RBA and the MBA, indicating that the RBA is equally protective of human health.

State Program Setting:

State health department

FTEs (Full-Time Equivalents):

Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Vacant
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:
Between 10/2016 and 09/2017, RBA for PSP Control staff will create **one** template and framework for the use of the RBA for routine regulatory testing in California for monitoring PSP. This framework will consist of SOPs for the entire analytical procedure and for determining the suitability of the reagents, and data characterizing the equivalence between the RBA and 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: *Since 1927, there have been **542** reported illnesses and **39** deaths attributed to PSP-contaminated shellfish in California (existing shellfish-testing data utilizing the MBA method). 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 the use of live animals.*

Data Source: Price DW, Kizer KW, Hansgen KH. 1991. California's paralytic shellfish poisoning prevention program, 1927–89, J. Shellfish Res. 10:119–145 (No newer published data of this type exists.)

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 consumer characteristics, 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 CDPH surveillance throughout the year, 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 and disparate populations** are the same: all consumers of commercial and sport-caught shellfish from California growing areas and coastal waters.

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 Source: California Census Data (2016), 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:	$265,000
Total Prior Year Funds Allocated to Health Objective:	$275,000
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Create a template for the use of the RBA for routine regulatory testing in California.

Between 10/2016 and 09/2017, RBA for PSP Control staff will develop **one** framework and template for use of the RBA for regulatory testing in California. This will consist of complete SOPs for all procedures as well as procedures to determine the suitability of the reagents, and data characterizing RBA method performance.

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. **Develop RBA SOPs for determination of PSP toxins in oysters.**
   Between 10/2016 and 09/2017, RBA for PSP Control staff will generate **one** detailed SOPs document for the determination of PSP toxins in oysters using the RBA. This document will finalize improvements to the testing protocol and incorporate best practices for quality control and results reporting as required by the Interstate Shellfish Sanitation Conference (ISSC) for regulatory testing of commercial shellfish. These will include: (1) starting extract dilutions; (2) trigger levels for subsequent dilutions; and (3) retesting and quality controls required. Specifications and acceptance checklist protocol for the tritiated-STX (3H-STX) will be included. These parameters must include: (1) hillslope; (2) IC50; (3) percent recovery of 3 nM STX cold spike; and (4) percent recovery of QC80 tissue spike.

2. **Test all shellfish samples submitted to CDPH using the RBA.**
   Between 10/2016 and 09/2017, RBA for PSP Control staff will analyze **all** shellfish samples 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 establish that the results generated from the two tests are comparable. This side-by-side testing needs to be done for a full year to characterize method performance in varying environmental conditions.

   Samples will be pre-screened using a qualitative immuno-test; only positive samples will be tested by RBA and MBA. This testing will establish whether the sample-processing and data-analysis time required for the RBA allow for timely results reporting (important for public safety and commercial interests).

   Through all of 2016, 150 positive samples were collected. These samples have been extracted and are currently stored at –20°C.

3. **Analyze archived shellfish samples from historic blooms and various locations.**
   Between 10/2016 and 09/2017, RBA for PSP Control staff will analyze **255** archived (collected since August 2009) shellfish samples for STX equivalence by RBA.

   It is necessary to analyze samples from historic blooms to: (1) establish that the results provided by the two assays are similar; and (2) demonstrate that the RBA is as protective of public health as the MBA before adopting the new method for surveillance. Bloom species and toxin profiles may differ.

4. **Develop an alternative RBA analysis.**
   Between 10/2016 and 09/2017, RBA for PSP Control staff will develop **one** novel STX testing method based on the RBA with liquid chromatography-mass spectrometry (LC-MS detection) and using a 15N-labeled STX substrate rather than 3H-STX. This alternative method would be a usable alternative should the 3H-STX ligand not be available commercially, as staff has experienced recently.

5. **Determine performance characteristics of the MBA for STX in shellfish.**
   Between 10/2016 and 09/2017, RBA for PSP Control staff will determine the detection limit and accuracy of **one** assay, the MBA, for STX in shellfish samples spiked with known amounts of STX.

   The overarching goal is to compare the performance of the RBA to the MBA, which is the approved assay for PSP surveillance. Comparative assays (specifically Bland–Altman statistical analysis) demonstrate that the RBA gives higher results than the MBA at low toxin concentrations. It is known that the RBA is more sensitive than the MBA. Additional information is needed to understand the discrepancy. In particular, formal determination of the detection limit, with controlled-spiked samples, for the MBA is required.

TB Free California

State Program Strategy:

Goal: The California Department of Public Health (CDPH) will address the *Healthy People 2020* "Reduce Tuberculosis (TB)" target: ***Reduce tuberculosis to one new case per 100,000 population***.

