Preventive Health and Health Services Block Grant: FFY 2021 State Plan

Version Date: May 21, 2021

Table of Contents

Executive Summary

This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2021. The California Department of Public Health (CDPH) will turn in this plan as the designated state agency for the allocation and administration of PHHSBG funds.

Program Descriptions

Program Title	Program Description	Allocation
Advancing Climate Change and Health Programs at local health departments, tribes and within CDPH	This program will support California Department of Public Health (CDPH) programs, tribes, and local health departments to prepare for and prevent the health and equity impacts of climate change. It will also support CDPH programs, tribes and local health departments to improve social determinants of health and meet existing health program objectives through engagement with climate change policy and planning.	$600,061
CA Behavioral Risk Factor Surveillance System (BRFSS) Program	BRFSS is a CA-specific surveillance system that surveys adults 18 years and older on self-reported health behaviors. Questions in the survey relate to nutrition, physical activity, tobacco use, hypertension, blood cholesterol, alcohol use, inadequate preventive health care, and other risk factors. An annual BRFSS report is published. Because the survey is conducted on an annual basis, the continuous use of this system allows analysis of trends over time.	$281,126
Cardiovascular Disease Prevention Program	This program increases blood pressure control in adults with hypertension to reduce deaths from coronary artery disease and to reduce the risk of stroke recurrence in post-stroke patients to decrease hospitalizations and deaths from stroke. The program utilizes the team-based care approach of Comprehensive Medication Management, linking attending physicians, community pharmacists, stroke coordinators, and community health workers to help patients achieve better hypertension control. This program promotes cardiovascular health through collaboration with the Healthy Hearts CA Alliance and will update the CA Heart Disease & Stroke Prevention & Treatment Master Plan.	$825,718
Emergency Medical Services (EMS)	This program provides for pre-hospital EMS data submissions into the state EMS database system	$1,199,869

Prehospital Data and Information Services and Quality Improvement Program	and unites the EMS system under a single data warehouse, fostering analyses on patient care outcomes, public health system services, and compliance with CA state and federal EMS service laws. The Program improves pre-hospital EMS services and public health systems statewide by providing measurable quality improvement oversight, resources, and technical assistance.	
EMS Systems Operations, Planning, and Specialty Care	Emergency Medical Services Authority, through its EMS Systems Division is mandated to coordinate EMS systems throughout the State of CA, the statewide Trauma System, Stroke and ST-Elevation Myocardial Infarction (STEMI) Systems, EMS for Children, and the CA Poison Control system. The EMS Systems Division has statutory and regulatory oversight responsibility of the EMS system for the State of CA and promulgates regulations for use by local EMS agencies and EMS providers, reviews and approves local EMS system and ambulance transportation plans ensuring that the required minimum standards are met, and manages the state's EMS data collection, performance management and quality assurance. EMS Systems Division staff provide state leadership, oversight, and regulation to ensure the best quality of care is available, reducing the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care in an emergency.	$1,440,375
Health in All Policies	This program facilitates the CA Health in All Policies Task Force, provides consultation to non-health agencies to integrate health and equity into their policies, programs, and procedures, and builds CDPH and Local Health Department capacity to promote health equity and implement Health in All Policies approaches through collaboration and integration of health and equity considerations statewide.	$574,610
Healthy People 2030 Program	This program supports the overall efforts of the PHHS Block Grant by enhancing the accountability and transparency of the PHHS Block Grant through measuring progress and impact of funded programs through quality improvement initiatives, as well as communicating current accomplishments.	$813,967

Injury Prevention Program	This Program seeks to maintain injury prevention as a core public health function and ensure capacity to address emerging cross-sector issues, such as: healthy aging, Adverse Childhood Experiences (ACEs), and firearm-related injuries and fatalities.	$1,099,910
Public Health Accreditation Program	On December 9, 2014, CDPH was awarded national accreditation via the Public Health Accreditation Board (PHAB). To maintain the Department's accreditation status, this program will make accreditation-related technical assistance available to CA's local and tribal public health agencies, and oversee internal Departmental efforts to maintain compliance with accreditation requirements.	$58,164
Rape Prevention Program	This program approaches sexual violence from a public health perspective. Like CA's smoking campaign that has made smoking unacceptable, it aims to change the behaviors and norms that make sexual violence tolerable by building the capacity of CA's local rape crisis centers to implement sexual violence primary prevention strategies.	$832,969
Southern CA Asylum Seeker Health Surveillance and Linkage to Care	This program is an active surveillance and rapid public health response program for individuals seeking asylum and intending to reside in CA. Active surveillance increases early identification of infectious diseases of public health significance, and services facilitate linkage to healthcare services and disease control.	$228,779
Surveillance Sampling of Leafy Greens for Shiga Toxin-Producing *E. coli.*	The goal of this program is to collect surveillance samples of high-risk food products that are known to be susceptible to microbial contamination, evaluate them for microbial contamination, and initiate interdiction efforts to remove them from the marketplace if determined to be adulterated, thereby preventing consumer exposure and reducing the incidence of food-borne illness.	$193,880

The Office of Strategic Development & External Relations, Fusion Center	This program builds cross-sectoral engagement in CDPH's State Health Assessment (SHA) and State Health Improvement Plan (SHIP) by enhancing capacity to address crosscutting priorities defined by public health through Comprehensive Assessment, Integrated Planning, and Collective Action addressing crosscutting priorities defined by public health with the purpose of organizing for impact.	$936,800
Toxicological Outbreaks Program	This program supports the administrative and technical infrastructure at CDPH to conduct non-infectious toxicological disease outbreak investigations.	$121,175
Tuberculosis Free CA	This program promotes prevention strategies to reduce tuberculosis (TB) disease among high-risk populations in CA. This is the sole statewide program focused on TB prevention, with the aim of averting significant morbidity, mortality, and healthcare costs associated with TB disease. Program activities include patient education for high-risk populations to reduce TB health disparities, measurement of testing and treatment of TB infection at key clinical sites, and provider training on evidence-based testing and treatment strategies to prevent TB disease.	$581,641
Workforce Development: Preventive Medicine Residency (PMR) and CA Epidemiologic Investigation Service (Cal-EIS) Fellowship	PMR and Cal-EIS programs are the key workforce pipeline for hard-to-fill epidemiology and public health medical officer positions in CA state and local public health agencies. Trainees perform data and policy analyses, provide disease outbreak and emergency preparedness response; community needs assessments and planning, clinical preventive medicine, systems quality improvement, etc.	$667,328

Advancing Climate Change and Health Programs at local health departments, tribes and within CDPH

Healthy People 2030 Objective

EH-D02: Reduce heat-related morbidity and mortality

Health Objective

Between 07/2021 and 06/2022, Program will provide support and expertise to state, local, and tribal health programs to increase incorporation of climate change into their health programs, plans, policies, and communications.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $526,152
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Technical assistance to local health departments and tribes, but not funding.
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of total funding that is PHHS Grant: 10-49% - Partial source of funding
- Existing funding source(s): State or local funding
- Role of PHHS Block Grant Funds in supporting this program: Enhance or expand the program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 4
- Number of FTEs in this program funded by the PHHS Block Grant: 3.65

Issue/Problem

Climate change impacts heat-related illnesses and deaths, air pollution-related exacerbations of cardiovascular and respiratory diseases, injuries and deaths due to severe storms and flooding, access to healthy foods and clean water due to impacts on agriculture, flooding, and sea level rise, and stress and mental trauma from loss of livelihoods, property loss, and displacement. Health departments and Tribal health programs have not had sufficient resources or technical expertise to prevent and reduce the health impacts associate with the changing climate.

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: Increasing temperatures associated with increasing climate change can lead to heat-related illnesses and deaths in absence of sufficient preparation and protective resources.

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

Data source for key indicator baseline: Tracking California website

Date key indicator baseline data was last collected: 2018

Program Strategy

Goal: Support CDPH programs, LDHs and tribes to prevent and reduce the health impacts of climate change.

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

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

Summary of Program Strategy: Provide technical assistance to support CDPH programs, LHDs, and tribes to prepare for and prevent the health impacts of climate change. Provide technical assistance to support CDPH programs, local health departments, and tribes to build climate change policy and planning into existing public health programs in order to further improve social determinants of health and meet existing health program objectives.

Primary Strategic Partners

External:

1. LHDs
2. California Tribes or Tribal Health Programs

Internal:

1. Environmental Health Investigations Branch
2. California Conference of Local Health Officers
3. Indoor Air Quality
4. Nutrition Education and Obesity Prevention Branch
5. Injury and Violence Prevention Branch

Planned non-monetary support to local agencies or organizations:

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

Evaluation Methodology: Program will evaluate progress toward objectives using: 1) process evaluation, including the numbers of meetings conducted, number of CDPH programs, tribes, and LHDs provided technical assistance; 2) outcome evaluation such as CDPH programs, tribes and LHDs addressing climate change in plans, program objectives, policies, or communications; and 3) impact evaluation by tracking heat-related emergency department visits and deaths.

Program Settings:

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

Target Population of Program

- *Target population data source*: CDPH Climate Change and Health Vulnerability Indicators for California, American Community Survey, Healthy Places Index
- *Number of people served:* 39,512,223
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

- Under 1 year

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- CDPH programs
- LHDs
- Tribes

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare

- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: Yes

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

Is the entire target population disproportionately affected by the problem, or only part? Answer: Part

Objectives and Activities

Objective 1:

Title: Support CDPH Programs to Address Climate Change and Health

Objective: Between 07/2021 and 06/2022, Program will increase the number of CDPH programs that incorporate climate change considerations into their health programs, plans, policies, or communications from 0 to 4.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will onboard and orient new staff, and identify CDPH programs with which to work.

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

Intervention Information: Program will provide support and expertise to state public health programs to increase incorporation of climate change into their health programs, plans, policies, and communications.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Model Practices Database (National Association of City and County Health Officials)
- Other: Centers for Disease Control & Prevention's Climate and Health Program, American Public Health Association's "Climate Change, Health & Equity: A Guide for Local Health Departments", CDPH's Climate Change and Health Equity Program's publications and data tools, and peer-reviewed journal articles.

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

- *Item to be measured:* CDPH programs that incorporate climate change considerations into their health programs, plans, policies, or communications.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program data
- *Date baseline was last collected:* 3/12/2021
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 4

Target Population

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

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

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

Activity 1

Host Cross-CDPH Climate Change Collaboration Meetings. Between 07/2021 and 06/2022, Program will meet at least three times with interested staff from across CDPH to collaboratively assess needs for support, plan and coordinate activities, and share resources addressing climate change.

Mid-year goal: Between 07/2021 and 12/2021, Program will onboard and train new staff responsible for this activity, and have one meeting with interested staff from across CDPH to collaboratively assess needs for support, plan and coordinate activities, and share resources addressing climate change.

Description of Activity: Between 07/2021 and 06/2022, the Health Program Manager I will meet at least three times with interested staff from across CDPH to collaboratively assess needs for support, plan and coordinate activities, and share resources addressing climate change.

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

Activity 2

Provide Technical Assistance to CDPH Programs. Between 07/2021 and 06/2022, Program will provide technical assistance to CDPH programs regarding climate change in the forms of communications, fact sheets, health warnings, and program objectives.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will identify CDPH programs to provide technical assistance regarding climate change in the forms of communications, fact sheets, health warnings, and program objectives.

Description of Activity: Between 07/2021 and 06/2022, The Health Program Manager I will be responsible to provide technical assistance to CDPH programs regarding climate change in the forms of communications, fact sheets, health warnings, and program objectives.

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

Activity 3

Provide Data and Vulnerability Assessment Tool Assistance to CDPH Programs. Between 07/2021 and 06/2022, Program will provide technical assistance to CDPH programs regarding the utilization of data sources and tools that address climate and health vulnerability and social determinants of health (eg., Climate Change and Health Vulnerability Indicators and Healthy Places Index) in prioritizing resources or program planning.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will identify CDPH programs to provide technical assistance regarding the utilization of data sources and tools that address climate and health vulnerability and social determinants of health (eg., Climate Change and Health Vulnerability Indicators and Healthy Places Index) in prioritizing resources or program planning.

Description of Activity: Between 07/2021 and 06/2022, the Health Program Manager I will be responsible to provide technical assistance to CDPH programs regarding the utilization of data sources and tools that address climate and health vulnerability and social determinants of health (eg., Climate Change and Health Vulnerability Indicators and Healthy Places Index) in prioritizing resources or program planning.

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

Activity 4

Support CDPH Programs to Advance Health Through Climate-Related Grants. Between 07/2021 and 06/2022, Program will provide technical assistance to CDPH programs regarding the submission of health equity input to climate change-related grant guidelines from other State agencies, and assist CDPH programs to participate in review of climate-related grant program applications to help select grantees and projects that will improve health equity outcomes.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will identify upcoming opportunities to submit health equity input to other State agencies' climate change-related

grant guidelines, and to participate in review of climate-related grant program applications to help select grantees and projects that will improve health equity outcomes.

Description of Activity: Between 07/2021 and 06/2022, the Health Program Manager I, with support from the Climate Change and Health Equity Section staff, will provide technical assistance to CDPH programs regarding the submission of health equity input to other State agencies' climate change-related grant guidelines, and assist CDPH programs to participate in review of climate-related grant program applications to help select grantees and projects that will improve health equity outcomes.

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

Objective 2:

Title: Support LHDs to Address Climate Change and Health

Objective: Between 07/2021 and 06/2022, Program will increase the number of LHDs that incorporate climate change considerations into their health programs, plans, policies, or communications, from 2 to 5.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will onboard and train the new staff person responsible for this activity, and identify LHDs to prioritize for technical assistance.

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

Intervention Information: Provide technical assistance to LHDs to incorporate climate change considerations into their health programs, plans, policies, or communications.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Model Practices Database (National Association of City and County Health Officials)
- Other: Centers for Disease Control & Prevention's Climate and Health Program, American Public Health Association's "Climate Change, Health & Equity: A Guide for Local Health Departments", CDPH's Climate Change and Health Equity Program's publications and data tools, and peer-reviewed journal articles.

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

- *Item to be measured:* LHDs that incorporate climate change considerations into their health programs, plans, policies, or communications.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 2
- *Data source for baseline value:* Program data
- *Date baseline was last collected:* 3/12/2021
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 5

Target Population

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

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

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

Activity 1

Support LHDs to Conduct Environmental Scans. Between 07/2021 and 06/2022, Program will provide technical assistance to LHDs to conduct environmental scans of local climate change planning activities, possible partners, gaps, and opportunities.

Mid-year goal: Between 07/2021 and 12/2021, Program will onboard and train the new staff person who will carry out this objective, and identify LHDs to prioritize for technical assistance.

Description of Activity: Between 07/2021 and 06/2022, the Health Program Specialist I will provide technical assistance to LHDs to conduct environmental scans of local climate change planning activities, possible partners, gaps, and opportunities.

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

Activity 2

Support Local Health Departments to Assess Climate and Health Vulnerability Data. Between 07/2021 and 06/2022, Program will provide technical assistance to LHDs to utilize data tools and local knowledge to assess local vulnerability to the health impacts of climate change.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will onboard and train the new staff person who will carry out this objective, and identify LHDs to provide technical

assistance in utilizing data tools and local knowledge to assess local vulnerability to the health impacts of climate change.

Description of Activity: Between 07/2021 and 06/2022, the Health Program Specialist I will provide technical assistance to LHDs to utilize data tools and local knowledge to assess local vulnerability to the health impacts of climate change.

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

Objective 3:

Title: Support Tribes to Address Climate Change and Health

Objective: Between 07/2021 and 06/2022, Program will increase the number of California tribes or tribal health programs that incorporate climate change considerations into their health programs, plans, policies, or communications, from 1 to 3.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will onboard and train the new staff person responsible for this objective, and identify California tribes or tribal health programs to provide technical assistance to regarding the incorporation of climate change considerations into their health programs, plans, policies, or communications.

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

Intervention Information: Provide technical assistance to California tribes or tribal health programs to incorporate climate change considerations into their health programs, plans, policies, or communications.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

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

- *Item to be measured:* Tribes or tribal health programs that incorporate climate change considerations into their health programs, plans, policies, or communications.
- *Unit of measurement:* Number

- *Baseline value for the item to be measured:* 1
- *Data source for baseline value:* Program data
- *Date baseline was last collected:* 3/12/2021
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 3

Target Population

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

- *Target population data source*: CDC population Information
- *Number of people served:* 328,112
- *Ethnicity:* Not Hispanic or Latino

Race:

- American Indian or Alaskan Native

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- Federally-recognized, and non-federally recognized tribes, and tribal clinics and health organizations

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: Yes

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

Is the entire target population disproportionately affected by the problem, or only part? Answer: Part

Activity 1

Support Tribes to Conduct Environmental Scans of Climate Change Activities. Between 07/2021 and 06/2022, Program will provide technical assistance to tribes or tribal health programs to conduct environmental scans of local climate change planning activities, possible partners, gaps, and opportunities.

Mid-year goal: Between 07/2021 and 12/2021, Program will onboard and train the new staff person who will carry out this objective, and will identify tribes and tribal health programs to prioritize for technical assistance.

Description of Activity: Between 07/2021 and 06/2022, the Health Program Specialist I will provide technical assistance to tribes or tribal health programs to conduct environmental scans of local climate change planning activities, possible partners, gaps, and opportunities.

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

Activity 2

Support Tribes to Assess Climate and Health Vulnerability. Between 07/2021 and 06/2022, Program will provide technical assistance to tribes or tribal health programs to utilize data tools and local knowledge to assess their communities' vulnerability to the health impacts of climate change.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will onboard the new staff person and identify tribes and tribal health programs to provide technical assistance to utilize data tools and local knowledge to assess local vulnerability to the health impacts of climate change.

Description of Activity: Between 07/2021 and 06/2022, the Health Program Specialist I will provide technical assistance to tribes and tribal health programs to utilize data tools and local knowledge to assess local vulnerability to the health impacts of climate change.

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

CA Behavioral Risk Factor Surveillance System (BRFSS) Program

Healthy People 2030 Objective

PHI-R06: Enhance the use and capabilities of informatics, including data-sharing, data exchange, and application to practice and use in decision-making

Health Objective

From 10/01/2020 to 10/01/2025, enhance the use of California BRFSS data in health decision making.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $281,126
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Public Health Survey Research Program; California State University, Sacramento.
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of total funding that is PHHS Grant: 10-49% - Partial source of funding
- Existing funding source(s): Other federal funding (CDC), Behavioral Risk Factory Surveillance Program
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Issue/Problem

Data source for health risk behaviors in California (CA), Healthy People 2030 and for leading health indicators, social determinants of health and overall well-being. By the early 1980s, scientific research showed that personal health behaviors played a major role in premature morbidity and mortality. Over time, telephone surveys emerged as an acceptable method for determining the prevalence of many health risk behaviors among populations. Surveys conducted annually are used to determine the proportion of California residents who engage in health behaviors that increase the probability of both positive and negative health outcomes. These data play a vital role in developing public policy and monitoring achievement of public health goals. BRFSS data have been used to associate information with the leading causes of premature death, increase public awareness of lifestyles and risk factors that significantly influence health, monitor trends in health behavior over time such as diet, exercise, and screenings for cancer and monitor progress towards meeting Healthy People 2030 objectives.

Public health program was prioritized as follows:

- Other: Collects data for CDC and CDPH programs

Key Indicator(s) affected by this problem: BRFSS is one of the sources of baseline data for Healthy People 2030 Objectives. The CA BRFSS Program interviews and collects data from more than 8,000 adults annually and provide analytic support to programs that will use BRFSS data as a source of baseline data for achieving a state health objective.

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

Data source for key indicator baseline: CA BRFSS Program is a data source for key indicators and provides data for baseline

Date key indicator baseline data was last collected: BRFSS survey is an annual survey and has been collected in CA since 1984. BRFSS data will be collected for survey year 2021 and 2022

Program Strategy

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

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

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- Education (e.g., low high school graduation rates, low literacy levels, poor early childhood education)
- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)
- Adverse Childhood Experiences (ACEs)

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

Primary Strategic Partners

External:

1. American Cancer Society
2. Alzheimer's Association

Internal:

1. Nutrition Education and Obesity Prevention Branch

2. Occupation Health Branch
3. Substance Abuse and Prevention Branch
4. Injury Prevention and Violence Branch
5. Oral Health Program

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

Program Settings:

- State health department
- University or college

Target Population of Program

- *Target population data source*: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, April 3, 2019
- *Number of people served:* 29,868,127
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender
- None of these

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: Yes

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

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

Objectives and Activities

Objective 1:

Title: Maintain Statewide Collection and Analysis of BRFSS Data

Objective: Program will collect 8,000 BRFSS surveys from July 1, 2021 to June 30, 2022.

Mid-year objective goal: Program will collect 4,000 BRFSS surveys by December 21, 2021.

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

Intervention Information: Identify Call Center with Lowest Cost Per Complete.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Identifying a call center that can increase the number of completed surveys in California and at a competitive price will assist researchers and programs that use BRFSS data to evaluate their programs and/or make programmatic decisions.

- *Item to be measured:* Invitation to Bid.
- *Unit of measurement:* Number of bids
- *Baseline value for the item to be measured:* 1
- *Data source for baseline value:* Release of last Invitation to Bid
- *Date baseline was last collected:* 2018
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

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

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

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

Activity 1

Maintain Statewide Collection of BRFSS Data. Program will oversee and coordinate the overall operations of the collection of CA BRFSS data that meets required CDC guidelines and include the timely submission of data to CDC quarterly from July 1, 2021 to June 30, 2022.

Mid-year goal: Program will oversee and coordinate the overall operations of the collection of CA BRFSS data that meets required CDC guidelines and include the timely quarterly submission of data to CDC through December 30, 2021.

Description of Activity: Between 07/2021 and 06/2022, Program will oversee and coordinate the overall operations of the collection of CA BRFSS survey data that meets required CDC guidelines and include the timely submission of data to CDC. Program monitors data collection and quarterly submission to CDC.

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

Activity 2

Provide Data to BRFSS Users. Program will provide data sets to external and internal BRFSS data users from July 1, 2021 to June 30, 2022.

Mid-year objective goal: Program will provide one CA BRFSS data set for to external and internal BRFSS data users by September 1, 2021.

Description of Activity: Program will provide California BRFSS data set. Data set is produced six week following receipt from CDC and distributed to users in August or September.

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

Activity 3

Release of Invitation to Bid (IFB) to Identify Call Center. Program will develop and release Invitation to Bid to identify most competitively priced call center by July 15, 2021.

Mid-year objective goal: Program will identify call center and process new contract by December 31, 2021.

Description of Activity: Program will develop and release IFB to identify most competitively priced call center by July 15. The release of IFB will identify call center with most competitive price and lowest price per complete for the 2022-2025 CA BRFSS surveys. A contract between CA BRFSS Program and company of winning bid will be developed by December 31, 2021.

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

Objective 2:

Title: Analyze BRFSS Data

Objective: Between 07/2021 and 06/2022, Program will analyze 1 set of core questions on the annual BRFSS survey.

Mid-year objective goal: Program will prepare core questions of the annual BRFSS survey and write programs for analysis.

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

Intervention Information: **Develop CA BRFSS Dashboard.** CA BRFSS program staff will analyze CA BRFSS data and will create dashboard. A dashboard will allow for broader use of BRFSS data and result in increased use for decision-making.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: This intervention supports the 2030 Healthy People Objective PHI-R06.

- *Item to be measured:* Creation of dashboard and in the future the number of hits on the dashboard.
- *Unit of measurement:* Creation of dashboard
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* No baseline data because dashboard has not been created
- *Date baseline was last collected:* 1/1/2022
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

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

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

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

Activity 1

Analyze BRFSS Data. Program will analyze data from core questions of the BRFSS and make available to public and programs through dashboard from July 1, 2021 to June 30, 2022.

Mid-year goal: Program will analyze data from core questions and create and prepare data for dashboard.

Description of Activity: Between 07/2021 and 06/2022, Program will analyze data collected from core questions on the annual BRFSS survey and produce a dashboard to display health risk behaviors of California's adult population.

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

Activity 2

Produce Four Factsheets. Between July 1, 2021 and June 30, 2022, Program will, upon completion of analysis, produce four factsheets.

Mid-year objective goal: Between July 1, 2021 and December 31, 2021, Program will, upon completion of analysis, produce two factsheets.

Description of Activity: Between 07/2021and 06/2022, Program will upon completion of analysis, produce four factsheets highlighting four health risk behaviors.

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

Activity 3

Creation of Dashboard. Between July 1, 2021 and June 30, 2022, Program will, upon completion of analysis, develop CA BRFSS dashboard.

Mid-year objective goal: Between July 1, 2021 and December 31, 2021, Program will have programs test dashboard and provide feedback.

Description of Activity: Between 07/2021and 06/2022, Program will, upon completion of analysis, develop CA BRFSS dashboard and work with other state programs to test dashboard before posting on website.

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

Cardiovascular Disease Prevention Program

Healthy People 2030 Objective

HDS-05: Increase the proportion of adults with hypertension whose blood pressure is under control

Health Objective

From 10/01/2020 to 10/01/2025, hypertension control will be increased by 5% from 67% to 73%, thereby reducing morbidity and mortality associated with coronary heart disease and stroke in California.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Support State Health Department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: Yes
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Enhance or expand the program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 11
- Number of FTEs in this program funded by the PHHS Block Grant: 4

Issue/Problem

Heart disease and stroke are the first and third leading causes of death in CA and a major cause of disability. In 2019, an estimated 79,320 Californians died from heart disease and stroke combined (CA Vital Statistics Data, 2019). Additionally, heart disease and stroke impose an enormous economic burden on the State. In 2018, the annual cost to CA for heart disease and stroke was approximately $51.8 billion (Yoo B-K, Xing G, Hoch JS, Taylor CW, Núñez de Ybarra J, and Peck C. 2018. Economic Burden of Chronic Disease in California, 2018.California Department of Public Health). The 2019 prevalence rate of hypertension in adults 18 and older was 25.9%, whereas that of heart disease and stroke was 7.0% and 2.3%, respectively (Ask California Health Interview Survey, 2019).

