Preventive Health and Health Services Block Grant: FFY 2022 State Plan

Version Date: April 21,2022

Contents

Executive Summary

This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2022. 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 Asylum Seeker Health Surveillance and Linkage to Care	This program is an active surveillance and rapid public health response program for individuals seeking asylum and intending to reside in CA. Active surveillance increases early identificaton of infectious diseases of public health significance, and services facilitate linkage to healthcare services and disease control.	$228,779
CA Behavioral Risk Factor Surveillance System (BRFSS) Program	BRFSS is a CA-specific surveillance system that surveys adults 18 years and older on self-reported health behaviors. Questions in the survey relate to nutrition, physical activity, tobacco use, hypertension, blood cholesterol, alcohol use, inadequate preventive health care, and other risk factors. Because the survey is conducted on an annual basis, the continuous use of this system allows analysis of trends over time.	$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	$825,718

	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.	
Emergency Medical Services (EMS) Prehospital Data and Information Services and Quality Improvement Program	This program provides for pre-hospital EMS data submissions into the state EMS database system and unites the EMS system under a single data warehouse, fostering analyses on patient care outcomes, public health system services, and compliance with CA state and federal EMS service laws. The Program improves pre-hospital EMS services and public health systems statewide by providing measurable quality improvement oversight, resources, and technical assistance.	$1,199,869
EMS Systems Operations, Planning, and Specialty Care	Emergency Medical Services Authority, through its EMS Systems Division is mandated to provide oversight of EMS systems 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, reviews and approves annual local EMS system plan ensuring statutory and regulatory compliance and manages the state's EMS data collection, performance management and quality assurance. EMS Systems Division staff provide state leadership and oversight to ensure the EMS Act is upheld and the best quality of care is available, reducing the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care in an emergency.	$1,440,375
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 on-going and emerging cross-sector issues, such as: healthy aging, Adverse Childhood Experiences (ACEs), School Based Health Centers, childhood injuries, and firearm-related injuries and fatalities. These injury areas stretch across the lifespan, affecting all age groups, and present significant opportunities to increase longevity and well-being through evidence-based prevention strategies.	$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
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.	$193,800

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 populations at higher risk in CA. This is the sole statewide program focused on TB prevention, with the aim of reducing morbidity, mortality, health disparities, and healthcare costs associated with TB disease. Program activities include development of culturally and linguistically appropriate patient education, 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 physician positions in CA state and local public health agencies. Trainees perform data and policy analyses, provide disease outbreak and emergency preparedness response; community needs assessments and planning, clinical preventive medicine, systems quality improvement, etc.	$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 July 1, 2022 and June 30, 2023, Program will provide support and expertise to state, local, and tribal health programs to plan to prevent and reduce health impacts of climate change through their health programs, plans, policies, and communications.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $526,152
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Both Tribal governments and local health departments (technical assistance, not funding).
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing 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

Position #1

Position Title:	Health Program Specialist I
Staff Name in Position:	Osamu Kumasaka
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #2

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Britt Higgins
Jurisdiction-level [% time]:	65
Total [% time]:	65

Position #3

Position Title:	Health Program Manager I
Position Vacant?	Yes
Jurisdiction-level [% time]:	100
Total [% time]:	100
Briefly describe recruitment/hiring plan	Program is in the process of re-posting this position in March 2022 and aims to have it filled by close of SFY 21-22

Position #4

Position Title:	Health Program Specialist I
Position Vacant?	Yes
Jurisdiction-level [% time]:	100
Total [% time]:	100
Briefly describe recruitment/hiring plan	Program is in the process of re-posting this position in March 2022 and aims to have it filled by close of SFY 21-22

Issue/Problem

Health departments and Tribal health programs have not received sufficient resources nor technical assistance to prevent and reduce climate change health-related impacts, which include: heat-related illness and death, air pollution-related exacerbations of cardiovascular and respiratory diseases, impacts on healthy food and clean water access, injury and death due to severe storms and flooding, vector-borne and water-borne disease, and stress and mental trauma from loss of livelihoods, property loss, and displacement. Climate change is considered the greatest global public health threat of the 21st Century and is impacting human health now. In California, communities across the State have responded to increasing, and sometimes devastating, health impacts associated with climate change in recent years, including injury, illness, and death from wildfires and wildfire smoke, extreme heat, drought, landslides, extreme weather events, vector-borne diseases, and associated mental health impacts. Climate change affects every Californian, but it harms those already facing inequities first and worst, including certain communities of color, immigrants, people with disabilities, people inadequately housed, pregnant people, and the very young and elderly, among others. Local health departments (LHDs) and Tribal health programs are on the front lines preparing for and responding to the health impacts of climate change; however, many express the need for increased public health resources to adequately address the crisis. Health departments and Tribal health program staff have extensive knowledge of their communities and are well-positioned to advance health and equity while preventing the most dire exposures and health impacts of climate change through planning, coordination, and additional resources

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. Extreme heat kills more people directly than any other climate-related health hazard.

Baseline value of the key indicator described above: 1.65 hospitalizations per 100,000 population (age-adjusted) in California.

Data source for key indicator baseline: Tracking California, Heat-related hospitalizations by county, 2000-2019

Date key indicator baseline data was last collected: 2019

Program Strategy

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

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

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

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

Primary Strategic Partners

External:

1. 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 receiving 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:* 39,538,223
- *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? Yes

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

Objectives and Activities

Objective 1:

Title: Support CDPH Programs to Address Climate Change and Health

Objective: Between 07/2022 and 06/2023, Program will increase the number of CDPH programs that incorporate climate change considerations into their health programs, plans, policies, or communications from 12 to 15.

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

Intervention Information

Program will provide data, tools, and expertise to State public health and California Health and Human Services Agency programs to incorporate climate change objectives and considerations into their health programs, plans, policies, and communications. The intervention will include meetings with interested program staff from different CDPH programs and other departments in the California Health and Human Services Agency to collaboratively identify and assess needs for support, develop program and activity plans, and facilitate resource and experience sharing on strategies to address climate change. Program will provide technical assistance that includes the utilization of data sources and other tools that assess climate and health vulnerability and social determinants of health to inform program planning and resource allocation. In addition, Program will provide support by advising in the design and dissemination of messaging and communications regarding climate change, such as fact sheets, health warnings, and communicating program objectives.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Model Practices Database (National Association of City and County Health Officials)
- Other: CDC Climate & Health Program, APHA Climate/Health LHDs Guide, CDPH Climate & Health Equity Section

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

- *Item to be measured:* Programs that incorporate climate change considerations into their health programs, plan, policies, and/or communications.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 12
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 03/18/2022
- *Interim target value to be achieved by the Annual Progress Report:* 13
- *Final target value to be achieved by the Final Progress Report:* 15

Target Population

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

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

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

Activity 1

Host Cross-CDPH Climate Change Collaboration Meetings. Between 07/2022 and 06/2023, 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.

Description of Activity: Between 07/1/2022 and 06/30/2023, 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?* No
- *Does the data collection involve public health data?* No

Activity 2

Provide Technical Assistance to CDPH Programs. Between 07/2022 and 06/2023, Program will provide technical assistance to CDPH programs regarding climate change in the forms of communications, fact sheets, health warnings, and program objectives.

Description of Activity: Between 07/1/2021 and 06/30/2022, The Health Program Manager I will be responsible to provide technical assistance to CDPH programs to integrate climate change messages, metrics, and considerations into program communications, fact sheets, health warnings, and program objectives.

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

Activity 3

Provide Data and Vulnerability Assessment Tool Assistance to CDPH Programs. Between 07/2022 and 06/2023, 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 (e.g., Climate Change and Health Vulnerability Indicators and Healthy Places Index) in prioritizing resources or program planning.

Description of Activity: Between 07/1/2022 and 06/30/2023, 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 (e.g., Climate Change and Health Vulnerability Indicators and Healthy Places Index) in prioritizing resources or program planning.

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

Objective 2:

Title: Support LHD Programs to Address Climate Change and Health

Objective: Between 07/2022 and 06/2023, Program will increase the number of LHDs that incorporate climate change considerations into their health programs, plans, policies, or communications from 3 to 6.

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

Intervention Information

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Model Practices Database (National Association of City and County Health Officials)
- Other: CDC Climate & Health Program, APHA Climate/Health LHDs Guide, CDPH Climate & Health Equity Section

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, plan, policies, and/or communications.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 3
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 03/18/2022
- *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? Yes

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

Activity 1

Support LHDs to Conduct Environmental Scans. Between 07/2022 and 06/2023, Program will provide technical assistance to LHDs to conduct environmental scans of local climate change planning activities, possible partners, gaps, and opportunities.

Description of Activity: Between 07/01/2022 and 06/30/2023, 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?* No
- *Does the data collection involve public health data?* No

Activity 2

Support Local Health Departments to Assess Climate and Health Vulnerability Data. Between 07/01/2022 and 06/30/2023, 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.

Description of Activity: Between 07/01/2022 and 06/30/2023, 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?* No
- *Does the data collection involve public health data?* No

Objective 3:

Title: Support Tribes to Address Climate Change and Health

Objective: Between 07/2022 and 06/2023, Program will provide technical assistance and work with Tribal partners to increase the number of California Tribes or Tribal health programs that incorporate climate change considerations into their health programs, plans, policies, and/or communications from two (2) to four (4). Alternatively, California Tribes or Tribal Health Programs may incorporate health equity considerations into climate change or environmental programs, plans, policies, and/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? The problem is the same.

Intervention Information

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

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

- *Item to be measured:* Tribes or Tribal health programs that incorporate climate change considerations into their health programs, plans, policies, and/or communications, and/or that incorporate health into climate change programs, plans, policies, and/or communications.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 2
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 03/18/2022
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 4

Target Population

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

- *Target population data source*: Indian Health Service (IHS)
- *Number of people served:* 631,016
- *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 Tribal territories, Tribal clinics, and Tribal 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? Yes

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

Activity 1

Technical assistance to Tribes to integrate climate change considerations into health plans and programs, and/or to incorporate health considerations into climate change programs, plans, policies, and/or communications. Between 07/2022 and 06/2023, the Tribal Program Specialist will assist two additional Tribes or Tribal health programs to integrate climate change considerations into their plans and programs, and/or to incorporate health considerations into climate change programs, plans, policies, and/or communications.

Description of Activity: Between 07/2022 and 06/2023, the Tribal Program Specialist will assist two additional Tribes or Tribal health programs on integrating considerations related to minimizing the health impacts of climate change into new or existing plans and programs, and/or to incorporate health considerations into climate change programs, plans, policies, and/or communications. The Tribal Program Specialist will assist Tribes in utilizing data tools, making data requests, and integrating local knowledge to assess Tribal communities' vulnerability to the health impacts of climate change, and to respond and prevent harms to health. Relevant plans might include comprehensive community plans, climate vulnerability assessments, climate adaptation plans, Tribal or Local Hazard Mitigation Plans (HMPs), or Community Health Improvement Plans (CHIPs).

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

Activity 2

Initiate a Community of Practice for Tribes or Tribal health organizations addressing the health impacts of climate change. Between 07/2022 and 06/2023, the Tribal Program Specialist will initiate and facilitate a Community of Practice for Tribes or Tribal health organizations to receive technical assistance, peer support, and share resources and tools to integrate climate change into health planning, and health into climate change planning.

Description of Activity: Between 07/2022 and 06/2023, the Tribal Program Specialist will initiate and facilitate a Community of Practice for Tribes or Tribal health organizations to receive technical assistance, peer support, and share resources and tools to integrate climate change into health planning, and health into climate change planning. The Community of Practice will convene via virtual meetings, calls, and/or an email list-serv. It will be convened at least three times during the year. Deliverables will include the distribution/participant list, agendas and notes from Community of Practice meetings or events, and any new climate and health planning resources generated by the Tribal Program Specialist for the Community of Practice such as a directory of relevant state and federal grant opportunities.

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

Activity 3

Hold a Public Health Workgroup public meeting on strategies Tribes can use to prevent and prepare for the health impacts of climate change. By June 30, 2023, the Tribal Program Specialist will help organize a Public Health Workgroup public meeting on strategies Tribes can use to prevent and prepare for the health impacts of climate change.

Description of Activity: By June 30, 2023, the Tribal Program Specialist will help organize a Public Health Workgroup public meeting (a sub-group of the California Climate Action Team) on strategies Tribes can use to prevent and prepare for the health impacts of climate change. Tools and templates will be showcased, as will the work of Tribes who have already addressed the health impacts of climate change. This will be at least a two-hour meeting, with virtual participation provided. The meeting will be recorded, and will provide closed captioning and/or American Sign Language interpretation to provide accessibility.

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

California Asylum Seeker Health Surveillance and Linkage to Care

Healthy People 2030 Objective

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

Health Objective

Between July 1, 2022 and June 30, 2023, 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: $214,000
- 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? 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: 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 2. 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: 28

Data source for key indicator baseline: Program FY 21-22

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)? Yes

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

Summary of Program Strategy: The California Asylum Seeker Health Surveillance and Linkage to Care program staff will promote the program among asylum seekers and legal and NGO service providers in 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 Francisco, DPH

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 seekers in the region.

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

Program Settings:

- Local health department

Target Population of Program

- *Target population data source*: TRACImmigration: Asylum Decisions; 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:* 150
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

- Asian
- Black or African American
- White

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban

Location:

- San Francisco County Public Health Department and Clinic

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

- Uninsured

Primarily Low Income: Yes

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

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

Objectives and Activities

Objective 1:

Title: Active Disease Surveillance of Asylum Seekers in California

Objective: July 1, 2022 and June 30, 2023, Program will collect 150 cases of asylum seeker health screening data including infectious diseases, immunizations and general demographic and heath data indicators.

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

Intervention Information

LHJs will utilize the Asylum Seeker Health Surveillance database in California to collect active surveillance data to identify diseases of public health concern and mental health conditions among asylum seekers. Between 07/2022 and 06/2023, ORH will provide technical assistance to LHJ to conduct active surveillance of approximately 150 asylum seekers annually for the monitoring and detection of infectious disease and mental health conditions, and prevention of vaccine-preventable diseases. This will include collection of specimen and health data, processing of labs, and review

and analysis of health and laboratory data. Data collection may also include follow-up to collect health data from primary or specialty care providers where patients have been linked to health services by LHJ. Patient health data will then be entered into the ASHS database where it will be accessible for program monitoring and disease surveillance reporting. The Asylum Seeker Health Surveillance database will be used to 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:* 150
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 2021
- *Interim target value to be achieved by the Annual Progress Report:* 50
- *Final target value to be achieved by the Final Progress Report:* 150

Target Population

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

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

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

Activity 1

Asylum Seeker Active Surveillance. Between 07/2022 and 06/2023, the ORH will provide technical assistance to LHJs to conduct active surveillance of approximately 150 asylum seekers annually for the monitoring and detection of infectious diseases and mental health conditions.