Health Priority: The TB Free California program is aligned with the CDPH *Public Health 2035* goals: the program will ***lead change and engage communities through prevention activities based on collaborative science-based practices that improve health equity throughout California.***

Role of Block Grant Funds: Funds will support a scientific and technical team to develop and implement changes in practice to eliminate tuberculosis in California. The budget covers: (1) salaries for three contract positions with expertise in tuberculosis clinical-prevention strategies and health systems; epidemiology, surveillance and evaluation methods; and training and communication; (2) travel for the three-person team; and (3) production costs for training materials.

The vacant positions are expected to be filled by July 1, 2017.

Primary Strategic Partnerships:

Internal:
- Office of AIDS
- Tobacco Control Program
- Chronic Disease Control Branch
- Refugee Health Program
- Office of Border and Binational Health

External:
- Department of Health Care Services, MediCal Managed Care
- 61 Local Public Health Departments in California
- Kaiser Permanente
- California Tuberculosis Controllers Association
- Federally Qualified Health Centers

Evaluation Methodology: On an ongoing basis, the program team will measure, using newly developed metrics, performance indicators for testing and treating latent TB infection in public health and other health care settings. The program team will track performance of each program objective.

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 equivalents):
Full-time equivalent positions that are funded with PHHSBG funds:

Position Name: Vacant
Position Title: Medical Epidemiologist
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Vacant
Position Title: Epidemiology and Evaluation Research Scientist
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

Position Name: Vacant
Position Title: Training and Communications Coordinator
State-Level: 100%; Local: 0%; Other: 0%; Total: 100%

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

National Health Objective:
HO IID-29: Tuberculosis

State Health Objective:
Between 10/2016 and 09/2017, TB Free California staff will work toward the goal of reducing the overall rate of tuberculosis in California to **less than one case per 100,000 population** by 2025 by: (1) combining efforts with CDPH programs that reduce tobacco use and diabetes, two known risk factors that accelerate the progression to TB disease from the latent (dormant) TB infection stage; and (2) aligning with *Let's Get Healthy California* Goal 2: "Preventing and Managing Chronic Disease," which supports the triple aims of better health, better care, and better costs.

Baseline: *California tuberculosis 2015 case rate:*
- *Overall: **5.5** cases per 100,000 population*
- *Persons born outside the United States: **16.3** cases per 100,000 population*

Data Source: CDPH Tuberculosis Control Branch: "Report on Tuberculosis in California, 2015" (All cases of TB in California are reported to the state TB Registry.)

State Health Problem:
Health Burden: A significant reduction in health inequity in California is expected by preventing TB among vulnerable populations, particularly among foreign-born populations disproportionately affected by TB. Foreign-born Asians have a rate of TB disease that is 30 times the rate of U.S.-born Caucasians.

Individuals throughout California in the following categories are affected by TB and represent the **target population:** male and female; all ages; Hispanic, non-Hispanic, Black, American Indian or Alaskan Native, Native Hawaiian or other Pacific Islander

origin; and Whites born in countries other than the United States, Canada, Australia, New Zealand, or countries in western/ northern Europe. Of these individuals, those who are low income or otherwise lack access to care are disproportionally affected by TB disease.

The **disparate population** is adults born in countries with high tuberculosis incidence, of all races and ethnicities, especially individuals of lower socioeconomic status.

Health Burden Data Source: CDPH, Tuberculosis Control Branch, Tuberculosis Registry: Report on Tuberculosis in California, 2015

Target Population:
Number: 2,500,000
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: Yes

Disparate Population:
Number: 2,100,000
Ethnicity: Hispanic, Non-Hispanic
Race: Asian, White, Other
Age: 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: CDPH Tuberculosis Control Branch: “Report on Tuberculosis in California, 2015”

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

- Best Practice Initiative (U.S. Department of Health and Human Services)
- Guide to Community Preventive Services (Task Force on Community Preventive Services)
- MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
- *Other*: U.S. Preventive Services Task Force “Recommendation on Latent Tuberculosis (TB) Screening, September 2016”

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

Total Current Year Funds Allocated to Health Objective:	$600,000
Total Prior Year Funds Allocated to Health Objective:	$0
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:

Aid public- and private-sector programs to identify and engage high-risk patients.

Between 10/2016 and 09/2017, TB Free California staff will provide training and guidance to improve the practice of engaging high-risk patients in testing and treatment for latent TB infection to **50** health care providers who see at-risk patients in large community and institutionally based settings.

Annual Activities:

1. **Train community and institutional health care providers.**
   Between 10/2016 and 09/2017, TB Free California staff will develop and provide **six** trainings and **12** consultations on testing and treatment of TB infection and TB prevention strategies for **at least 50** health care providers in community and institutionally based settings, to build capacity for identifying, assessing, and treating populations at risk.