Public health program was prioritized as follows:

- Identified via surveillance systems or other data sources

- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: The key indicators affected are (1) Age-adjusted coronary heart disease deaths, (2) Percentage of adults diagnosed with hypertension in California, (3) Rate of stroke deaths in California, and (4) Percentage of adults experiencing hospitalizations for stroke.

Baseline value of the key indicator described above: Heart Disease (HDS-02): In 2019, the age-adjusted coronary heart disease mortality rate in California was 75.9 per 100,000 population. Blood Pressure (HDS-05): In 2019, an estimated 25.9 % of California adults had been diagnosed with hypertension. Stroke (HDS-03): In 2019, the age-adjusted stroke mortality rate in California was 35.3 per 100,000 population. In 2019, an estimated 2.17% of adults experienced a stroke hospitalization.

Data source for key indicator baseline: Prevalence (HDS-05): California Health Interview Survey. Mortality (HDS-03 and HDS-03): California Vital Statistics Data. CA Office of Statewide Health Planning and Development (OSHPD), Patient Discharge Data, 2019

Date key indicator baseline data was last collected: 2019

Program Strategy

Goal: To increase blood pressure control in adults with hypertension, to reduce deaths from coronary artery disease, and to reduce the risk of stroke recurrence in post-stroke patients to decrease hospitalizations and deaths from stroke.

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

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

Summary of Program Strategy: The program strategy will focus on utilizing the team-based care approach of Comprehensive Medication Management (CMM). CMM will link attending physicians, community pharmacists, stroke coordinators, and community health workers (CHWs) to help the patient achieve better hypertension control. Better control of blood pressure will reduce deaths from coronary artery disease and strokes, and recurring heart attacks and strokes, and increase medication management. Promoting CMM has the capacity to improve cardiovascular health outcomes and reduce rate of hospitalizations/emergency room visits due to cardiovascular events.

Primary Strategic Partners

External:

1. University of Southern California (USC), School of Pharmacy/CA Right Meds Collaborative
2. Inland Empire Health Plan (IEHP)
3. Desert Regional Medical Center (DRMC), Riverside County
4. American Heart Association (AHA)/American Stroke Association (ASA)
5. Riverside County Emergency Medical Agency (RCEMA)

Internal:

1. Prevention Forward (Centers for Disease Control & Prevention 1815 Grant)
2. California Stroke Registry/California Coverdell Program
3. CA Emergency Medical Services Authority (EMSA)
4. California Department of Health Care Services (DHCS)
5. California WISEWOMAN

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids
- Other: Workflows and Guidelines

Evaluation Methodology: CDPP staff will evaluate the implemented annual activities for progress and outcomes on a yearly basis. This evaluation includes 1) Post-webinar evaluation of Healthy Hearts California collaboration; 2) Annual evaluation of post-stroke patient team-based care CMM pilot project for control of hypertension in Riverside County; and 3) Evaluation of collaborative efforts between CDPH; USC, School of Pharmacy-CA Right Meds Collaborative (CRMC); IEHP and DRMC to prevent recurrence of stroke and decrease the rate of hospitalization and emergency room visits in post-stroke patients in Riverside County.

Program Settings:

- Community based organization
- Home
- Local health department
- Medical or clinical site
- State health department
- University or college

Target Population of Program

- *Target population data source*: Behavioral Risk Factor Surveillance Survey (BRFSS), 2019; California Health Interview Survey (CHIS), 2019
- *Number of people served:* 9,353,524

- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- For Objective 1, the location is Riverside County, Southern California: This county consistently reports heart disease, stroke and hypertension prevalence rates higher

than the rates at the state level and are inconsistent with the Healthy People 2030 Objectives.
- For Objectives 2 and 3, the location is the entire state of CA.

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: Yes

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

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

Objectives and Activities

Objective 1:

Title: Improve Post-Stroke Patient Care Through CMM for Hypertension Control

Objective: Between 07/2021 and 06/2022, increase hypertension control and reduce stroke recurrence through CMM in majority of post-stroke adults discharged from hospital care.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will launch of a CMM pilot project in Riverside county for post-stroke patients after discharge from hospital.

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

Problem for this Objective: **Poor management and control of hypertension in post-stroke patients after discharge from hospital care**. After stroke, the risk of disability and recurrent events must be mitigated to improve quality of life for patients with uncontrolled hypertension while also lowering the costs to treat cardiovascular disease (CVD). People who survive a stroke are at high risk for a recurrent stroke event and other chronic CVD. Research has identified effective prevention strategies, including appropriate medications, to reduce the risk of a second event, rate of stroke hospitalization, and stroke deaths.

Key indicator(s) affected by this problem: Hospitalizations for stroke.

Baseline value for the key indicator: Stroke hospitalization in CA: 2.17%

Data source for key indicator baseline: CA OSHPD, Patient Discharge Data

Date key indicator baseline data was last collected: 2019

Intervention Information: **Pilot project for providing team-based CMM for improvement of post-stroke patient care**. CDPP staff will coordinate a CMM pilot with a minimum of 30 post-stroke adults from DRMC, Riverside County. These patients will be referred to CMM to receive care under supervision of a multidisciplinary patient care team including: attending physician, community pharmacist, stroke coordinator, and community health worker. This CMM pilot project will be carried out by CDPH and will include CDPP staff working in collaboration with CDPH CA Stroke Registry; USC, CRMC; and IEHP (Riverside County Managed Care Organization). The pilot will include formal data/database use agreements with DRMC, AHA-Get with the Guidelines-Stroke, and Collaborative Practice Agreements (CPAs) between physician(s) and pharmacists participating in CMM provision.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Guide to Clinical Preventive Services (Task Force on Community Preventive Services)
- National Guideline Clearinghouse (Agency for Healthcare Research and Quality)
- Other: Health Care Quality Measures are tools that help quantify health care processes, outcomes, patient perceptions and systems that are associated with the ability to provide high quality health care that relates to one or more quality goals of the National Quality Strategy. CMM is considered an evidence-based intervention according to Health Care Quality Measures approved by National Quality Forum

Rationale for choosing the Intervention: Scientific evidence suggests that CMM is most valuable for high-risk chronic disease patients with complex medication needs such as post-stroke patients discharged from hospital care.

- *Item to be measured:* 1) Number of post-stroke patients referred to CMM after getting discharged from hospital; 2) Time period of CMM utilization by these patients; and 3) Number of patients with blood pressure under control after 90 days under CMM.
- *Unit of measurement:* 1) Number of post-stroke patients referred to CMM after getting discharged from hospital, 2) Number of days of CMM utilization by these patients; and 3) Number of patients with blood pressure under control after 90 days under CMM.
- *Baseline value for the item to be measured:* 1) Number of post-stroke patients; 2) Time period for CMM utilization: 90 days for each patient after referral and enrollment into CMM; and 3) Baseline blood pressure value for each patient.
- *Data source for baseline value:* De-identified post-stroke patient data from DRMC, Riverside County, under hospital's data use agreement (DUA) with CDPH.
- *Date baseline was last collected:* 7/1/2021
- *Interim target value to be achieved by the Annual Progress Report:* Achieve and maintain hypertension control in at least 40% of post-stroke patients referred to CMM
- *Final target value to be achieved by the Final Progress Report:* Achieve and maintain hypertension control in at least 60% of post-stroke patients referred to CMM

Target Population

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

- *Target population data source*: De-identified post-stroke patient data from Desert Regional Medical Center, Riverside County, under hospital's data use agreement (DUA) with CDPH.
- *Number of people served:* 30
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

- 15-24 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55-64 years
- 65-74 years

- 75-84 years
- 85 years and older

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- Riverside County, CA

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

- Uninsured
- Medicaid
- Medicare

Primarily Low Income: Yes

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

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

Activity 1

Implement Hospital CMM Referral System for Post-Stroke Patients Upon Discharge. Between 07/2021 and 06/2022, CDPP will collaborate with hospitals and health plans in Riverside County for post-stroke patients to be referred by hospital or health plan case managers to CMM for care provided by a team comprised of an attending physician, stroke coordinators, community pharmacist, and Community Health Workers (CHWs).

Mid-year goal: Between 07/2021 and 12/2021, Establish hospital CMM referral for a minimum of 15 post-stroke patients with progress feedback loop.

Description of Activity: CDPP staff with support from CSUS contract staff will convene a CA CMM pilot project subcommittee meeting to discuss the implementation of the CMM pilot project in Riverside County that utilizes CMM and technical assistance to implement coordination of team-based care for post stroke patients. CMM-based patient care team including attending physician, stroke coordinators, community pharmacist, and CHWs will be responsible for this activity. The deliverable for this activity will be a document outlining the process and workflow of CMM referral to improve control of hypertension in post-stroke patients. The clinician-stroke coordinator-pharmacist-CHW patient care team will enroll post-stroke patients to receive CMM-based care and follow-up to control hypertension and prevent further cerebrovascular events. The deliverable will be a document providing detail of CMM team-based care provided to the post-stroke patients, including patient progress and clinical outcomes regarding hypertension control. The time frame for this activity is between 07/2021 and 06/2022.This activity will be completed between 07/2021 and 06/2022.

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

Activity 2

Incorporate/Integrate CHWs in the CMM Patient Care Team. Between 07/2021 and 06/2022, CDPP will collaborate with CHW/promotoras to facilitate incorporation of CHWs into the CMM care team.

Mid-year objective goal: Between 07/2021 and 12/2021, Coordination of information collection and exchange between USC-CRMC, IEHP, and CHWs regarding roles and justification of responsibilities of CHWs as part of the CMM care team.

Description of Activity: Program will collaborate with CHWs to develop a report defining the roles and justifying the responsibilities of CHWs in the CMM care team. The deliverable for this activity will be a document defining the roles and providing the justification of CHWs responsibilities as CMM patient care team members and will be written by the CDPP staff with support from CSUS. The time frame for this activity will be between 07/21 and 06/22.

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

Activity 3

CMM Implementation Workgroup Meetings. Between 07/2021 and 06/2022, CDPP staff will convene the CMM Implementation Workgroup quarterly to share best practices on CMM implementation and solicit technical assistance from the experts on the Workgroup.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will have two meetings completed.

Description of Activity: CDPP staff will convene the CMM Implementation Workgroup quarterly to share best practices on CMM implementation and solicit technical assistance from the experts on the Workgroup. CDPP staff with support from CSUS contractor will plan and conduct one virtual meeting/webinar prior to June 2022. CDPP staff will develop minutes from each meeting and resources will be shared via stakeholder email distribution listserves. The timeframe is one meeting quarterly.

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

Objective 2:

Title: Develop and Conduct Webinars in Collaboration with Healthy Hearts California (HHC)

Objective: Between 07/2021 and 06/2022, Program will coordinate with HHC to develop and conduct two webinars presenting best practices protocols, team-based care models, and improvements in Health Information Technology for improved management of cardiovascular disease statewide.

Mid-year objective goal: CDPP will confer with HHC on requested topics for webinars to present best practices protocol, team-based care models, and improvements in Health Information Technology for improved management of cardiovascular disease.

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

Intervention Information: **Conduct informative webinars for improved management of CVD in coordination with HHC**. HHC is administered by CDPP and was created specifically to coordinate statewide heart disease control and prevention efforts, decrease silos to increase efficiency and effectiveness, and address factors that contribute to heart disease and stroke and eliminate health disparities. The HHC goals align with Let's Get Healthy California, "Living well;" the CDPH CA Wellness Plan; the Million Hearts Initiative; and the American Heart Association's Target: Blood Pressure Initiative. These plans are designed to reduce the burden of heart disease and stroke in CA, and provide guidance to individuals and organizations spanning a wide range of health and social disciplines that play a role in reducing the risk and prevalence of heart disease and stroke among all Californians. CDPP staff with support from CSUS contractor will coordinate with HHC to develop and conduct webinars presenting best practices protocols, team-based care models and improvements in Health Information Technology for improved management of cardiovascular disease and better cardiovascular health outcomes in CA.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: HHC includes representatives from a variety of organizations working in heart disease and stroke prevention and control in CA, including state and local governments; private and nonprofit organizations; health, medical, and business communities; academic institutions; researchers; survivors; caregivers; and advocates. Through collaborative and collective action, HHC is a driving force behind reducing the risk and prevalence of heart disease and stroke in CA. Coordination with HHC for presenting webinars can improve the reach of information to a variety of audiences and across different settings thus increasing the number of populations with whom cardiovascular health information is shared.

- *Item to be measured:* Webinars
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Evidence-based and promising practices from HHC members
- *Date baseline was last collected:* 2021-2022
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 2

Target Population

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

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

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

Activity 1

Develop and Conduct Two Webinars on Best Practice Protocols on CVD Prevention and Management. Between 07/2021 and 06/2022, Program will develop and conduct webinars in coordination with HHC on best practices protocols and utilization of: 1) Health Information Technology and Health Information Exchange at the health care/clinical systems level for improvement of cardiovascular health, and 2) team-based care models including CMM for improved and effective treatment, management, and control of hypertension.

Mid-year goal: Between 07/2021 and 12/2021, Program will solicit input from subject matter experts and invite them to be the speakers at the webinars.

Description of Activity: CDPP will develop and present webinars in coordination with HHC for HHC participants, state-contracted cardiovascular disease partners, and state and local organizations on best practices protocols and utilization of team-based care models, including CMM, to support effective treatment, management and control of hypertension. CDPP-CDPH staff will develop and conduct these webinars between 07/21 and 06/22.

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

Activity 2

Update CDPP Website to Incorporate Links to CVD Data and Health Resources. Between 07/2021 and 06/2022, CDPP team will update the CDPH program homepage to ensure that links to relevant CVD health resources and fact sheets and CVD prevalence are listed.

Mid-year goal: Between 07/2021 and 12/2021, Program will survey HHC to inquire into materials need for CVD prevention and treatment.

Description of Activity: CDPP team will update the CDPH program homepage to ensure that links to relevant CVD health resources and fact sheets and CVD prevalence are listed.CDPP-CDPH staff will update the website between 07/21 and 06/22.

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

Objective 3:

Title: California Heart Disease and Stroke Prevention and Treatment Master Plan (Master Plan) Update

Objective: Between 07/2021 and 06/2022, CDPP will coordinate with subject matter experts to update the California Heart Disease and Stroke Prevention and Treatment Master Plan (2007-2015) and disseminate the updated Master Plan to HHC partners, contracted CVD partners and state, and local organizations. The updated Master Plan will also be posted on the CDPH website.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will mobilize CVD partners to inform the Master Plan update.

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

Intervention Information: **Provide updates to the Master Plan (2007-2015) in light of new research and cardiovascular health data, practices, and guidance**. The original Master Plan was adopted in 2007 to coordinate and focus statewide CVD prevention and treatment efforts. The current and relevant best practices, data, and resources will be assessed by subject matter experts and cardiovascular health partners and stakeholders to update the Master Plan. The updated Master Plan and its accompanying strategic document will provide goals and recommendations to modify health behaviors and improve health care systems in CA communities to prevent initiation and recurrence of CVD, improve outcomes, and establish efficient and effective systems of heart disease and stroke care.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Guide to Clinical Preventive Services (Task Force on Community Preventive Services)
- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)
- Other: In 2003, the State of CA recognized the need to take the lead in coordinating and focusing the statewide assault on heart disease and stroke. The CA legislature passed Assembly Bill 1220 (Chapter 395, Berg, Statutes of 2003), which established a 12-member Heart Disease and Stroke Prevention and Treatment Task Force (Task Force) to write CA's Master Plan for Heart Disease and Stroke Prevention and Treatment. The Task Force also created a Strategic Document as a companion to the Master Plan that details action steps needed to implement the Master Plan's recommendations and identifies potential partners.

Rationale for choosing the Intervention: The updated Master Plan will be used as a guide for cardiovascular health partners and stakeholders to adopt and implement meaningful action to bring about positive changes in their health care systems and communities to improve cardiovascular health throughout CA.

- *Item to be measured:* Master plan
- *Unit of measurement:* 1 Plan

- *Baseline value for the item to be measured:* 1
- *Data source for baseline value:* OSHPD, Vital Statistics, CA BRFSS, and CHIS as needed. Literature on CMM.
- *Date baseline was last collected:* 2014
- *Interim target value to be achieved by the Annual Progress Report:* 0.1
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

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

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

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

Activity 1

Initiate Master Plan Update. Between 07/2021 and 06/2022, Program staff will plan and convene a Strategic Planning meeting to bring together cardiovascular health partners, stakeholders, and medical and public health professionals to review and assess the Master Plan for needed updates.

Mid-year goal: Between 07/2021 and 12/2021, the Task Force will assess the current and relevant best practices, data, and resources in consideration of the Master Plan update.

Description of Activity: By Winter 2021, CDPP staff with support from CSUS contractor will plan and convene the first Strategic Planning meeting for cardiovascular health partners, medical professionals, and public health stakeholders to review and discuss the CA Assembly Bill 1220 that led to the formation of the Task Force for the original Master Plan, assign roles and responsibilities, determine approach objectives, and schedule milestone timeline meetings for updating the Master Plan. The deliverables for this activity will be determined and distributed to stakeholders with a detailed account of the proceedings of the above convening (meeting minutes).

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

Activity 2

Finalize Master Plan Final Recommendations for Goals and Strategic Document Update. Between 07/2021 and 06/2022, CDPP staff with support from CSUS contractor will plan and

convene the second and final Master Plan update Strategic Planning meeting providing final recommendations for the update to the Master Plan goals.

Mid-year goal: Completed draft of update recommendations.

Description of Activity: By Spring 2022, the CDPP staff with CSUS contractor support will plan and convene the second and final CA Master Plan Update Strategic Planning meeting to present the final recommendations for providing an update to the nine Master Plan goals as well as to the Master Plan strategic document. The deliverable for this activity will be the updated CA Master Plan document. The updated Master Plan will be submitted for CDPH review and will be posted on CDPH website after approval and American Disabilities Act (ADA) compliance.

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

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

Healthy People 2030 Objective

HC/HIT-D06: Increase the proportion of hospitals that have necessary information electronically available at the point of care

Health Objective

Between 7/2021 and 6/2022, Emergency Medical Services Authority (EMSA) will maintain one emergency medical services (EMS) Prehospital Data and information Services and Quality Improvement Program by providing statewide collection and analysis of patient-level EMS data from emergency medical services systems and quality improvement measuring and patient care assessments based on EMS QI Plan submissions.

Program Funding Details

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

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 4.5
- Number of FTEs in this program funded by the PHHS Block Grant: 4.5

Issue/Problem

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

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

Public health program was prioritized as follows:

- Prioritize within a strategic plan
- Other: Mandated by statute and regulation

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

Baseline value of the key indicator described above: 25 LEMSAs participating in Quality Core Measures.

Data source for key indicator baseline: Core Measures 2020 (2019 data)

Date key indicator baseline data was last collected: 2020

Program Strategy

Goal: The program goal is to have all 33 LEMSAs submitting the Core Quality Measures.

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

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

Primary Strategic Partners

External:

1. California Ambulance Association
2. EMS Administrators' Association
3. EMS Medical Directors Association
4. National EMS Data Analysis Resource Center

Internal:

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

Planned non-monetary support to local agencies or organizations:

- Technical Assistance

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

Program Settings:

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

Target Population of Program

- *Target population data source*: US Census Bureau (July 1, 2019)
- *Number of people served:* 39,512,223
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School
- High School Diploma
- Some College

- College Degree
- Graduate Degree

Health Insurance Status:

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

Primarily Low Income: No

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

Objectives and Activities

Objective 1:

Title: EMS Prehospital Data and Information Services and Quality Improvement

Objective: Between 7/2021 and 6/2022, Program will increase accurate representation of EMS data for all LEMSAs that voluntarily submit data into CEMSIS which will unite the EMS system under a single data warehouse, fostering analyses on patient-care outcomes, public health system services, compliance with California state and federal EMS service laws, and provide measurable quality improvement resources to LEMSAs.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will review and analyze 100% of submitted data.

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

Intervention Information: **Data submitted into CEMSIS will be analyzed and shared with LEMSAs to increase transparency.** Program will provide technical assistance and outreach to the LEMSAs to encourage participation in CEMSIS while increasing transparency. Data submitted by the LEMSAs into the CEMSIS database will be analyzed to ensure accuracy of data submitted. This will allow for successful Quality Improvement (QI) and Quality Assurance (QA) data reporting on the overall status of EMS 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 and help analyze outcome data with hospitals.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

Rationale for choosing the Intervention: Quality Core Measures is mandated by statute and regulations and the sole purpose of the measures is to evaluate system impact on patients and the continuum of care from dispatch to prehospital to hospital disposition.

- *Item to be measured:* LEMSA Core Measure data submission
- *Unit of Measurement*: Total number of LEMSAs submitting Core Measures
- *Baseline value for the item to be measured:* 25
- *Data source for baseline value:* Core Measures
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 15
- *Final target value to be achieved by the Final Progress Report:* 27

Target Population

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

Primarily Low Income: No

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

Activity 1

Publish One EMS Report. Between 07/2021 and 06/2022, Program will produce one Annual EMS Report based on analyzing 100% of the NEMSIS/CEMSIS data set to show the current status of the EMS System.

Mid-year goal: EMSA Staff will be in the process of developing and approving the CY 2020 Annual EMS Data report.

Description of Activity: Between 7/2021 and 6/2022, Program Staff will compile and analyze 100% of the EMS data set submitted by LEMSAs into the CEMSIS database and develop the annual CY 2020 EMS Report which will be published to the EMSA website by the 6/2022 deadline.

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

Activity 2

Send out LEMSA Data Letters. Between 07/2021 and 06/2022, Program will analyze EMS data for each LEMSA and provide a letter that outlines the previous year's data submission, providers and how much data is anticipated based on the LEMSA's EMS Plans.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will be in the process of developing and compiling EMS data for all 33 LEMSAs.

Description of Activity: Program Staff will compile and analyze 100% of the EMS data set submitted by LEMSAs into the CEMSIS database and develop 33 individual LEMSA letters which will providing the data submission of each LEMSA.

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

Activity 3

Choose a Related Health Data Set to Compare and Analyze EMS Data. Between 07/2021 and 06/2022, Program will determine which related health/EMS data elements will be evaluated for completeness and quality for further analysis and research.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will be in the process of collecting and cleaning viable data from chosen health data set.

- *Description of Activity*: Between 07/2021 and 06/2022, Program will obtain records from related health database where data will be cleaned and standardized for further analysis and comparison. *Does the activity include the collection, generation, or analysis of data?* Answer: Yes
- *Does the data collection involve public health data?* Answer: No

Activity 4

Geocoding EMS and Other Health Related Data. Between 07/2021 and 06/2022 Program will initiate data comparison analysis for geocoding in Aeronautical Reconnaissance Coverage Geographic Information System (ArcGIS) software.

Mid-year objective goal: Between 07/2021 and 06/2022, Program will be in the process of cleaning and analyzing data to see quality and relational value of matched health related data.

Description of Activity: Between 07/2021 and 06/2022, Program will compare two data sets using probabilistic matching with an emphasis on motor vehicle collision (MVC) information. Program will compare EMS data and the chosen related health data set to see if linked records can be further analyzed and geocoded in ArcGIS.

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

Activity 5

Publish Report of Data Matching and Geocoding Results on EMSA Website. Between 07/2021 and 06/2022, Program will create a report of data matching and geocoding results.

Mid-year objective goal: Between 07/2021 and 06/2022, Program will be in the process of creating a report for publication.

Description of Activity: Between 07/2021 and 06/2022, Program will produce one report summarizing data matching and geocoding results and publish to the EMSA website.

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

Activity 6

Facilitate Core Quality Measures Work Group. Between 07/2021 and 06/2022, Program will facilitate a Core Quality Measures Work Group by planning and leading at least two meetings annually to review and revise the California Core Quality Measures Instruction Manual.

Mid-year objective goal: Between 07/2021 and 06/2022, Program will have planned and/or held at least one of two meetings with the Core Quality Measures Work Group by mid-year.

Description of Activity: Between 07/2021 and 06/2022, Program will engage members from various LEMSAs to assist in a review and revision process of the California Core Quality Measures Instruction Manual to ensure specifications are written accurately and appropriately by inclusion of EMS stakeholders and experts. Program will plan and facilitate at least two meetings with the work group to accomplish this work.

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

Activity 7

Develop annual Core Quality Measures Report. Between 07/2021 and 06/2022, Program will produce one Annual Core Quality Measures Report based on analyzing 100% of the aggregated data provided by LEMSAs to show the current status of statewide EMS QI measurement.

Mid-year objective goal: Between 07/2021 and 06/2022, Program will be in the process of developing the 2021 Annual Core Quality Measures Report for CY 2020 data.

Description of Activity: Between 07/2021 and 06/2022, Program will develop one summary report of all LEMSA Core Quality Measures data submitted for the previous calendar year to

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

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

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

Healthy People 2030 Objective

AHS-04: Reduce the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care

Health Objective

Between 7/2021 and 6/2022, EMSA will maintain one EMS Systems Division Operations and provide statewide coordination and leadership to Local EMS Agencies (LEMSAs) for the planning, development, and implementation of local EMS systems to determine the need for additional EMS, coordination of EMS, and effectiveness of EMS, assisting with adherence to California EMS statutes and regulations for optimum patient care. EMS Systems Division staff provide state leadership, oversight, and regulation to ensure the best quality of care is available, reducing the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care in an emergency.

Program Funding Details

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

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 8.5
- Number of FTEs in this program funded by the PHHS Block Grant: 8.5

Issue/Problem

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

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

Public health program was prioritized as follows:

- Other: Mandated by statute and regulation

Key Indicator(s) affected by this problem: EMSA, through its EMS Systems Division is mandated to coordinate EMS systems throughout the State of California, the statewide Trauma System, Stroke and ST-Elevation Myocardial Infarction (STEMI) Systems, EMS for Children, and the California Poison Control system. The EMS Systems Division has statutory and regulatory oversight responsibility of the EMS system for the State of California and promulgates regulations for use by LEMSAs and EMS providers, reviews and approves local EMS system and ambulance transportation plans ensuring that the required minimum standards are met, and manages the state's EMS data collection, performance management and quality assurance. Key indicators are number of LEMSAs with current approved EMS Plans.