Description of Activity: Between 07/2022 and 06/2023, the ORH will provide technical assistance to LHJs to conduct active surveillance of approximately 150 asylum seekers annually for the monitoring and detection of infectious diseases and mental health conditions. This will include collection of specimen and health data, processing of labs, and review and analysis of health and laboratory data. Data collection may also include follow-up to collect health data from primary or specialty care providers where patients have been linked to health services by LHJs. Patient health data will then be entered into the ASHS database for asylum seekers where it will be accessible for program monitoring and disease surveillance reporting.

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

Activity 2

Maintain Health Data Collection. Between 07/2022 and 06/2023, Program will maintain data in the asylum seeker health surveillance system database (ASHS database), which is used to capture surveillance data and reports of infectious diseases of public health concern and mental health conditions among asylum seekers, and monitoring referrals for linkage to health care.

Description of Activity: Patient health data will be entered into the ASHS database for asylum seekers by local health jurisdictions. The ASHS database is used to capturing surveillance data and reports of infectious diseases of public health concern and mental health conditions among asylum seekers, and monitoring referrals for linkage to health care. Surveillance reports will be developed annually for distribution to local healthcare providers and public health.

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

Objective 2:

Title: Analyze and Publish Asylum Seeker Surveillance Data

Objective: Between July 1, 2022 and June 30, 2023, Program will analyze one (1) sample of asylum seeker health data and publish prevalence estimates.

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

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: 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: 7/1/2022

Intervention Information

Program will analyze asylum seeker health surveillance data and publish report. Between 07/2022 and 06/2023, Program will analyze data collected from the ASHS database to identify disease prevalence and trends and mental health conditions among newly arriving asylum seekers and distribute one (1) 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:* 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? Yes

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

Activity 1

Surveillance Data Analysis. Between 07/2022 and 06/2023, Program will analyze data collected from the enhanced RHEIS to identify disease prevalence and trends among asylum seekers in Southern California.

Description of Activity: Program will analyze data collected from ASHS database for asylum seekers to identify disease prevalence and trends and mental health conditions among newly arriving asylum seekers in California.

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

Activity 2

Report Production. Between 07/2022 and 06/2023, Program will produce a report summarizing disease prevalence and trends among asylum seekers in Southern California.

Description of Activity: Program utilizes analysis of data collected from the ASHS database for asylum seekers to identify disease prevalence and trends and mental health conditions among newly arriving asylum seekers in 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?* Yes
- *Does the data collection involve public health data?* Yes

Objective 3:

Title: Facilitate Linkage to Health Services for Asylum Seekers

Objective: Between 07/2022 and 06/2023, Program will provide health case management to 150 asylum seekers residing 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? 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 program 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:* 150
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 50
- *Final target value to be achieved by the Final Progress Report:* 150

Target Population

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

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

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

Activity 1

Linkage to Health Services. Between 07/2022 and 06/2023, LHJ programs will provide one-on-one case management services for linkage to healthcare to 150 asylum seekers.

Description of Activity: Between 07/2022 and 06/2023, LHJ program will provide one-on-one case management services to 150 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?* Yes
- *Does the data collection involve public health data?* Yes

Activity 2

Continuity of Healthcare. Between 07/2022 and 06/2023, LHJ program will provide case management for 150 referrals to health providers for asylum seekers in California.

Description of Activity: Between 07/2022 and 06/2023, LHJ program will provide case management for 150 referrals to health providers for asylum seekers in California.

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

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: Call Center Program – Abt Associates, Inc
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of total funding that is PHHS Grant: 10-49% - Partial source of funding
- Existing funding source(s): 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

One paragraph the 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 provides 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 has been collected for survey year 2021.

Program Strategy

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

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

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- 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: CA BRFSS Program will follow methodology provided by the CDC for the collection of BRFSS data which is used for all 50 states and territories.

Primary Strategic Partners

External:

1. American Cancer Society
2. Alzheimer's Association

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

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? Yes

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

Objectives and Activities

Objective 1:

Title: Maintain Statewide Collection and Analysis of BRFSS Data

Objective: From July 1, 2022 to June 30, 2012, Program will manage the integration of processes and services to the newly identified data collection partner to collect at least 8,000 BRFSS surveys.

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

Intervention Information

Manage transitioning of processes and services between call centers. CA BRFSS has identified a call center that can increase the number of completed surveys in California at a competitive price and that will provide datasets to BRFSS data users. CA BRFSS will be managing the integration of processes and services to the newly identified call center.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Managing the transition and integration of call center processes and services to the newly identified data collection partner will help with meeting CDC guidelines and timely submission of BRFSS data to the CDC

- *Item to be measured:* Completed surveys
- *Unit of measurement:* Number of surveys
- *Baseline value for the item to be measured:* 0

- *Data source for baseline value:* Data Collection Partner
- *Date baseline was last collected:* 07/01/2022
- *Interim target value to be achieved by the Annual Progress Report:* 4,000
- *Final target value to be achieved by the Final Progress Report:* 8,000

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? Yes

Is the entire target population disproportionately affected by the problem, or only part? 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, 2022 to June 30, 2023.

Description of Activity: Between 07/2022 and 06/2023, 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?* Yes
- *Does the data collection involve public health data?* Yes

Activity 2

Provide Data to BRFSS Users. Program will provide data sets to external and internal BRFSS data users from July 1, 2022 to June 30, 2023.

Description of Activity: Program will provide one CA BRFSS data set to external and internal BRFSS data users by September 1, 2022.

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

Objective 2:

Title: Analyze BRFSS Data

Objective: Between 07/2022 and 06/2023, Program will analyze 1 set of core questions on the annual BRFSS survey.

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

Intervention Information

CA BRFSS Program has full-time research scientist to analyze BRFSS data. A full-time research scientist will analyze 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:* Dashboard deployment.
- *Unit of measurement:* Deployment of analytical dashboard
- *Baseline value for the item to be measured:* 1
- *Data source for baseline value:* CA BRFSS data, 2015-2020
- *Date baseline was last collected:* 7/1/2022
- *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? Yes

Is the entire target population disproportionately affected by the problem, or only part? 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, 2022 to June 30, 2023.

Description of Activity: Between 07/2022 and 06/2023, 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?* Yes
- *Does the data collection involve public health data?* Yes

Activity 2

Produce Four Factsheets. Between July 1, 2022 and June 30, 2023, Program will, upon completion of analysis, produce four factsheets.

Description of Activity: Between 07/2022 and 06/2023, 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?* Yes
- *Does the data collection involve public health data?* 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 10/01/2023, hypertension control will be increased by 5% from 58% to 63%, 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? 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: 8
- Number of FTEs in this program funded by the PHHS Block Grant: 3.45

Position #1

Position Title:	Health Program Manager II
Staff Name in Position:	Lisa E. Rawson, MA
Jurisdiction-level [% time]:	50
Total [% time]:	50

Position #2

Position Title:	Research Scientist III
Staff Name in Position:	Dharma Bhatta, PhD, MPH
Jurisdiction-level [% time]:	50
Total [% time]:	50

Position #3

Position Title:	Health Program Specialist II
Staff Name in Position:	Kaye Pulupa, MPH
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #4

Position Title:	Staff Services Manager I
Staff Name in Position:	LeeAnn Velasquez
Jurisdiction-level [% time]:	25
Total [% time]:	25

Position #5

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Myrna Lim
Jurisdiction-level [% time]:	50
Total [% time]:	50

Position #6

Position Title:	Associate Governmental Program Analyst
Is this position vacant:	Yes
Jurisdiction-level [% time]:	20
Total [% time]:	20
Briefly describe recruitment/hiring plan:	Currently recruiting, should be completed by May 1, 2022

Position #7

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Michael Radman
Jurisdiction-level [% time]:	30
Total [% time]:	30

Position #8

Position Title:	Research Scientist Supervisor
Staff Name in Position:	Catrina Taylor, PhD, MSPH
Jurisdiction-level [% time]:	20
Total [% time]:	20

Issue/Problem

Heart disease and stroke are the first and third leading causes of death and disability in California (CA); the Cardiovascular Disease Prevention Program (CDPP) will work to increase HTN control thereby reducing morbidity and mortality associated with coronary heart disease and stroke in CA. Heart disease and stroke are the first and third leading causes of death in CA and a major cause of disability. In 2020, an estimated 66,538 Californians died from heart disease and 17,916 from stroke (CDC Wonder, 2020). 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 2020 age-adjusted prevalence rate of hypertension in adults 18 and older was 22.7% (California Health Interview Survey [CHIS 2020], any heart disease 5.6 [CHIS 2020], and stroke 2.6 (Behavioral Risk Factor Surveillance System [BRFSS 2020]).

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: HDS-02: 84.8 per 100,000; HDS-05: 22.7%; HDS-03: 39.1 per 100,000; stroke hospitalization: 2.17%

Data source for key indicator baseline: Prevalence (HDS-05): California Health Interview Survey and Behavioral Risk Factor Surveillance System. Mortality (HDS-03 and HDS-03): CDC WONDER. California Vital Statistics Data. California Department of Healthcare Access and Information (HCAI), Patient Discharge Data, 2019

Date key indicator baseline data was last collected: 2020

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)? 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 patients achieve better hypertension control. Better control of blood pressure will reduce deaths from coronary artery disease and strokes from recurring heart attacks and strokes and will 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. ST-Elevation Myocardial Infarction (STEMI) and Stroke Advisory Committee with Emergency Medical Services Agency (EMSA)
4. California Department of Health Care Services (DHCS)

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 team-based care CMM pilot project for control of hypertension in post-stroke patients 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), 2020; California Health Interview Survey (CHIS), 2020
- *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? Yes

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

Objectives and Activities

Objective 1:

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

Objective: Between 07/2022 and 06/2023, increase hypertension control and reduce stroke recurrence through CMM in approximately 60% (18 people) of post-stroke adults discharged from hospital care.

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

Problem for this Objective: **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 percentage in CA.

Baseline value for the key indicator: 2.17

Data source for key indicator baseline: HCAI, 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 an attending physician, community pharmacist, stroke coordinator, and community health worker. This CMM pilot project will be carried out by CDPP staff working in collaboration with 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 the CMM pilot.

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: CMM is evidence-based 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:* Number of post-stroke patients referred to CMM with blood pressure under control after 90 days under CMM.
- *Unit of measurement:* Number of post-stroke patients referred
- *Baseline value for the item to be measured:* 0
- *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:* 7/1/2022
- *Interim target value to be achieved by the Annual Progress Report:* 12
- *Final target value to be achieved by the Final Progress Report:* 18

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? Yes

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

Activity 1

Implement Hospital CMM Referral System for Post-Stroke Patients Upon Discharge. Between 07/2022 and 06/2023, 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 CHWs.

Description of Activity: CDPP staff, with support from CSUS contract staff, will convene CA CMM pilot project subcommittee meetings 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 an 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 07/2022 and 06/2023.

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

Activity 2

Incorporate/Integrate CHWs in the CMM Patient Care Team. Between 07/2022 and 06/2023, CDPP will collaborate with CHW/promotoras to facilitate incorporation of CHWs into 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?* No
- *Does the data collection involve public health data?* No

Activity 3

CMM Implementation Workgroup Meetings. Between 07/2022 and 06/2023, 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.

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 2023. CDPP staff will develop minutes from each meeting, and resources will be shared via stakeholder email distribution listservs. The timeframe is one meeting quarterly.

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

Objective 2:

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

Objective: Between 07/2022 and 06/2023, CDPP will coordinate with the AHA co-chair and HHC to develop and conduct two (2) webinars presenting best practices protocols, team-based care models, and improvements in Health Information Technology for improved management of cardiovascular disease statewide.

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

Intervention Information: **Conduct informative webinars for improved management of CVD in coordination with HHC**. HHC is administered by CDPP and co-chaired by AHA 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. 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, including 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
- *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? Yes

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

Activity 1

Develop and Conduct Two Webinars on Best Practice Protocols on CVD Prevention and Management. Between 07/2022 and 06/2023, 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.

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 staff will develop and conduct these webinars between 07/2022 and 06/2023.

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

Activity 2

Update HHC Membership Packet to Incorporate Updated Goals and Links to CVD Data and Health Resources. Between 07/2022 and 06/2023, CDPP will update the HHC new membership packet to ensure that the goals align with Healthy People (HP) 2030.

Description of Activity: CDPP will update the HHC new membership packet to ensure that links to relevant CVD health resources and fact sheets and CVD prevalence are listed and that the goals align with HP 2030. CDPP will update the membership packet between 07/2022 and 06/2023.

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

Activity 3

Create CDPP Webpage on CDPH Website. Between 07/2022 and 06/2023, Program will create CDPP webpage on CDPH website and include information on each state plan objective and links to CVD and stroke resources.

Description of Activity: By summer 2023, program will create a CDPP webpage on the CDPH website, helping to increase public awareness of CVD and stroke through providing resources and information. The CDPP webpage will also provide resources to health professionals. The deliverable is the CDPP webpage.

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

Activity 4

Promote CVD and Stroke Awareness through Educational Campaign using the CDPH-established social media channels. Between 07/2022 and 06/2023, CDPP will develop social media messaging for CDPH social media channels to increase public awareness of CVD and stroke through promotion of health resources.

Description of Activity: Between 07/2022 and 06/2023, CDPP will develop social media messages for CDPH social media channels to increase public awareness of CVD and stroke through promotion of health resources. The deliverable is one social media message per quarter.

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

Objective 3:

Title: California Cardiovascular Disease and Stroke Prevention and Treatment Master Plan Update

Objective: Between 07/2022 and 06/2023, CDPP will coordinate with subject matter experts by conducting two (2) quarterly steering committee meetings to update the California Heart Disease and Stroke Prevention and Treatment Master Plan (2007-2015).

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

Intervention Information

Provide updates to the Master Plan (2007-2015) based on new research and cardiovascular health data, practices, and guidance. The original CVD and Stroke Prevention and Treatment 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 and updates by the CVD Master Plan Steering Committee that was formed in FY 2021-2022, which consists of subject matter experts, cardiovascular health partners, and stakeholders. 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)

Rationale for choosing the Intervention: The updated CVD 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:* Committee meetings
- *Unit of measurement:* Number of committee meetings
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* HCAI, Vital Statistics, CA BRFFS, and CHIS as needed. Literature on CMM.
- *Date baseline was last collected:* 2014
- *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? Yes

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

Activity 1

Convene CVD Master Plan Steering Committee Meetings. Between 7/2022 and 6/2023, Program staff will plan, organize, and hold strategic planning meetings to bring together cardiovascular health partners, stakeholders, and medical and health professionals to review and assess the original CVD Master Plan for needed updates.