Impact Objective 2:

Create new latent TB infection reporting metrics for measuring program performance.

Between 10/2016 and 09/2017, TB Free California staff will develop **two** latent TB infection reporting metrics to measure program performance on latent TB infection testing and treatment.

Annual Activities:

1. **Develop a template for reports on latent TB infection testing and treatment.**
   Between 10/2016 and 09/2017, TB Free California staff will develop **at least one** template, process, and procedure for generating reports to track progress on latent TB testing and treatment conducted in public health and other health care settings.

Impact Objective 3:

Develop a latent TB infection testing and treatment guideline document.

Between 10/2016 and 09/2017, TB Free California staff will develop **one** guideline on testing and treatment for latent TB infection for providers. Providers do not have protocols for treating infection, only treating disease. The guideline should be incorporated into the standards of practice for all health care providers that see patients at risk for TB disease.

Annual Activities:

1. **Determine standards and procedures for identifying and treating latent TB infection.**
   Between 10/2016 and 09/2017, TB Free California staff will work with the California TB Controllers Association to identify best practices for assessing, screening, and treating people with latent TB infection who are likely to progress to TB disease if untreated. The information will be incorporated into **one** guideline document to be used to guide practices of providers in public-sector and private-sector health care settings.

Impact Objective 4:

Develop tools on latent TB infection testing and treatment.

Between 10/2016 and 09/2017, TB Free California staff will develop **at least two** education tools: at least one patient-education tool and at least one community-education tool on latent TB infection to health care providers of populations at increased risk for progression of TB infection to TB disease throughout California.

Annual Activities:

1. **Determine appropriate latent TB infection and TB disease education messages and methods.**
   Between 10/2016 and 09/2017, the TB Free California Training and Communications Coordinator will develop **at least two** culturally and linguistically appropriate educational print materials and electronic media for **at least 50** providers' use with patients and communities at risk for latent TB infection and TB disease.

2. **Disseminate community-education tools.**
   Between 10/2016 and 09/2017, the TB Free California Training and Communications Coordinator will work with local health department (LHD) staff and staff of community-based programs to disseminate **at least two** tools to **at least 100** providers seeing clients at risk for TB disease.

Impact Objective 5:

Train LHD staff on latent TB infection practices.

Between 10/2016 and 09/2017, TB Free California staff will conduct **six** trainings for staff from 30 LHDs to promote the adoption of recommended practices for screening, testing, and treatment of latent TB infection.

Annual Activities:

1. **Assess training needs.**
   Between 10/2016 and 09/2017, TB Free California staff will assess practice deficits among **at least 60** LHD staff. The assessment will: (1) ensure that training is targeted to meet specific LHD personnel needs; and (2) address ways to reach specific populations in their jurisdictions.

Using HIV Surveillance Data to Prevent HIV Transmission

State Program Strategy:
Goals: The California Department of Public Health (CDPH) Office of AIDS (OA) is responsible for meeting the goals of the President's National HIV/AIDS Strategy in California: to: (1) ***reduce the number of people who become 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.***

Health Priority: California ranks second in the nation for cumulative AIDS cases; as of December 31, 2014, ***an estimated 139,000 people were living with HIV in California.*** Of those, 91% know their HIV status, 64% are in HIV care, and 52% achieved viral suppression. 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.

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

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.

Evaluation Methodology: HIV surveillance data in the funded counties will be used to determine the proportion of people living with HIV not in health care and the change in the rates of HIV-positive persons in care over the funding period. The increase in those newly identified as HIV-positive by Partner Services will be measured by the Local Evaluation Online (LEO) database, managed by the OA Prevention Research and Evaluation Branch, and from STD surveillance data available from the CDPH STD Control Branch.

Program Setting:
- Local health department
- Medical or clinical site
- State health department

FTE (Full-Time Equivalent) Allocation
Full-time equivalent positions that are funded with PHHSBG funds:

Total Number of Positions Funded:	**0**
Total FTEs Funded:	**0**

National Health Objective:
HO HIV-1: HIV Diagnoses

State Health Objective
Between 10/2015 and 12/2020, increase the proportion of people living with HIV/AIDS who are in continuous care from 71 to **90%**, 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 **8,655**. This is based on OA HIV surveillance data of those diagnosed with HIV as of December 31, 2013, and living with HIV on December 31, 2014.*

Data Source: OA HIV Surveillance Case Registry (an ongoing, secure, non-public database of all people with HIV in California)

State Health Problem:
Health Burden: California ranks second in the nation for cumulative AIDS cases; as of December 31, 2014, approximately 139,000 Californians were living with HIV. The **target population** is all people in San Diego, Orange, and Alameda Counties who have HIV but are not engaged in HIV care and treatment. The **disparate population** is all men who have sex with men of color in San Diego, Orange, and Alameda Counties who have HIV but are not engaged in HIV care and treatment.