Baseline value of the key indicator described above: Thirty-three LEMSAs serve all California residents. This includes six multicounty EMS agencies that service over two-thirds of the State's geographic region.

Data source for key indicator baseline: Emergency Medical Services Authority

Date key indicator baseline data was last collected: 2020

Program Strategy

Goal: Conduct assessment of California's 33 local EMS systems in order to coordinate EMS activities based on community needs for the effective and efficient delivery of EMS services, ensuring no person is unable to obtain or delayed in obtaining medical care.

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

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

Primary Strategic Partners

External:

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

Internal:

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

Planned non-monetary support to local agencies or organizations:

- Technical Assistance

Evaluation Methodology: LEMSAs are required by law to submit an annual EMS Plans which EMSA uses to evaluate progress toward the goal of statewide coordination for transportation, quality improvement, planning, and development and implementation for any specialty care systems in place such as Stroke and STEMI Critical Systems and EMS for Children. Separate plans for Trauma Systems are required from the 33 LEMSAs.

Program Settings:

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

Target Population of Program

- *Target population data source*: US Census Bureau (July 1, 2019)
- *Number of people served:* 39,512,223
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

- Uninsured
- Medicaid

- Medicare
- Private Health Insurance
- Affordable Care Act Plan

Primarily Low Income: No

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

Objectives and Activities

Objective 1:

Title: Maintain EMS Systems Planning and Oversight to LEMSAs

Objective: Between 7/2021 and 6/2022, Program will provide oversight to 100% of LEMSAs required to submit annual EMS plans through coordination of EMS plan submission by LEMSA Administrators, technical assistance, and EMS plan determinations, in accordance with statutory and regulatory authorities.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will receive one EMS plan from at least ten LEMSAs.

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

Intervention Information: **Conduct assessment of California's 33 local EMS systems in order to coordinate EMS activities based on community needs for the effective and efficient delivery of EMS services.** Increase quality patient-care outcomes through statewide coordination and leadership for the planning, development, and implementation of local EMS systems.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

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

- *Item to be measured:* EMSA plans
- *Unit of Measurement*: One plan per LEMSA
- *Baseline value for the item to be measured:* 33
- *Data source for baseline value:* EMS Authority

- *Date baseline was last collected:* 2021
- *Interim target value to be achieved by the Annual Progress Report:* 10
- *Final target value to be achieved by the Final Progress Report:* 33

Target Population

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

Primarily Low Income: No

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

Activity 1

EMS Plan Tracking. Between 07/2021 and 06/2022, Program will maintain one internal tracking log to reflect EMS plan activity for 33 LEMSAs, including receipt of EMS plans, status of active EMS plans within the EMS Authority, plan outcomes, coordination with LEMSA Administrators and staff, and collaboration with EMSA staff on EMS plan review, to ensure effective oversight of the internal EMS plan review process for timely, comprehensive, and effective plan development and decisions.

Mid-year goal: Between 07/2021 and 12/2021, EMSA Staff will update tracking activity for each LEMSA when an EMS plan is received, reviewed, and a decision made.

Description of Activity: Between 7/2021 and 6/2022, the EMS Authority's EMS Plans Coordinator is responsible for providing coordination of receipt of EMS plan submissions from LEMSA Administrators, assignment of EMS plan reviews to EMS Authority subject matter experts, and overall tracking of EMS plan review from receipt to decision to approve/deny.

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

Activity 2

Quarterly Activity Report Submission. Between 07/2021 and 06/2022, Program will provide oversight to six multicounty LEMSAs required to submit quarterly activity reports through coordination and technical assistance of quarterly activity report submissions with multicounty LEMSA Administrators, in accordance with statutory and contractual authorities.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will receive one quarterly activity report from each of the six multicounty LEMSAs.

Description of Activity: The EMS Authority's EMS Plans Coordinator is responsible for monitoring six multicounty LEMSAs through coordination and review of contractually required quarterly reports.

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

Activity 3

Review Forms Submitted as the Transportation Component of the EMS Plans. Between 07/2021 and 06/2022, Program will review all transportation components (Ambulance Zone Summary Form(s) and Table 8 Resource Directory(s)) for approval and maintain Exclusive Operating Area (EOA) and EMS Responder spreadsheets.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will update spreadsheets and historical documentation for each LEMSA when an EMS plan reviewed.

Description of Activity: Between 7/2021 and 6/2022, the Transportation Coordinator is responsible for reviewing and approving the transportation components of an EMS Plan based on statute, regulation, and case law. The date is then tracked in a "transportation data spreadsheet".

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

Activity 4

Maintain LEMSA Competitive Process Transportation Service Log. Between 07/2021 and 06/2022, Program will update internal service log to track contract start and end dates of the competitive processes.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will update one spreadsheet with competitive process information (expiration or re-approval of competitive process).

Description of Activity: Between 7/2021 and 6/2022, the Transportation Coordinator will maintain one competitive process transportation log through a continuous update with each EMS Plan and competitive process approval/ denial and utilize the log monthly for formal LEMSA notification of status of exclusive rights.

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

Activity 5

Review LEMSA Transportation Competitive Processes. Between 07/2021 and 06/2022, Program will review all competitive processes, regarding EOAs for transportation, as they come in.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will review at least one competitive process.

Description of Activity: Between 7/2021 and 6/2022, the Transportation Coordinator will review at least one LEMSA competitive process for emergency ambulance services, regarding prospective EOAs and discuss any changes needed to approve the competitive process. EMSA's collaboration with LEMSAs promotes successful competitive bidding for local ambulance services, which in turn assures patient care during an emergency.

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

Activity 6

Assess LEMSA EMS Plan transportation component appeal hearing documents. Between 07/2021 and 06/2022, Program will review historical documentation for EMS Plan appeal hearings.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will review one disapproved EMS Plan where the LEMSA requested an appeal hearing.

Description of Activity: Between 7/2021 and 6/2022, the EMS Authority's Transportation Coordinator will research one LEMSA appeal by reviewing submitted transportation documents, researching and investigating history of EMS EOAs and Non-EOAs, provider company sales, and EMS Plans to prepare for hearings. Hearings are filed with the Office of Administrative Hearings and program staff provide hearing testimony as Subject Matter Experts.

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

Activity 7

Provide Technical Assistance. Between 07/2021 and 06/2022, Program will answer all email, phone calls, face-to-face inquiries dealing with EMS transportation questions.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will answer at least 20 transportation request for technical assistance.

Description of Activity: Between 7/2021 and 6/2022, the EMS Authority's Transportation Coordinator will provide technical assistance in all areas related to EMS ambulance transportation for all requests received. Requests are received from LEMSAs, the general public, EMS Providers, and other state agencies through email, phone calls, zoom calls, and face-to-face meetings.

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

Objective 2:

Title: Maintain the EMS for Children Program

Objective: Between 7/2021 and 6/2022, Program will maintain one EMS for Children (EMSC) program providing statewide coordination and leadership by implementing regulations regarding specialized medical care for children with acute illness or injuries and providing guidance for EMSC program implementation at the LEMSA Level.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will assist interested LEMSAs with incorporating EMSC into their jurisdiction in compliance with the EMSC regulations.

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

Program for this Objective: **Children across California need specialized medical care to treat injuries and illness.** Healthy development dramatically affects children's ability to excel in cognitive, socio-emotional, and educational growth. To ensure that California's children receive optimum emergency medical care, EMSC must be integrated into the overall EMS system. Continued development of these programs to a standardized and optimum level of care across California is needed.

Key indicator(s) affected by this program: The key indicators are LEMSAs that have implemented portions of EMSC into their EMS systems.

Baseline value for the key indicator: 4

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2020

Intervention Information: **Integrate EMSC into the Overall EMS System.** Ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California. Using the California EMS Data Information System data to establish quality-

improvement measures EMSA will evaluate additional needs for LEMSAs to enhance their EMSC programs.

Type of Intervention: Evidence-Based Intervention

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

Evidence Source of Intervention:

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

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

- *Item to be measured:* Number of LEMSAs with EMSC programs in place
- *Unit of Measurement*: LEMSAs
- *Baseline value for the item to be measured:* 4
- *Data source for baseline value:* EMS Authority
- *Date baseline was last collected:* 2/1/2021
- *Interim target value to be achieved by the Annual Progress Report:* 5
- *Final target value to be achieved by the Final Progress Report:* 7

Target Population

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

- *Target population data source*: US Census Bureau, July 1, 2019.
- *Number of people served:* 7,319,741
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

- I don’t know the answer

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- N/A

Education Attainment:

- Some High School
- High School Diploma

Health Insurance Status:

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

Primarily Low Income: No

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

Activity 1

Statewide Coordination and Leadership of EMSC Program. Between 07/2021 and 06/2022, Program will provide statewide coordination and leadership of EMSC program based on regulations.

Mid-year goal: Between 07/2021 and 12/2021, EMSA Staff will provide technical assistance to at least one LEMSA.

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

Activity 2

Review EMSC Plans. Between 07/2021 and 06/2022, Program will review all EMSC plans submitted.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will review 100% of all EMSC plans submitted.

Description of Activity: Between 7/2021 and 6/2022, Program staff will review 100% of EMSC plans submitted to ensure all components fulfill the EMSC regulation requirements.

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

Activity 3

Strengthen State EMSC Collaboration. Between 07/2021 and 06/2022, Program will host EMSC Advisory Committee meetings to strengthen collaboration with EMSC stakeholders.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will host one meeting.

Description of Activity: Between 07/2021 and 06/2022, Program will host two meetings with EMSC Advisory Committee members to continue in the development, coordination and maintenance of the EMSC program.

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

Objective 3:

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

Objective: Between 7/2021 and 6/2022, Program will maintain one EMS Trauma Care System Program by reviewing and approving local trauma system plans to provide statewide

leadership for the planning, development, and implementation of a state trauma plan that incorporates 33 LEMSA county/region trauma plans and is informed by CEMSIS-Trauma Registry data submissions from 79 trauma centers.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will provide comprehensive management of 12 LEMSA trauma plans and trauma incidence submissions through CEMSIS-Trauma.

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

Program for this Objective: **Injuries from trauma and traumatic illness impacts all age groups in California and is the leading cause of death for Californians aged 1-44.** 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.

Key indicator affected by this program: Each of the 33 LEMSA's have an approved trauma plan representing their EMS county/region. Only 27 LEMSAs (40 counties) have designated trauma centers. California has 79 designated trauma centers throughout the state. Key indicators are the number of LEMSAs with approved trauma plans.

Baseline value for the key indicator: 33

Data source for key indicator baseline: (1) EMS Authority, 2021; (www.emsa.ca.gov, listing of designated trauma centers); (2) American College of Surgeons, 2021; (www.facs.org, listing of verified trauma centers).

Date key indicator baseline data was last collected: 2021

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: 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 edn.) 3. 2011 Guidelines for Field Triage of Injured Patients, CDC, 201120

Rationale for choosing the Intervention: California's trauma system is comprised of 33 LEMSAs with 79 designated trauma centers located in 40 counties. Each LEMSA must annually update their approved trauma plan for their county/region with guidance and leadership provided by EMS program staff.

- *Item to be measured:* EMS Trauma Care System Program
- *Unit of Measurement*: Number of trauma plan status updates reviewed from LEMSAs to include submission of trauma data by hospitals within LEMSA jurisdictions
- *Baseline value for the item to be measured:* 25
- *Data source for baseline value:* 2019 Trauma Plan Status Update submissions to EMSA
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 12
- *Final target value to be achieved by the Final Progress Report:* 25

Target Population

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

Primarily Low Income: No

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

Activity 1

Review and Analyze Trauma Plan Status Updates (TSSRs). Between 07/2021 and 06/2022, Program will review and analyze LEMSA trauma plan status updates submitted to EMSA.

Mid-year goal: Between 07/2021 and 12/2021, EMSA Staff will provide an analysis of 12 trauma plan status updates.

Description of Activity: Between 7/2021 and 6/2022, Program will analyze a minimum of 25 trauma plan status updates submitted to EMSA. Program will provide LEMSAs with feedback of analysis as part of EMS plan submission approvals/denials.

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

Activity 2

Collection of Trauma Registry Data. Between 07/2021 and 06/2022, Program will provide oversight of trauma registry data collection.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will collect 35,000 trauma incidents.

Description of Activity: Between 7/2021 and 6/2022, Program will oversee and coordinate the overall collection of trauma registry data into CEMSIS-Trauma from 79 trauma centers for a minimum of 70,000 trauma incidents.

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

Activity 3

Facilitate Input from Trauma Stakeholders. Between 07/2021 and 06/2022, Program will facilitate input on proposed trauma regulations revisions from trauma stakeholders throughout the state by providing presentations on progress to five Regional Trauma Coordinating Committees (RTCCs).

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will to conduct two of five presentations to RTCCs.

Description of Activity: Between 7/2020 and 6/2022, Program will provide a minimum of one presentation at each of the five Regional Trauma Coordinating Committees (RTCCs) to facilitate feedback on the progress of state trauma regulation revision efforts.

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

Activity 4

Develop and Host a Virtual Trauma Summit Program. Between 07/2021 and 06/2022, Program will create and host a one-day, virtual Trauma Summit.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will develop a virtual trauma program summit program.

Description of Activity: Between 07/2021 and 06/2022, Program will create a one-day program with five hours of educational sessions, and will seek subject matter guidance from the State Trauma Advisory Committee and Trauma Managers. EMSA staff host the event and coordinate with an accredited institution to provide Continuing Education (CEs) credits to eligible attendees.

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

Activity 5

Strengthen State Trauma System Collaboration. Between 07/2021 and 06/2022, Program will host State Trauma Advisory Committee Meetings to promote collaboration with trauma stakeholders.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will host two meetings.

Description of Activity: Between 07/2021 and 06/2022, Program will host four quarterly meetings with State Trauma Advisory Committee members to continue in the development coordination and maintenance of the state trauma system.

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

Objective 4:

Title: Maintain EMS Partnership for Injury Prevention and Public Education

Objective: Between 07/2021 and 06/2022, Program will maintain one EMS Partnership for Injury Prevention and Public Information program by providing statewide coordination and leadership for the planning, development and implementation of Illness and Injury Prevention resources for California EMS partners within the EMS community.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will provide one source of education for EMS partners to promote injury prevention within the EMS community.

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

Program for this Objective: **The mortality rate for injury deaths in California is 44.9 per 100,000 in the U.S.** California has the highest number of injury deaths (18,152) in the country. California also has 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 from injuries. California had the third-lowest rate of all intentional injury deaths (44.9 per 100,000) in the U.S.

Key indicator affected by this program: Key indicators are the number of EMS partners attending the Injury Prevention workshops at the Virtual Trauma Summit.

Baseline value for the key indicator: 140

Data source for key indicator baseline: 2019 Trauma Summit attendance

Date key indicator baseline data was last collected: 2019

Intervention Information: **Increase access to and effectiveness of rapid prehospital EMS by developing statewide injury-prevention training standards and initiatives with local EMS providers and stakeholders.** Inclusion of an EMS role in statewide prevention and public-education initiatives, programs, and policies will be used to evaluate the success of the overall program goal of ensuring the recognition of EMS as a vital partner in prevention and public-education activities.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: The American College of Surgeons report, "Resources for Optimal Care of the Injured Patient: 2014" and Clarification Document, updated 2016

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

- *Item to be measured:* Usage of Injury Prevention and Public Information resources established by EMSA
- *Unit of Measurement*: EMS Injury Prevention and Public Information program webpage visits
- *Baseline value for the item to be measured:* 50
- *Data source for baseline value:* EMSA Injury Prevention and Public Information webpage
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 25
- *Final target value to be achieved by the Final Progress Report:* 50

Target Population

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

Primarily Low Income: No

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

Activity 1

Maintain EMS Partnership for Injury Prevention and Public Information Program webpage. Between 07/2021 and 06/2022, Program will maintain one injury and Illness-prevention web page on the EMS website.

Mid-year goal: Between 07/2021 and 12/2021, EMSA Staff will complete at least one quarterly review of injury prevention web page links on EMSA's website.

Description of Activity: Between 7/01/2021 and 6/30/2022, Program will maintain one illness and injury prevention web page that will provide sources for education and promote injury prevention in the EMS community. On a quarterly basis, Program will review sixty-six links to ensure they are accessible, updated, and working.

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

Activity 2

Provide Data to Local/State Stakeholders. Between 07/2021 and 06/2022, Program will provide trauma registry data to local or state trauma stakeholders that use it for injury prevention education and awareness.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will provide one data set to one local or state trauma stakeholder.

Description of Activity: Between 07/2021 and 06/2022, Program will provide two data sets to local or state trauma stakeholders for use in developing injury prevention initiatives aimed at deceasing traumatic injuries and death.

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

Objective 5:

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

Objective: Between 07/2021 and 06/2022, EMSA Program will maintain one EMS STEMI program by providing leadership for the implementation of the state STEMI regulations. Program will also provide statewide coordination and support to entities developing STEMI Critical-Care Systems, and those that have the system in place, through education and technical support to improve and increase the level of care for STEMI patients in California.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will increase by one, the number of LEMSAs that have the STEMI Critical Care Systems in place.

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

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

Key indicator affected by this program: The key indicator is the number of LEMSAs which have this system in place. The standardized system created based on the STEMI Critical Care Regulations can provide the highest level of Care for the patient in the shortest time at the specialty care facilities equipped with the highest technology and expert staff.

Baseline value for the key indicator: 22 LEMSAs out of 33 have implemented a standardized STEMI Critical Care System with a plan approved by the State EMS Authority program staff.

Data source for key indicator baseline: EMSA approved STEMI Critical Care System plans received from LEMSAs.

Date key indicator baseline data was last collected: 2021

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: The evidence based on the Mission Lifeline from American Heart Association Guidelines, The American College of Cardiology recommendations, and the National Institute of Health studies.

Rationale for choosing the Intervention: Since the evidence-based care for this time-sensitive emergency is continually updated according to new literature, and the newest innovative technologies become available over time, it is essential to provide frequent educational updates and technical support for LEMSAs, specialty care centers, health care providers,

public, and other stakeholders. This will increase the level of care and reduce morbidity and mortality for patients experiencing STEMI in California.

- *Item to be measured:* Technical Assistance in interpretation of regulations, and other guidance provided to LEMSAs, state departments, specialty care centers, members of the public, and other stakeholders.
- *Unit of Measurement*: The number Technical Assistance in the forms of emails, phone calls, and virtual meetings
- *Baseline value for the item to be measured:* 45
- *Data source for baseline value:* EMSA staff record
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 25
- *Final target value to be achieved by the Final Progress Report:* 50

Target Population

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

Primarily Low Income: No

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

Activity 1

Provide Education on Current Trends for Optimal STEMI care. Between 07/2021 and 06/2022, Program will conduct one State STEMI Summit.

Mid-year goal: Between 07/2021 and 12/2021, Program will be developing the summit schedule, topics for the event, and scheduling speakers. A “save the date” card will be created, and the process will be started to provide attendees with CE/CME credits.

Description of Activity: Between 7/01/2021 and 6/30/2022, Program will conduct one state STEMI Summit to educate emergency physicians, cardiologists, STEMI nurses, hospital registrars, paramedics, EMTs and administration staff on clinical and system aspects of care for STEMI patients, to increase the level of care in California.

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

Activity 2

Technical Advisory Committee (TAC) Meetings. Between 07/2021 and 06/2022, the TAC will meet on a regular basis to advise EMSA STEMI program on all aspects of the specialty care systems.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will facilitate at least two meetings.

Description of Activity: Between 07/2021 and 06/2022, Program staff facilitate and coordinate four virtual meetings each year to discuss the status of the state specialty care systems and receive advice from the TAC to increase the level of care and improve the system for STEMI patients in California. This committee also has subcommittees that meet separately as needed for planning of the educational STEMI Summit and all the related activities, on State STEMI data collection system and the creation of QI activities at the state level in the future.

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

Objective 6:

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

Objective: Between 07/2021 and 06/2022, EMSA Program will maintain one EMS Stroke program by providing leadership for the implementation of the state Stroke regulations. Program will also provide statewide coordination and support to entities developing Stroke Critical-Care Systems, and those that have the system in place, through education and technical support to improve and increase the level of care for Stroke patients in California.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will increase by one, the number of LEMSAs that have the Stroke Critical Care Systems in place.

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

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

Key indicator affected by this program: The key indicator is the number of LEMSAs which have this system in place. The standardize system created based on the Stroke Critical Care Regulations can provide highest level of Care for the patient in the shortest time at the specialty care facilities equipped with the highest technology and expert staff.

Baseline value for the key indicator: 22 LEMSAs out of 33 have implemented a standardized Stroke Critical Care System with a plan approved by the State EMS Authority

Data source for key indicator baseline: EMSA approved Stroke Critical Care System plans received from LEMSAs.

Date key indicator baseline data was last collected: 2021

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: The evidence based on the Stroke Get with the Guideline from American Heart Association, The American College of Neurology recommendations, The Coverdell National Acute Stroke Program, and the National Institute of Health studies (NIH).

Rationale for choosing the Intervention: Since the evidence-based care for this time-sensitive emergency is continually updated according to new literature, and the newest innovative technologies become available over time, it is essential to provide frequent educational updates and technical support for LEMSAs, specialty care centers, health care providers, public, and other stakeholders. This will increase the level of care and reduce morbidity and mortality for patients experiencing stroke in California.

- *Item to be measured:* Technical Assistance in interpretation of regulations, and other guidance provided to LEMSAs, state departments, specialty care centers, members of the public, and other stakeholders.
- *Unit of Measurement*: The number Technical Assistance in the forms of emails, phone calls, and virtual meetings
- *Baseline value for the item to be measured:* 50
- *Data source for baseline value:* EMSA staff record
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 30
- *Final target value to be achieved by the Final Progress Report:* 50

Target Population

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

Primarily Low Income: No

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

Activity 1

Provide Education on Current Trends for Optimal Stroke care. Between 07/2021 and 06/2022, Program will conduct one State Stroke Summit.

Mid-year goal: Between 07/2021 and 12/2021, Program will be developing the summit schedule, topics for the event, and scheduling speakers. A "save the date" card will be created, and the process will be started to provide attendees with CE/CME.

Description of Activity: Between 07/2020 and 06/2021, Program will conduct one state Stroke Summit to educate neurologists, stroke nurses, hospital registrars, paramedics, EMTs and administration staff on clinical and system aspects of care for stroke patients, to increase the level of care in California.

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

Activity 2

Technical Advisory Committee (TAC) Meetings. Between 07/2021 and 06/2022, the TAC will meet on a regular basis to advise EMSA stroke program on all aspects of the specialty care systems.

Mid-year objective goal: Between 07/2021 and 12/2021, EMSA staff will facilitate at least two meetings.

Description of Activity: Between 07/2021 and 06/2022, Program staff facilitate and coordinate four virtual meetings each year to discuss the status of the state specialty care systems and receive advice from the TAC to increase the level of care and improve the system for stroke patients in California. This committee also has subcommittees that meet separately as needed for planning of the educational Stroke Summit and all the related activities, on state stroke data collection system and the creation of QI activities at the state level in the future.

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

Objective 7:

Title: Provide Oversight to CPCS

Objective: Between 07/2021 and 06/2022, EMSA Program will provide oversight to one CPCS required to provide poison control services to 100% of Californians for the prevention of

unnecessary ambulance transports and emergency department visits through coordination and monitoring of activities, in accordance with statutory and regulatory authorities, and contractual requirement.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will confirm CPCS provides contracted poison control services to Californians.

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

Program for this Objective: **EMSA has designated CPCS as the sole provider of poison control services for the State of California and requires quarterly progress reports be submitted to evaluate and monitor CPCS operations and ensure compliance with state standards for poison control services and contractual scope of work.** Statute and regulations mandate a California poison control center (PCC) or regional PCC be designated by the EMS Authority. Poison centers reduce health care expenditures by preventing unnecessary ambulance transports and emergency department visits. Without CPCS services, emergency department visits would substantially increase.

Key indicator affected by this program: The key indicator is the number of poison control cases managed by CPCS. CPCS manages an average of 216,305 cases per year, with 69% of the cases managed on site (caller/patient was able to remain at call location). Cases involving children aged five and under accounted for 53% of the on-site managed cases.

Baseline value for the key indicator: 216,305

Data source for key indicator baseline: CDCS

Date key indicator baseline data was last collected: 2018

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

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

- *Item to be measured:* Compliance with contractual requirements as reported in Quarterly reports received from CPCS
- *Unit of Measurement*: Quarterly report
- *Baseline value for the item to be measured:* 4
- *Data source for baseline value:* Quarterly reports submitted by CPCS
- *Date baseline was last collected:* 1/15/2021
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 4

Target Population

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

Primarily Low Income: No

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

Activity 1

Review Quarterly Activity Report Submissions. Between 07/2021 and 06/2022, Program will provide oversight to one CPCS required to submit quarterly activity reports through coordination and technical assistance of quarterly activity report submissions with CPCS Business Director, in accordance with statutory and regulatory authorities, and contractual requirements.

Mid-year goal: EMSA Staff will review two quarterly activity reports from CPCS.

Description of Activity: Between 7/2021 and 6/2022, the EMS Authority's EMS Plans Coordinator is responsible for monitoring the CPCS through coordination and review of contractually required quarterly reports.