Description of Activity: By spring 2023, CDPP staff, with support from CSUS, will plan and convene two steering committee meetings for cardiovascular health partners, medical professionals, and public health stakeholders (steering committee chair identified and steering committee formed in FY 2021-2022) to review and discuss the original CVD Master Plan, assign roles and responsibilities, determine approach objectives, and schedule milestone timeline meetings for updating the CVD 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?* No
- *Does the data collection involve public health data?* No

Activity 2

Finalize CVD Action Plan Revisions. Between 07/2022 and 06/2023, CDPP staff, with support from the CVD Action Plan Steering Committee, will finalize changes to the Master plan objectives, goals, recommendations, and data.

Description of Activity: By summer 2023, CDPP staff and the CVD Master Plan Steering Committee will finalize the CA Master Plan including the nine Master Plan goals, objectives, recommendations, and data. The deliverable for this activity is the updated CVD Master Plan.

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

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

Healthy People 2030 Objective

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

Health Objective

Between 07/2022 and 06/2023, Emergency Medical Services Authority (EMSA) will maintain one Emergency Medical Services (EMS) Prehospital Data and Information Services and Quality Improvement Program by providing statewide collection and analysis of patient-level EMS data from emergency medical services systems and quality improvement measuring and patient care assessments based on 911 call volume indicated in EMS Plan submissions.

Program Funding Details

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

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 5
- Number of FTEs in this program funded by the PHHS Block Grant: 4.5

Position #1

Position Title:	Staff Services Manager I
Staff Name in Position:	Adrienne Kim
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #2

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Michelle McEuen
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #3

Position Title:	Research Program Specialist I
Staff Name in Position:	Victoria Lupinetti
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #4

Position Title:	Associate Governmental Program analyst
Staff Name in Position:	Ashley Stewart
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #5

Position Title:	Health Program Manager II
Staff Name in Position:	Tom McGinnis
Jurisdiction-level [% time]:	50
Total [% time]:	50

Issue/Problem

The California Emergency Medical Services Information System (CEMSIS), the statewide data repository for EMS data, receives voluntary EMS data from the local EMS agencies (LEMSAs) in a two-tiered system which reduces the quality of data received. Determining morbidity and mortality rates is complicated by the State's data-collection system. The best use of mortality and morbidity rates is to provide a meaningful tool to support infrastructure development, such as roads, schools, hospitals, and power and water utilities. Optimally, data from local areas would be available in a timely and easily accessible manner; however, California does not have an enforceable mandate for the electronic collection or submissions of patient-care information by local agencies to EMSA and with the two-tiered system, each jurisdiction has their own policies and procedures. Therefore, participation in data-related activities by local stakeholders is voluntary. EMSA has worked with stakeholders and software vendors to develop state data standards, and adopt national data standards, and continues to encourage local participation in the state database system, CEMSIS. Although EMS data may exist at the EMS provider, trauma center, or LEMSA level, statewide data is not captured centrally. Thus, the comprehensive collection of EMS data is limited and directly affects program efficacy in establishing QI measures and objectives.

Public health program was prioritized as follows:

- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: The Quality Core Measures develop 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 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.

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

Data source for key indicator baseline: Emergency Medical Services Authority

Date key indicator baseline data was last collected: 2021

Program Strategy

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

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

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

Primary Strategic Partners

External:

1. 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:

- State health department

Target Population of Program

- *Target population data source*: US Census Bureau, July 1, 2021
- *Number of people served:* 39,237,836
- *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? No

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

Objectives and Activities

Objective 1:

Title: EMS Prehospital Data and Information Services and Quality Improvement

Objective: Between 07/2022 and 06/2023, Program will increase accurate representation of EMS data for all LEMSAs that voluntarily submit data into CEMSIS which will unite the EMS system under a single data warehouse, fostering analyses on patient-care outcomes, public health system services, compliance with California state and federal EMS service laws, and provide measurable quality improvement resources to LEMSAs. Data submitted into CEMSIS will be analyzed and shared with LEMSAs to increase transparency. Program will provide technical assistance and outreach to the LEMSAs to encourage participation in CEMSIS while increasing transparency with a target of 165 engagements among the 34 LEMSAs.

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

Intervention Information

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention: National EMS Information System (NEMSIS)/National Highway Traffic Safety Administration

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

- *Item to be measured:* TA, outreach, and engagement with LEMSAs regarding data submissions into CEMSIS
- *Unit of Measurement*: Number of Email engagements with each LEMSA regarding data submissions into CEMSIS
- *Baseline value for the item to be measured:* 34
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 66

- *Final target value to be achieved by the Final Progress Report:* 165

Target Population

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

Primarily Low Income: No

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

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

Activity 1

Develop the Core Quality Measures Process Manual. Between 07/2022 and 06/2023, Program will develop one Core Quality Measures Process Manual.

Description of Activity: Between 07/2022 and 06/2023, Program will develop the Core Quality Measures Process Manual to include the lifecycle of measure adoption and re-specification; the approach to research and testing of measures; the project objectives, approach, deliverables, and approvals process; and all other relevant components of the project such as reporting and evaluating data results.

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

Activity 2

Develop the Annual Core Quality Measures Report. Between 07/2022 and 06/2023, 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.

Description of Activity: Between 07/2022 and 06/2023, Program will develop one summary report of all LEMSA Core Quality Measures data submitted for the previous calendar year to present data to the public and EMS stakeholders. If appropriate, the report will be published on the EMSA website.

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

Activity 3

Publish One EMS Data Report. Between 07/2022 and 06/2023, 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.

Description of Activity: Between 07/2022 and 06/2023, Program Staff will compile and analyze 100% of the EMS data set submitted by LEMSAs into the CEMSIS database and develop the annual CY 2021 EMS Report which will be published to the EMSA website by the 6/2023 deadline.

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

Activity 4

Send out LEMSA CEMSIS Letters. Between 07/2022 and 06/2023, Program will analyze EMS data for each LEMSA and provide a letter that outlines the previous year's data submission, providers and anticipated based on LEMSA's EMS Plans.

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

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

Activity 5

Data Matching Analysis Report. Between 07/2022 and 06/2023, Program will publish a Data Matching and Geocoding Report on the EMSA Website.

Description of Activity: Between 07/2022 and 06/2023, Program staff will publish a report on EMSA's website detailing the successes and outcomes of matching EMS data with outside data sources.

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

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

Healthy People 2030 Objective

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

Health Objective

Between 07/2022 and 06/2023, The Emergency Medical Services Authority (EMSA) will maintain one EMS Systems Division Operations and provide statewide coordination and leadership to Local EMS Agencies (LEMSAs) for the planning, development, and implementation of local EMS systems to determine the need for additional EMS, coordination of EMS, and effectiveness of EMS, assisting with adherence to California EMS statutes and regulations for optimum patient care. EMS Systems Division staff provide state leadership, oversight, and regulation to ensure the best quality of care is available, reducing the proportion of persons who are unable to obtain or delayed in obtaining necessary medical care in an emergency.

Program Funding Details

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

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 8
- Number of FTEs in this program funded by the PHHS Block Grant: 8.5

Position #1

Position Title:	Health Program Manager II
Staff Name in Position:	Tom McGinnis
Jurisdiction-level [% time]:	50
Total [% time]:	50

Position #2

Position Title:	Staff Services Manager I
Staff Name in Position:	Angela Wise
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #3

Position Title:	Management Services Technician
Staff Name in Position:	John Skarr
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #4

Position Title:	Health Program Specialist II
Staff Name in Position:	Elizabeth Winward
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #5

Position Title:	Health Program Specialist II
Staff Name in Position:	Farid Nasr, MD
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #6

Position Title:	Health Program Specialist I
Is this position vacant?	Yes
Staff Name in Position:	Farid Nasr, MD
Jurisdiction-level [% time]:	100
Total [% time]:	100
Briefly describe recruitment/hiring plan:	EMSA is currently in the process of recruiting for this position. The duty statement and RPA has been approved by DGS and is posted.

Position #7

Position Title:	Health Program Specialist I
Staff Name in Position:	Lisa Galindo
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #8

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Lori O'Brien
Jurisdiction-level [% time]:	100
Total [% time]:	100

Issue/Problem

The EMS Authority is charged with providing leadership in developing and implementing EMS systems throughout California and plays a central role in improving the quality of emergency medical services available for all Californians through its work with Local EMS Agencies (LEMSAs). California's emergency care is fragmented and emergency departments, ambulance transportation and trauma centers need effective coordination to avoid unmanaged patient flow. Training and certification of emergency medical technicians needs to consistently conform to national and state standards to ensure trained and qualified personnel are working the front lines of EMS. Critical-care specialists need to be available to provide emergency and trauma care for patients of all ages to ensure the emergency-care system is fully prepared to handle major disasters and pandemics.

Public health program was prioritized as follows:

- Other: Mandated by statute and regulation

Key Indicator(s) affected by this problem: 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: 34 LEMSAs serve all California residents. This includes six multicounty EMS agencies that service over 2/3 of the State's geographic region.

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2022

Program Strategy

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

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

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

Primary Strategic Partners

External:

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

Internal:

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

Planned non-monetary support to local agencies or organizations:

- Technical Assistance

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

Program Settings:

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

Target Population of Program

- *Target population data source*: US Census Bureau, July 1, 2021
- *Number of people served:* 39,237,863
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

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

Objectives and Activities

Objective 1:

Title: Maintain the EMS for Children Program

Objective: Between 07/2022 and 06/2023, 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. Program will provide technical assistance and advisory service to LEMSAs wishing to implement an EMSC program. 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. Review of at least 6 EMS Plans will be conducted to ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California.

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

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

Key indicator(s) affected by this problem: LEMSAs that have implemented 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: 2021

Intervention Information

Integrate EMSC into the overall EMS System. Program will provide technical assistance and advisory service to LEMSAs wishing to implement an EMSC program and ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California. Using 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

Evidence Source of Intervention:

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

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

- *Item to be measured:* EMS Plan review of EMSC and pediatric care components
- *Unit of Measurement*: Number of EMS Plans
- *Baseline value for the item to be measured:* 6
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 2021
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 6

Target Population

The target population of this Program SMART Objective is the 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? No

Activity 1

Host Educational Forum. Between 07/2022 and 06/2023, Program will provide education on trends in emergency medical care of pediatric patients.

Description of Activity: Between 07/2022 and 06/2023, Program will conduct one California EMSC Educational Forum to provide educational opportunities for EMS and hospital providers related to medical treatment of pediatric patients.

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

Activity 2

Provide Technical assistance to EMSC Programs. Between 07/2022 and 06/2023, Program will provide technical assistance to EMSC programs who have and are developing EMSC plans.

Description of Activity: Between 07/2022 and 06/2023, Program will provide technical assistance to at least four LEMSAs with EMSC program implementation in their jurisdiction. Technical assistance will be provided by email, phone, and resources on the EMSA website.

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

Objective 2:

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

Objective: Between 07/2022 and 06/2023, 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 34 LEMSA county/region trauma plans and is informed by CEMSIS-Trauma Registry data submissions from 80 trauma centers.

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

Program for this Objective: **Injuries from trauma and traumatic illness 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 34 LEMSA's have an approved trauma plan representing their EMS county/region. Only 28 LEMSAs (40 counties) have designated trauma centers. California has 80 designated trauma centers throughout the state. Key indicators are the number of LEMSAs with approved trauma plans.

Baseline value for the key indicator: 34

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2022

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

Rationale for choosing the Intervention: California's trauma system is comprised of 34 LEMSAs with 80 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 Programs
- *Unit of Measurement*: Number of trauma plan status updates reviewed from LEMSAs to include submission of trauma data
- *Baseline value for the item to be measured:* 34
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 16
- *Final target value to be achieved by the Final Progress Report:* 34

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? No

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

Activity 1

Review and Analyze Trauma Plan Status Updates (TSSRs). Between 07/2022 and 06/2023, Program will review and analyze LEMSA Trauma Plan Status Updates submitted to EMSA.

Description of Activity: Between 7/2022 and 6/2023, Program will analyze a minimum of 20 trauma plan status updates submitted to EMSA. Program will provide LEMSAs with feedback of analysis as part of EMS plan submission approvals/denials.

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

Activity 2

Collection of Trauma Registry Data. Between 07/2022 and 06/2023, Program will provide oversight of trauma registry data collection.

Description of Activity: Between 07/2022 and 06/2023, Program will oversee and coordinate the overall collection of trauma registry data into CEMSIS-Trauma from 80 trauma centers for a minimum of 80,000 trauma incidents.

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

Activity 3

Develop and Host a Virtual Trauma Summit Program. Between 07/2022 and 06/2023, Program will create and host a one-day, virtual Trauma Summit.

Description of Activity: Between 07/2022 and 06/2023, Program will create a one-day program with 4.5 hours of educational sessions and will seek subject matter guidance from the State Trauma Advisory Committee. EMSA staff host the event and coordinate with an accredited institution to provide Continuing Education (CEs) hours to eligible attendees.

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

Activity 4

Strengthen State Trauma System Development. Between 07/2022 and 06/2023, Program will facilitate State Trauma Advisory Committee meetings to promote the development of the state trauma system with trauma stakeholders.

Description of Activity: Between 07/2022 and 06/2023, Program will facilitate four quarterly meetings with State Trauma Advisory Committee members to continue in the development and implementation of the state trauma system.

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

Objective 4:

Title: Maintain EMS Partnership for Injury Prevention and Public Education

Objective: Between 07/2022 and 06/2023, 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. Inclusion of an EMS role in statewide prevention and public-education initiatives, programs, and policies will be used to evaluate the success of the overall program goal of ensuring the recognition of EMS as a vital partner in prevention and public-education activities. Prevention resources will be maintained on the Illness and Injury Prevention website, which is expected to receive 80 unique page views.

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

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: The number of EMS partners attending the Injury Prevention workshops at the Virtual Trauma Summit.

Baseline value for the key indicator: 450

Data source for key indicator baseline: Attendance at the 2021 Virtual Trauma Summit

Date key indicator baseline data was last collected: 10/07/2021

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: 2022 Standards

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

- *Item to be measured:* Usage of Injury Prevention and Public Information resources established by EMSA
- *Unit of Measurement*: Number of EMS Injury Prevention and Public Information program webpage visits
- *Baseline value for the item to be measured:* 88
- *Data source for baseline value:* Number of unique pageviews of website

- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 60
- *Final target value to be achieved by the Final Progress Report:* 80

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? No

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

Activity 1

Maintain EMS Partnership for Injury Prevention and Public Information Program webpage. Between 07/2022 and 06/2023, Program will maintain one injury and illness-prevention web page on the EMSA website.

Description of Activity: Between 07/2022 and 06/2023, 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-four links to ensure they are accessible, updated, and working.

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

Activity 2

Attend Trauma Managers Association of California (TMAC) General Membership meetings. Between 07/2022 and 06/2023, Program will attend three General Membership Meetings.