Target Population:
Number: 8,655
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: 4,305
Ethnicity: Both
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander

Age: 12–19 years, 20–24 years, 25–34 years, 35–49 years, 50–64 years, 65 years and older
Gender: Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Alameda, Orange, and San Diego Counties

Target and Disparate Data Sources: California HIV Surveillance Data collected by OA. Data provided in April 2015.

Evidence-Based Guidelines/Best Practices:
- MMWR Recommendations and Reports (CDC);
- *Other:* California HIV surveillance data from 2014 HIV Continuums of Care (2015 data will be available in June 2017)

Funds Allocated to Address this Health Objective

Total Current Year Funds Allocated to Health Objective:	$500,000
Total Prior Year Funds Allocated to Health Objective:	$500,000
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 and Process Objective outcomes and to carry out Annual Activities that are based on Evidence-Based Guidelines and Best Practices identified in this work plan.

Impact Objective 1:
Establish Alameda County–specific priority populations for linkage to care.
Between 10/2016 and 9/2017, the Alameda OA contractor will establish **at least four** Alameda County–specific populations with HIV that will be prioritized for linkage-to-care (LTC) activities.

Annual Activities:

1. **Evaluate Alameda laboratory and HIV surveillance data.**
   Between 10/2016 and 9/2017, the Alameda OA contractor will evaluate Alameda laboratory and HIV surveillance data to determine **at least four** demographic populations that should be prioritized for LTC activities.

2. **Develop protocols for LTC staff to use for priority populations.**
   Between 10/2016 and 9/2017, the Alameda OA contractor will develop **at least two** protocols for HIV LTC staff to assist in prioritizing populations for LTC activities.

Impact Objective 2:

Evaluate Orange County LTC and Partner Services Activities.

Between 10/2016 and 9/2017, the Orange County OA contractor will evaluate **at least 14** reports that will provide Quality Improvement (QI) and Quality Assurance (QA) information to outreach, LTC, and partner services staff; and the Division Manager of Disease Control and Epidemiology in Orange County.

1. **Establish reporting policies and procedures for integration of electronic health records and HIV surveillance data.**
   Between 10/2016 and 9/2017, the Orange County OA contractor will consult with **six** Orange County Information Technology staff to integrate newly implemented electronic health records (EHRs) and HIV surveillance data to provide **biannual** reports for the outreach and LTC teams.

2. **Develop reports using QI/QA database to provide LTC information.**
   Between 10/2016 and 9/2017, the Orange County OA contractor will provide **monthly (12)** reports identifying patients who are newly diagnosed with HIV or previously diagnosed but not in HIV care to assist the LTC team in determining the most appropriate LTC intervention.

Impact Objective 3:

Interview patients to provide LTC and partner-services elicitation in San Diego.

Between 10/2016 and 9/2017, the San Diego OA contractor will conduct **100** interviews with people co-infected with non-virally suppressed HIV and gonorrhea (GC) to provide LTC, ascertain appropriate GC treatment, and elicit information about sex or needle-sharing partners.

Annual Activities:

1. **Identify those co-infected with HIV and GC.**
   Between 10/2016 and 9/2017, the San Diego OA contractor will assess **1,500** records reported to the Electronic Laboratory Reporting System (ELR) and the Enhanced HIV/AIDS Reporting System (eHARS) surveillance data to identify people who have been recently diagnosed with GC who have non-virally suppressed HIV.

2. **Conduct interviews with identified patients.**
   Between 10/2016 and 9/2017, the San Diego OA contractor will: (1) contact **300** identified patients and determine if they are in HIV care and receiving appropriate GC treatment, and discuss the reasons for their non-viral suppression; and (2) elicit identifying information about their sex and/or needle-sharing partners that can allow for anonymous third-party notification.

Impact Objective 4:

Provide individual mentorship to State Disease Investigators.

Between 10/2016 and 9/2017, the STD Control OA contractor will implement **one** statewide individual mentoring program for State Disease Investigators, to increase the proportion of people living with HIV/AIDS who are in continuous care.

Annual Activities:

1. **Investigate capacity of State Disease Investigators.**
   Between 10/2016 and 9/2017, the STD Control OA contractor will investigate the training and skill level of **ten** State Disease Investigators to provide linkage to HIV care and pre-exposure prophylaxis (PrEP) education, to determine their mentoring needs.

2. **Develop a one-on-one training program for State Disease Investigators.**
   Between 10/2016 and 9/2017, the STD Control OA contractor will develop and provide a program to meet individual training and skill-building needs of **six** State Disease Investigators.