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

Health in All Policies

Healthy People 2030 Objective

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

Health Objective

Between 07/2021 and 6/2022, Program staff will (1) embed health and equity into at least 10 California programs, policies, and processes that impact the social determinants of health, such as land use, active transportation, transit-oriented affordable housing development, social welfare, natural resources, and environmental pollution; (2) maintain or build new partnerships with at least 10 state-level departments, agencies, and programs to achieve this objective.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $592,748
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: State Health Department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: Yes
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 3.35
- Number of FTEs in this program funded by the PHHS Block Grant: 3.35

Issue/Problem

California has long-standing health, racial, and social inequities that adversely impact population health, yet public health infrastructure does not effectively advance equity. The COVID-19 pandemic has highlighted and exacerbated the long-standing health, racial, and social inequities in California. COVID-19 disproportionately affects California's low income, Latino, Black, and Pacific Islander communities, as well as essential workers such as those in health care, grocery, and cleaning services. Social determinants of health, such as food insecurity, lack of health insurance, and housing instability can increase the risk of poor outcomes. These social determinants of health are often the result of structural racism. The State of California is identifying communities most impacted and directing resources to address COVID-19 health inequities. Reducing COVID-19 risk in all communities is good for

everyone, and California is committed to making it part of our reopening plan. While these inequities are particularly stark for COVID-19, sadly the same trends are visible for almost all health outcomes with low-income communities and communities of color fairing worse. Utilizing the equity best practices learned from the COVID-19 pandemic and a targeted universalism framework, Program will explore the use and impact of quality improvement as a means for increasing efficiency and/or effectiveness outcomes in health departments. Public health programs and interventions should include assessment of their effectiveness to advance equity so as to be more efficient with limited public health resources. By improving public health infrastructure to better serve the needs of vulnerable populations, those experiencing the greatest inequities and therefore worse health outcomes, the State will be better prepared to improve overall population health outcomes.

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: OHE targets California's resources to vulnerable populations as a strategy to improve health and reduce inequities including, low-income individuals and racial and ethnic minorities (Health and Safety Code Section 131019.5). The consequences of poverty include high rates of poorer health and lower life expectancy among vulnerable populations. Evidence has shown a strong correlation between poverty-level income and cardiovascular disease, low birth weight, hypertension, arthritis, and diabetes. One-third of deaths in the United States can be linked to income inequality, and it is estimated that nearly 900,000 deaths could have been prevented nationally in 2007, had the level of income inequality been lower. Overall Poverty in California, 2011-2015 was 36.1%. Poverty for Whites was 22.9%, Latinos was 52%, African Americans was 44.4%, American Indian/Alaskan Native was 44.3%, Native Hawaiian Other Pacific Islander was 39.8%.

Baseline value of the key indicator described above: 36.1% Overall Poverty in California, 2011-2015

Data source for key indicator baseline: CHHS Poverty Rate by California Regions - Fact Sheet

Date key indicator baseline data was last collected: May 2019

Program Strategy

Goal: Increase effectiveness and/or efficiency of public health programs and departments by advancing equity in policies and procedures.

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

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

Summary of Program Strategy: Using equity best practices and a targeted universalism framework, Program will explore the use and impact of quality improvement as a means for increasing efficiency and/or effectiveness outcomes in health departments. Public health programs and interventions should include assessment of their effectiveness to advance equity so as to be more efficient with limited public health resources. By improving public health infrastructure to better serve the needs of vulnerable populations, those experiencing the greatest inequities and therefore worse health outcomes, the State will be better prepared to improve overall population health outcomes.

Primary Strategic Partners

External:

1. Health in All Policies Task Force
2. Governor's Strategic Growth Council
3. Public Health Institute Health in All Policies
4. Local health departments and associated initiatives such as the Bay Area Regional Health Inequities Initiative and Public Health Alliance of SoCal
5. Race Forward/Government Alliance on Race and Equity

Internal:

1. The Office of Strategic Development & External Relations, Fusion Center
2. Center for Health Communities
3. Center for Infectious Diseases
4. Center for Family Health
5. Office of Quality Performance and Accreditation

Planned non-monetary support to local agencies or organizations:

- Technical Assistance

Evaluation Methodology: Ongoing tracking of outcomes including number of meetings, meeting participants, changes in policies or programs, etc.

Program Settings:

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

Target Population of Program

- *Target population data source*: CHHS Poverty Rate by California Regions - Fact Sheet
- *Number of people served:* 12,900,000
- *Ethnicity:* Hispanic or Latino and Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female

- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: Yes

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

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

Objectives and Activities

Objective 1:

Title: Build Public Health Capacity to Implement Equity in Policies, Systems, and Environment

Objective: Between July 1, 2021 to June 30, 2022, Program will conduct (8) 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 racial and health equity, implement health in all policies activities, and understand and address the social determinants of health, including the built and social environment.

Mid-year objective goal: Between 7/2021 and 12/2021, Program will conduct 4 meetings, training, or one-on-one TA sessions.

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

Intervention Information: **Increase the capacity of public health staff to promote racial and health equity, implement health in all policies activities, and understand and address the social determinants of health, including the built and social environment.** Through equity strategies and a targeted universalism framework, Program will explore the use and impact of quality improvement as a means for increasing efficiency and/or effectiveness outcomes in health departments. This will include increasing the capacity of public health staff to promote racial and health equity, implement health in all policies activities, and understand and address the social determinants of health, including the built and social environment.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: CDPH Equity Playbook
  Racial Equity Alliance Approach
  UC Berkeley Targeted Universalism
  Health Affairs Article on Health Equity

Rationale for choosing the Intervention: Health in All Policies (HiAP), racial and health equity, and the social determinants of health are still relatively new concepts in public health. The intent is to provide the education and tools to CDPH and local health department staff so they can better understand their program goals and ultimately achieve better health and health equity for all.

- *Item to be measured:* Trainings, presentations, and consultations provided to local health departments and partners in CDPH
- *Unit of measurement:* Number of trainings, presentations, and consultations to local health departments and partners in CDPH
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activities
- *Date baseline was last collected:* 2021-2022

- *Interim target value to be achieved by the Annual Progress Report:* (4) meetings, trainings, or one-on-one technical assistance (TA) sessions
- *Final target value to be achieved by the Final Progress Report:* (8) meetings, trainings, or one-on-one technical assistance (TA) sessions

Target Population

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

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

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

Activity 1

CDPH Equity Capacity. Between 07/2021 and 06/2022, Program will build CDPH capacity to promote equity in Policies, Systems, and Environment.

Mid-year goal: Between 07/2021 and 12/2021, Program will provide 1 trainings or consultations to at least two CDPH programs or offices.

Description of Activity: Between July 1, 2021 and June 30, 2022, Program will provide 2 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/or (3) understand and address the social determinants of health, including the built and social environment.

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

Activity 2

LHD Equity Capacity. Between 07/2021 and 06/2022, Program will build LHD capacity to promote equity in Policies, Systems, and Environment.

Mid-year goal: Between 07/2021 and 12/2021, Program will provide trainings or technical assistance to at least one LHD.

Description of Activity: Between July 1, 2021 and June 30, 2022, Program will provide trainings or technical assistance 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/or (3)

increase understanding of and address the social determinants of health, including the built and social environment.

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

Objective 2:

Title: Increase Collaboration and Integration of Health and Equity Considerations

Objective: Between July 1, 2021 and June 30, 2022, Program will implement 5 health and equity considerations into non-health department polices, programs, or practices to impact the social determinants of health, including the built and social environment.

Mid-year objective goal: Program will implement 3 health and equity considerations into non-health department polices, programs, or practices.

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

Intervention Information: **Embed health and equity into non-health program plans, policies, and procedures.** HiAP seeks to embed health and equity into non-health departments' policies, programs, and practices to improve the social and living conditions of people so that the healthy choice is also the easy choice. OHE HiAP Staff works with the Health in All Policies Task Force, which consists of 22 departments, agencies, and offices, to collaboratively educate and increase capacity to promote health and equity.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

Other: CDPH Equity Playbook
Racial Equity Alliance Approach
UC Berkeley Targeted Universalism
Health Affairs Article on Health Equity

Rationale for choosing the Intervention: An estimated 60-80% of health is determined by factors outside of public health and health care's jurisdiction including housing, transportation, education, environment, etc. The State of California's HiAP Program has developed partnerships with more than 22 agencies and departments to advance racial and health equity. This intersectoral approach will optimize the impact on the social determinants of health. The HiAP program has leveraged a targeted universalism framework and equity strategies to advance this work.

- *Item to be measured:* Policies/procedures developed and/or embedded

- *Unit of measurement:* Number of policies/procedures developed/embedded
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activities
- *Date baseline was last collected:* 2021-2022
- *Interim target value to be achieved by the Annual Progress Report:* 3 health and equity considerations into non-health department polices, programs, or practices
- *Final target value to be achieved by the Final Progress Report:* 5 health and equity considerations into non-health department polices, programs, or practices

Target Population

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

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

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

Activity 1

Equity in Programs. Between 07/2021 and 06/2022, Program increase health and equity considerations in non-health department programs.

Mid-year goal: Between 07/2021 and 12/2021, Program will partner with at least 3 non-health departments to integrate health and equity considerations in at least 2 programs.

Description of Activity: Between July 1, 2021 and June 30, 2022, Program will increase health and equity considerations in non-health department and programs through the Health in All Policies Task Force, OHE staff will partner with at least five non-health departments to integrate health and equity considerations in at least four programs, such as the Strategic Growth Council's (SGC's) Affordable Housing and Sustainable Communities Grant program, and Department of Social Services.

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

Activity 2

Equity in Practice. Between 07/2021 and 06/2022, Program will increase health and equity considerations in non-health department practices.

Mid-year goal: Between 07/2021 and 12/2021, Program will partner with at least 6 non-health departments to increase capacity and integrate health and/or equity considerations into at least 2 policy, practice, or guidance documents.

Description of Activity: Between July 1, 2021 and June 30, 2022, Program will increase health and equity considerations in non-health department practices through the Health in All Policies Task Force, OHE staff will partner with at least twelve non-health departments to increase capacity and integrate health and/or equity considerations into at least 3 policies, practices, or guidance documents.

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

Healthy People 2030 Program

Healthy People 2030 Objective

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

Health Objective

Between 07/2021 and 06/2022, HPP 2030 will implement one quality improvement (QI) process, using the CDC evaluation framework and the Plan Do Check Act (PDCA) QI model, to increase efficiency and effectiveness of the Preventive Health and Health Services Block Grant (PHHSBG)-funded programs.

Program Funding Details

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

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 6
- Number of FTEs in this program funded by the PHHS Block Grant: 4.3

Issue/Problem

Funding for public health in California has been historically low. Annual per-capita spending for public health is $286, and annual per-capita CDC funding for public health is $20.02 (Trust for America's Health, 2020). 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, services, 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. Until recently, HPP 2030 did not have an evaluation or QI process. Using the CDC

evaluation framework and a QI model, HPP 2030 staff will continue to institute a QI process for selected PHHSBG-funded program.

Public health program was prioritized as follows:

- Other: Supports CDPH's mission which is dedicated to optimizing the health and wellbeing of the people of California; Aligned with Healthy People 2030 Health Objectives

Key Indicator(s) affected by this problem: The number of met, unmet, and partially met objectives and associated activities in the previous year for all PHHSBG-funded programs.

Baseline value of the key indicator described above: QI process for PHHSBG funded-programs in State Fiscal Year (SFY) 20/21

Data source for key indicator baseline: CDPH PHHSBG Final Annual Progress Report (APR)

Date key indicator baseline data was last collected: 2020

Program Strategy

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

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

Summary of Program Strategy: A QI process for PHHSBG-funded programs will strengthen public health infrastructure to improve public health outcomes, decrease health disparities, premature death, and disabilities, and improve health equity.

Primary Strategic Partners

External:

1. Emergency Medical Services Authority

Internal:

1. Center for Healthy Communities
2. Center for Environmental Health
3. Center for Infectious Diseases
4. Office of Health Equity
5. The Office of Strategic Development & External Relations, Fusion Center

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids

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

Program Settings:

- State health department

Target Population of Program

- *Target population data source*: US Census Data, 2018
- *Number of people served:* 39,512,223
- *Ethnicity:* Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

- Gay (lesbian or gay)

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- All California counties

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

Objectives and Activities

Objective 1:

Title: Institute a QI Process to Improve PHHSBG Program Outcomes

Objective: Between 07/2021 and 06/2022, HPP 2030 will implement one QI process to contribute to PHHSBG program evaluation.

Mid-year objective goal: HPP 2030 will assess all PHHSBG-funded programs and determine which program requires a QI intervention most.

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

Intervention Information: **Utilize QI process to assess, improve, or modify PHHSBG program objectives that were either partially or not met.** A QI process for PHHSBG-funded programs will strengthen public health infrastructure to improve public health outcomes, decrease health disparities, premature death, and disabilities, and improve health equity.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Best Practice Initiative (U.S. Department of Health and Human Services)
- Other: Healthy People 2030; 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

Rationale for choosing the Intervention: A QI process will help ensure that PHHSBG is being utilized efficiently and effectively for state priorities.

- *Item to be measured:* QI Process
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* CDPH PHHSBG Final APR
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

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

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

Activity 1

Perform QI Analysis of PHHSBG-Funded Programs. Between 07/2021 and 06/2022, HPP 2030 will analyze the PHHSBG POR to determine which program requires QI intervention most.

Mid-year goal: Between 07/2021 and 12/2021, Program will choose one PHHSBG-funded program for QI intervention.

Description of Activity: Between 07/2021 and 06/2022, HPP 2030 will analyze the PHHSBG POR, which includes reviewing and analyzing all PHHSBG-funded Programs' met or unmet objectives and activities. For Programs that did not achieve their objectives and activities, HPP 2030 will identify at least one Program for a QI analysis, utilizing the PDCA Model.

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

Activity 2

Assist One PHHSBG-Funded Program on QI Process. Between 07/2021 and 06/2022, HPP 2030 will provide at least one Training/Technical Assistance (TTA) to one PHHSBG-funded program.

Mid-year goal: Between 07/2021 and 12/2021, Program will ensure PHHSBG-funded program staff have all resources to complete QI process.

Description of Activity: Between 07/2021 and 06/2022, HPP 2030 will provide at least one TTA to PHHSBG-funded program staff via email, phone, or other communications, as appropriate; and conduct at least one QI meeting to ensure the QI process is understood.

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

Objective 2:

Title: Effectively Communicate Program Outcomes and Success

Objective: Between 07/2021 and 06/2022, HPP 2030 will implement two communication strategies to highlight the outcomes and successes of the PHHSBG-funded programs.

Mid-year objective goal: Gather, review, and analyze all PHHSBG-funded programs' Final APR and Success Stories.

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

Intervention Information: **Effectively communicate the program outcomes and successes to the public and stakeholders.** HPP 2030 will develop a Final APR to share and keep stakeholders informed of the status and progression of the PHHSBG-funded programs. Additionally, HPP 2030 will publish at least ten Success Stories on the CDPH website to share the value of the work being done with the PHHSBG awards.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

Rationale for choosing the Intervention: Communicating statuses and successes of the PHHSBG-funded programs will assist in decision-making of what state priorities should be focused on.

- *Item to be measured:* Communication strategies
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* CDPH PHHSBG Final APR; Success Stories
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 2

Target Population

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

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

Activity 1

Share Final APR with Public and Stakeholders. Between 07/2021 and 06/2022, HPP 2030 will publish and share one final APR with all stakeholders.

Mid-year goal: Between 07/2021 and 12/2021, Program will gather, review, and analyze all PHHSBG-funded programs' Final APR.

Description of Activity: Between 07/2021 and 06/2022, HPP 2030 will publish one POR on the CDPH website to disseminate information to the public. Additionally, the POR will be shared with at least eight stakeholders.

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

Activity 2

Publish Success Stories Online. Between 07/2021 and 06/2022, HPP 2030 will publish at least ten success stories on the CDPH website.

Mid-year goal: Between 07/2021 and 12/2021, Program will gather and review all PHHSBG-funded programs' success stories.

Description of Activity: Between 07/2021 and 06/2022, HPP 2030 will publish at least ten success stories on the CDPH website to disseminate information to the public.

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

Injury Prevention Program

Healthy People 2030 Objective

IVP-01: Reduce fatal injuries

Health Objective

Between 07/2021 and 06/2022, Program will strive to reduce by 5% the crude rate of total, unintentional, and intentional injury deaths in California from the current 2017 rates (51.9, 34.4 and 16.1 per 100,000 California residents respectively) toward their baseline 2013 levels of 45.6, 28.7 and 15.2 per 100,000, respectively.

Program Funding Details

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

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 12
- Number of FTEs in this program funded by the PHHS Block Grant: 5.33

Issue/Problem

Injuries are the leading cause of death, hospitalization, and disability for Californians ages 1 - 44 years old and have significant impacts on individuals, their communities, and the economy. Injuries are the leading cause of death, hospitalization, and disability for people ages 1 - 44 years old in California, and have substantial impacts and consequences for the economy, communities, and the well-being of the State's population. Each year, injuries in California lead to over (1) 20,000 deaths, (2) 250,000 hospital visits, and (3) 2.5 million visits to emergency departments. The CDC has estimated the cost of only FATAL intentional and

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

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: Rate of injury deaths in California in 2017 for three indicators: total injuries, unintentional injuries, intentional injuries.

Baseline value of the key indicator described above: Total = 51.9 per 100,000; Unintentional = 34.4 per 100,000; Intentional = 16.1 per 100,000

Data source for key indicator baseline: EpiCenter: California Injury Data Online, assessed March 2020.

Date key indicator baseline data was last collected: 2017

Program Strategy

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

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

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

Summary of Program Strategy: The California Wellness Plan includes 15 goals/objectives consistent with this program, including the goals of increasing accessible and usable health information and expanding access to comprehensive statewide data. There are several specific objectives for injury and violence, including objectives to decrease the annual incidence rate of unintentional injury deaths in California from 27 (baseline data from 2011) to 20 per 100,000, and decrease the annual incidence rate for homicides from 5 (baseline data from 2011) to 4 per 100,000, by the year 2020.

Primary Strategic Partners

External:

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

Internal:

1. Chronic Disease Control Branch
2. Office of Health Equity
3. Maternal, Child, and Adolescent Health Branch
4. The Office of Strategic Development & External Relations, Fusion Center
5. Health in All Policies Program.

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: Injury numbers/rates overall and for specific injury types tracked using vital statistics and administrative health data. 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).

Program Settings:

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

Target Population of Program

- *Target population data source*: All Californians
- *Number of people served:* 40,639,392
- *Ethnicity:* Hispanic or Latino and Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender
- None of these

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

Objective 1:

Title: Preventing ACEs in California

Objective: Between 7/2021 and 6/2022, Program will increase availability of data and information on early childhood adversity (ACEs) and positive childhood experiences (PCEs) by developing and disseminating 2 data briefs, reports, or presentations, which will be facilitated by partnering with a minimum of 10 internal and external partners and working with staff from KidsData to add or update at least one (1) relevant data set.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will work with 10 partners to obtain, access, and advocate for data on ACEs and PCEs in California.

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

Program for this Objective: **Data are essential in the development of effective and sustainable strategies to prevent child adversity, neglect, and maltreatment.** A key function for governmental public health and social services agencies in addressing child adversity is to collect and analyze data to better understand the problem, identify risk and protective factors, and support the development of data-informed interventions that reduce risk factors and support protective factors to mitigate child adversity, abuse and neglect. Data are essential in the development of effective and sustainable prevention strategies.

Key indicator(s) affected by this program: The indicator that is affected by this problem is the number of documents or publications that are released by our program that address ACEs and detail PCEs. Collecting and analyzing data will help us understand the problem better and support the development of evidence-based interventions.

Baseline value for the key indicator: 0

Data source for key indicator baseline: Publications released by program on childhood adversity and/or PCEs

Date key indicator baseline data was last collected: 11/2020

Intervention Information: **Engage with partners to obtain, access, and disseminate data and information on childhood adversity.** Program will partner with internal and external stakeholders, such as the Essentials for Childhood Initiative coalition and others, to obtain access to, analyze, and disseminate data and information on childhood adversity. This includes data on ACEs and PCEs.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Aligns with the CDC's Technical Package on Preventing Child Abuse and Neglect, which mentions using data to inform actions: CDC Preventing Child Abuse and Neglect Technical Package

Rationale for choosing the Intervention: Accessing, understanding, and disseminating data on childhood adversity aligns with the public health mission of the program, to use data to inform prevention strategies.

- *Item to be measured:* Publications, data briefs, and presentations
- *Unit of Measurement*: Number of publications, data briefs, and presentations
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Documentation of publications
- *Date baseline was last collected:* 11/2020
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 2

Target Population

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

- *Target population 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.

- *Number of people served:* 9,270,025
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- N/A

Education Attainment:

- Some High School

Health Insurance Status:

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

Primarily Low Income: No

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

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

Activity 1

Foster Collaboration to Prevent Childhood Adversity. Between 07/2021 and 06/2022, Program will partner with stakeholders to increase access to, analyze, and publish data and information on childhood adversity and PCEs.

Mid-year goal: Between 07/2021 and 12/2021, Program will continue to maintain 60 existing partnerships as part of the Essentials for Childhood Initiative coalition.

Description of Activity: Between 07/2021 and 06/2022, program will work with a minimum of ten (10) internal and external partners to strengthen data sources on childhood adversity. This also involves partnering with others in order to improve access to the data sources and surveys, and strengthen expertise to analyze, interpret, and disseminate the data.

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

Activity 2

Disseminate Childhood Adversity Data. Between 07/2021 and 06/2022, Program will publish two (2) data briefs, reports, or presentations on early childhood adversity or positive childhood experiences in California.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will publish one (1) data brief, report, or presentation on early childhood adversity or positive childhood experiences in California.

Description of Activity: Between 07/2021 and 06/2022, program will publish two (2) data briefs, reports, or presentations on early childhood adversity or positive childhood experiences in California based on 2021 Behavioral Risk Factor Surveillance System (BRFSS) ACEs and PCEs modules and/or other ACEs/PCEs data. Program will engage partners in the analysis, review, and approval process for the publications.

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

Activity 3

Update Childhood Adversity Data Strengthen State EMSC Collaboration. Between 07/2021 and 06/2022, Program will update Childhood Adversity Data on KidsData.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will meet with partners 2-3 times to plan activities to plan activities and efforts necessary to analyze and disseminate data on KidsData.

Description of Activity: Between 07/2021 and 06/2022, program will work with staff from KidsData, a program of Population Reference Bureau (PRB), to add or update at least one (1) relevant data set to inform prevention strategies and policies. The web-based data platform promotes the health and well-being of children in California by providing an easy-to-use resource that offers high quality, wide ranging, local data to those who work on behalf of children. KidsData aims to raise the visibility of key issues affecting California's children and families and to make it easy for leaders and policymakers to use data in assessing community needs, setting priorities, tracking progress, making program and policy decisions, preparing grant proposals and reports, and other work.

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

Objective 2:

Title: Increase Capacity for Local Childhood Unintentional Injury Prevention Programs

Objective: Between 7/2021 and 6/2022, Program will provide at least fifty-five (55) technical assistance resource opportunities to the childhood unintentional injury prevention community and Kids' Plates grantees to increase knowledge, best practice programs, and partnership efforts across California.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will complete at least twenty (20) technical assistance resource opportunities with Kids Plates, local public health departments and unintentional childhood injury prevention advocates.

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

Program for this Objective: **Children under the age of 18 are at high risk for unintentional injury and death and rely on caregivers, their environments and policies to protect them. To accomplish this support for data, research, education and program interventions coordinated at the state level and implemented uniformly at the local level, can best address prevention efforts.** According to CDC NCHS 2018 data, unintentional injury is the most common cause of death to everyone in the U.S. from ages 1-44. In 2017, 7,838 youth ages 1-14 died from unintentional injuries in the United States, while millions more children suffer injuries requiring treatment in the emergency department. Leading causes of child injury include motor vehicle crashes, suffocation, drowning, poisoning, fires, and falls. Child injury is predictable and preventable, and it's also among the most under-recognized public health problems. In order to increase access to statewide education, tools, resources and interventions, CDPH can facilitate this coordination and collaboration with local public health departments, through the Kids' Plates grantees, and other advocates and organizations to disseminate information and best practices to better protect California's children.

Key indicator(s) affected by this program: The number of children affected disproportionately by unintentional injuries, which will be tracked through deaths, hospitalizations, and ED visits.

Baseline value for the key indicator: 1,225 unintentional injury deaths to children under the age of 18 years in California.

Data source for key indicator baseline: CDPH EpiCenter

Date key indicator baseline data was last collected: 2017-2019

Intervention Information: **Provide technical and program support to unintentional childhood injury prevention advocates and organizations, including Kids' Plates grantees, in California.** In partnership with the Kids' Plates program funding which is used exclusively for local interventions, CDPH provides the staff to support the annual dissemination, monitoring and success of the Kids' Plates program while supporting all local unintentional childhood injury prevention programs. California's local public health departments (61) rely on CDPH to provide childhood unintentional injury prevention research, program best practice and when possible safety equipment and funding.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Aligns with the National Action Plan from CDC.
  CDC National Action Plan for Child Injury Prevention

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

- *Item to be measured:* Technical assistance opportunities including emails, phone calls, meetings or webinars
- *Unit of Measurement*: The number of technical assistance and webinars
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Log of technical assistance and webinars
- *Date baseline was last collected:* 2021-2022
- *Interim target value to be achieved by the Annual Progress Report:* 20 technical assistance occurrences, 2 webinars
- *Final target value to be achieved by the Final Progress Report:* 55 technical assistance occurrences, 4 webinars

Target Population

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

- *Target population data source*: Population data from the Department of Finance.
- *Number of people served:* 10,000,000
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

- Some High School

Health Insurance Status:

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

Primarily Low Income: Yes

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

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

Activity 1

Website Development. Between 07/2021 and 06/2022, Program will update and maintain one (1) Kids' Plates website on the CDPH website to provide unintentional childhood injury research and resources.

Mid-year goal: Between 07/2021 and 12/2021, Program will update Kids' Plates/CDPH website with technical information and resources.

Description of Activity: Between 07/2021 and 06/2022, Program staff will maintain one (1) web page on the CDPH website on unintentional childhood injury prevention topics and resources for use by Kids' Plates programs, local entities and the public. The website provides information to professionals and the public on program development, coalition building, and topic-specific technical information for agencies who are addressing childhood unintentional injury risks and prevention education and outreach to local communities. The website will be updated every six (6) months.