Description of Activity: Between 07/2022 and 06/2023, Program will attend three TMAC General meetings to provide leadership in the coordination of injury prevention activities at the local and regional level.

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

Objective 4:

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

Objective: Between 07/2022 and 06/2023, 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. Program will provide technical assistance to encourage LEMSAs without an existing STEMI Critical Care System to create one and become part of the system statewide and provide leadership to the LEMSAs with existing systems to improve the system based on the newest technology and evidence-based studies, on aspects of both clinical and system management to provide the highest level of care for STEMI patients. At least 75 stakeholder engagements will be conducted in the form of annual plan reviews, technical assistance emails, phone calls, meetings, and educational events.

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

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 STEMI Critical Care System Regulations.

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

Baseline value for the key indicator: 22

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2022

Intervention Information

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: AHA Guidelines' Mission Lifeline, the American College of Cardiology recs, National Institute of Health

Rationale for choosing the Intervention: Since the evidence-based care for this time-sensitive emergency is continually updated according to new literature, and the newest innovative technologies become available over time, it is essential to provide frequent educational updates and technical support for LEMSAs, specialty care centers, health care providers, public, and other stakeholders. This will increase the level of care and reduce morbidity and mortality for patients experiencing STEMI in California. 22 LEMSAs out of 34 have the approved standardized STEMI Critical Care System. Per regulations, LEMSAs who have implemented STEMI Critical Care Systems are required to submit an annual plan, to report any changes and the QI activities to the EMSA for approval; EMSA Staff program reviews to ensure the program is compliant with regulations.

- *Item to be measured:* Technical Assistance in interpretation of regulations, annual plan review, and other guidance provided to LEMSAs, etc.
- *Unit of Measurement*: Number of stakeholder engagements in the form of annual plan reviews, technical assistance emails, phone calls, meetings, and educational events
- *Baseline value for the item to be measured:* 75
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 40
- *Final target value to be achieved by the Final Progress Report:* 75

Target Population

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

Primarily Low Income: No

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

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

Activity 1

Provide Education on Current Trends for Optimal STEMI care. Between 07/2022 and 06/2023, California Emergency Medical Services Authority will conduct one State STEMI Summit.

Description of Activity: Between 07/2022 and 06/2023, Program will conduct one state STEMI Summit to educate Cardiologists, STEMI nurses, hospital registrars, paramedics, EMTs and administration staff on clinical and system aspects of care for STEMI patients with the newest and outcome report and study, to increase the level of care in California.

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

Activity 2

Facilitate and Coordinate Technical Advisory Committee (TAC) Meetings. Between 07/2022 and 06/2023, the TAC meets in a regular basis to advise EMSA Director and the STEMI program on all aspects of the specialty care systems.

Description of Activity: Between 07/2022 and 06/2023, Program staff facilitate and coordinate at least 4 virtual meetings each year to discuss the status of the state specialty care systems, receiving advice from the TAC to increase the level of care and improve the system for STEMI patients in California. This committee also has sub committees that meet separately as needed to plan the annual educational summit and related activities. The TAC also develops plans to improve the State STEMI data collection system to create QI activities at the state level in the future, which will be facilitated and organized by the EMSA program staff.

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

Activity 3

Review and Analyze STEMI Critical Care System Annual Plan. Between 07/2022 and 06/2023, Program will review and analyze LEMSA submitted STEMI Critical Care System Annual Plans.

Description of Activity: Between 07/2022 and 06/2023, Program will analyze a minimum of 11 STEMI Critical Care System Annual Plans submitted to EMSA. Program will provide LEMSAs with feedback of analysis as part of EMS plan submission approvals/denials.

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

Objective 5:

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

Objective: Between 07/2022 and 06/2023, 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. Program will provide technical assistance to encourage LEMSAs without an existing Stroke Critical Care System to create one and become part of the system statewide and provide leadership to the LEMSAs with existing systems to improve the system based on the newest technology and evidence-based studies, on aspects of both clinical and system management to provide the highest level of care for Stroke patients. At least 75 stakeholder engagements will be conducted in the form of annual plan reviews, technical assistance emails, phone calls, meetings, and educational events.

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

Program for this Objective: **Currently there is no Standardized Stroke Critical Care System Statewide.** Based on the California Title 22, Division 9, Chapter 7.2, the Stroke Critical Care System is not a mandatory program for LEMSAs, therefore, 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 required by regulations for each specific level of care for stroke patients.

Baseline value for the key indicator: 21

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2022

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

Rationale for choosing the Intervention: Since the evidence-based care for this time-sensitive emergency is continually updated according to new literature, and the newest innovative technologies become available over time, it is essential to provide frequent educational updates and technical support for LEMSAs, specialty care centers, health care providers, public, and other stakeholders. This will increase the level of care and reduce morbidity and mortality for patients experiencing stroke in California. 21 LEMSAs out of 34 have the approved standardized Stroke Critical Care System. Per regulations, LEMSAs with Stroke Critical Care Systems are required to submit an annual plan and report any changes and the QI activities to the EMSA for approval. EMSA Program staff reviews annual plans to ensure the program is in compliant with the regulations.

- *Item to be measured:* Technical assistance in interpretation of regulations, annual plan review, and other guidance provided to LEMSAs, etc.
- *Unit of Measurement*: Number of stakeholder engagements in the form of annual plan reviews, technical assistance emails, phone calls, meetings, and educational events
- *Baseline value for the item to be measured:* 75
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 40
- *Final target value to be achieved by the Final Progress Report:* 75

Target Population

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

Primarily Low Income: No

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

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

Activity 1

Provide education on Current Trends for Optimal Stroke care. Between 07/2022 and 06/2023, Program will conduct one State Stroke Summit.

Description of Activity: Between 07/2022 and 06/2023, 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?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Facilitate and Coordinate Technical Advisory Committee (TAC) Meetings. Between 07/2022 and 06/2023, the TAC meets in a regular basis to advise EMSA Stroke program on all aspects of the specialty care systems.

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

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

Activity 3

Review and Analyze Stroke Critical Care System Annual Plans. Between 07/2022 and 06/2023, Program will review and analyze LEMSA submitted Stroke Critical Care System Annual Plans.

Description of Activity: Between 07/2022 and 06/2023, Program will analyze a minimum of 11 Stroke Critical Care System Annual Plans submitted to EMSA. Program will provide LEMSAs with feedback of analysis as part of EMS plan submission approvals/denials.

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

Objective 6:

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

Objective: Between 07/2022 and 06/2023, 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. Program will conduct assessments of one CPCS in order to monitor poison control service activities provided to Californians. Program will review four (4) quarterly reports to ensure compliance with state standards for poison control services and contractual scope of work.

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

Program for this Objective: **Statute and regulations mandate a California poison control center (PCC) or regional PCC be designated by the EMSA.** EMSA has designated CPCS as the sole provider of poison control services for the State of California to reduce health care expenditures by preventing unnecessary ambulance transports and emergency department visits. CPCS manages an average of 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. Without CPCS services, emergency department visits would substantially increase.

Key indicator affected by this program: EMSA 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.

Baseline value for the key indicator: 4

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2022

Intervention Information

Increase quality patient-care outcomes through statewide coordination and leadership for the planning, development, and implementation of a CPCS. 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.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

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

- *Item to be measured:* Compliance with contractual requirements as reported in Quarterly reports received from CPCS
- *Unit of Measurement*: Quarterly reports
- *Baseline value for the item to be measured:* 4
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 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? No

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

Activity 1

Collect and Review Quarterly Report Submissions. Between 07/2022 and 06/2023, Program will provide oversight to one CPCS required to submit quarterly reports through coordination and technical assistance of quarterly report submissions with the CPCS Business Director, in accordance with statutory and regulatory authorities and contractual requirements.

Description of Activity: Between 07/2022 and 06/2023, 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?* Yes
- *Does the data collection involve public health data?* No

Objective 7:

Title: Maintain EMS Systems Planning and Oversight to LEMSAs

Objective: Between 07/2022 and 06/2023, Program will provide oversight to 34 LEMSAs required to submit annual EMS plans through coordination of EMS plan submission by LEMSA Administrators, technical assistance, and EMS plan determinations, in accordance with statutory and regulatory authorities. Program will review at least eight (8) EMS plans.

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

Intervention Information

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: 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:* EMS plans
- *Unit of Measurement*: One plan per LEMSA
- *Baseline value for the item to be measured:* 34
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 6
- *Final target value to be achieved by the Final Progress Report:* 8

Target Population

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

Primarily Low Income: No

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

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

Activity 1

Collect EMS Plan Submissions. Between 07/2022 and 06/2023, Program will provide oversight to 100% of LEMSAs required to submit annual EMS plans through coordination of EMS plan submission with LEMSA Administrators, technical assistance, and EMS plan determinations, in accordance with statutory and regulatory authorities.

Description of Activity: Between 07/2022 and 06/2023, Program is responsible for providing coordination, technical assistance, and developing annual EMS plan determinations to LEMSA Administrators.

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

Activity 2

Track and Monitor EMS Plans. Between 07/2022 and 06/2023, Program will provide coordination of receipt of EMS plan submissions from LEMSA Administrators, assignment of EMS plan reviews to EMS Authority subject matter experts, and overall tracking and monitoring of EMS plan review from receipt to decision to approve or deny.

Description of Activity: Between 07/2022 and 06/2023, Program will keep current and update one internal tracking log to reflect EMS plan activity, including receipt of EMS plans, status of active EMS plans within the EMS Authority, plan outcomes, coordination with LEMSA Administrators and staff, and collaboration with EMSA staff on EMS plan review, to ensure effective oversight of the internal EMS plan review process for timely, comprehensive, and effective plan development and decisions.

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

Activity 3

Collect and Review Quarterly Report Submissions. Between 07/2022 and 06/2023, Program will provide coordination and technical assistance to multicounty LEMSA Administrators.

Description of Activity: Between 07/2022 and 06/2023, Program will provide oversight to six multicounty LEMSAs required to submit quarterly reports through coordination and technical assistance of quarterly report submissions, in accordance with statutory and contractual authorities.

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

Activity 4

Review forms submitted as the transportation component of the EMS Plans. Between 07/2022 and 06/2023, 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.

Description of Activity: Between 7/2022 and 6/2023, Program will review and approve or deny the transportation components of an EMS Plan based on statute, regulation, and case law. The date is then tracked in a "transportation data spreadsheet".

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

Activity 5

Maintain LEMSA competitive process transportation service log. Between 07/2022 and 06/2023, Program will update internal service log to track contract start and end dates of the competitive processes.

Description of Activity: Between 07/2022 and 06/2023, Program will maintain one competitive process transportation log through a continuous update with each EMS Plan and competitive process approval/ denial. Log will be used monthly for formal LEMSA notification of status of exclusive rights.

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

Activity 6

Review LEMSA transportation competitive processes. Between 07/2022 and 06/2023, Program will review all competitive processes, regarding EOAs for transportation, as they come in.

Description of Activity: Between 07/2022 and 06/2023, Program will review at least one LEMSA competitive process for emergency ambulance services, regarding prospective EOAs and discuss any changes needed to approve the competitive process. EMSA's collaboration with LEMSAs promotes successful competitive bidding for local ambulance services, which in turn assures patient care during an emergency.

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

Activity 7

Assess LEMSA EMS Plan transportation component appeal hearing documents. Between 07/2022 and 06/2023, Program will review historical documentation for EMS Plan appeal hearings.

Description of Activity: Between 07/2022 and 06/2023, Program 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?* No
- *Does the data collection involve public health data?* No

Activity 8

Provide Technical Assistance. Between 07/2022 and 06/2023, Program will answer all email, phone calls, face-to-face inquiries dealing with EMS transportation questions.

Description of Activity: 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?* No
- *Does the data collection involve public health data?* 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 07/2022 and 6/2023, 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? 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: 4
- Number of FTEs in this program funded by the PHHS Block Grant: 3.35

Position #1

Position Title:	Health Program Specialist II
Job Vacant?	Yes
Jurisdiction-level [% time]:	100
Total [% time]:	100
Briefly describe recruitment:	Duty statements and job posting are in development and goal is to hire and onboard by summer 2022

Position #2

Position Title:	Health Program Specialist I
Staff Name in Position:	Chantel (Ann) Griffin
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #3

Position Title:	Health Program Specialist I
Job Vacant?	Yes
Jurisdiction-level [% time]:	100
Total [% time]:	100
Briefly describe recruitment:	Duty statements and job posting are in development and goal is to hire and onboard by summer 2022

Position #4

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Britt Higgins
Jurisdiction-level [% time]:	35
Total [% time]:	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: Poverty Rate (<200% FPL) and Child (under 18) Poverty Rate by California Regions - Poverty Fact Sheet - California Health and Human Services Open Data Portal

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)? 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*: Poverty Rate (<200% FPL) and Child (under 18) Poverty Rate by California Regions - Poverty Fact Sheet - California Health and Human Services Open Data Portal
- *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? Yes

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

Objectives and Activities

Objective 1:

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

Objective: Between July 1, 2022 to June 30, 2023, 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.

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

Intervention Information

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: Equity Alliance; Othering and Belonging Institute; HiAP Approach; COVID-19 Equity Playbook

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 that by providing the education and tools to CDPH and local health department staff that they will be better able to realize 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
- *Baseline value for the item to be measured:* 0

- *Data source for baseline value:* Internal Program Tracking
- *Date baseline was last collected:* 07/01/2022
- *Interim target value to be achieved by the Annual Progress Report:* 4
- *Final target value to be achieved by the Final Progress Report:* 8

Target Population

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

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

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

Activity 1

CDPH Equity Capacity. Between 07/2022 and 06/2023, Program will build CDPH capacity to promote equity in Policies, Systems, and Environment.

Description of Activity: Between July 1, 2022 and June 30, 2023, 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?* No
- *Does the data collection involve public health data?* No

Activity 2

LHD Equity Capacity. Between 07/2022 and 06/2023, Program will build LHD capacity to promote equity in Policies, Systems, and Environment.

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

Healthy People 2030 Program

Healthy People 2030 Objective

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

Health Objective

Between 07/2022 and 06/2023, the Healthy People Program (HPP) 2030 will implement one quality improvement (QI) process, using the CDC evaluation framework and the Plan Do Check Act (PDCA) QI model, to increase efficiency and effectiveness of the Preventive Health and Health Services Block Grant (PHHSBG)-funded programs.