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

Activity 2

Quarterly Webinars. Between 07/2021 and 06/2022, Program will facilitate four (4) childhood unintentional injury prevention webinars to Kids' Plates grantees and the professional public health community.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will conduct half the number (2) of childhood unintentional injury prevention webinars and prepare for the remaining webinars.

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

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

Activity 3

Technical Assistance to Kids' Plates Grantees. Between 07/2021 and 06/2022, Program will provide fifty total (50) one-on-one technical assistance to Kids' Plates grantees for program

development and childhood unintentional injury prevention expertise to enhance and maintain program interventions and activities. Approximately twelve (12) per quarter.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will conduct half of all (25) technical assistance activities to Kids' Plates grantees.

Description of Activity: CDPH program staff will provide a total of fifty (50) individual technical assistance to the Kids' Plates grantees (6-9 grantees) to ensure deliverables for their unintentional injury prevention interventions are met. Technical assistance will include virtual meetings, emails and/or phone calls. Grantees are local public health departments, Safe Kids Chapters/Coalitions and/or other non-profit organizations working on the topics of drowning prevention, vehicle occupant safety, gun safety, sports safety, poisoning prevention, fall prevention, bicycle and pedestrian safety. At least twelve technical assistance opportunities will be provided quarterly.

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

Objective 3:

Title: Healthy Aging Initiative

Objective: Between 7/2021 and 6/2022, Healthy Aging Initiative will provide at least ten (10) technical assistance activities to support healthy aging across CDPH and partner organizations.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will provide four (4) activities supporting collaboration and coordination of healthy aging activities.

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

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

Key indicator(s) affected by this program: The key indicators for this objective are the number of older adult deaths, hospitalizations, and ED visits.

Baseline value for the key indicator: 2017-2019 average for older adults age 65 and older: total number of deaths from all causes (199,106); total number of hospitalizations from all causes (1,238,661); total number of ED visits from all causes (1,973,800)

Data source for key indicator baseline: OSHPD and EpiCenter

Date key indicator baseline data was last collected: 2017-2019

Intervention Information: **The Healthy Aging Initiative will provide technical assistance across CDPH and to partner organizations to expand capacity for serving the health needs of older Californians and their caregivers.** The Healthy Aging Initiative (HAI) will provide technical assistance across CDPH and to partner organizations. HAI will coordinate a convening for key stakeholders, strengthen current relationships and build new relationships with internal and external related partners, as well as provide consultation and guidance to state agencies, Local Health Jurisdictions (LHJ), community agencies, or members of the public, to expand capacity for serving the health needs of older Californians and their caregivers.

Type of Intervention: Innovative/Promising Practice

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

- *Item to be measured:* Technical Assistance Activities
- *Unit of Measurement*: Number of Activities Provided
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Activity Tracking Log
- *Date baseline was last collected:* 6/30/2021
- *Interim target value to be achieved by the Annual Progress Report:* 4
- *Final target value to be achieved by the Final Progress Report:* 10

Target Population

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

- *Target population data source*: Department of Finance (2020).
- *Number of people served:* 6,398,047
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

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

Activity 1

Convene Healthy Aging Stakeholders. Between 07/2021 and 06/2022, Program will host one (1) convening of state and local public health leaders to: 1) strategize and share best practices around older adult and caregiver health; and 2) support collective problem solving and build upon the work from the 2020/2021 Healthy Aging Initiative Convenings.

Mid-year goal: Between 07/2021 and 12/2021, Healthy Aging Staff will have contracted with California State University, Sacramento, to provide facilitation and technical assistance for the Spring 2022 Convening.

Description of Activity: Between 07/2021 and 06/2022, Program will be building upon efforts during the last grant iteration, the Healthy Aging Initiative staff will plan and coordinate a virtual convening for state and local public health leaders by June 30, 2022. This convening will continue the conversation around older adult and caregiver health in relation to health equity and the role public health can play in in promoting health equity in this population.

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

Activity 2

Expand Partnerships With Healthy Aging Stakeholders. Between 07/2021 and 06/2022, Healthy Aging Initiative will strengthen the relationship within internal and external healthy aging partners by coordinating/participating in at least four (4) related meetings.

Mid-year objective goal: Between 07/2021 and 12/2021, Healthy Aging Initiative will coordinate/participate in at least two (2) meetings. These would include the Healthy Aging Workgroup meetings and/or external partner meetings.

Description of Activity: Between 07/2021 and 06/2022, Healthy Aging Initiative staff will strengthen internal and external relationships with healthy aging partners through regular Healthy Aging Workgroup meetings (internal staff engagement) and externally by collaborating with the California Department of Aging and the California Healthier Living Coalition.

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

Activity 3

Conduct Technical Assistance on Healthy Aging Programs and Resources. Between 07/2021 and 06/2022, Program will provide five (5) technical assistance consultations to advise state agencies, LHJs, community agencies, or members of the public, via telephone/e-mail/educational webinars on aging resources.

Mid-year objective goal: Between 07/2021 and 06/2022, Program will have provided at least two (2) technical assistance consultations to any of the following: state agencies, LHJs, community agencies, or members of the public.

Description of Activity: Between 07/2021 and 06/2022, Healthy Aging Initiative staff will provide technical assistance consultations to state agencies, Local Health Jurisdictions (LHJ), community agencies, or members of the public to enable sharing of best practices and healthy aging related resources. CDPH will also serve as the license holder and technical assistance provider for the evidence-based fall prevention program "Stepping On".

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

Objective 4:

Title: Reduce Fatal Injuries

Objective: Between 07/2021 and 06/2022, the Crash Medical Outcomes Data project will provide at least eight (8) technical assistance activities to support Local Health Jurisdictions (LHJ) and partner organizations and at least one (1) data brief/report on our work to reduce motor vehicle crash-related injuries and deaths.

Mid-year objective goal: Determine a baseline for unintentional motor vehicle crash-related injuries using probabilistically linked crash circumstance data and medical outcomes data.

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

Intervention Information: **Increase the availability and usefulness of motor vehicle traffic (MVT) injury data.** Between 07/2021 and 06/2022, Program will conduct 3 technical

assistance and/or training sessions/presentations to LHJs, stakeholders and other traffic safety partners to build their capacity to expand data-informed efforts to reduce traffic crashes, fatalities and serious injuries towards attaining the Vision Zero goal.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

Rationale for choosing the Intervention: To work towards attaining the Vision Zero goal - towards zero deaths.

- *Item to be measured:* Serious motor vehicle traffic (MVT) crash-related injuries and deaths
- *Unit of measurement:* Rate/percentage of serious injuries/deaths per year
- *Baseline value for the item to be measured:* 0%
- *Data source for baseline value:* Emergency Department (ED)/hospital & Fatality Analysis Reporting System (FARS) data
- *Date baseline was last collected:* 2016
- *Interim target value to be achieved by the Annual Progress Report:* 50% (rate/percentage of serious injuries/deaths calculated for baseline year)
- *Final target value to be achieved by the Final Progress Report:* 100% (rate/percentage of serious injuries/deaths calculated for baseline year)

Target Population

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

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

Activity 1

Understanding the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Coding System. Between 07/2021 and 06/2022, Program will provide training on the application of the ICD-10-CM coding system.

Mid-year goal: Between 07/2021 and 12/2021, Program will conduct 1-2 training sessions/webinars/presentations on the application of the ICD-10-CM codes using linked data to at least 3 LHDs, stakeholders and other traffic safety partners.

Description of Activity: Between 07/2021 and 06/2022, Program will conduct 3 training sessions/webinars/presentations to LHDs, stakeholders and other traffic safety partners on expanding and increasing the use of actionable traffic-safety data.

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

Activity 2

Interpreting the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Coding System. Between 07/2021 and 06/2022, Program will provide technical assistance to LHDs on FARS data and ICD-10-CM coding system

Mid-year goal: Between 07/2021 and 12/2021, Program will share data briefs/reports with Injury Surveillance and Transportation stakeholders using FARS & CMOD linked data.

Description of Activity: Between 07/2021 and 06/2022, Program will conduct 5 technical assistance (TA) sessions/webinars/presentations to LHDs, stakeholders and other traffic safety partners on the use and application of the ICD-10-CM coding system (non-fatal) and FARS (fatal) for generating transportation related injury data from ED/hospital fatal crash data sources.

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

Activity 3

Medical Outcomes and Injury Severity of Crashes. Between 07/2021 and 06/2022, Program will produce International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) data report for injury medical outcomes/severity

Mid-year goal: Between 07/2021 and 12/2021, Program will draft data report/brief using new/piloted probabilistic data linkage methodology for medical outcomes and injury severity of MVT crash-related injuries.

Description of Activity: Between 07/2021 and 06/2022, Program will use linked crash and ICD-10-CM medical data to conduct data analyses on the impact of crashes, external causes of injury, injury severity and the medical outcomes and produce one data report.

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

Objective 5:

Title: Update EpiCenter

Objective: Between 07/2021 and 06/2022, the Injury and Violence Prevention Branch (IVPB) will Increase accessibility of timely statewide injury surveillance data by updating its EpiCenter online injury surveillance web site to include the most recent injury surveillance data and five

(5) data visualizations. IVPB staff will support the EpiCenter update by providing technical assistance (TA) to at least twenty-five (25) EpiCenter users.

Mid-year objective goal: EpiCenter will update framework in place: have statistical software code ready to process new data when available, data visualization mock-ups complete, and TA content complete.

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

Intervention Information: **Empower injury prevention stakeholders across the state with timely, relevant, and easy-to-use data.** EpiCenter is the IVPB's online injury surveillance web site. IVPB will update the EpiCenter site to include the most recent data sources for fatal and non-fatal injury surveillance. IVPB will make data insights more accessible by providing data visualizations that can enable users to quickly identify risk and protective factors and trends in injury and violence and help inform interventions. To ensure users get the most from this resource, technical assistance will be made available in a convenient format.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

Rationale for choosing the Intervention: Surveillance is the foundation of public health. By expanding the availability and utility of timely data for injury and violence prevention on its EpiCenter online injury site, IVPB can support myriad interventions across California, helping practitioners identify and respond to emerging injury and violence trends.

- *Item to be measured:* EpiCenter data query downloads
- *Unit of measurement:* Downloads per day
- *Baseline value for the item to be measured:* 40
- *Data source for baseline value:* EpiCenter report log
- *Date baseline was last collected:* 02/2020
- *Interim target value to be achieved by the Annual Progress Report:* 40 (no change expected)
- *Final target value to be achieved by the Final Progress Report:* 44 (10% increase)

Target Population

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

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

Activity 1

Update EpiCenter Data. Between 07/2021 and 06/2022, IVPB staff will process and upload to EpiCenter the most recently available injury data from 3 injury data sources: death, hospital, and emergency department visits.

Mid-year goal: Between 07/2021 and 12/2021, Program will have statistical software code ready to process new data when available.

Description of Activity: IVPB receives annual files for California deaths, hospital visits, and emergency department visits from state partners. IVPB will process these data to classify and extract injury-related deaths, hospitalizations, and ED visits. IVPB will then make the processed data available for query on its EpiCenter website by June 30, 2022.

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

Activity 2

EpiCenter Data Visualizations. Between 07/2021 and 06/2022, IVPB staff will develop 5 data visualizations on the EpiCenter web site to allow users to quickly gain injury burden insights.

Mid-year goal: Between 07/2021 and 12/2021, Program will have data visualization mock-ups complete.

Description of Activity: IVPB's EpiCenter injury surveillance web site allows users to query data and view tabular summaries of California injury-related deaths, hospital visits, and emergency department visits. IVPB staff will make data insights more accessible by adding at least 5 data visualizations to the EpiCenter website by June 30, 2022.

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

Activity 3

EpiCenter Technical Assistance. Between 07/2021 and 06/2022, IVPB staff will provide TA and guidance to at least 25 EpiCenter users on how to use the online injury data tools (e.g., query system; dashboards) to translate data into actionable information for use in program planning and evaluation.

Mid-year goal: Between 07/2021 and 12/2021, Program will have TA content complete.

Description of Activity: IVPB's EpiCenter injury surveillance web site allows users to query data and view tabular summaries of California injury-related deaths, hospital visits, and emergency department visits. IVPB staff will make data insights more accessible by providing TA and

guidance to at least 25 EpiCenter users by June 30, 2022. TA will teach participants to use the online injury data tools (e.g., query system; dashboards) to translate data into actionable information for use in program planning and evaluation.

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

Objective 6:

Title: School-Based Health Centers Support

Objective: Between 7/2021 and 6/2022, Program will work to expand CA's school-based health centers (SBHC) and/or services to increase the number of California adolescents who have had a preventive health care visit in the last 12 months by 5%.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will hold 2 SBHC Workgroup meetings with state staff and stakeholders to plan and coordinate statewide activities.

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

Program for this Objective: **Many California adolescents do not receive annual necessary, regular preventive health care visits; this objective aims to increase these visits.** As defined by Health and Safety Code §124174, a school health center may conduct routine physical, mental health, and oral health assessments, and provide referrals for any services not offered onsite. School health centers help to ensure children are healthy and ready to learn. Offering preventive and ongoing care at school can reduce trauma and injuries, health inequities and improve a child’s ability to succeed in the classroom.

Key indicator(s) affected by this program: SBHCs facilitate preventive health care services for CA's adolescents such as: provide diagnostic and treatment services, including direct primary and mental health care for acute and chronic illnesses, Child Health and Disability Prevention (CHDP) exams, health education including injury prevention, case management assistance, and immunizations. SBHC may also provide counseling to reduce risk factors such as smoking, substance abuse, teen sex, violence and safety issues, as well as behavioral problems.

Baseline value for the key indicator: 78.7% of adolescents ages 12 -17

Data source for key indicator baseline: National Survey of Children's Health

Date key indicator baseline data was last collected: 2016-2017

Intervention Information: **Supporting the establishment of School-Based Health Centers in California will increase the numbers of adolescents receiving preventive health care**

visits which in part can reduce trauma and injuries. The CDPH SBHC project will aim to provide coordination support to the existing SBHC network by strengthening relationships within the SBHC Workgroup and partners while providing technical assistance to the state's SBHCs. By conducting a needs assessment of existing SBHCs, CDPH and the Workgroup will identify where SBHCs currently need help - a critical data point given the past year of school closures at the majority of California's middle and high school campuses. Finally, the information gleaned from the needs assessment will enable CDPH staff to tailor the technical assistance provided virtually via webinar to the SBHCs.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Guide to Clinical Preventive Services (Task Force on Community Preventive Services

Rationale for choosing the Intervention: Evidence-base; health equity focus.

- *Item to be measured:* CA adolescents ages 12-17 receiving annual preventive health care visits
- *Unit of Measurement*: Preventive health care visits
- *Baseline value for the item to be measured:* 78.7% of CA adolescents receive preventive health care visits annually.
- *Data source for baseline value:* National Survey of Children's Health
- *Date baseline was last collected:* 2016-2017
- *Interim target value to be achieved by the Annual Progress Report:* 80.3% of adolescents receiving preventive health care visits (2% increase)
- *Final target value to be achieved by the Final Progress Report:* 82.6% of adolescents receiving preventive health care visits (5% increase)

Target Population

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

- *Target population data source*: National Survey of Children’s Health
- *Number of people served: #* CA school children age 12-17
- *Ethnicity:* Not Hispanic or Latino

Race:

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

Age:

- 5-14 years
- 15-24 years

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- Middle school; high school student

Education Attainment:

- Some High School

Health Insurance Status:

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

Primarily Low Income: No

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

Is the entire target population disproportionately affected by the problem, or only part? Answer: Part

Activity 1

School-Based Health Center Coordination. Between 07/2021 and 06/2022, Program will improve coordination statewide by convening the School-Based Health Center Workgroup (Workgroup) comprised of representatives from CDPH, CDE, DHCS and the School-Based Health Center Alliance.

Mid-year goal: Between 07/2021 and 12/2021, Program will hold 2 SBHC Quarterly Workgroup meeting.

Description of Activity: In the FFY 2021 the School-Based Health Center Workgroup will be convened by CDPH's IVPB staff. The Workgroup membership will be contacted and invited to quarterly meetings during the project's 12 month timeframe.

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

Activity 2

Assess Needs of SBHCs. Between 07/2021 and 06/2022, Program will conduct a needs assessment among existing SBHCs to identify areas of technical assistance required from CDPH.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will perform needs Assessment survey administered to SBHCs.

Description of Activity: In the next year, CDPH's Injury and Violence Prevention Branch (IVPB) staff, with the support of the SBHC Workgroup, will develop and administer a needs assessment survey to the state's existing SBHCs and or stakeholders. The survey results will be collected by CDPH-IVPB staff and shared back with the Workgroup. CDPH-IVPB and the Workgroup will identify SBHC technical assistance needs and share back the findings with the field.

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

Activity 3

Provide Technical Assistance to SBHCs. Between 07/2021 and 06/2022, Program will provide technical assistance to California's SBHCs on topics identified in the needs assessment.

Mid-year objective goal: Between 07/2021 and 06/2022, Program will deliver one technical assistance webinar to SBHCs.

Description of Activity: CDPH will provide at least 2 technical assistance events to California's SBHCs on topics identified in the needs assessment which may include: increasing enrollments of eligible students in Medi-Cal and suicide prevention. Technical assistance events will be in the form of webinars during the 12 month project year due to continued concerns raised by the COVID-19 pandemic.

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

Public Health Accreditation

Healthy People 2030 Objective

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

Health Objective

Between 10/01/2021-09/30/2026, Program will increase the amount of training and technical assistance (TA) provided to local public health agencies seeking accreditation by 20%.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $58,164
- Amount of funding to local agencies or organizations: $58,164
- Type of supported local agency/organization: Local health departments
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: No
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Enhance or expand the program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: No

Issue/Problem

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 local health departments (LHDs) and tribal public health partners. Up to thirty-nine million people in California may receive public health services from local and tribal health departments. Accreditation serves as the mechanism to systematically review and evaluate the effectiveness of local and tribal health department systems in delivering Ten Essential Public Health Services. This evaluative process helps improve the provision of public health services, and improve health outcomes for the communities served by these facilities..

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: Currently, of 60 Local Health Jurisdictions (LHJs) in California (58 counties and 2 cities), 19 have achieved Public Health Accreditation Board

(PHAB) accreditation. Another 32 are either in the process of accreditation or have reported that they are considering accreditation. Accreditation provides a framework for a health department to identify performance improvement opportunities, to improve management, develop leadership, and improve relationships with the community. However, many LHJs do not have funding for the training required to meet PHAB accreditation standards. CDPH provides accreditation-related training and TA to LHJs seeking accreditation to help them meet PHAB standards. The key indicator is how many LHJs seeking accreditation have training or TA provided by the CDPH Accreditation program (PHA).

Baseline value of the key indicator described above: 3

Data source for key indicator baseline: PHA Program

Date key indicator baseline data was last collected: 05/2020

Program Strategy

Goal: Program will increase California's local and tribal agency capacity to pursue, achieve, and sustain national public health accreditation, contributing to optimal public health services and improved health outcomes for Californians.

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

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

Summary of Program Strategy: Between 07/2021 and 06/2022, Program will provide TA services to increase accreditation readiness and capacity to at least three local and/or tribal public health agencies. These services will provide participating agencies an opportunity to develop, complete, and/or implement a process or project conforming to Public Health Accreditation Board (PHAB) standards, thereby demonstrating readiness and capacity to apply for national public health accreditation.

Primary Strategic Partners

External:

1. California Accreditation Coordinators Collaborative
2. Centers for Disease Control and Prevention
3. County Health Executives Association of California (CHEAC)
4. Public Health Accreditation Board (PHAB)
5. Public Health Institute

Internal:

1. California Conference of Local Health Officers

2. The Office of Strategic Development & External Relations, Fusion Center
3. Office of Health Equity

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training

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.

Program Settings:

- Local health department
- Tribal nation or area

Target Population of Program

- *Target population data source*: All Californians served by local and tribal health departments
- *Number of people served:* 39,000,000
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

- 75-84 years
- 85 years and older

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: Yes

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

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

Objectives and Activities

Objective 1:

Title: Accreditation-Related Technical Assistance (TA) and Support Services to Local and/or Tribal Public Health Agencies

Objective: Between 07/2021 and 06/2022, Program will provide accreditation-related TA services to three local and/or tribal public health agencies to improve capacity to prepare for national public health accreditation.

Mid-year objective goal: By 12/2021, Program will have provided accreditation-related TA services to at least one local or tribal public health agency to improve capacity to prepare for national public health accreditation.

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

Intervention Information: **Program will administer one CDPH Public Health Accreditation Mini-Grant Program for California's local and/or tribal public health agencies to receive accreditation-readiness TA services**. Between 07/2021 and 06/2022, Program will administer one CDPH Public Health Accreditation Mini-Grant Program for California's local and/or tribal public health agencies to receive accreditation-readiness TA services. Mini-grants are awarded to local and/or tribal public health agencies in the form of vendor trainings, consultation, and technical assistance. These services may be used to support development of accreditation-related activities, such as community health assessment and improvement planning, workforce development, quality improvement, strategic planning, performance management, or documentation selection.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Mini-grants have been used in previous years to provide accreditation-readiness technical assistance services.

- *Item to be measured:* Mini-grants for accreditation-readiness technical assistance services
- *Unit of measurement:* Number of mini-grants provided

- *Baseline value for the item to be measured:* 3
- *Data source for baseline value:* PHA Program
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 3

Target Population

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

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

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

Activity 1

Accreditation-Related Technical Assistance technical assistance (TA) and Support Services to Local and/or Tribal Public Health Agencies. Between 07/2021 and 06/2022, Program will provide accreditation-related TA services to three local and/or tribal public health agencies to improve capacity to prepare for national public health accreditation.

Mid-year goal: Between 07/2021 and 12/2021, Program will provide accreditation-related TA services to one local or tribal public health agency.

Description of Activity: Between 07/2021 and 06/2022, Program will administer one CDPH Public Health Accreditation Mini-Grant Program for California's local and/or tribal public health agencies to receive accreditation-readiness TA services. These services support development of accreditation-related activities, such as community health assessment and improvement planning, workforce development, quality improvement, strategic planning, performance management, or documentation selection.

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

Rape Prevention Program

Healthy People 2030 Objective

IVP-17: Reduce adolescent sexual violence by anyone

Health Objective

Between July 1, 2021 and June 30, 2022, Program will implement 12 local prevention projects using community/societal-level prevention strategies by local rape crisis centers (RCCs) that provide sexual offense prevention programs to victims, potential victims, and potential perpetrators in order to create environmental and community changes.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $832,969
- Amount of funding to local agencies or organizations: $575,000
- Type of supported local agency/organization: Local organization
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 10-49% - Partial source of funding
- Existing funding source(s): Other federal funding (CDC): Rape Prevention and Education
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 5
- Number of FTEs in this program funded by the PHHS Block Grant: 1.35

Issue/Problem

This program will prevent sexual violence perpetration and victimization among adolescents. 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 (CDC, 2008). Adolescents are particularly at risk. According to the National Intimate Partner and Sexual Violence Survey conducted in 2015, 81% of women and 71% of men who reported a completed or attempted rape experienced the victimization before the age of 25.

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: Rate of sexual violence among adolescents.

Baseline value of the key indicator described above: 19.2% of high school students reported they were forced to do sexual things they did not want to do 1 or more times during the past 12 months (YRBSS, 2019)

Data source for key indicator baseline: Youth Risk Behavior Surveillance System (YRBSS)

Date key indicator baseline data was last collected: 2019

Program Strategy

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

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

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- Education (e.g., low high school graduation rates, low literacy levels, poor early childhood education)
- Neighborhood and Built Environment (e.g., poor quality of housing, limited access to transportation, food desert, poor water/air quality, neighborhood crime and violence)

Summary of Program Strategy: Program will implement 12 local prevention projects using community/societal-level prevention strategies by local rape crisis centers (RCCs) that provide sexual offense prevention programs to victims, potential victims, and potential perpetrators, aligned with the CDC resources to prevent sexual violence.

Primary Strategic Partners

External:

1. *California Coalition Against Sexual Assault*
2. *University of California, San Diego*
3. *California Partnership to End Domestic Violence*
4. *California State University, Sacramento*
5. *California Office of Emergency Services*

Internal:

1. CDPH Domestic Violence Prevention Program

2. CDPH Violence Prevention Initiative
3. CDPH Essentials for Childhood

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training

Evaluation Methodology: RPP implements a standardized evaluation that includes collection of process and outcome data. Local organizations are able to access their own data to inform their own program and processes, and CDPH receives data from all organizations, which is used to determine the impact of the program throughout the state.

Program Settings:

- Community based organization
- Rape crisis center

Target Population of Program

- *Target population data source*: 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
- *Number of people served:* 11,055,951
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

- 5-14 years
- 15-24 years

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- N/A

Education Attainment:

- Some High School
- High School Diploma
- Some College

Health Insurance Status:

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

Primarily Low Income: No

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

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

Objectives and Activities

Objective 1:

Title: Community/Societal-level Prevention Strategies

Objective: Between July 1, 2021 and June 30, 2022, Program will implement 12 local prevention projects using community/societal-level prevention strategies by local RCCs that provide sexual offense prevention programs to victims, potential victims, and potential perpetrators in order to create environmental and community changes.

Mid-year objective goal: Program will implement 6 local prevention projects using community/societal-level prevention strategies by local RCCs that provide sexual offense prevention programs to victims, potential victims, and potential perpetrators in order to create environmental and community changes.

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

Intervention Information: **Community/societal-level prevention strategies**. Program will implement 12 local prevention projects using community/societal-level prevention strategies by local RCCs that provide sexual offense prevention programs to victims, potential victims, and potential perpetrators, aligned with the CDC resources to prevent sexual violence.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: 1) CDC RPE CE19-1902 Using the Best Available Evidence for Sexual Violence Prevention (CDC, 2018); 2) STOP SV: A Technical Package to Prevent Sexual Violence (CDC, 2016)

Rationale for choosing the Intervention: The CDC has documented that sexual violence is a preventable, public health issue, and that many times is first experienced before the age of 25. Program's intervention aligns with the framework established by the CDC's STOP SV Technical Package, which recommends evidence-based or evidence-informed strategies has served as our guide to developing interventions (prevention programs) implemented in local jurisdictions.

- *Item to be measured:* Number of local projects implemented
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* RPP process data; Annual reports
- *Date baseline was last collected:* 2019
- *Interim target value to be achieved by the Annual Progress Report:* 12
- *Final target value to be achieved by the Final Progress Report:* 12

Target Population

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

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

Activity 1

Fund Comprehensive Community-based Projects. Between 07/2021 and 06/2022, Program will fund 8 local comprehensive community-based projects using a community mobilization strategy in order to impact community/societal-level change.

Mid-year goal: Between 07/2021 and 12/2021, Program will fund 8 local comprehensive community-based projects using a community mobilization strategy in order to impact community/societal-level change.

Description of Activity: Between July 1, 2021 and June 30, 2022, Program will fund 8 local comprehensive community-based projects using a community mobilization strategy in order to impact community/societal-level change. Program and partners (CSUS, UCSD, CALCASA) will provide training and technical assistance to 8 local projects in order to promote social norm change and create protective environments in neighborhoods. Program will meet monthly with partners to coordinate program implementation and evaluation of state sexual violence prevention efforts.

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

Activity 2

Fund Comprehensive School-based Projects. Between 07/2021 and 06/2022, Program will fund 4 comprehensive school-based projects using a strategy of healthy relationships, gender equity, or active bystander intervention in order to impact community/societal-level change.

Mid-year goal: Between 07/2021 and 12/2021, Program will fund 4 comprehensive school-based projects using a strategy of healthy relationships, gender equity, or active bystander intervention in order to impact community/societal-level change.

Description of Activity: Between July 1, 2021 and June 30, 2022, Program will fund 4 comprehensive school-based projects using a strategy of healthy relationships, gender equity, or active bystander intervention in order to impact community/societal-level change. Program and partners (CALCSA, UCSD) will provide training and technical assistance to 4 local projects in order to create protective environments in schools through climate and policy change. Program will meet monthly with partners to coordinate program implementation and evaluation of state sexual violence prevention efforts.

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

Southern CA Asylum Seeker Health Surveillance and Linkage to Care

Healthy People 2030 Objective

AHS-04: Reduce the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care

Health Objective

Between July 1, 2021 and June 30, 2022, Program will seek to reduce the number of asylum seekers unable to obtain or delayed in obtaining medical care, screen for medical needs and provide a referral to a primary care provider; and evaluate asylum seekers for health insurance eligibility and assist with enrollment when eligible.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $228,779
- Amount of funding to local agencies or organizations: $100,000
- Type of supported local agency/organization: Local health department
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: Yes
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: No

Issue/Problem

Asylum seekers face barriers in accessing and navigating new health systems, and there is limited health surveillance to understand complex medical needs of these new arrivals to California. Every year thousands of migrants of diverse ethnic backgrounds globally, including countries in Southeast Asia, the Middle East, Central America, and East Africa among others, arrive in California seeking asylum or protection from persecution. The asylum process can take up to two years for an interview date and decision to be made, yet there is no mechanism in place to ensure outreach, linkage to health care and disease surveillance while asylum seekers remain in California. Because public benefits and health services are limited or absent (i.e., for those >26 years) for this population, asylum seekers may not seek out preventive health services (i.e., immunizations), and may delay accessing needed healthcare. Prior to entering the United States (U.S.), many of these migrants wait in overcrowded shelters in Mexico or other congregate settings at California Border Patrol facilities under conditions which increase risks for exposure to various communicable

diseases. Recent surveillance in Mexico and California have identified COVID-19, influenza, tuberculosis (TB), measles, varicella, ectoparasites, and other infectious conditions. Also, current surveillance data of those whose asylum has been granted show a higher prevalence of Hepatitis B and C compared to refugees. However, no data currently captures those who have not yet been granted asylum. Therefore, outreach efforts to increase linkage to care and improve surveillance for asylum seekers is necessary for monitoring infectious conditions and reducing disease transmission.

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem:

- Program: Screen participating asylum seekers for medical needs and link them with a primary care provider. Key Indicator: the number of asylum seekers screened for medical needs and linked with a primary care provider
- Program: Evaluate asylum seekers for insurance eligibility and enrolled if qualified. Key Indicator: the number of asylum seekers evaluated for insurance eligibility and enrolled if qualified

Baseline value of the key indicator described above: Program Baseline ASH-04 100%; ASH-01 67%

Data source for key indicator baseline: Program FY 20-21

Date key indicator baseline data was last collected: 2021

Program Strategy

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

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

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

Summary of Program Strategy: The Southern California Asylum Seeker Health Surveillance and Linkage to Care program staff will promote the program among asylum seekers and legal and NGO service providers in Southern California to enroll participants in the program. Working with local health jurisdictions (LHJs) in San Diego and Los Angeles, LHJ staff will screen and evaluate patient medical/mental health and social needs, and provide referrals for

comprehensive health screening and resources for other food, housing, legal and other supportive services. In addition, LHJ staff will work with patients to identify a primary care home and evaluate eligibility for Medi-Cal or other health insurance and provide enrollment support. Data collected from the comprehensive health screening will be used for health surveillance, and will be analyzed and developed into a published report for distribution. The program will receive guidance from a Physician Community Advisory Panel of subject matter experts working with the population.

Primary Strategic Partners

External:

1. County of San Diego, Public Health Services
2. TB Control and Refugee Health Branch
3. Los Angeles County Department of Public Health

Internal:

1. Office of Refugee Health
2. Office of Binational and Border Health

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Other: Health Surveillance reports will be distributed to healthcare providers working with asylum seeker in their communities.

Evaluation Methodology: Project evaluation will be conducted with data reports from the RHEIS database enhanced for asylum seekers, including number of patient encounters, referrals, demographics, mental health and disease surveillance outcomes and insurance enrollment. Project activities will also be evaluated through performance monitoring and site visits, along with feedback from county partners and stakeholders.

Program Settings:

- Local health department
- Medical or clinical site

Target Population of Program

- *Target population data source*: TRAC Immigration Asylum Decisions Data; CDPH, Office of Refugee Health, RHEIS (2017-19); San Diego County Public Services (2018-19); DHS Annual Flow Report of Refugees and Asylums (2017)
- *Number of people served:* 600

- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- Asian
- Black or African American
- White

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- Los Angeles County
- San Diego County

Occupation:

- N/A

Education Attainment:

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

Health Insurance Status:

- Uninsured

Primarily Low Income: Yes

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

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

Objectives and Activities

Objective 1:

Title: Active Disease Surveillance of Asylum Seekers in Southern California

Objective: Between July 1, 2021 and June 30, 2022, Program will collect 600 cases of asylum seeker health screening data including infectious diseases, immunizations and general demographic and heath data indicators.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will collect 300 cases of asylum seeker health screening data including infectious diseases, immunizations and general demographic and heath data indicators.

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

Intervention Information: **LHJs will utilize the RHEIS enhanced for asylum seekers and health screening tool in Southern California to collect active surveillance data to identify diseases of public health concern and mental health conditions among asylum seekers.** Between 07/2020 and 06/2021, ORH and OBBH will provide technical assistance to LHJs to conduct active surveillance of approximately 600 asylum seekers annually for the

monitoring and detection of infectious disease and mental health conditions, and prevention of vaccine-preventable diseases. This will include collection of specimen and health data, processing of labs, and review and analysis of health and laboratory data. Data collection may also include follow-up to collect health data from primary or specialty care providers where patients have been linked to health services by LHJs. Patient health data will then be entered into the enhanced RHEIS where it will be accessible for program monitoring and disease surveillance reporting. Expansion of the current refugee surveillance system database enhanced for asylum seekers will be used to capturing surveillance data and reports of infectious diseases of public health concern and mental health conditions among asylum seekers, and monitoring referrals for linkage to health care.

Type of Intervention: Innovative/Promising Practice

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

- *Item to be measured:* Asylum seeker health data and linkage to healthcare and insurance
- *Unit of measurement:* Individual health screening data
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 2021 (Currently in progress)
- *Interim target value to be achieved by the Annual Progress Report:* 300
- *Final target value to be achieved by the Final Progress Report:* 600

Target Population

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

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

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

Activity 1

Asylum Seeker Active Surveillance. Between 07/2021 and 06/2022, the ORH will provide technical assistance to LHJs to conduct active surveillance of approximately 600 asylum seekers annually for the monitoring and detection of infectious diseases and mental health conditions.

Mid-year goal: Between 07/2021 and 12/2021, the ORH will provide technical assistance to LHJs to conduct active surveillance of approximately 300 asylum seekers annually for the monitoring and detection of infectious diseases and mental health conditions.

Description of Activity: Between 07/2021 and 06/2022, the ORH will provide technical assistance to LHJs to conduct active surveillance of approximately 600 asylum seekers annually for the monitoring and detection of infectious diseases and mental health conditions. This will include collection of specimen and health data, processing of labs, and review and analysis of health and laboratory data. Data collection may also include follow-up to collect health data from primary or specialty care providers where patients have been linked to health services by LHJs. Patient health data will then be entered into the enhanced RHEIS for asylum seekers where it will be accessible for program monitoring and disease surveillance reporting.

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

Activity 2

Health Data Collection Enhancement. Between 07/2021 and 06/2022, Program will expand of the current refugee surveillance system database enhanced for asylum seekers will be used to capture surveillance data and reports of infectious diseases of public health concern and mental health conditions among asylum seekers, and monitoring referrals for linkage to health care.

Mid-year goal: Between 07/2021 and 12/2021, Program will enter patient data for monitoring of patient linkage and surveillance of health conditions.

Description of Activity: Patient health data will be entered into the enhanced RHEIS for asylum seekers by local health jurisdictions. Expansion of the current refugee surveillance system database enhanced for asylum seekers will be used to capturing surveillance data and reports of infectious diseases of public health concern and mental health conditions among asylum seekers, and monitoring referrals for linkage to health care. Surveillance reports will be developed annually for distribution to local healthcare providers and public health.

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

Objective 2:

Title: Analyze and Publish Asylum Seeker Surveillance Data

Objective: Between July 1, 2021 and June 30, 2022, Program will analyze one (1) sample of asylum seeker health data and publish prevalence estimates.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will perform a mid-year analysis of available asylum seeker health data.

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

Program for this Objective: **Health surveillance for asylum seekers is largely not available.** Prior to entering the U.S., many asylum seekers are forced into overcrowded shelters in Mexico or other congregate settings at California Border Patrol facilities under conditions which increase risks for exposure to various communicable diseases. Recent surveillance in Mexico and California have identified influenza, TB, measles, varicella, ectoparasites, and other infectious conditions. Also, current asylee (granted) surveillance data show a higher prevalence of Hepatitis B and C among asylum granted compared to refugees. However, no data currently captures those who have not yet been granted asylum.

Key indicator(s) affected by this program:

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

Baseline value for the key indicator: 1

Data source for key indicator baseline: Program surveillance data

Date key indicator baseline data was last collected: 7/1/2021

Intervention Information: **Program will analyze asylum seeker health surveillance data and publish report.** Between 07/2020 and 06/2021, Program will analyze data collected from the RHEIS enhanced for asylum seekers to identify disease prevalence and trends and mental health conditions among newly arriving asylum seekers in Southern California and distribute a report to healthcare providers and public health agencies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

Rationale for choosing the Intervention: Analysis and summary report of disease and mental health surveillance and trends of newly arriving asylum seekers supports monitoring the burden of disease, identification of risk factors and guides public health response.

- *Item to be measured:* Report on asylum seeker health data published for distribution to healthcare providers and local public health agencies

- *Unit of measurement:* 1 report completed
- *Baseline value for the item to be measured:* 1
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 2021 (Currently in progress)
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

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

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

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

Activity 1

Surveillance Data Analysis. Between 07/2021 and 06/2022, Program will analyze data collected from the enhanced RHEIS to identify disease prevalence and trends among asylum seekers in Southern California.

Mid-year goal: Between 07/2021 and 12/2021, Program will perform a mid-year analysis of available asylum seeker health data.

Description of Activity: Program will analyze data collected from the RHEIS enhanced for asylum seekers to identify disease prevalence and trends and mental health conditions among newly arriving asylum seekers in Southern California.

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

Activity 2

Report Production. Between 07/2021 and 06/2022, Program will produce a report summarizing disease prevalence and trends among asylum seekers in Southern California.

Mid-year goal: Between 07/2021 and 12/2021, Program will perform a mid-year data analysis that will be contribute to a final report.

Description of Activity: Program utilizes analysis of data collected from the RHEIS enhanced for asylum seekers to identify disease prevalence and trends and mental health conditions

among newly arriving asylum seekers in Southern California to produce one report for distribution to healthcare providers and public health agencies.

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

Objective 3:

Title: Community Outreach

Objective: Between July 1, 2021 and June 30, 2022, Program will engage with ten (10) partnerships and actively conduct outreach to asylum seeking communities throughout Southern California to facilitate linkage to health screening and health services.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will identify three (3) new partnerships and collaborators by participating in monthly refugee forums and continue networking with multi-sector organizations serving immigrant populations.

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

Intervention Information: **Program will build new partnerships with service providers and non-governmental organizations that assist asylum seekers and sustain the partnerships developed during Year 1.** Program will build cross-sector collaboration in Southern California to facilitate referrals for asylum seekers to receive linkage to health screening and health services. This will include developing new multi-sector partnerships with service providers and non-governmental organizations that assist asylum seekers and sustain the partnerships developed during Year 1.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

Rationale for choosing the Intervention: Engaging new partners and sustaining relationships developed during Year 1 will allow the program to actively conduct outreach to asylum seeking communities throughout Southern California. Efficient outreach through collaboration with partners that have already established a relationship and built trust in the asylum seeker population will help ensure successful efforts regarding linkage to health services and health screenings.

- *Item to be measured:* New partnerships
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 5

- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 12/20/2020
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 5

Target Population

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

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

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

Activity 1

Establish New Partnerships. Between 07/2021 and 06/2022, Program will identify partners and collaborators working with the asylum seeker population.

Mid-year goal: Between 07/2021 and 12/2021, Program will attend regular monthly meeting of refugee networks and meet with potential partners to share information about the program.

Description of Activity: Between 7/2021 and 6/2022, Program will identify partners and collaborators by participating in virtual refugee forums, school events, asylum seeker orientation events as well as scheduling meetings with legal aid programs. OBBH will also network with federally qualified clinics and other non-profit agencies serving immigrant populations. Program will gather partner contact information and compile information in a matrix.

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

Activity 2

Sustain Current Partnerships. Between 07/2021 and 06/2022, Program will sustain the different partnerships developed during Year 1, by actively participating in monthly meetings to provide updates and also receive feedback from partners about the program.

Mid-year goal: Between 07/2021 and 12/2021, Program will develop a one-page informational sheet to share with all partners at potential meetings.

Description of Activity: Between 7/2021 and 6/2022, Program will sustain the different partnerships developed during Year 1 by actively participating in monthly meetings. Program

will provide updates and also request to receive feedback from partners about the program. Program will develop a one-page informational sheet to share with all partners at potential meetings.

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

Activity 3

Focus Group. Between 07/2021 and 06/2022, Program will conduct focus group sessions with asylum seekers living in Tijuana, Baja California (B.C.) to assess the re-settling destination (counties) of asylum seekers once they cross into the U.S.

Mid-year goal: Between 07/2021 and 12/2021, Program will identify a meeting location, virtual platform and non-profit partner to convene small-group discussion with asylum seeker individuals living in Tijuana, B.C.

Description of Activity: Program will conduct two (2) focus group sessions with asylum seekers living in Tijuana, B.C., to assess the re-settling destination (counties) of asylum seekers once they cross into the U.S. This will include guided small-group discussions with 7-10 women and 7-10 men living in Tijuana, B.C. that are seeking asylum in the U.S.

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

Objective 4:

Title: Facilitate Linkage to Health Services for Asylum Seekers

Objective: Between 07/2021 and 06/2022, Program will provide health case management to 600 asylum seekers residing in Southern California.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will provide health case management to 300 asylum seekers residing in Southern California.

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

Intervention Information: **Through a multidisciplinary team approach, asylum seekers will be provided case management support based on individualized needs assessment to improve access to healthcare services.** LHJ programs will provide one-on-one case management services to asylum seekers to ensure patient linkage to Medi-Cal and healthcare services for those who are age-eligible (under the age of 26) and referrals to low cost Federally Qualified Health Centers (FQHCs) or other health coverage for those outside of eligibility. As

needed, asylum seekers will receive referrals to legal services, social services, and mental health support.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Guide to Clinical Preventive Services (Task Force on Community Preventive Services)
- Model Practices Database (National Association of City and County Health Officials)

Rationale for choosing the Intervention: Newly arriving asylum seekers may delay access to needed medical care due to unfamiliarity in navigating the health system in California.

- *Item to be measured:* Number of asylum seekers in program
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 600
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 2021 (Currently in progress)
- *Interim target value to be achieved by the Annual Progress Report:* 300
- *Final target value to be achieved by the Final Progress Report:* 600

Target Population

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

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

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

Activity 1

Linkage to Health Services. Between 07/2021 and 06/2022, LHJ programs will provide one-on-one case management services for linkage to healthcare to 600 asylum seekers.

Mid-year goal: Between 07/2021 and 12/2021, LHJ programs will provide one-on-one case management services for linkage to healthcare to 300 asylum seekers.

Description of Activity: Between 07/2021 and 06/2022, LHJ programs will provide one-on-one case management services to 600 asylum seekers to ensure patient linkage to Medi-Cal and healthcare services for those who are age-eligible (under the age of 26) and referrals to low cost FQHCs or other health coverage for those outside of eligibility.

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

Activity 2

Continuity of Healthcare. Between 07/2021 and 06/2022, LHJ programs will provide case management for 600 referrals to health providers for asylum seekers in Southern California.

Mid-year goal: Between 07/2021 and 12/2021, LHJ programs will provide case management for 300 referrals to health providers for asylum seekers in Southern California.

Description of Activity: Between 07/2020 and 06/2021, LHJ programs will provide case management for referrals to health providers for asylum seekers in Southern California.

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

Surveillance Sampling of Leafy Greens for Shiga Toxin-Producing *E. coli*

Healthy People 2030 Objective

FS-D04: Reduce the number of infections due to outbreaks of Shiga toxin-producing *E. coli*, or Campylobacter, Listeria or Salmonella species associated with leafy greens

Health Objective

By 6/30/2022, reduce the incidence of illness caused by shiga toxin-produce *E. coli* from ingestion of contaminated U.S. grown produce, through effective surveillance of high-risk food commodities and prompt interdiction to remove contaminated foods from commerce once identified.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: Yes
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 2
- Number of FTEs in this program funded by the PHHS Block Grant: 1.2

Issue/Problem

This program will attempt to decrease the burden of foodborne illness for California residents. The U.S. Centers for Disease Control and Prevention (CDC) estimates that each year roughly one in six Americans (or 48 million people) gets sick, 128,000 are hospitalized, and 3,000 die of foodborne diseases. These numbers could be reduced by identifying leafy greens contaminated with shiga toxin-producing *E. coli* and removing them from commerce prior to consumption. The goal of this surveillance sampling project will be to reduce the burden of foodborne illness associated with leafy green consumption.

Public health program was prioritized as follows:

- Conducted a topic- or program-specific assessment (e.g., tobacco assessment, environmental health assessment)
- Identified via surveillance systems or other data sources
- Other: The U.S. Food and Drug Administration have identified safe leafy greens as a priority under the 2020 Leafy Greens shiga toxin-producing *E. coli* (STEC) Action Plan

Key Indicator(s) affected by this problem: The key indicator affected by this problem is the burden of foodborne illness for Americans. The CDC estimates that each year roughly one in six Americans (or 48 million people) gets sick, 128,000 are hospitalized, and 3,000 die of foodborne diseases. Using these national statistics, California's proportionate burden of foodborne illness would result in 5.86 million getting sick, 15,600 being hospitalized, and 366 dying each year. Each year California residents become ill after consuming leafy greens contaminated with shiga toxin-producing *E. coli*. The burden of illness for California residents may be decreased if contaminated leafy greens can be identified and removed from commerce prior to consumption.

Baseline value of the key indicator described above: 48 million U.S. residents affected by foodborne illness each year

Data source for key indicator baseline: CDC Foodborne Germs and Illnesses

Date key indicator baseline data was last collected: 2/23/2021

Program Strategy

Goal: The goal of this program is to reduce the incidence of foodborne illness and prevent consumer exposure to leafy greens that may be contaminated with shiga toxin-producing *E. coli*.

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

Summary of Program Strategy: Samples of leafy greens will be collected from retail grocery stores in California by Food and Drug Branch (FDB) staff. These samples will be delivered to the Food and Drug Laboratory Branch (FDLB) staff in Richmond, CA for shiga toxin-producing *E. coli* testing. If positive samples are identified, investigational work and product recalls may be initiated. Identification and removal of leafy greens contaminated with shiga toxin-producing *E. coli* from the food supply will reduce the incidence of foodborne illness and injury.

Primary Strategic Partners

External:

1. *U.S. Food and Drug Administration*
2. *U.S. Centers for Disease Control and Prevention*
3. *Industry Trade Associations*

Internal:

1. CDPH, Division of Communicable Disease Control, Infectious Diseases Branch

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

Program Settings:

- Business, corporation or industry
- State health department
- Work site

Target Population of Program

- *Target population data source*: the U.S. Census Bureau lists the population of California at 39,512,223 individuals. U.S. Census for California
- *Number of people served:* 39,512,223
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

Objectives and Activities

Objective 1:

Title: Implement a Shiga Toxin-Producing *E. Coli* Testing Program in U.S. Grown Leafy Greens

Objective: Between July 1, 2021 and June 30, 2022, Program will collect 300 samples of U.S. grown leafy greens and test the lettuce for shiga toxin-producing *E. coli*.

Mid-year objective goal: By 12/2021, Program will collect and analyze 150 samples of leafy greens for shiga toxin-producing *E. coli*.

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

Intervention Information: **Any samples that test positive for shiga toxin-producing *E. coli* will receive regulatory follow-up in an attempt to reduce foodborne illness.** FDB staff will complete necessary regulatory follow-up pending any positive shiga toxin-producing *E. coli* findings. This may include recalls, market withdrawals, inspections, or investigations. This regulatory follow-up will ensure that any adulterated leafy greens in the marketplace is removed and will reduce the chance of illness in consumers.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Regulatory follow-up, including food recalls, ensures that at least a portion of the adulterated leafy greens are not further distributed to consumers.

- *Item to be measured:* Number of regulatory follow-up investigations completed
- *Unit of measurement:* Count
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Regulatory follow-up has not been needed in FFY 2020 as all samples to date have tested negative for pathogens.
- *Date baseline was last collected:* 2/23/2021
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

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

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

Activity 1

Collect Samples of Leafy Greens. Between 07/2021 and 06/2022, FDB staff will collect 300 samples of leafy greens from grocery stores in California.

Mid-year goal: Between 07/2021 and 12/2021, FDB staff will collect 150 samples of leafy greens from grocery in stores in California.

Description of Activity: Between 7/1/2021 and 6/30/2022, FDB staff will collect 300 samples of leafy greens from grocery stores in California.

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

Activity 2

Test Leafy Green Samples for Shiga Toxin-Producing *E. Coli*. FDLB staff will test 300 samples of leafy greens for shiga toxin-producing *E. coli*.

Mid-year goal: Between 07/2021 and 12/2021, FDLB staff will test 150 samples of leafy greens for shiga toxin-producing *E. coli*.

Description of Activity: Between 7/1/2021 and 6/30/2022, FDLB staff will test 300 samples of leafy greens for shiga toxin-producing *E. coli*. All testing will be completed at FDLB in Richmond, CA.

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

Activity 3

Conduct Regulatory Follow-Up. Between 07/2021 and 06/2022, FDB staff will conduct regulatory follow-up pending any positive laboratory findings.

Mid-year goal: Between 07/2021 and 12/2021, FDB staff will conduct regulatory follow-up pending any positive laboratory findings. This may take place prior to or after the mid-year point.

Description of Activity: Between 7/1/2021 and 6/30/2022, FDB staff will complete necessary regulatory follow-up pending any positive laboratory findings. This may include recalls, market withdrawals, inspections, or investigations. This regulatory follow-up will ensure that any adulterated leafy greens in the marketplace is removed and will reduce the chance of illness in consumers.

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

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

The Office of Strategic Development & External Relations, Fusion Center

Healthy People 2030 Objective

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

Health Objective

Between 07/01/2021 and 06/30/2022 The Fusion Center will strengthen the primary prevention focus and cross-program alignment of California's state and community health improvement plans. Fusion Center initiatives will support movement of population health improvement efforts further upstream through multisector and interdisciplinary initiatives; including strategies for more proactive and effective CDPH response to public health issues, and supporting development and alignment of community health improvement plans. The focus of these efforts will include enhanced data, messaging and policy approaches incorporating social determinants of health, regional disparities, and performance analytics.

Program Funding Details

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

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 6
- Number of FTEs in this program funded by the PHHS Block Grant: 5.25

Issue/Problem

This program will address the need for comprehensive information and integrated approaches to address complex inequities and current challenges in the current population health landscape in California. California has seen significant health improvements over the last decade, for example, progress in healthcare coverage and certain quality measures as a result of the Affordable Care Act, or reduction in tobacco use and improvements in immunizations as a result of policy and prevention work. However, when you

look closely, significant disparities across health outcomes persist. There are limited opportunities for better health among groups that have been historically marginalized, including people of color and low socioeconomic status. The cumulative effect is that the opportunity to live a long and healthy life does not exist for everyone. As such, one of the underlying principles that guided this plan was that in order to advance a safe and healthy California for all, we must address the systemic barriers that have led to these inequities in the first place. These challenges have been severely exacerbated by the COVID-19 pandemic. Underlying inequities have contributed to many communities experiencing disproportionate impacts of COVID-19 exposure and severity, as well as disparities in the capacity to buffer the negative impacts of socioeconomic and behavioral health impacts of the pandemic. Many public health services have also been delayed or deferred during this period as resources are intensely focused on the COVID-19 response. The impact of the pandemic on population health in California is not yet known and will require proactive assessment and monitoring to promote recovery and ongoing health improvement. The pandemic illuminated limitations in statewide capacity to identify and address the experiences of disproportionately impacted and historically underrepresented populations, and the available assets and resources that could be mobilized to address those priorities. Addressing the landscape of population health in California and the complex underlying inequities requires comprehensive information and an integrated strategic response.