Program Funding Details

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

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 6
- Number of FTEs in this program funded by the PHHS Block Grant: 4.25

Position #1

Position Title:	Staff Services Manager II
Staff Name in Position:	Steven Yokoi
Jurisdiction-level [% time]:	25
Total [% time]:	25

Position #2

Position Title:	Health Program Specialist II
Staff Name in Position:	Phu Hoang
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #3

Position Title:	Health Program Specialist I
Staff Name in Position:	Amy Yan
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #4

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Matthew Herreid
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #5

Position Title:	Staff Services Analyst
Staff Name in Position:	Erika Yuson
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #6

Position Title:	Management Services Technician
Staff Name in Position:	Heather Black
Jurisdiction-level [% time]:	10
Total [% time]:	10

Issue/Problem

Funding for public health in California is low, so there is a need to ensure that the PHHSBG is being utilized efficiently and effectively for state priorities. Funding for public health in California has been historically low. Annual per-capita spending for public health is approximately $286, and annual per-capita CDC funding for public health is $18.66 (Trust for America's Health, 2021). Consequently, there is a need to use public health dollars wisely. The COVID-19 pandemic on top of other emergencies over the past year, such as wildfires, further amplifies the importance of public health resources. California has the opportunity to use the PHHSBG for state priorities developed in conjunction with stakeholders. Once the funds have been allocated to critical public health programs, services, and activities, it is imperative that program statuses and outcomes are tracked and evaluated to assure that the funds are used in the most efficient and effective way possible. If there is a lack of progress or impact, decision makers will be alerted, and funds can be allocated elsewhere. With recent success in program quality improvement experienced this past year, HPP 2030 will continue to use the CDC evaluation framework and the QI Model- Plan Do Check Act, to analyze all PHHSBG-funded programs for further QI opportunities.

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: The number of 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: CDPH PHHSBG Final Annual Progress Report (APR)

Data source for key indicator baseline: FFY 2021 Final APR and QI Selection Criteria State Fiscal Year (SFY) 21/22

Date key indicator baseline data was last collected: 02/01/2022

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 we communicate current accomplishments.

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

Summary of Program Strategy: Utilizing the QI Model- PDCA Cycle to assess and evaluate all 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*: United States Census Bureau, 2021
- *Number of people served:* 39,237,836
- *Ethnicity:* Hispanic or Latino/ Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- All California counties

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

Objectives and Activities

Objective 1:

Title: Provide Programmatic and Fiscal Support to PHHSBG Funded Programs

Objective: Between 07/2022 and 06/2023, Program will provide continuous program and fiscal support, evaluation, and quality improvement opportunities to PHHSBG-funded programs by conducting at least four (4) training webinars.

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

Intervention Information

Provide Programmatic and Fiscal Support to PHHSBG Funded Programs. Providing continuous information, analysis and feedback to all PHHSBG-funded programs will help ensure the integrity of the PHHSBG program as well as 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

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

- *Item to be measured:* Webinars
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 2
- *Data source for baseline value:* Internal Program tracking
- *Date baseline was last collected:* 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? No

Activity 1

Perform QI Analysis of PHHSBG-Funded Programs. Between 07/2022 and 06/2023, HPP 2030 will analyze the PHHSBG FFY 2021 APR and Final APR to determine which program requires QI intervention most.

Description of Activity: 07/2022 and 06/2023, Program will analyze the PHHSBG FFY 2021 APR and Final APR, 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 program staff 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?* No
- *Does the data collection involve public health data?* No

Activity 2

Assist One PHHSBG-Funded Program on QI Process. Between 07/2022 and 06/2023, Program will provide at least one (1) QI training webinar to one PHHSBG-funded program.

Description of Activity: Between 07/2022 and 06/2023, Program will provide at least one QI training webinar to one (1) PHHSBG-funded program via virtual meetings. Additionally, Program will ensure quality improvement objectives are met by identifying key barriers program experienced in the past fiscal year and elicit potential alternatives to mitigate or avoid these barriers moving forward.

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

Activity 3

Provide Training Webinar on Monthly Expenditure Reporting. Between 07/2022 and 06/2023, Program will provide one (1) training webinar to all PHHSBG-funded programs to assist all programs in monitoring and tracking their monthly Block Grant expenditures.

Description of Activity: Between 07/2022 and 06/2023, Program will provide one (1) training webinar to assist all PHHSBG-funded programs in tracking their monthly Block Grant expenditures. The training consists of how to track monthly expenditures utilizing the Fi$Cal Online Reporting Environment, project planned expenses and corrections, and tracking specific program spending.

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

Activity 4

Provide Training Webinars on Annual Programmatic and Fiscal Deliverables. Between 07/2022 and 06/2023, Program will provide at least two (2) training webinars to all PHHSBG-funded programs to assist all programs to successfully complete their annual programmatic and fiscal deliverables per CDC requirements.

Description of Activity: Between 07/2022 and 06/2023, Program will provide at least two (2) training webinars to assist all PHHSBG-funded programs to successfully complete their annual programmatic and fiscal deliverables per CDC requirements. The webinars will focus on developing each program's Work Plan, APR, Final APR, and year-end closeout process.

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

Objective 2:

Title: Effectively Communicate Program Outcomes and Success

Objective: Between 07/2022 and 06/2023, Program will implement two (2) communication strategies to highlight the outcomes and successes of the PHHSBG-funded programs.

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

Intervention Information

Effectively communicate the program outcomes and successes to all internal and external stakeholders. Program will implement two communication strategies via email, webinars, or published documents on the Department's webpage to highlight program outcomes and successes.

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, outcomes, 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:* FFY 2021 APR; FFY 2021 Final APR; FFY 2021 QI Analysis
- *Date baseline was last collected:* 02/01/2022
- *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? No

Activity 1

Share FFY 2021 Final APR with Internal and External Stakeholders. Between 07/2022 and 06/2023, Program will share the FFY 2021 Final APR with all internal and external stakeholders.

Description of Activity: Between 07/2022 and 06/2023, Program will share the FFY 2021 Final APR with all internal and external stakeholders via email and/or virtual webinars to highlight all program statuses and outcomes for FFY 2021.

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

Activity 2

Share Program Success with Internal and External Stakeholders. Between 07/2022 and 06/2023, Program will share at least one (1) program success with all internal and external stakeholders.

Description of Activity: Between 07/2022 and 06/2023, Program will publish at least one (1) program success onto the CDPH PHHSBG webpage.

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

Injury Prevention Program

Healthy People 2030 Objective

IVP-01: Reduce fatal injuries

Health Objective

Between 07/2022 and 06/2023, Program will strive to reduce by 5% the crude rate of total, unintentional, and intentional injury deaths in California from the current 2020 rates (62.0, 44.7 and 15.9 per 100,000 California residents, respectively).

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: Health Department/Agency
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? No
- Funding role of the PHHS Block Grant for this program: Supplement other existing funds
- Percentage of funding for this program that is PHHS Block Grant: 10-49% - Partial source of funding
- Existing funding source(s): Other: 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: 9
- Number of FTEs in this program funded by the PHHS Block Grant: 5.325

Position #1

Position Title:	Health Program Manager II
Staff Name in Position:	Jeffery Rosenhall
Jurisdiction-level [% time]:	40
Total [% time]:	40

Position #2

Position Title:	Health Education Consultant III
Staff Name in Position:	Kate Bernacki
Jurisdiction-level [% time]:	50
Total [% time]:	50

Position #3

Position Title:	Health Education Consultant III
Staff Name in Position:	Elizabeth Jones
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #4

Position Title:	Health Program Specialist I
Staff Name in Position:	Karissa Anderson
Jurisdiction-level [% time]:	75
Total [% time]:	75

Position #5

Position Title:	Office Technician
Staff Name in Position:	Joseph Kinkead
Jurisdiction-level [% time]:	25
Total [% time]:	25

Position #6

Position Title:	Research Scientist III
Staff Name in Position:	Orion Stewart
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #7

Position Title:	Research Scientist III
Staff Name in Position:	Nana Tufuoh
Jurisdiction-level [% time]:	10
Total [% time]:	10

Position #8

Position Title:	Research Scientist II
Job Vacant?	Yes
Jurisdiction-level [% time]:	10
Total [% time]:	10
Briefly describe recruitment	Hiring processes is in progress w/ a closed date of 3/23/2022. This position has been revised from an RS II to a RS I

Position #9

Position Title:	Research Scientist III
Staff Name in Position:	Carolyn Zambrano
Jurisdiction-level [% time]:	10
Total [% time]:	10

Position #10

Position Title:	Health Program Specialist II
Staff Name in Position:	Clark Marshall
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #11

Position Title:	Health Program Specialist I
Staff Name in Position:	Mary Lackey
Jurisdiction-level [% time]:	10
Total [% time]:	10

Position #12

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Claudia Angela
Jurisdiction-level [% time]:	2.5
Total [% time]:	2.5

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) 25,000 deaths, (2) 285,000 hospital visits, and (3) 2 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 for three indicators: total injuries, unintentional injuries, intentional injuries.

Baseline value of the key indicator described above: Total = 62.0 per 100,000; Unintentional = 44.7 per 100,000; Intentional = 15.9 per 100,000

Data source for key indicator baseline: EpiCenter: California Injury Data Online at: http://epicenter.cdph.ca.gov.

Date key indicator baseline data was last collected: 2020

Program Strategy

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

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

- Economic Stability (e.g., poverty, unemployment, food insecurity, housing instability)
- Health and Health Care (e.g., poor access to healthcare, low health insurance coverage, low health literacy)
- Adverse Childhood Experiences (ACEs)
- 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 2023.

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

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

Program Settings:

- Local health department
- Medical or clinical site
- State health department
- Other: Senior residence or community; School-Based Health Centers

Target Population of Program

- *Target population data source*: California Department of Finance. Demographic Research Unit. Report *P-3: Population Projections, California, 2010-2060* (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021.
- *Number of people served:* 39,782,419
- *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? No

Objective 1:

Title: Preventing ACEs in California

Objective: By June 30, 2023, Program will increase availability of data and information on Adverse Childhood Experiences (ACEs) and Positive Childhood Experiences (PCEs) by engaging with internal and external partners to develop and disseminate one (1) data report or presentation and one (1) publication and update one (1) dashboard on Kidsdata.

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

Program for this Objective: **Current and relevant data are essential for 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. Reliable and current 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, presentations, or publications that are released by our program that address ACEs and detail PCEs. Collecting, analyzing, and disseminating the 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: Internal tracking of the number of materials released by program on childhood adversity and/or PCEs

Date key indicator baseline data was last collected: 2021

Intervention Information

Engage with partners to analyze 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 analyze and disseminate ACEs and PCEs data and information on prevention of childhood adversity.

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:

Rationale for choosing the Intervention: 2021 ACEs and PCEs BRFSS data will be available for analysis in the Fall of 2022 and Positive and Adverse Childhood Experiences (PACEs) stakeholders rely on these data to undertake prevention work at the state and local level. The EfC Initiative utilizes a collective impact model to undertake its work and therefore, engages PACEs stakeholders in analysis and dissemination of these important data.

- *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:* Internal tracking of reports and publications
- *Date baseline was last collected:* 7/1/2022
- *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 sub-set of the Program.

- *Target population data source*: California Department of Finance. Demographic Research Unit. Report P-3: *Population Projections, California, 2010-2060* (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021.
- *Number of people served:* 13,116,130
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- N/A

Education Attainment:

- Some High School

Health Insurance Status:

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

Primarily Low Income: No

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

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

Activity 1

Foster Collaboration to Prevent Childhood Adversity. Between 07/2022 and 06/2023, Program will partner with stakeholders to increase access to, analyze, and publish data and information on childhood adversity and PCEs.

Description of Activity: Between 07/2022 and 06/2023, 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 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?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Disseminate Childhood Adversity Data. Between 07/2022 and 06/2023, Program will meet with partners at least 2 times to plan activities and efforts necessary to analyze and disseminate data on KidsData.

Description of Activity: Between 07/2022 and 06/2023, program will work with staff from KidsData, a program of Population Reference Bureau (PRB), to add or update at least one relevant data set to inform prevention strategies and policies. The web-based data platform promotes the health and wellbeing 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?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Disseminate Childhood Adversity Data. Between 07/2022 and 06/2023, Program will publish or facilitate two reports or presentations on ACEs or PCEs in California.

Description of Activity: Between 07/2022 and 06/2023, program will publish or facilitate two data reports or presentations on ACEs or PCEs in California utilizing 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?* Yes
- *Does the data collection involve public health data?* No

Objective 2:

Title: Increase Capacity for Local Childhood Unintentional Injury Prevention Programs

Objective: By June 30, 2023, program will conduct at least fifty-four (55) technical assistance activities for the childhood unintentional injury prevention community and Kids' Plates grantees to increase knowledge, best practice programs, and partnership efforts across California.

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

Program for this Objective: **Children under the age of 19 are at high risk for unintentional injury and death and rely on caregivers, their environments, and policies to protect them.** According to the CDC, unintentional injury is the leading cause of death to children ages 1-19, and third most common for children under 1. In 2019, 7,444 youth ages 0-18 died from unintentional injuries in the United States, while millions more children suffered from injuries requiring treatment in the emergency department. Leading causes of child injury include motor vehicle crashes, suffocation, drowning, poisoning, fires, and falls. Child injury is predictable and preventable, and it's also among the most under-recognized public health problems. 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: Children/youth die from unintentional injury in disproportionate numbers. As such, we will track the number and rate of children who die as the result of unintentional injuries.

Baseline value for the key indicator: 1,693 unintentional injury deaths, or 5.7 deaths per 100,000 persons, among Californian children under age 19.

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

Date key indicator baseline data was last collected: 2018-2020

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 (58) rely on CDPH to provide childhood unintentional injury prevention research, program best practice and when possible safety equipment and funding.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Aligns with the National Action Plan from CDC.

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

- *Item to be measured:* Technical assistance opportunities including 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:* Internal tracking of number of TA activities
- *Date baseline was last collected:* 07/01/2022
- *Interim target value to be achieved by the Annual Progress Report:* 27
- *Final target value to be achieved by the Final Progress Report:* 55

Target Population

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

- *Target population data source*: California Department of Finance Demographic Research Unit. Report P-3: Population Projections, California, 2010-2060 (Baseline 2019 Population Projections; Vintage 2020 Release). Sacramento: California. July 2021.
- *Number of people served:* 13,116,130
- *Ethnicity:* Hispanic or Latino, Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

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? Yes

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

Activity 1

Website Development. Between 07/2022 and 06/2023, Program will update and maintain one (1) Kids' Plates website on the CDPH website to provide unintentional childhood injury research and resources.

Description of Activity: 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?* No
- *Does the data collection involve public health data?* No

Activity 2

Quarterly Webinars. Between 07/2022 and 06/2023, Program will facilitate quarterly childhood unintentional injury prevention webinars to Kids' Plates grantees.

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

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

Activity 3

Technical Assistance to Kids' Plates Grantees Between 07/2022 and 06/2023, Program will provide fifty total (50) technical assistance activities for Kids' Plates grantees for program development and childhood unintentional injury prevention expertise to enhance and maintain program interventions and activities.