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: Key indicators affected by this problem are the number of major initiatives integrated with the State Health Improvement Plan (SHIP). The State Health Assessment (SHA) leverages a wide range of data and information to assess, monitor and report on the health status of California, which will be especially important in building a shared understanding around the true impact of the pandemic and drivers of inequity. The SHIP supports integrated planning and collective action by strategically aligning strategies, actions, and resources around shared priorities and a comprehensive population health strategy. The number of initiatives effectively aligned through the SHIP is a key indicator of progress and action toward addressing underlying inequities and promoting recovery.

Baseline value of the key indicator described above: 3

Data source for key indicator baseline: Program tracking is the data source for indicator on key initiatives integrated with SHIP. Additional data sources leveraged in the SHA process include CDPH Vital Statistics Death Data; Let's Get Healthy California Indicator for Overall Health Status (California Health Interview Survey, UCLA Center for Health Policy Research).

Date key indicator baseline data was last collected: 2020

Program Strategy

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

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

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

Summary of Program Strategy: The SHA/SHIP process will be employed to increase the Department's capacity to address priority public health burdens, root causes and contributing factors of health disparities and inequities. As the SHA/SHIP, Let's Get Healthy California (LGHC) contributes to building a safe, healthier California for all by monitoring progress on health improvement priorities; promoting community innovations; and informing and convening cross-sector collaborations. The program will maintain a current SHA/SHIP by conducting ongoing activities and implementing enhancements related to comprehensive assessment, integrated planning, and collective action. The comprehensive assessment process provides a shared understanding of population health and identifies and prioritizes person-centered and data-driven improvement opportunities – including exploring underlying inequities and tracking the long-term impact of the COVID-19 pandemic. Integrated planning is used to advance a statewide population health strategy, which incorporates plans for influencing changes in areas that span beyond traditional public health in order to align strategies, actions, and resources to maximize impact. LGHC also supports state and local public health in addressing complex challenges through collective action. Collective action efforts focus on shared activities that advance equity in areas that cannot be addressed through a single entity but require strategic collaboration. Through the SHA/SHIP process, the Fusion Center will facilitate cross-disciplinary CDPH efforts to proactively address emerging issues, as well as support movement of public health efforts upstream to improve community health outcomes by addressing social determinants of health.

Primary Strategic Partners

External:

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

Internal:

1. Office of Health Equity
2. Center for Health Statistics and Informatics
3. Office of Quality Performance and Accreditation
4. Office of Legislative and Governmental Affairs

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training

Evaluation Methodology: The Fusion Center is responsible for a diverse range of activities, each of which has a project-level evaluation plan to track the status of the project and its objectives. Evaluation methods may include informal stakeholder input, surveys, participation levels, and web analytic tools. The Fusion Center also employs Results-Based Accountability approaches for specific efforts to track progress on performance measures designed to contribute to advancing population results.

Program Settings:

- State health department

Target Population of Program

- *Target population data source*: Data on the target population is assembled from a range of data sources including CDPH Vital Statistics Death Data (2020); Let's Get Healthy California Indicator for Overall Health Status (2020), and California Health Interview Survey, UCLA Center for Health Policy Research, (2019)
- *Number of people served:* 39,000,000 (statewide population)
- *Ethnicity:* Hispanic or Latino

Race:

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

- White

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- All California counties

Occupation:

- All

Education Attainment:

- Some High School

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

Health Insurance Status:

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

Primarily Low Income: Yes

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

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

Objectives and Activities

Objective 1:

Title: Conduct a Comprehensive State Health Assessment

Objective: Between 07/2021 and 06/2022, Program will conduct two activities to enhance the SHA.

Mid-year objective goal: Program will enhance data standards (specifically, disease condition groupings) and expand resources (e.g. Social Determinants of Health data) to support conducting a comprehensive SHA including the annual “State of Public Health” (SoPH) update. Program will perform in-depth analyses of excess mortality in 2020 due to COVID-19 by key demographic characteristics; an in-depth analysis of a specific health problem affecting a key population of concern, such as septicemia hospitalizations affecting older adults.

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

Intervention Information: **The program will conduct the SHA and Improvement Plan process.** The SHA provides a snapshot of health for the entire population across a range of conditions and factors. This includes defining health issues and contributing factors, elevating disparities across communities and populations, and identifying assets and resources that can be mobilized to address these health improvement opportunities. The SHIP builds on the SHA

by defining shared priorities and indicators to track progress, establishing cross-cutting strategies, and identifying organizations that are responsible for implementing these strategies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: The SHA/SHIP is a requirement for national public health accreditation and the Center for Disease Control and Prevention (CDC) includes the SHA/SHIP under the category of Public Health Systems and Best Practices
  CDC Community Health Assessments & Improvement Plans

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

- *Item to be measured:* Activities implemented to enhance and conduct the SHA/SHIP
- *Unit of measurement:* Number of Activities
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activity tracking
- *Date baseline was last collected:* 2020 (for 2020-2021 cycle)
- *Interim target value to be achieved by the Annual Progress Report:* 50% of two activities
- *Final target value to be achieved by the Final Progress Report:* 100% of two activities

Target Population

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

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

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

Activity 1

Data Analytics Project: Disparities, Hidden Populations, Issues of Concern. Between 07/2021 and 06/2022, Program will conduct in-depth comparative and statistical analysis of

patterns and trends for one or more conditions identified as significantly important, for which information is lacking.

Mid-year goal: Between 07/2021 and 12/2021, Program will conduct in-depth analysis of a key cause of hospitalizations for older Californians, such as septicemia, and assess associated demographic and Social Determinant of Health characteristics. Program will also assess excess mortality in 2020 over time due to COVID-19 and other conditions, by race/ethnicity and other key characteristics.

Description of Activity: Between 07/01/2021 and 06/30/2022, Program will conduct in-depth comparative and statistical analysis of patterns and trends for one or more conditions identified as significantly important, for which information is lacking; use a collaborative process to identify such conditions; collect and analyze data and information for use in developing priorities, adopting or revising policies, and planning actions to improve the population's health.

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

Activity 2

Process to Enhance the Annual State Health Assessment. Between 07/2021 and 06/2022, Program will continue and enhance the process to describe the overall health of the population, including hidden populations, and identify areas for health improvement and assets available to address health priorities.

Mid-year goal: Between 07/2021 and 12/2021, Program will further enhance data standards (specifically, disease condition groupings) and increase automation for retrieval of external sources (specifically, Social Determinants of Health data).

Description of Activity: Between 07/01/2021 and 06/30/2022, Program will continue and enhance our comprehensive process for updating the annual SHA. The update will incorporate data and information about health burden, including mortality and morbidity, quality of life, disparities, socioeconomic factors, emerging issues and contextual factors in the policy landscape, and community priorities. The process will be enhanced with increased standardization of data and increased automation of data processing. Program will engage a wide range of stakeholder input in order to describe the overall health of the population, including hidden populations, and identify areas for health improvement and assets available to address. Summary findings on the state of health in California are shared with policy makers and stakeholder audiences.

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

Objective 2:

Title: Leverage SHIP to Advance Progress on Shared Priorities Through Integrated Planning

Objective: Between 07/01/2021 and 06/30/2022, Program will conduct activities to advance integrated planning across shared public health priorities.

Mid-year objective goal: Program will complete 50% of the activities relative to this SMART Objective.

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

Intervention Information: **Program will conduct the SHA/SHIP process.** The SHA provides a snapshot of health for the entire population, across a range of conditions and factors. This includes defining health issues and contributing factors, elevating disparities across communities and populations, and identifying assets and resources that can be mobilized to address these health improvement opportunities. The SHIP builds on the SHA by defining shared priorities and indicators to track progress, establishing cross-cutting strategies, and identifying organizations that are responsible for implementing these strategies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: The SHA/SHIP is a requirement for national public health accreditation and the Center for Disease Control and Prevention (CDC) includes the SHA/SHIP under the category of Public Health Systems and Best Practices
  CDC Community Health Assessments & Health Improvement Plans

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

- *Item to be measured:* Activities implemented to enhance and conduct the SHA/SHIP
- *Unit of measurement:* Number of Activities
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activity tracking
- *Date baseline was last collected:* 2020 (for 2020-2021 cycle)

- *Interim target value to be achieved by the Annual Progress Report:* 50% of two activities
- *Final target value to be achieved by the Final Progress Report:* 100% of two activities

Target Population

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

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

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

Activity 1

Enhance the SHIP to advance shared priorities and improve our ability to measure progress in advancing population health and addressing health inequities. Between 07/2021 and 06/2022, Program will share Priorities and Measurement System.

Mid-year goal: Between 07/2021 and 12/2021, Program will complete at least 50% of the indicator updates and incorporate at least 5 new topics.

Description of Activity: Between 07/01/2021 and 06/30/2022, The Fusion Center will conduct targeted enhancements to the SHIP, including the facilitation of a collaborative process to complete indicator updates, establish state-level baselines and targets for priority areas, and incorporate new or modified topics to address elevated topics related to healthy aging and Pandemic-related impacts.

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

Activity 2

Facilitate Strategic Alignment and Integrated Planning Through Shared Action Plans to Address Priorities that Unify Actions Across the State. Between 07/2021 and 06/2022, Program will establish shared action plans to track implementation around shared priorities.

Mid-year goal: Between 07/2021 and 12/2021, Program will facilitate engagement with at least three strategic initiatives and/or existing programs to promote alignment and support integration.

Description of Activity: Between 07/01/2021 and 06/30/2022 The Fusion Center will develop and implement at least one shared action plan to align strategies, actions, and resources around shared priorities. This will include facilitating a collaborative process to identify and

integrate key strategies and initiatives under the broader context of the state health improvement plan.

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

Objective 3:

Title: Support Collective Action Around Shared Public Health Priorities

Objective: Between 07/01/2021 and 6/30/2022, Program will conduct two activities to support collective action.

Mid-year objective goal: The Fusion Center will support collective action around at least one shared public health priority.

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

Intervention Information: **Program will conduct the SHA/SHIP process.** The SHA provides a snapshot of health for the entire population, across a range of conditions and factors. This includes defining health issues and contributing factors, elevating disparities across communities and populations, and identifying assets and resources that can be mobilized to address these health improvement opportunities. The SHIP builds on the SHA by defining shared priorities and indicators to track progress, establishing cross-cutting strategies, and identifying organizations that are responsible for implementing these strategies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: The SHA/SHIP is a requirement for national public health accreditation and the Center for Disease Control and Prevention (CDC) includes the SHA/SHIP under the category of Public Health Systems and Best Practices
  CDC Community Health Assessments & Health Improvement Plans

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

- *Item to be measured:* Activities implemented to enhance and conduct the SHA/SHIP
- *Unit of measurement:* Number of Activities
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activity tracking
- *Date baseline was last collected:* 2020 (for 2020-2021 cycle)
- *Interim target value to be achieved by the Annual Progress Report:* 50% of two activities
- *Final target value to be achieved by the Final Progress Report:* 100% of two activities

Target Population

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

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

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

Activity 1

Address Cross-Cutting Priorities Through Department-Wide Initiatives. Between 07/2021 and 06/2022, Program will facilitate collective action initiatives, engaging internal, interdepartmental, and multisector partners.

Mid-year goal: Between 07/2021 and 12/2021, Program will facilitate one collective action initiative.

Description of Activity: Between 07/01/2021 and 06/30/2022, The Fusion Center will advance progress in addressing the cross-cutting priorities identified in the public health policy agenda, the Fusion Center will facilitate collective action initiatives, engaging internal, interdepartmental, and multisector partners. These initiatives will focus on elevating the public health role, promoting upstream focus on influencing systems toward more equitable outcomes, and exploration of strategies to expand state and local resources to act on shared public health priorities. Activities may include exploratory efforts such as environmental scans and ad hoc workgroups, development of issue briefs, and coordination of workshops and trainings related to key emerging issues of public health significance.

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

Activity 2

Facilitate Engagement and Capacity-Building Projects with Local Health Departments. Between 07/2021 and 06/2022, Program will engage with Local Health Departments –

including providing tools, training, and technical assistance – to advance strategies and policy approaches.

Mid-year goal: Between 07/2021 and 12/2021, Program will facilitate at least one engagement activity.

Description of Activity: Between July 1, 2021 and June 30, 2022, the Fusion Center will facilitate targeted cross-functional projects to enable alignment and engagement across programs and partners. These activities will include collaboration with partners to increase linkages and decrease community barriers, engaging and providing technical assistance to Local Health Departments, and advancing strategies or policy approaches.

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

Toxicological Outbreaks Program

Healthy People 2030 Objective

IVP-02: Reduce emergency department visits for nonfatal injuries

Health Objective

Improve the detection and reporting ability of outbreaks with a common toxicological source to reduce preventable morbidity, mortality, emergency department visits, and hospitalizations in California by the end of FY22-23.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 75-99% - Primary source of funding
- Existing funding source(s): State or local funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 1
- Number of FTEs in this program funded by the PHHS Block Grant: 0.6

Issue/Problem

California lacks sufficient infrastructure to identify outbreaks with a toxicological source. Toxic agents are substances that arise outside the human body and can cause injury, illness, or even death. Classic examples of toxic agents include heavy metals (e.g., mercury, lead), organophosphate pesticides, gases (e.g., chlorine, ammonia) and even certain biological weapons (e.g., ricin). Outbreaks caused by toxic agents (non-infectious disease outbreaks) occur periodically in California, including the recent dramatic 2019 outbreak of lung injuries associated with vaping. The National Association of County and City Health Officials has identified that local health departments report being less prepared for responses to toxic

chemical incidents than any other emergency. Public Health has the authority to conduct special investigations into the sources of injury and illness, including their causes and means of prevention (Health and Safety Code, section 100325). Public Health's successes are most visible when responding to infectious disease outbreaks, and Public Health has substantial history and capacity responding to infectious diseases. In contrast, Public Health does not have a core team dedicated to noninfectious disease outbreak investigations, and previous investigations have been mostly ad hoc.

Public health program was prioritized as follows:

- Identified via surveillance systems or other data sources
- Declared as an emergency within your jurisdiction
- Governor (or other political leader) established as a priority

Key Indicator(s) affected by this problem:

- Program: Create standardized approaches to case finding for toxicological outbreaks. Key indicator: The number of standardized approaches to case finding for toxicological outbreaks in collaboration with 5 health jurisdictions.

Baseline value of the key indicator described above: 0 standardized approach

Data source for key indicator baseline: Poison Control Center; syndromic surveillance; CalREDIE

Date key indicator baseline data was last collected: 2020

Program Strategy

Goal: Reduce statewide morbidity and mortality associated with exposure to toxic substances by building capacity for CDPH and local jurisdictions to identify and respond to toxicological outbreaks.

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

Summary of Program Strategy: CDPH will use multiple strategies to build capability and capacity to respond to toxicological outbreaks: (1) strengthen and unify CDPH's internal processes for conducting toxicological outbreak investigations; (2) establish partnerships with external data providers (e.g., California Poison Control System) to conduct surveillance; (3) in collaboration with internal CDPH programs, assess feasibility of using syndromic surveillance to identify toxicological outbreaks; and (4) strengthen local capacity and capability for outbreak response by designing a toxicological outbreak response exercise.

Primary Strategic Partners

External:

1. *California Poison Control System*
2. *Local health jurisdictions*
3. *CDC*
4. *CalEPA*

Internal:

1. *Information Technology Service Division*
2. *Emergency Preparedness Office*
3. *Injury and Violence Prevention Branch*
4. *Substance Abuse Prevention Branch*
5. *Division of Communicable Disease Control*
6. *Center for Laboratory Sciences*

Planned non-monetary support to local agencies or organizations

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: Progress will be evaluated by the completion of steps outlined in the objectives and activities: 1) number of represented health jurisdictions participating; 2) number of data use agreements (DUAs)/memorandums of understanding (MOUs)/data sharing agreements; and 3) number of internal partnership meetings.

Program Settings:

- State health department

Target Population of Program

- *Target population data source*: Entire population of California using data from the U.S. Census Bureau, Decennial Census, and American Community Survey
- *Number of people served:* ~39.5 million
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native
- Asian
- Black or African American

- Native Hawaiian or Other Pacific Islander
- White

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

Objectives and Activities

Objective 1:

Title: Build Partnerships to Conduct Toxicological Outbreak Surveillance, Response, and Exercises

Objective: Between 07/2021 and 06/2022, Program will conduct at least 5 meetings or collaborative activities with internal and external data partners to ensure efficient and secure data sharing and data management for identifying and responding to toxicological outbreaks. Program will also design at least one functional or tabletop toxicological outbreak exercise including local emergency management and environmental and/or public health agencies.

Mid-year objective goal: Secure one data use agreement and establish ongoing data sharing with at least one external partner for toxicological outbreak surveillance (e.g., poison control), and convene one regular working group of internal stakeholders for toxicological outbreak response (laboratory, information technology, Emergency Preparedness Office, E&O Emergency Preparedness Team).

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

Intervention Information: **Technical assistance to local health jurisdictions.** Investigating outbreaks caused by non-infectious, toxic agents requires some unique considerations and skills that are different from those used to investigate infectious disease outbreaks. California LHDs currently lack that capacity and may require technical assistance from CDPH.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)
- Other: National Center for Environmental Health Toxicological Outbreak Toolkit

Rationale for choosing the Intervention: Increased LHD capacity needed to effectively investigate and respond to toxicological outbreaks. For example, the 2019 EVALI outbreak highlighted the gap in timely, coordinated reporting.

- *Item to be measured:* Increased capacity of LHDs to identify and report toxicological outbreaks
- *Unit of measurement:* Number of LHDs
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Contracts or agreements with LHDs
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 5

Target Population

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

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

Activity 1

Toxicological Outbreak Response Workgroup. Between 07/2021 and 06/2022, Program will establish a workgroup including CDPH emergency management, environmental investigations, injury control, substance abuse prevention, information technology, and laboratory staff to establish an internal framework and procedures for conducting toxicological outbreak investigations.

Mid-year goal: Between 07/2021 and 12/2021, Program will convene a standing meeting with CDPH program representatives and establish a draft document identifying triggers for an outbreak investigation and an agreement outlining the roles and responsibilities of each program in coordinating an investigation.

Description of Activity: CDPH does not have a core team dedicated to toxicological outbreak investigations. This gap was conspicuous during CDPH's response to the 2019 e-cigarette, or vaping, product use-associated lung injury (EVALI) response, in which CDPH's Environmental & Occupational Emergency Preparedness Team in the Center for Healthy Communities was tasked to lead a response which required coordination with the Emergency Preparedness

Office, Center for Environmental Health, Center for Infectious Diseases, and Information Technology Services Division. This complex arrangement included unwieldy methods for sharing data and unclear divisions of scope and labor. The purpose of this activity is to clarify scope and division of labor among participating CDPH programs, identify efficient methods of data sharing, and establish procedures for coordinately conducting toxicological outbreak investigations by 6/30/2022.

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

Activity 2

Poison Control Surveillance. Between 07/2021 and 06/2022, Program will establish infrastructure for toxicological outbreak surveillance using state Poison Control data.

Mid-year goal: Between 07/2021 and 12/2021, Program will establish infrastructure for toxicological outbreak surveillance using state Poison Control data.

Description of Activity: Any surveillance program requires access to ongoing data collection from relevant data sources. California Poison Control System (CPCS) answers calls from the public and clinicians and documents symptom and exposure reports from the public on an ongoing basis and represents a rich data source for identifying patterns indicative of toxicological outbreaks. Currently CDPH does not have a formal relationship with CPCS for toxicological outbreak surveillance. In this activity, we propose to establish an MOU or data use agreement with CPCS to allow either (1) CDPH access to CPCS data to conduct outbreak surveillance or (2) for CPCS to regularly search their data systems using criteria developed by CDPH and report data to CDPH in a specified electronic format. Deliverables include establishing this agreement, identifying best practices for poison control-based outbreak surveillance through consultation with CDC and/or other states.

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

Activity 3

Syndromic Surveillance for Toxicological Outbreaks. Between 07/2021 and 06/2022, Program will conduct a feasibility study for identifying toxicological outbreaks using syndromic surveillance.

Mid-year goal: Between 07/2021 and 12/2021, In collaboration with the Injury and Violence Prevention Branch, Substance Abuse Prevention Branch, and local health departments in California that currently use syndromic surveillance, Program will establish a case definition and a query for identifying a toxicological outbreak through syndromic surveillance use and use historic data for evaluation of these definitions and queries.

Description of Activity: Syndromic surveillance in collaboration with sentinel healthcare providers is commonly used for defining disease trends and for early identification of outbreaks. Syndromic surveillance is regularly conducted by a limited number of jurisdictions in California for public health threats such as opioid misuse. Syndromic surveillance has the potential for early identification of clusters of illness associated with a toxicological outbreak, but the feasibility and utility of this approach has not been evaluated in California. We propose to evaluate and pilot the use of existing syndromic surveillance data available to CDPH for detection of toxicological outbreaks--possible approaches include a retrospective analysis to identify potential cases of EVALI and compare to the known 2019 outbreak cases. We will establish case definitions and queries in consultation with CDC and other states that might regularly conduct syndromic surveillance for exposure to toxic substances and provide a report of our pilot findings using these search criteria.

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

Activity 4

Toxicological Outbreak Exercise. Between 07/2021 and 06/2022, Program will develop a toxicological outbreak exercise for use by local emergency managers and public health officials.

Mid-year goal: Between 07/2021 and 12/2021, Program will develop a draft scenario for either a tabletop or functional toxicological outbreak exercise.

Description of Activity: Local jurisdictions regularly exercise emergency responses and outbreak investigations to identify response and internal communication gaps and prepare for responding to a real emergency. Tabletop and functional exercises led by CDPH typically involve an infectious disease outbreak scenario (e.g., anthrax). There have been few examples of toxicological outbreak exercises, and therefore correspondingly little opportunity for local jurisdictions to prepare for a toxicological outbreak. The purpose of this activity is to, in collaboration with CDPH's Emergency Preparedness Office, design a Homeland Security Exercise and Evaluation Program (HSEEP) compliant toxicological outbreak exercise for use by local jurisdictions to improve their preparedness for response to an actual outbreak.

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

Tuberculosis Free CA

Healthy People 2030 Objective

IID-17: Reduce tuberculosis (TB)

Health Objective

Approximately 80% of California's annual tuberculosis (TB) cases arise from untreated latent TB infection (LTBI). TB disease is preventable through the diagnosis and treatment of LTBI, however, persons with LTBI are often unaware of their infection and do not seek treatment. The TB Free California Program provides technical assistance to >90% of local public health programs and community healthcare clinics that request assistance with LTBI care, education, and quality improvement projects. Activities include measurement of LTBI testing and treatment at clinic sites, patient education for high-risk populations with a goal of reducing TB health disparities based on race and ethnicity, and provider training and consultation for LTBI care. By treating LTBI, we will avert morbidity, mortality, and healthcare costs associated with TB disease and improve health equity related to TB outcomes. Our aim is to reduce the California TB case rate over a five year performance period.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: Yes
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

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

Issue/Problem

TB disease in California occurs primarily in people with longstanding LTBI and could be prevented by treating LTBI; because LTBI is asymptomatic and no other statewide programs exist to specifically address LTBI, many patients do not seek testing or treatment. The incidence of TB disease in California is nearly twice the national incidence.

Californians born outside the U.S., as well as racial and ethnic minorities, experience disproportionately high rates of TB disease. TB disease in California occurs primarily in people with longstanding LTBI, and because LTBI is asymptomatic, many patients do not seek testing or treatment. The goal of our program is to identify and treat those with LTBI, in order to prevent cases of TB disease in California. The TB Free California program aims to avert TB disease based on evidence-based practices, which will in turn improve overall health status and health equity throughout California.

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: Our key indicator is the California TB case rate. Due to the long latency period of TB disease, and the fact that the vast majority of public health and medical efforts currently focus on TB control rather than prevention, we rely on intermediate outcomes for our yearly program evaluation (described in evaluation methodology).

Baseline value of the key indicator described above: 5.3 per 100,000

Data source for key indicator baseline: California Department of Public Health, TB Control Branch: Report on TB in CA, 2019.

Date key indicator baseline data was last collected: 2019

Program Strategy

Goal: The goal of our program is to identify and treat those with LTBI, in order to prevent cases of TB disease in California.

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

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

Summary of Program Strategy: Californians born outside the U.S., as well as racial and ethnic minorities, experience disproportionately high rates of TB disease. In 2019, the TB rates among Asians, Blacks, and Hispanics born outside the U.S., were 46, 45, and 20 times greater, respectively than of U.S.-born whites. The TB Free California program engages groups disproportionately impacted by TB, to coordinate patient education and targeted testing and treatment for high-risk populations, and produces culturally and linguistically appropriate materials for use with a diverse group of patients.

Primary Strategic Partners

External:

1. *Association of Asian Pacific Community Health Organizations*
2. *Federally Qualified Health Center*
3. *Kaiser Permanente*
4. *UC Berkeley University Health Services & UC Irvine Santa Ana Family Health Center*
5. *Hep B Free Los Angeles*

Internal:

1. *Office of Public Affairs*
2. *Office of Refugee Health*
3. *Office of Border and Binational Health*
4. *Chronic Disease Control Branch*
5. *Department of Health Care Services, Medi-Cal Managed Care*

Evaluation Methodology: Program will evaluate progress towards objectives using process evaluation with the following measures: the number of trainings performed, consultations performed, and clinics using patient education materials. Additionally, Program will assess feedback from partners and stakeholders, electronic and paper surveys, emails, and intermediate outcome evaluations, which may include: 1) proportion of at-risk patients receiving testing for LTBI, 2) proportion of persons testing positive for TB infection who are prescribed LTBI treatment, and 3) proportion of patients who are motivated to speak to a medical provider about LTBI testing and treatment after reviewing patient education materials.