Description of Activity: CDPH program staff will provide a total of fifty (50) individual technical assistance activities for the Kids' Plates grantees (7 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?* No
- *Does the data collection involve public health data?* No

Objective 3:

Title: Healthy Aging Initiative

Objective: By June 30, 2023, Healthy Aging Initiative will provide at least thirty-one (31) technical assistance activities to support healthy aging across California Department of Public Health and partner organizations.

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

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: As mentioned in the problem statement above, older adult deaths are affected disproportionately by a variety of chronic disease conditions. As such, we will track number and rate of older adult deaths.

Baseline value for the key indicator: The total number of deaths from all causes for older adults aged 55 and older was 277,546 (2,437 per 100,000).

Data source for key indicator baseline: CHHS Statewide Death Data

Date key indicator baseline data was last collected: 2020

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:* Internal Activity Tracking Log
- *Date baseline was last collected:* 07/01/2022
- *Interim target value to be achieved by the Annual Progress Report:* 10
- *Final target value to be achieved by the Final Progress Report:* 31

Target Population

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

- *Target population data source*: Department of Finance (2021).
- *Number of people served:* 11,432,213
- *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? Yes

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

Activity 1

Convene Healthy Aging Stakeholders. Between 07/2022 and 06/2023, Program will convene state and local public health leaders to: 1) strategize and share best practices around older adult and caregiver health; and 2) provide educational resources with an emphasis on health equity.

Description of Activity: Building upon past grant efforts, the Healthy Aging Initiative staff will plan and coordinate a minimum of one (1) virtual convening for state and local public health leaders by June 30, 2023. The convening(s) will highlight leaders in the aging field who will present their work in older adult and caregiver health with the goal of engaging statewide stakeholders (participants) in proactive discussion.

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

Activity 2

Expand Partnerships With Healthy Aging Stakeholders. Between 07/2022 and 06/2023, Healthy Aging Initiative will strengthen the relationships with internal and external healthy aging partners by coordinating/participating in at least twenty-five (25) related meetings.

Description of Activity: Between 07/2022 and 06/2023, Healthy Aging Initiative staff will strengthen internal and external relationships with healthy aging partners through 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?* No
- *Does the data collection involve public health data?* No

Activity 3

Conduct Technical Assistance on Healthy Aging Programs and Resources. Between 07/2022 and 06/2023, program will provide five (5) technical assistance consultations to advise state agencies, LHJs, community agencies, or members of the public, and via telephone/e-mail.

Description of Activity: Between 07/2022 and 06/2023, 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?* No
- *Does the data collection involve public health data?* No

Objective 4:

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

Objective: By June 30, 2023, program will increase access to its injury surveillance data by making recent motor vehicle traffic (MVT) crash, medical outcomes, and fatality data available via creation of one (1) data product/resource and provision/completion of at least six (6) related technical assistance (TA) 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? The problem is the same.

Intervention Information

Program will use currently available traffic and medical outcomes data to create a data-focused resource and provide related technical assistance for data partners, local health jurisdictions, and traffic safety stakeholders. Program will analyze available traffic crash and injury/medical outcomes data and translate relevant findings into actionable information (i.e., a data brief and technical assistance) for stakeholders, traffic safety partners, local health jurisdictions, and the general public. The data brief will include an overview of relevant findings and associated recommendations. Technical assistance may include participation in calls/meetings, responses to queries, and/or presentations made to various groups.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

Rationale for choosing the Intervention: The resource and technical assistance that will be developed and provided will help bring a public health perspective to injury surveillance and traffic safety work. These resources will provide useful information to help guide the implementation of preventive measures in reducing serious injuries and death among Californians involved in traffic crashes.

- *Item to be measured:* Resources produced; technical assistance (TA) activities
  Unit of measurement: Number of resources produced; number of TA activities provided
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Internal tracking system
- *Date baseline was last collected:* 07/01/2022
- *Interim target value to be achieved by the Annual Progress Report:* 4

- *Final target value to be achieved by the Final Progress Report:* 7

Target Population

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

Activity 1

Data Brief on traffic patterns, crashes, and medical outcomes. Between 07/2022 and 06/2023, Program will analyze data on traffic patterns, crashes, and medical outcomes and develop a data brief to share relevant results.

Description of Activity: By June 30, 2023, program will have analyzed data on traffic patterns, rates of crashes, and medical outcomes to identify a topic of focus and outline results to highlight within a data brief. One data brief describing these findings will be produced.

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

Activity 2

Technical assistance (TA) to support use of crash and medical outcomes data. Between 07/2022 and 06/2023, Program will provide TA to relevant entities focused on use of crash and medical outcomes data for injury prevention purposes.

Description of Activity: By June 30, 2023, program will complete at least six (6) TA activities focused on use of crash and medical outcomes data for injury prevention purposes. TA activities may include participation in calls/meetings, responses to queries, and/or presentations made to various groups. TA audiences include stakeholders, data partners, local health jurisdictions, and others working to prevent injury and death that may result from motor vehicle traffic collisions.

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

Objective 5:

Title: Update and Expand EpiCenter

Objective: By June 30, 2023, IVPB will Increase accessibility of timely statewide injury surveillance data by updating its EpiCenter online injury surveillance dashboard to include the most recent death, hospital, and emergency department injury surveillance data. Furthermore, by June 30, 2023, IVPB will expand upon EpiCenter by publishing a similar online data dashboard on the specific topic of firearm injuries. These updates are intended to increase EpiCenter usage, resulting in an average of 36 data queries per day.

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

Intervention Information

Empower injury prevention stakeholders across the state with timely, relevant, and easy-to-use data. EpiCenter is the IVPB's online injury surveillance dashboard. In the FFY 2021 State Plan year, IVPB staff are upgrading EpiCenter to feature a more user-friendly interface and various interactive data visualization tools. In the FFY 2022 State Plan year, IVPB will keep the new EpiCenter site up to date by adding the most recent data sources for fatal and non-fatal injury surveillance. IVPB will also expand its injury surveillance dashboard offerings by publishing a new dashboard on the specific topic of firearm injury prevention. The firearm injury prevention dashboard will allow users to easily access and explore multiple relevant data sources on firearm injuries and risk and protective factors. These dashboards will make injury prevention data insights more accessible, supporting injury prevention stakeholders with key information to inform interventions.

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 and other dashboards, IVPB can support myriad interventions across California, helping practitioners identify and respond to emerging injury and violence trends.

- *Item to be measured:* IVPB online data dashboard data queries
- *Unit of measurement:* Total data queries per day

- *Baseline value for the item to be measured:* 30
- *Data source for baseline value:* EpiCenter report log
- *Date baseline was last collected:* 12/2021
- *Interim target value to be achieved by the Annual Progress Report:* 33
- *Final target value to be achieved by the Final Progress Report:* 36

Target Population

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

Activity 1

Update EpiCenter Data. Between 07/2022 and 06/2023, Program will process and upload to EpiCenter the most recently available injury data from three (3) injury data sources: death, hospital, and emergency department visits.

Description of Activity: IVPB receives annual files for California deaths, hospital visits, and emergency department visits from state partners. By June 30, 2023, IVPB research staff 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.

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

Activity 2

Firearm injury prevention data dashboard. Between 07/2022 and 06/2023, Program will publish one (1) online data dashboard on the topic of firearm injury prevention.

Description of Activity: By June 30, 2023, IVPB staff will publish one (1) online firearm injury prevention data dashboard. The dashboard design will be based on the newly redesigned EpiCenter, which allows users to interactively query and visualize general injury surveillance data. The firearm injury prevention dashboard will focus on firearm injuries and risk and protective factors. It will utilize multiple relevant data sources, including state death, hospital discharge, emergency department visit, and Behavioral Risk Factor Surveillance System (BRFSS) data. In addition to data insight tools, the dashboard will feature content and resources on effective measures to prevent firearm injuries. The dashboard will be developed with input from CDPH's Violence Prevention Initiative (VPI) and include links to relevant VPI resources.

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

Objective 6:

Title: School-Based Health Centers Support

Objective: By June 30, 2023, IVPB will provide at least six (6) statewide technical assistance events that educate public health and student health stakeholders on the benefits School Based Health Centers have for improving student health.

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

Program for this Objective: **Many California adolescents do not receive annual necessary, regular preventive health care visits; this objective aims to increase the number of School-Based Health Centers where students may receive this type of care.** 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. The California School-based Health Center Alliance estimates the need for SBHCs statewide at 500; there are currently 293. The activities within this objective should assist with increasing support for expanding SBHCs statewide.

Key indicator(s) affected by this program: Once established within a school, SBHCs may 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. They can also provide counseling for such risk factors as smoking, substance abuse, sexual health, violence, and safety issues, as well as behavioral problems. More SBHC across the state will result in more school-enrolled adolescents receiving health care.

Baseline value for the key indicator: 70.6% 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: 2019-2020

Intervention Information

IVPB will host technical assistance activities for a statewide audience on the benefit of School-Based Health Centers in California with the intent to expand their numbers and impact on student health in California. The IVPB SBHC project will strengthen coordination of the existing SBHC network by promoting relationships between the Statewide SBHC Workgroup members and partners. IVPB will use existing SBHC data, needs assessments, and Workgroup input to identify current technical assistance needs and content. The information culled from these sources will allow IVPB staff to tailor the technical assistance provided via webinar and presentations to the SBHCs and partners including LHDs. The technical assistance and workgroup meetings will support the effort to expand SBHC sites and services statewide.

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:* Technical assistance (TA) activities and workgroup meetings
- *Unit of Measurement*: Number of technical assistance (TA) activities
- *Baseline value for the item to be measured:* 0
- *Data source of baseline value:* Internal tracking log
- *Date baseline was last collected:* 07/01/2022
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *Final target value to be achieved by the Final Progress Report:* 6

Target Population

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

- *Target population data source*: National Survey of Children's Health, 2019-2020
- *Number of people served:* 3,109,123
  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 (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? Yes

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

Activity 1

School-Based Health Center Coordination. Between 07/2022 and 06/2023, Program will improve coordination statewide by convening the School Based Health Center Workgroup (Workgroup) comprised of representatives from CDPH, CDE, MCAH, MHSOAC, DHCS and the School-Based Health Center Alliance.

Description of Activity: In the FFY 2022, the School Based Health Center Program Statewide Collaborative Workgroup will be convened quarterly by CDPH's IVPB staff. The Workgroup membership will be invited to quarterly (4) meetings during the project's 12-month timeframe.

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

Activity 2

Assess on-going needs of SBHCs. Between 07/2022 and 06/2023, Program will review findings from existing needs assessments and available data among California's SBHCs to identify areas of technical assistance needs.

Description of Activity: CDPH, with the support of the SBHC Workgroup, will continue to analyze existing needs assessments, surveys and available data related to SBHCs. The results will be collected by CDPH staff and shared back with the Workgroup. CDPH and the Workgroup will then identify SBHC gaps and technical assistance needs and share back the findings with the field.

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

Activity 3

Provide technical assistance to SBHCs and their partners (e.g., LHJs, CBOs, FQHCs, etc.). Between 07/2022 and 06/2023, Program will provide technical assistance events to California's SBHCs, LHJs, CBOs, County Departments of Education or FQHC's on topics identified from the needs assessments and or the available data.

Description of Activity: Program will provide at least 2 technical assistance events (e.g., webinars, presentations, fact sheets, etc.) to California's SBHCs and their partners 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?* No
- *Does the data collection involve public health data?* 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: Yes
- Total Positions in this program funded by PHHS Block Grant: 1
- Number of FTEs in this program funded by the PHHS Block Grant: 0.20

Position #1

Position Title:	Associate Governmental Program Analyst
Position Vacant?	Yes
Jurisdiction-level [% time]:	20
Total [% time]:	20
Briefly describe recruitment	Recruit to fill open AGPA position within OQPA to support the PHA Program during FY 22-23.

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
- Other: Required to maintain Public Health Accreditation Board (PHAB) Accreditation

Key Indicator(s) affected by this problem: Currently, of 61 Local Health Jurisdictions (LHJs) in California (58 counties and 3 cities), 23 have achieved PHAB Accreditation. Another 29 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 and technical assistance (TA) 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)? Yes

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

Summary of Program Strategy: Between 07/2022 and 06/2023, Program will provide training and TA services to increase accreditation readiness and capacity to three local health jurisdictions. These services will provide participating LHJs 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. Public Health Accreditation Board (PHAB)
4. 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: 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
- State health department

Target Population of Program

- *Target population data source*: US Census Bureau population estimate
- *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? Yes

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

Objectives and Activities

Objective 1:

Title: Increase the proportion of local public health agencies that are accredited

Objective: From 07/1/2022 to 6/30/2023 program will provide accreditation-related training and technical assistance to at least three (3) Local Health Jurisdictions (LHJs) seeking Public Health Accreditation Board (PHAB) 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? The problem is the same.

Intervention Information

Provide accreditation-related training and technical assistance to LHJs seeking accreditation. CDPH will provide accreditation-related training and technical assistance to LHJs seeking accreditation to help them meet PHAB standards.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: As an accredited state public health department, the California Department of Public Health (CDPH) is required to provide accreditation-readiness technical assistance to California's local health departments 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.

- *Item to be measured:* Number of LHJs who receive TA
- *Unit of measurement:* Number of LHJs
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program internal tracking
- *Date baseline was last collected:* 07/01/2022
- *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? Yes

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

Activity 1

Accreditation-related Technical Assistance (TA). Between 07/2022 and 06/2023, Program will provide accreditation-related TA to three local and/or tribal public health agencies to improve capacity to prepare for national public health accreditation.

Description of Activity: Between 07/2022 and 06/2023, Program will provide accreditation-readiness TA and/or training to three Local Health Jurisdictions that are preparing for PHAB accreditation or re-accreditation. TA and training will support accreditation-related activities, including Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) development and alignment, training, networking, PHAB document selection, and may include workforce development, quality improvement, strategic planning, equity training, and/or performance management training and TA.

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

Rape Prevention Program

Healthy People 2030 Objective

IVP-17: Reduce adolescent sexual violence by anyone

Health Objective

Between July 1, 2022 and June 30, 2023, 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: $600,783
- Type of supported local agency/organization: Local organization
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 10-49% - Partial source of funding
- Existing funding source(s): Other federal funding (CDC): Rape Prevention and Education
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 4
- Number of FTEs in this program funded by the PHHS Block Grant: 0.75

Position #1

Position Title:	Health Program Manager II
Staff Name in Position:	Sara Mann
Jurisdiction-level [% time]:	20
Total [% time]:	20

Position #2

Position Title:	Research Scientist Supervisor I
Staff Name in Position:	Renay Bradley
Jurisdiction-level [% time]:	5
Total [% time]:	5

Position #3

Position Title:	Office Technician
Staff Name in Position:	Joseph Kinkead
Jurisdiction-level [% time]:	25
Total [% time]:	25

Position #4

Position Title:	Staff Services Manager II
Job Vacant:	Yes
Jurisdiction-level [% time]:	25
Total [% time]:	25
Describe Briefly Recruitment	Currently waiting on HRs final approval before the recruitment process begins.

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 percentage of sexual violence among 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)

Baseline value of the key indicator described above: 19.2

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)? 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 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. *ValorUS*
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
- Other: Schools

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, June 2019.
- *Number of people served:* 11,072,270
- *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? Yes

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

Objectives and Activities

Objective 1:

Title: Community/Societal-level Prevention Strategies

Objective: Between July 1, 2022 and June 30, 2023, Program will implement 12 local prevention projects using community/societal-level prevention strategies by 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? 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: Using the Best Available Evidence for SV Prevention (2018); STOP SV Technical Package (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? No

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

Activity 1

Fund Comprehensive Community-based Projects. Between 07/2022 and 06/2023, 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, 2022 and June 30, 2023, Program will fund 8 local comprehensive community-based projects using a community mobilization strategy through June 2023 in order to impact community/societal-level change. Program and partners (CSUS, UCSD and, VALORUS) 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?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Fund Comprehensive School-based Projects. Between 07/2022 and 06/2023, 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, 2022 and June 30, 2023, 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 (UCSD and VALORUS) 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?* Yes
- *Does the data collection involve public health data?* No

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

Reduce the incidence of illness caused by shiga toxin-producing 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? 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

Position #1

Position Title:	Research Scientist II
Staff Name in Position:	Eun-Jung Choi
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #2

Position Title:	Environmental Scientist
Staff Name in Position:	Nik Storm
Jurisdiction-level [% time]:	20
Total [% time]:	20

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:

- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan
- Other: The FDA has identified safe leafy greens as a priority under the 2020 Leafy Greens 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 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. 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 Food Safety

Date key indicator baseline data was last collected: 01/31/2022

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)? 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) 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 Association*

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. In addition, the effectiveness of interdiction activities will be evaluated using the number of food recalls initiated and the affected retail establishments.

Program Settings:

- Business, corporation or industry
- State health department
- Work site

Target Population of Program

- *Target population data source*: The U.S. Census Bureau for CA
- *Number of people served:* 39,237,836
- *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? No

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

Objectives and Activities

Objective 1:

Title: Implement a Shiga Toxin-Producing *E. Coli* Testing Program in U.S. Grown Leafy Greens

Objective: Between 7/1/2022 and 6/30/2023, Program will collect 300 samples of U.S. grown leafy greens and test the lettuce 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? The problem is the same.

Intervention Information

Any samples that test positive for shiga toxin-producing E. coli will receive regulatory follow-up 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 are 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 a portion of the adulterated leafy greens are not further distributed to consumers.

- *Item to be measured:* Number of samples collected and tested
- *Unit of measurement:* Count
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program internal tracking.
- *Date baseline was last collected:* 7/1/2022
- *Interim target value to be achieved by the Annual Progress Report:* 150
- *Final target value to be achieved by the Final Progress Report:* 300

Target Population

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

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

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

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.

Description of Activity: Between 7/1/2022 and 6/30/2023, Program will collect 300 samples of leafy greens from grocery stores in California.

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

Activity 2

Test Leafy Green Samples for Shiga Toxin-Producing *E. Coli*. Between 7/1/2022 and 6/30/2023, Program will test 300 samples of leafy greens for shiga toxin-producing E. *coli*.

Description of Activity: Between 7/1/2022 and 6/30/2023, 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?* Yes
- *Does the data collection involve public health data?* No

Activity 3

Conduct Regulatory Follow-Up. Between 7/1/2022 and 6/30/2023, Program will conduct regulatory follow-up pending any positive laboratory findings.

Description of Activity: Between 7/1/2022 and 6/30/2023, FDB staff will complete necessary regulatory follow-up pending any positive findings. This may include recalls, market withdrawals, inspections, or investigations. This regulatory follow-up will ensure that any adulterated leafy greens in the marketplace are removed and will reduce the chance of illness in consumers.

- *Does the activity include the collection, generation, or analysis of data?* No
- *Does the data collection involve public health data?* 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 07/01/2022 and 06/30/2023 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, planning 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? 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

Position #1

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Kelly Kelley
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #2

Position Title:	Associate Governmental Program Analyst
Position Vacant?	Yes
Jurisdiction-level [% time]:	100
Total [% time]:	100
Briefly describe recruitment	This position vacancy is being filled though the state recruitment process.

Position #3

Position Title:	Research Data Analyst I
Staff Name in Position:	Jaspreet Kang
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #4

Position Title:	Health Program Specialist I
Position Vacant?	Yes
Jurisdiction-level [% time]:	75
Total [% time]:	75
Briefly describe recruitment	This position vacancy is being filled though the state recruitment process

Position #5

Position Title:	Health Program Specialist II
Staff Name in Position:	Leslie Stribling
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #6

Position Title:	Staff Services Manager II
Staff Name in Position:	Christine Fenlon
Jurisdiction-level [% time]:	25
Total [% time]:	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, 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. These differences in opportunity are often a result of deeply rooted, historical policies and practices – such as unfair bank lending practices, school funding based on local property taxes, and discriminatory policing and prison sentencing. 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 the identification of the shared priorities and strategies in this plan was that in order to advance a safe and healthy California for all, we must address the systemic barriers that have led to these inequities in the first place. The factors that impact these outcomes require action across multiple systems and sectors, and through state, local and community collaboration. 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 most acute aspects of the COVID-19 response. The full impact of the pandemic on population health in California is not yet known and will require proactive assessment and monitoring to help promote recovery and ongoing health improvement. The pandemic further 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 new landscape of population health in California and the complex underlying inequities requires comprehensive information and an integrated strategic response.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)
- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan
- 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: 2021

Program Strategy

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

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

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

Summary of Program Strategy: The SHA/SHIP process will be employed to increase the Department's capacity to address priority public health burdens, root causes and contributing factors of health disparities and inequities. As the SHA/SHIP, Let's Get Healthy California (LGHC) contributes to building a safe, healthier California for all by monitoring progress on health improvement priorities; promoting community innovations; and informing and convening cross-sector collaborations. The program will maintain a current SHA/SHIP by conducting ongoing activities and implementing enhancements related to 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
- Local 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 (2021); Let's Get Healthy California Indicator for Overall Health Status (2021), and California Health Interview Survey, UCLA Center for Health Policy Research, (2020)
- *Number of people served:* 39,000,000 (statewide population)
- *Ethnicity:* Hispanic or Latino/Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- All California counties

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: Yes

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

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

Objectives and Activities

Objective 1:

Title: Conduct a Comprehensive State Health Assessment

Objective: Between 7/01/2022 and 6/30/2023, Program will conduct two (2) activities to enhance the State Health Assessment (SHA).

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

Intervention Information: **The program will conduct the SHA and Improvement Plan process.** The State Health Assessment (SHA) provides a snapshot of health for the entire population across a range of conditions and factors. This includes defining health issues and contributing factors, elevating disparities across communities and populations, and identifying assets and resources that can be mobilized to address these health improvement opportunities. The State Health Improvement Plan 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

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:* Activity
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activity tracking
- *Date baseline was last collected:* 2021
- *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? Yes

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

Activity 1

Conduct and Enhance the Annual SHA. Between 7/01/2022 and 6/30/2023, Program will conduct two activities to enhance the State Health Assessment (SHA).

Description of Activity: Conduct the SHA based on standard sets of inputs and measures. enhance documentation of systems for collecting, integrating, analyzing, and sharing information on health outcomes, social determinants of health (SDoH), population characteristics, and other data to improve assessment of burden of disease among special populations, including among veterans and immigrants; and to strengthen systems for compilation of Hospital Discharge and Emergency Department data for rapid burden assessment.

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

Activity 2

Conduct a Data Analytics Project (Disparities, Hidden Populations, Issues of Concern). Between 7/01/2022 and 6/30/2023, Program will conduct two activities to enhance the State Health Assessment (SHA).

Description of Activity: Conduct targeted analyses based on SHA findings including SDoH-informed Cause of Death Analysis, a Mental/Behavioral Health Data Brief, and an assessment around impacts and issues of race/ethnic disaggregation and tabulation based on different approaches. Continue assessing data quality with various population data sources and collaborating with partners to evaluate policy considerations and develop recommendations for standards.

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

Objective 2:

Title: Foster shared implementation by facilitating strategic alignment and integrated planning

Objective: Between 7/01/2022 and 6/30/2023, Program will conduct two (2) activities to foster shared implementation by facilitating strategic alignment and integrated planning.

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

Intervention Information

The program will conduct the State Health Assessment and Improvement Plan process. The State Health Assessment (SHA) provides a snapshot of health for the entire population, across a range of conditions and factors. This includes defining health issues and contributing factors, elevating disparities across communities and populations, and identifying assets and resources that can be mobilized to address these health improvement opportunities. The State Health Improvement Plan 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

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:* Activity
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activity tracking
- *Date baseline was last collected:* 2021
- *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? Yes

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

Activity 1

Maintain and enhance the State Health Improvement Plan (SHIP) framework to define shared priorities and measure progress in advancing population health and addressing health inequities. Between 07/2022 and 06/2023, Program will foster shared implementation by facilitating strategic alignment and integrated planning.

Description of Activity: Complete annual indicator data updates and publish a '10-Year Review Summary'; evaluate and adopt key metrics and publish dashboards for targeted new and/or modified indicators to measure progress on shared priorities in the SHIP; publish updated baselines and targets for indicators in the SHIP framework; and conduct research, develop, and/or adopt an equity target-setting methodology.

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

Activity 2

Unifying actions across the state to address shared priorities. Between 07/2022 and 06/2023, Program will foster shared implementation of the State Health Equity Plan (SHEP) with LGHC.

Description of Activity: The Fusion Center will foster shared implementation of the State Health Equity Plan (SHEP), as an integrated component of Let's Get Healthy California (LGHC) - the SHIP to unify actions that advance progress in shared priorities by facilitating strategic alignment on targeted programmatic activities in key areas including, but not limited to prevention and health promotion strategies; surrounding mental and behavioral health and improving accessibility in the built environment.

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

Objective 3:

Title: Support Collective Action Around Shared Public Health Priorities

Objective: Between 07/01/2022 and 6/30/2023, Program will conduct two (2) activities to support collective action.

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

Intervention Information

The program will conduct two activities to support collective action. The State Health Assessment (SHA) provides a snapshot of health for the entire population, across a range of conditions and factors. This includes defining health issues and contributing factors, elevating disparities across communities and populations, and identifying assets and resources that can be mobilized to address these health improvement opportunities. The State Health Improvement Plan 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

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:* Activity
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Program activity tracking
- *Date baseline was last collected:* 2021
- *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? Yes

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

Activity 1

Address Cross-Cutting Priorities Through Department-Wide Initiatives. Between 07/2022 and 06/2023, Program will facilitate collective action initiatives, engaging internal, interdepartmental, and multisector partners.

Description of Activity: Collaborate with internal partners to identify priorities and align messages on emerging issues efforts related to behavioral health prevention strategies such as CDPH Overdose Prevention Group and the Substance Use Disorder (SUD) Workgroup Prevention team. Facilitate efforts to engage Health Equity Liaisons in informing the State Health Improvement Plan process. Support implementation of the Violence Prevention Initiative.

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

Activity 2

Facilitate Engagement and Capacity-Building Projects with Local Health Departments. Between 07/2022 and 06/2023, Program will engage with Local Health Departments – including providing tools, training, and technical assistance – to advance strategies and policy approaches.

Description of Activity: Facilitate and provide technical assistance to LHJs to develop and implement the SHEP; continue to review and refine LHJs Community Health Assessment/Community Health Improvement Plan (CHA/CHIP) metrics with Strategic Plans for measures dedicated to the Public Health Infrastructure Initiative funding; collaborate to offer peer-learning opportunities for LHJs, and provide resources through the Health Equity Playbook to inform ongoing efforts focused on equitable recovery.

- *Does the activity include the collection, generation, or analysis of data?* Yes
- *Does the data collection involve public health data?* 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 FY 23-24.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 50-74% - 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: 0.65

Position #1

Position Title:	Research Scientist II
Staff Name in Position:	Beverly Shen
Jurisdiction-level [% time]:	65
Total [% time]:	65

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. CDPH has the authority to conduct special investigations into the sources of injury and illness, including their causes and means of prevention (Health and Safety Code, section 100325). CDPH's successes are most visible when responding to infectious disease outbreaks, and public health has substantial history and capacity responding to infectious diseases. In contrast, CDPH does not have a core team dedicated to noninfectious disease outbreak investigations, and previous investigations have been mostly ad hoc.

Public health program was prioritized as follows:

- 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: 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

Data source for key indicator baseline: Poison Control Center; syndromic surveillance; CalREDIE

Date key indicator baseline data was last collected: 2021

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)? 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. *Center for Laboratory Sciences*
4. *Substance Abuse Prevention Branch*
5. *Division of Communicable Disease Control*

Planned non-monetary support to local agencies or organizations

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: Progress will be evaluated by the completion of steps outlined in the 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
- Local 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? No

Objectives and Activities

Objective 1:

Title: Build Partnerships to Conduct Toxicological Outbreak Surveillance, Response, and Exercises

Objective: Between 07/2022 and 06/2023, Program will provide technical assistance by conducting at least five (5) meetings or collaborative activities with internal and external data partners, especially local health jurisdictions, to ensure efficient and secure data sharing and data management for identifying and responding to toxicological outbreaks. Program will also implement at least one (1) functional or tabletop toxicological outbreak exercise including local emergency management and environmental and/or public health agencies.

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

Intervention Information

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 lacks 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:* Activity with LHDs to identify and report toxicological outbreaks
- *Unit of measurement:* Activity
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Contracts or agreements with LHDs
- *Date baseline was last collected:* 2021
- *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? No

Activity 1

Toxicological Outbreak Exercise. Between 07/2022 and 06/2023, Program will implement a toxicological outbreak exercise for use by local emergency managers and public health officials.

Description of Activity: Tabletop and functional exercises with local health departments 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, implement a Homeland Security Exercise and Evaluation Program (HSEEP) compliant toxicological outbreak exercise designed by the Toxicological Outbreak Program for use by local jurisdictions to improve their preparedness for response to an actual outbreak. One exercise will be conducted by the end of FY 22-23 with one local health jurisdiction.

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

Activity 2

Toxicological Outbreak Response Information Sharing System. Between 07/2022 and 06/2023, Program will maintain toxicological outbreak information sharing with internal and external partners including CDPH emergency management, environmental investigations, injury control, substance abuse prevention, information technology, and laboratory staff to maintain internal framework and procedures for conducting toxicological outbreak investigations.