Program Settings:

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

Target Population of Program

- *Target population data source*: State of California, Department of Public Health, TB Control Branch: Report on Tuberculosis in California 2020
- *Number of people served:* 2,100,000
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- American Indian or Alaskan Native

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

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

Objectives and Activities

Objective 1:

Title: Measure and Analyze Data on LTBI Testing and Treatment Practices in Community Clinics

Objective: Between 07/2021 and 06/2022, Program will measure and analyze two (2) metrics including: 1) proportion of at-risk population receiving testing for LTBI, and 2) proportion of persons who test positive for TB infection prescribed LTBI treatment, at a minimum of two community clinic sites providing primary care in California to high-risk populations.

Mid-year objective goal: Program will measure two (2) metrics including: 1) proportion of at-risk population receiving testing for LTBI, and 2) proportion of persons who test positive for TB infection who are prescribed LTBI treatment at two community clinic sites from July – December, 2021.

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

Problem for this Objective: **Preventing cases of TB disease in California depends on identifying and treating LTBI in primary care settings, yet there are few estimates of LTBI testing and treatment performance in primary care clinics.** Preventing cases of TB disease in California depends on identifying and treating LTBI, yet there are few estimates of LTBI testing and treatment performance in primary care clinics. Two key metrics that are fundamental to TB prevention include: 1) proportion of at-risk population receiving testing for LTBI, and 2) proportion of persons who test positive for TB infection who are prescribed LTBI treatment. Our goal is to measure these metrics in California clinics providing primary care to at-risk populations, to document incremental progress over time, and to ultimately inform work to build systems that enable collection of LTBI care cascade data statewide.

Key indicator(s) affected by this problem: Persons who test positive for TB infection who are prescribed LTBI treatment in California

Baseline value for the key indicator: Stroke hospitalization in CA: <20%

Data source for key indicator baseline: Alsdurf H et al. The cascade of care in diagnosis and treatment of LTBI: a systemic review and meta-analysis. Lancet Infect Dis. 2016.

Date key indicator baseline data was last collected: 2016

Intervention Information: **Measure and analyze two (2) baseline metrics including: 1) proportion of at-risk populations receiving testing for LTBI, and 2) proportion of persons who test positive for TB infection who are prescribed LTBI treatment, at two community clinic sites providing primary care to high-risk patients in California.** Between 07/2021 and 06/2022, Program will analyze two (2) baseline metrics including: 1) proportion of at-risk population receiving testing for LTBI, and 2) proportion of persons who test positive for TB infection who are prescribed LTBI treatment, at two community clinic sites. These activities will occur in partnership with local health departments, and will complement and inform work with state and national partners to build infrastructure to collect data on LTBI testing and treatment for monitoring and quality improvement within individual primary care settings. Our goal is to help build systems that enable collection of LTBI care cascade data statewide.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Guide to Clinical Preventive Services (Task Force on Community Preventive Services)
- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)
- Other: (1) Sterling TR, Njie G, et al. Guidelines for the Treatment of Latent Tuberculosis Infection: Recommendations from the National Tuberculosis Controllers Association and CDC, 2020; (2) California Tuberculosis Elimination Advisory Committee. California

Tuberculosis Elimination Plan 2016-2020. Richmond, CA; (3) Latent Tuberculosis Infection: A Guide for Primary Health Care Providers. CDC, 2020.

Rationale for choosing the Intervention: One of the TB Free California objectives is to define baseline rates of testing and treatment in California, in order to identify and address gaps in care and measure incremental improvement in performance. Our work with individual primary care sites also allows us to inform work with state and national partners to build infrastructure to collect data on LTBI testing and treatment for monitoring and quality improvement.

- *Item to be measured:* Proportion of at-risk clinic population receiving testing or prescribed LTBI treatment
- *Unit of measurement:* Persons at-risk/persons tested; persons who test positive for TB infection/persons prescribed LTBI treatment
- *Baseline value for the item to be measured:* <10%
- *Data source for baseline value:* Baseline data from individual clinics
- *Date baseline was last collected:* 2019
- *Interim target value to be achieved by the Annual Progress Report:* N/A
- *Final target value to be achieved by the Final Progress Report:* 20%

Target Population

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

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

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

Activity 1

Support Community Clinics in Measuring LTBI Testing and Treatment. Between 07/2021 and 06/2022, Program will assist with data collection, management, and analysis at clinics with two key metrics regarding LTBI testing and treatment.

Mid-year goal: N/A; given that we are usually working with clinics who have never measured their baseline data, we will not set a mid-year target.

Description of Activity: Between 07/2021 and 06/2022, Program will assist with data collection, management, and analysis at clinics with metrics including: 1) proportion of at-risk population receiving testing for LTBI, and 2) proportion persons who test positive for TB infection who are prescribed LTBI treatment, at a minimum of two (2) community clinic sites. We will provide technical assistance to clinics through direct consultation, provision of data management tools and templates with modifiable data fields, and analysis of collected data. By 6/2022, we will

have estimates of two (2) metrics at each clinic site. Program Epidemiologist is primarily responsible for this activity.

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

Activity 2

Produce TB Prevention Guidance Booklet for Primary Healthcare Clinics. Between 07/2021 and 06/2022, Program will produce a TB prevention guidance booklet, to be used by clinics or health systems serving high-risk populations, which includes stepwise instructions on how to assess clinic population risk, increase LTBI testing and treatment, and measure the LTBI care cascade.

Mid-year goal: Between 07/2021 and 12/2021, Program will complete draft, and compile and review feedback on draft version of booklet with external partners, including Curry International TB Center.

Description of Activity: By 6/2022, Program will produce and disseminate a TB prevention guidance booklet with a target audience of primary care clinics and health care systems that want to increase LTBI testing and treatment to prevent TB in their patient population. Booklet will include stepwise instructions on how to assess clinic population risk, support providers in providing LTBI testing and treatment, and measure the LTBI care cascade using data elements from an electronic medical record (EMR). This product has been directly requested by TB Free California partners and will be produced by 6/2022, with additional plans for dissemination and evaluation in subsequent years. Program Epidemiologist is primarily responsible for this activity.

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

Objective 2:

Title: Increase Access to High-Quality Culturally Appropriate LTBI Patient Education to Reduce TB Health Disparities

Objective: Between 07/2021 and 06/2022, Program will increase awareness of LTBI as a health issue among high-risk populations in California by developing at least two (2) culturally appropriate and in-language patient education materials, partnering with a minimum of five (5) community organizations that serve high-risk patients to disseminate patient education materials, and maintaining a website with downloadable LTBI education materials.

Mid-year objective goal: Between 7/1/2021 and 12/31/2021, Program will engage at least two (2) community organizations serving high-risk groups, and update TB Free California website with all downloadable materials.

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

Problem for this Objective: **TB disease disproportionately impacts non-U.S.-born and non-white persons in California; although disease can often be avoided through treatment of LTBI, most patients do not know they are infected and do not seek preventative treatment.** Persons at highest risk of TB infection and disease are disproportionately non-U.S.-born and non-white persons. Based on systematic research conducted by the CDC, persons with LTBI need access to culturally appropriate patient messaging with accessible language, including materials translated into non-English languages. Patients with LTBI often do not know they are infected and do not seek treatment, and require engagement and education by trusted community partners in order to seek care and reduce existing health disparities related to TB disease.

Key indicator(s) affected by this problem: Proportion of patients who report being motivated to speak to a medical provider about LTBI testing and treatment

Baseline value for the key indicator: Stroke hospitalization in CA: 25%

Data source for key indicator baseline: Surveys of >30 patients from partner clinics, unpublished data, TB Free California.

Date key indicator baseline data was last collected: 2018

Intervention Information: **Develop and distribute culturally appropriate patient education materials regarding LTBI testing and treatment.** Program will develop and distribute culturally appropriate patient education materials regarding LTBI testing and treatment, maintain a website with downloadable LTBI education materials, and partner with community organizations to disseminate patient education materials in order to increase awareness of LTBI in high-risk populations.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: (1) California Tuberculosis Elimination Advisory Committee. California Tuberculosis Elimination Plan 2016-2020. Richmond, CA. (2) “Shining a light on an Invisible, Dormant Threat: Lessons for Developing a Communications Campaign to Encourage Testing & Identification of Latent Tuberculosis Infection”, CDC Division of Tuberculosis Elimination, September 25, 2020 (Internal Report).

Rationale for choosing the Intervention: Patients with LTBI often do not know they are infected and do not seek treatment, and need engagement and education by trusted community partners in order to seek care. Furthermore those at highest risk of LTBI are disproportionately

non-U.S.-born and non-white persons, and need access to culturally appropriate and in-language patient messaging.

- *Item to be measured:* Proportion of patients who report being motivated to speak to a medical provider about LTBI testing and treatment, after reviewing TB Free California patient education materials
- *Unit of measurement:* Patients who report being motivated to speak to a medical provider about LTBI testing and treatment/All patients surveyed
- *Baseline value for the item to be measured:* 25%
- *Data source for baseline value:* Unpublished data, TB Free California
- *Date baseline was last collected:* 2018
- *Interim target value to be achieved by the Annual Progress Report:* 50%
- *Final target value to be achieved by the Final Progress Report:* 75%

Target Population

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

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

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

Activity 1

Develop and Distribute Culturally Appropriate TB Education Materials. Between 07/2021 and 06/2022, Program will develop and distribute culturally appropriate TB education materials.

Mid-year goal: Between 07/2021 and 12/2021, Program will develop one (1) new TB patient education material.

Description of Activity: Between 07/2021 and 06/2022, Program will develop and provide at least two (2) patient education materials to medical clinics on the topics of LTBI, testing, and treatment in key languages including Simplified Chinese, Vietnamese, Spanish, Tagalog, Hindi, Punjabi, and/or Urdu. Program will incorporate findings from CDC systematic research with non-U.S.-born patients, including a focus on the “inactive” LTBI state, the availability of medication to prevent TB disease, and preferred language and/or motivators based on ethnicity. Program Health Educator is primarily responsible for this activity.

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

Activity 2

Collaborate with organizations serving high-risk populations. Between 07/2021 and 06/2022, Program will collaborate with organizations serving high-risk populations.

Mid-year goal: Between 07/2021 and 12/2021, Program will collaborate with two (2) organizations.

Description of Activity: By 6/2022, Program will produce and disseminate a TB prevention guidance booklet with Between 07/2021 and 06/2022, Program will develop and/or maintain partnerships with at least five (5) organizations that serve a group at high-risk of TB infection or progression to TB disease, namely: (1) non-U.S.-born persons, (2) Asian and Pacific Islanders, (3) African Americans, (4) Hispanic/Latinx persons, (5) persons with diabetes mellitus, (6) persons with end stage renal disease, (7) persons who use tobacco products, (8) persons living with HIV, and (9) persons experiencing homelessness. Staff will work with each organization to ascertain the best mechanism for providing patient education to the target group, which may include attendance and education at organization meetings, providing patient education materials for use in a community center or referral center, creating a joint media campaign to encourage LTBI testing and treatment, or coordinating a targeted testing program from high-risk populations. Program Health Educator is primarily responsible for this activity.

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

Activity 3

Maintain Public Website for LTBI Education. Between 07/2021 and 06/2022, Program will maintain public website for LTBI education.

Mid-year goal: Between 07/2021 and 12/2021, Program will update website with existing materials developed in 2020-2021.

Description of Activity: Between 07/2021 and 06/2022, Program will develop and maintain content for a website where anyone can access high-quality patient and provider educational materials regarding TB and LTBI, and sign up to become a TB Free California partner clinic site. This public-facing website will allow access to materials developed by the TB Free California team, and can be a source of consistent and reliable messaging for health departments, providers, and community members across the state. Program Health Educator is primarily responsible for this activity.

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

Objective 3:

Title: Provide LTBI Training and Clinical Consultation to Providers Serving High-Risk Patients, Including Primary Care and Civil Surgeon Provider Group

Objective: Between 07/2021 and 06/2022, Program will engage at least six (6) community clinics and/or provider groups to receive training or technical assistance related to LTBI.

Mid-year objective goal: Between 07/2021 and 12/2021, Program will engage at least four (4) community clinics and/or provider groups to receive training or technical assistance related to LTBI.

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

Problem for this Objective: **Many primary care providers remain unaware of risk groups, ideal testing strategies, and medication options for treating LTBI.** Tuberculosis clinical care involves many diagnostic and therapeutic nuances, including distinguishing latent TB from active disease, interpretation of discordant tests, treating special populations including infants and pregnant women, and managing drug side effects. Many primary care providers remain unaware of risk groups, ideal testing strategies, and medication options for treating LTBI. Furthermore, civil surgeons (i.e. providers that evaluate patients immigrating to the U.S.) have a mandate to systematically test for TB infection, but are often unfamiliar with prescribing and managing LTBI treatment. There is a high demand for training, consultation, and concise clinical tools, including algorithms, treatment cards, and drug fact sheets, that providers can use to guide LTBI testing and treatment decisions.

Key indicator(s) affected by this problem: Proportion of primary care and civil surgeon providers who are comfortable prescribing CDC-preferred LTBI therapy

Baseline value for the key indicator: Stroke hospitalization in CA: 55%

Data source for key indicator baseline: Provider survey of >100 California primary care providers, unpublished data, TB Free California.

Date key indicator baseline data was last collected: 2019

Intervention Information: **Engage at least six (6) community clinics and/or provider groups to receive training related to LTBI.** Between 07/2020 and 06/2021, Program will engage at least six (6) community clinics to receive training related to LTBI. Our goal is to provide the skills training necessary for primary care providers in California to effectively screen, test, and treat patients for LTBI. Program will work in collaboration with local TB control programs, clinics, and training centers to execute trainings on LTBI testing and treatment, and as an additional activity, will provide direct clinical consultation on testing and treatment of TB

infection and TB prevention strategies for healthcare providers in community and institutional settings.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Guide to Clinical Preventive Services (Task Force on Community Preventive Services)
- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)
- Other: (1) Sterling TR, Njie G, et al. Guidelines for the Treatment of Latent Tuberculosis Infection: Recommendations from the National Tuberculosis Controllers Association and CDC, 2020; (2) California Tuberculosis Elimination Advisory Committee. California Tuberculosis Elimination Plan 2016-2020. Richmond, CA.

Rationale for choosing the Intervention: Tuberculosis clinical care involves many diagnostic and therapeutic nuances, including distinguishing latent TB from active disease, interpretation of discordant tests, treating special populations including infants and pregnant women, and managing drug side effects. Many primary care providers remain unaware of risk groups, ideal testing strategies, and medication options for treating LTBI.

- *Item to be measured:* Number of clinics or provider groups that receive training
- *Unit of measurement:* Number of clinics or provider groups
- *Baseline value for the item to be measured:* 4
- *Data source for baseline value:* Unpublished data, TB Free California
- *Date baseline was last collected:* 2020
- *Interim target value to be achieved by the Annual Progress Report:* 4
- *Final target value to be achieved by the Final Progress Report:* 6

Target Population

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

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

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

Activity 1

Conduct Training on LTBI Best Practices and Guidelines. Between 07/2021 and 06/2022, Program will conduct training on LTBI best practices and guidelines.

Mid-year goal: Between 07/2021 and 12/2021, Program will conduct trainings with four (4) clinics or provider groups

Description of Activity: Between 07/2021 and 06/2022, Program will work in collaboration with local TB control programs, clinics, and civil surgeon groups to execute six (6) trainings on LTBI testing and treatment. Trainings will be completed at each site once or twice annually, depending on specific needs of site. Trainings will emphasize best practices for providers and will target providers who serve high-risk populations and patients at most risk for progression. Particular emphasis will be placed on use of interferon gamma release assay (IGRA) for non-U.S. born patients, and use of short-course regimens, including 12-dose once-weekly isoniazid-rifapentine or four months of rifampin, for LTBI treatment. Program Physician is primarily responsible for this activity.

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

Activity 2

Provide Expert Consultation to Medical Providers Regarding LTBI Care. Between 07/2021 and 06/2022, Program will provide expert consultation to medical providers regarding LTBI care.

Mid-year goal: Between 07/2021 and 12/2021, Program will provide expert consultation to medical providers regarding LTBI care to >90% of clinics and/or providers that request help.

Description of Activity: Between 07/2021 and 06/2022, Program will provide clinical consultation and subject matter expertise on testing and treatment of TB infection for healthcare providers in community and institutional settings; our goal is to provide support to >90% of clinics and/or providers that request consultation. Common consultation topics include interpretation of discordant tests for TB infection, work-up of TB disease prior to starting LTBI therapy, addressing drug interactions with LTBI medications, and accounting for partially completed LTBI therapy. Program will disseminate clinical algorithms, protocols, fact sheets, and workflow modifications developed by TB Free California to enable clinics to implement screening, testing, and treatment of patients with LTBI. Examples of current clinical tools can be found on the TB Free California website: Program physician is primarily responsible for this activity.

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

Workforce Development: Preventive Medicine Residency (PMR) and CA Epidemiologic Investigation Service (Cal-EIS) Fellowship

Healthy People 2030 Objective

PHI-R02: Expand pipeline programs that include service learning or experiential learning components in public health settings

Health Objective

Between 07/2021 and 06/2022, Program will increase the public health (PH) workforce by graduating at least 13 trainees from the Preventive Medicine Residency (PMR) or the California Epidemiologic Investigative Service (Cal EIS), to become qualified PH physicians and epidemiologists who contribute to and/or lead efforts to improve the health of Californians.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Answer: No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 50-74% - Significance source of funding
- Existing funding source(s): Multiple sources: Local health department and state agency funds; federal non-CDC (HRSA); general fund
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 3
- Number of FTEs in this program funded by the PHHS Block Grant: 2.45

Issue/Problem

PH agencies have difficulty recruiting and hiring qualified, diverse PH physicians and epidemiologists. Shortages of PH physicians and epidemiologists in public agencies is a long-standing problem. A 2017 Association of State and Territorial Health Officials (ASTHO) report indicated an 8.7% decline in the PH workforce nationwide from 2010-2016. California's

state PH workforce is small relative to its population: California has fewer than 10 FTE per 100,000 population, compared to an average of 23 FTE per 100,000 among large states. Nationwide, the average age of state PH employees is 47; the median age is 48. Based on ASTHO projections, more than 41% of California's PH workforce was eligible to retire in 2020. As older PH physician and epidemiologist leaders retire, there is a need to replace them with a more diverse cohort that better represents the California population, and has novel perspectives and insights into methods of meeting current PH challenges. PMR and Cal EIS ensure a steady supply of critically needed, diverse, well-trained PH physicians and epidemiologists to assume leadership positions in state and local PH agencies in California. These positions include Local Health Officers, state agency Medical Directors, Data Directors and Division/Branch/Section Chief physicians and epidemiologists. California needs trained experts ready to respond to PH emergencies that result in illness, injury, deaths and inequity, such as influenza, corona virus, floods and wildfires, as well as to respond to the alarming rise in chronic diseases that decrease life expectancy.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)
- Conducted a topic- or program-specific assessment (e.g., tobacco assessment, environmental health assessment)
- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan
- Other: State and Local Health Departments, Research and Educational Institutions

Key Indicator(s) affected by this problem: Number of PH physicians and epidemiologists that graduate each year; ready and able to apply for PH agency jobs in California

Baseline value of the key indicator described above: Graduation of 12 PH physicians and epidemiologists who are ready and able to apply for PH agency jobs in California

Data source for key indicator baseline: PMR and Cal EIS records, including Competency/Milestone charts, monthly/quarterly activity reports, preceptor/faculty evaluations, program evaluations of trainee performance and number of trainees that graduate from PMR and Cal EIS

Date key indicator baseline data was last collected: 2020

Program Strategy

Goal: The California Department of Public Health (CDPH) will conduct PH professional training through the PMR and the Cal EIS to increase the pipeline and graduate diverse qualified physicians and epidemiologists to work in California PH agencies.

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

- Education (e.g., low high school graduation rates, low literacy levels, poor early childhood education)

Summary of Program Strategy: PMR and Cal EIS objectives align with the CDPH Strategic Map 2019-2022 "Empower the Public Health Workforce" as they strengthen CDPH and local health departments by developing a workforce of trained physicians and epidemiologists with the competencies needed to become PH professionals, supporting and facilitating the work of state and local health agencies. This priority relates to the Healthy People 2030 Objectives (PHI-R02) by expanding pipeline programs that include service learning or experiential learning components in PH settings.

Primary Strategic Partners

External:

1. California Conference of Local Health Officers
2. Office of Statewide Health Planning and Development
3. Department of Health Care Services
4. Multiple Local Health Departments
5. Universities of California (Davis, Los Angeles, Berkeley)

Internal:

1. Environmental Health Investigations Branch
2. Tobacco Control Branch
3. Food and Drug Branch
4. Office of Oral Health
5. Injury and Violence Prevention Branch

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: Program goals and objectives are aligned with physician and epidemiologist national organization requirements. State health objectives are monitored and evaluated yearly. Monitoring tools include trainee competency or milestone progress, monthly/quarterly trainee reports, preceptor/trainee evaluations, site visits, Advisory Committee meetings, a Program Evaluation Committee, program policies and procedures, the American Board of Preventive Medicine resident pass rate and the type and location of employment after completing the program.

Program Settings:

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

Target Population of Program

- *Target population data source*: California Department of Finance Demographics
- *Number of people served:* 39,782,870
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male

- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

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

Objectives and Activities

Objective 1:

Title: Increase the # of Trainees Who Achieve Either Preventive Medicine and PH Competencies or Epidemiology Competencies.

Objective: Between 07/2021 and 06/2022, Program will increase the number of trainees who, over the course of their training period, have satisfactorily achieved American College of Preventive Medicine (ACPM) Competencies OR Council of State and Territorial Epidemiologist (CSTE) Competencies for Applied Epidemiologists in Governmental PH Agencies, by working in local or state PH agency programs and/or completing academic coursework, from 120 residents and 217 fellows to at least 122 residents and 228 fellows.

Mid-year objective goal: Between 7/2021 and 12/2021, Program will increase the number of trainees who have shown progress to satisfactorily achieve ACPM OR CSTE Competencies for Applied Epidemiologists in Governmental PH Agencies, by working in local or state PH agency programs and/or completing academic coursework.

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

Intervention Information: **Applied training in which physicians and scientists gain ACPM Competencies OR CSTE Competencies.** Program will recruit, select, hire, place, monitor, teach and evaluate PMR and Cal EIS trainees placed in state and local PH agencies under a doctoral level preceptor, with the curriculum and practicum targeted to the achievement of ACPM Competencies OR CSTE Competencies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common and Preventive Medicine Requirements for Graduate Medical Education; ACPM Competencies for Preventive Medicine Physicians; CSTE, Competencies for Applied Epidemiologists in Governmental PH Agencies.

Rationale for choosing the Intervention: These national organizations accredit graduate medical education in the US (ACGME), serve as the society for the medical specialty of preventive medicine (ACPM) and serve as the society for all state and territorial epidemiologists. They have a vested interest in the training and competence of those practicing in preventive medicine and PH, and have committees to set the bar for what those benchmarks are. Therefore, adopting these requirements and competencies in the CDPH training programs assures that the graduates will be well qualified to enter the field of PH and preventive medicine.

- *Item to be measured:* Number of trainees achieving competencies.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Number of trainees in the program
- *Date baseline was last collected:* 7/1/2020
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 13

Target Population

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

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

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

Activity 1

Recruit and Interview Applicants for PMR and Cal EIS Positions. Between 07/2021 and 06/2022, Program will recruit and interview at least 5 PMR applicants and 15 Cal EIS applicants. The competitive recruitment and selection process includes distributing PMR and Cal EIS information to schools of PH, residency programs, local health agencies and posting on various websites, such as FREIDA Online, Electronic Residency Application Service and PH Employment Connection. Applications from this pool will be reviewed by the PMR and Cal EIS Advisory Committees and top candidates will be selected for interview.

Mid-year goal: Between 07/2021 and 12/2021, Program will recruit and interview at least 5 PMR applicants and 15 Cal EIS applicants. The competitive recruitment and selection process includes distributing PMR and Cal EIS information to schools of public health and residency programs.

Description of Activity: The Program Director, PMR Coordinator and Cal EIS coordinator are responsible for the recruitment of the trainees, the trainees are then offered placement sites for their training. Both trainee programs begin 7/2021.

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

Activity 2

Place Residents and Fellows in a PH Training Experience. Between 07/2021 and 06/2022, Program will train at least 13 individuals in the relevant competencies. Experienced preceptors

will mentor and guide trainees to meet competencies through applied state and local PH experiences, providing training needed to develop California's PH workforce.

Mid-year goal: Between 7/2021 and 12/2021, Program will be training at least 13 individuals in the relevant competencies.

Description of Activity: Between 7/2021 and 6/2022, experienced preceptors will mentor and guide trainees to meet competencies through applied state and local PH experiences, providing training needed to develop California's PH workforce.

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

Activity 3

Develop and Implement PH Practice Curriculum. Between 07/2021 and 06/2022, Program will conduct at least 15 PH/preventive medicine seminars for PMR and Cal EIS trainees. These bi-monthly seminars address ACGME Milestones and ACPM/CSTE competencies and provide trainees with knowledge, insights and resources for PH practice, epidemiologic investigation procedures and other processes that prepare trainees to enter the PH workforce.

Mid-year goal: Between 07/2021 and 12/2021, Program will conduct at least 7 PH/preventive medicine seminars for PMR and Cal EIS trainees.

Description of Activity: The Cal EIS coordinator schedules presenters from CDPH, Local Health Departments and Universities to educate the trainees. These PH/preventive medicine seminars begin 7/2021 and will run through 6/2022.

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