Description of Activity: In the past fiscal year, CDPH has established a main point of contact for toxicological outbreak investigations. The toxicological outbreaks program opened channels of communication with multiple partners to establish data sharing including Center for Health Statistics and Informatics, Environmental Health Laboratory Branch, Food and Drug Branch, Food and Drug Laboratory Branch, Information Technology Services Division, Injury and Violence Prevention Branch, Substance Abuse Prevention Branch, California Poison Control Center, CDC. We will maintain information sharing for scope and division of labor among participating CDPH programs, identify efficient methods of data sharing, and establish procedures for coordinately conducting toxicological outbreak investigations. Program contacts will meet at least once quarterly during FY 22-23. At end of fiscal year, the program will produce documentation of information sharing procedures.

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

Tuberculosis Free CA

Healthy People 2030 Objective

IID-17: Reduce tuberculosis (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? 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)

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 per 100,000 persons. 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

Data source for key indicator baseline: California Department of Public Health, TB Control Branch, TB in California: 2020 Snapshot.

Date key indicator baseline data was last collected: 2020

Program Strategy

Goal: The goal of our program is to identify and treat those with LTBI in order to prevent cases of TB disease in California.

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

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

Summary of Program Strategy: Californians born outside the U.S., as well as racial and ethnic minorities, experience disproportionately high rates of TB disease. In 2020, the TB rates among Asians, Blacks, and Hispanics born outside the U.S., were 50, 51, and 20 times greater, respectively than of U.S.-born whites; more than half of all California's TB cases occurred in Asians. The TB Free California program engages groups disproportionately impacted by TB and the providers that serve them to coordinate patient education and targeted testing and treatment for high-risk populations and produces culturally and linguistically appropriate materials for use with a diverse group of patients.

Primary Strategic Partners

External:

1. *Association of Asian Pacific Community Health Organizations*
2. *Federally Qualified Health Centers (North East Medical Services)*
3. *San Diego County Tuberculosis Elimination Initiative*
4. *UC Berkeley University Health Services*
5. *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*

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Other: Patient and provider health education materials, printed and online

Evaluation Methodology: Program will evaluate progress towards objectives using process evaluation with the following measures: the number of clinics or health systems partnered with to measure LTBI testing and treatment practices, proportion of requesting clinics who receive trainings or clinical consultation, and number of patient education materials created and distributed. Additionally, Program will assess feedback from partners and stakeholders, electronic and paper surveys, emails, and intermediate outcome evaluations, which may include: 1) proportion of at-risk patients receiving testing for LTBI, 2) proportion of persons testing positive for TB infection who are prescribed LTBI treatment, and 3) proportion of patients who are motivated to speak to a medical provider about LTBI testing and treatment after reviewing patient education materials.

Program Settings:

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

Target Population of Program

- *Target population data source*: 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? Yes

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

Objectives and Activities

Objective 1:

Title: Measure and Analyze Data on LTBI Testing and Treatment Practices in Community Clinics

Objective: Between 07/2022 and 06/2023, Program will measure and analyze two (2) metrics including: proportion of at-risk population receiving testing for LTBI, and proportion of persons who test positive for TB infection prescribed LTBI treatment, at a minimum of two (2) community clinic sites providing primary care in California to high-risk populations. Program will support testing and patient follow-up of at least 8,500 at-risk persons at >2 clinical sites.

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

Problem for this Objective: **Preventing cases of TB disease in California depends on identifying and treating LTBI 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 in primary care settings, 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. Using the steps described in the LTBI Guidebook (produced in FY21 by the TB Free CA team), Program will support clinics who wish to construct a LTBI care cascade to estimate how much LTBI testing and treatment is performed at their clinic.

Key indicator(s) affected by this problem: Proportion of persons who test positive for TB infection who are prescribed LTBI treatment in California

Baseline value for the key indicator: 16.6%

Data source for key indicator baseline: Civil surgeon report, California Department of Public Health (unpublished)

Date key indicator baseline data was last collected: 2021

Intervention Information

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 07/2022 and 06/2023, 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. Using the attrition table presented in the Guidebook, program will help clinics identify gaps in their LTBI care cascade and problem solve barriers to LTBI testing and treatment at their clinics.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)
- Other: (1) California Tuberculosis Elimination Advisory Committee. California TB Elimination Plan 2021-2025. Richmond, CA)

Rationale for choosing the Intervention: One of the TB Free California objectives is to define baseline rates of testing and treatment in California, in order to identify and address gaps in care and measure incremental improvement in performance. Our work with individual 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:* Persons at-risk receiving testing
- *Unit of measurement:* Number of persons tested
- *Baseline value for the item to be measured:* 7,107
- *Data source for baseline value:* Data from student health services at University of California, Berkeley
- *Date baseline was last collected:* 2021
- *Interim target value to be achieved by the Annual Progress Report:* 4,000
- *Final target value to be achieved by the Final Progress Report:* 8,500

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? Yes

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

Activity 1

Support Community Clinics in Measuring LTBI Testing and Treatment. Between 07/2022 and 06/2023, Program will assist with data collection, management, and analysis at clinics with two key metrics regarding LTBI testing and treatment.

Description of Activity: Between 07/2022 and 06/2023, 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?* Yes
- *Does the data collection involve public health data?* No

Activity 2

Disseminate and Provide Technical Assistance on the TB Prevention Guidebook for Primary Care Clinics. Between 07/2022 and 06/2023, Program will disseminate The TB Prevention Guidebook to clinics and health systems serving populations at higher risk for TB.

Description of Activity: The Guidebook (which was produced in FY21) includes stepwise instructions on how to assess clinic population risk, increase LTBI testing and treatment, measure the LTBI care cascade and improve outcomes. Program will 1) disseminate the Guidebook to current partners and other community health centers in the state; and 2) provide technical assistance/training on how to develop, measure and evaluate a care cascade, using the Guidebook as the tool, to providers in at least one (1) virtual learning collaborative (LC) established specifically for this work. The LCs will also provide a forum for Guidebook users to share their best practices and recommendations to colleagues. Program Epidemiologist is primarily responsible for this activity.

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

Objective 2:

Title: Produce Training and Education Materials Designed for Populations at Higher Risk for TB and Their Providers, in order to reduce TB Health Disparities

Objective: Between 07/2022 and 06/2023, Program will increase awareness of LTBI as a health issue among populations at higher risk for TB by creating and pilot testing a TB prevention one (1) curriculum for non-licensed health workers in community health centers and other organizations.

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

Problem for this Objective: **TB disease disproportionately impacts non-U.S.-born and non-white persons in California and additional culturally appropriate materials are needed to educate these populations about their TB risk and promote LTBI treatment.** TB disease disproportionately impacts non-U.S.-born and non-white persons in California. Although TB disease can often be avoided through treatment of LTBI, most patients do not know they are infected and do not seek preventive treatment. Community Health Workers (CHWs) are non-licensed health care providers who are usually trusted members of communities and form a bridge between providers and patients to provide support services to persons receiving health care. Currently, there are not any CHW training programs in California that provide training on TB or TB prevention. Training CHWs and other similar professionals (e.g., promotoras, medical assistants) to include TB prevention messaging in their work with patients at higher risk for TB can motivate patients to be tested for LTBI, and, if necessary, treated. In addition, immigration status adjustors are required to undergo medical evaluations when requesting a change in their immigration status; testing for TB infection is part of this evaluation. Civil surgeons, the physicians who conduct these exams, are not required to provide their patients who have LTBI with treatment, or even linkage to care. Few interventions are being conducted directly for status adjustors. There are many important TB prevention messages that can motivate status adjustors to seek treatment if they have LTBI.

Key indicator(s) affected by this problem: Number of TB prevention curricula available for community health workers

Baseline value for the key indicator: 0

Data source for key indicator baseline: Internet search, review of existing CDPH web-based materials, discussion with TB elimination partners.

Date key indicator baseline data was last collected: 2022

Intervention Information

Develop and pilot test one (1) curriculum for non-licensed health workers in community health centers and other organizations in order to increase awareness of LTBI in high-risk populations. Although TB disease can often be avoided through treatment of LTBI, most patients do not know they are infected and do not seek preventive treatment. Community Health Workers (CHWs) are non-licensed health care providers who are usually trusted members of communities and form a bridge between providers and patients to provide support services to persons receiving health care. Currently, there are not any CHW training programs in California that provide training on TB or TB prevention.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: California Tuberculosis Elimination Advisory Committee. California TB Elimination Plan 2021-2025. Richmond, CA.

Rationale for choosing the Intervention: Persons with LTBI often do not know they are infected and therefore do not seek treatment. Persons at higher risk for TB often have little information about LTBI and may have encountered misinformation or stigma about TB. Effective training can inform patients about the importance of TB prevention and encourage them to speak to their providers about getting tested for LTBI, and treated, when necessary. Populations at higher risk for TB benefit from engagement and education by trusted community partners. CHWs and CHW organizations that already serve these communities are the optimal partners to provide this education and messaging.

- *Item to be measured:* Number of pilot-tested curricula
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Internet search and discussion with TB elimination partners
- *Date baseline was last collected:* 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? Yes

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

Activity 1

Create and pilot test a TB prevention curriculum for non-licensed health workers in community health centers and other organizations. Between 7/1/2022 and 6/30/23, Program will increase awareness of LTBI as a health issue among populations at higher risk for TB by creating and pilot testing a TB prevention curriculum for non-licensed health workers in community health centers and other organizations.

Description of Activity: Program Health Educator will review existing (non-TB specific) CHW curricula and together with at least two CHW and/or CBO partners, create a curriculum for training CHWs on TB prevention, including topics such as: TB 101 (including overview of populations at higher risk for TB), LTBI testing and treatment, and common misinformation/ stigma about TB. TB prevention messaging to patients and patient education materials will be included in the curriculum. The curriculum will be piloted tested and then subsequently finalized to create a product that can be disseminated and utilized by multiple community health centers, CHW organizations and local health departments. Program Health Educator is primarily responsible for this activity.

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

Activity 2

Produce and disseminate a TB prevention brochure for immigration status adjustors in at least two languages (in English plus one other language). Between 07/2022 and 06/2023, Program will produce and disseminate a TB prevention brochure for immigration status adjustors in at least two languages (in English plus one other language).

Description of Activity: Program Health Educator will collaborate with other health education staff from California local TB programs and other state/federal agencies to create a TB prevention education brochure specifically for status adjustors. After pilot-testing and finalizing the piece, it will be translated into at least one additional language and pilot tested with the appropriate populations. Both brochures will then be printed and distributed to civil surgeons throughout California. Program Health Educator is primarily responsible for this activity.

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

Objective 3:

Title: Provide LTBI Training, Provider Education Materials, and Clinical Consultation to Providers Serving High-Risk Patients, Including Primary Care and Civil Surgeon Provider Group

Objective: Between 07/2022 and 06/2023, Program will provide technical assistance in the form of training, provider education materials, or clinical consultation to at least six (6) of programs who request our 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? Subset of the larger problem.

Problem for this Objective: **In 2020, the CDC published a new "Guidelines for the Treatment of Latent Tuberculosis", however due to competing priorities, 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.

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: 33%

Data source for key indicator baseline: Provider survey of >100 California primary care providers, unpublished data, TB Free California

Date key indicator baseline data was last collected: 2017-2021

Intervention Information

Engage >90% of community clinics and/or provider groups who request support (and at least six (6) clinics/groups) to receive technical assistance related to LTBI. Engage >90% of community clinics and/or provider groups who request support (and at least six (6) clinics/groups) to receive technical assistance related to LTBI. Between 07/2022 and 06/2023, Program will engage at least six (6) community clinics or providers to receive training or consultation related to LTBI. Our goal is to provide the skills training necessary for primary care providers in California to effectively screen, test, and treat patients for LTBI. Program will work in collaboration with local TB control programs, clinics, and training centers to execute trainings on LTBI testing and treatment, and as an additional activity, will provide direct clinical consultation on testing and treatment of TB infection and TB prevention strategies for healthcare providers in community and institutional settings.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

Rationale for choosing the Intervention: Tuberculosis clinical care involves many diagnostic and therapeutic nuances, including distinguishing latent TB 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 or consultation
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 6
- *Data source for baseline value:* Unpublished data, TB Free California
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 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? Yes

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

Activity 1

Develop a provider education tool regarding drugs used for LTBI treatment. Between 07/2022 and 06/2023, Program will develop a provider education tool regarding drugs used for LTBI treatment.

Description of Activity: Between 07/2022 and 06/2023, Program will work develop and/or review content for one (1) new provider education resource regarding medications used for LTBI therapy. This activity is building upon previous years' activities and trainings and motivated by lack of physician comfort with LTBI medications, particularly in terms of drug-drug interactions and prescribing for special populations, including pregnant women, elderly patients, and patients with medical co-morbidities. Provider education tool will take the form of either a slide deck or website that can be disseminated by local TB programs, and will focus on evidence based LTBI 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?* No
- *Does the data collection involve public health data?* No

Activity 2

Conduct Training on LTBI Best Practices and Guidelines. Between 07/2022 and 06/2023, Program will work in collaboration with local TB control programs, clinics, and civil surgeon groups to execute trainings on LTBI testing and treatment. *Description of Activity*: Between 07/2022 and 06/2023, Program will work in collaboration with local TB control programs, clinics, and civil surgeon groups to execute 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?* No
- *Does the data collection involve public health data?* No

Activity 3

Provide Expert Consultation to Medical Providers Regarding LTBI Care. Between 07/2022 and 06/2023, Program will provide clinical consultation and subject matter expertise on testing and treatment of TB infection for healthcare providers in community and institutional settings.

Description of Activity: Between 07/2022 and 06/2023, 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?* No
- *Does the data collection involve public health data?* 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 07/2022 and 6/30/2023, Program will increase the public health (PH) workforce by graduating at least 14 trainees from the PMR or the Cal EIS, to become qualified PH physicians and epidemiologists who contribute to and/or lead efforts to improve the health of Californians.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? Yes
- Funding role of the PHHS Block Grant for this program: Supplement other existing funding
- Percentage of funding for this program that is PHHS Block Grant: 50-74% - Significance source of funding
- Existing funding source(s): 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: 2.35

Position #1

Position Title:	Health Program Specialist II
Staff Name in Position:	Jami Chan
Jurisdiction-level [% time]:	100
Total [% time]:	100

Position #2

Position Title:	Health Program Specialist II
Staff Name in Position:	Ester Jones
Jurisdiction-level [% time]:	85
Total [% time]:	85

Position #3

Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Yuliya Kravtsov
Jurisdiction-level [% time]:	50
Total [% time]:	50

Issue/Problem

PH agencies have difficulty recruiting and hiring qualified, diverse PH physicians and epidemiologists. According to a deBeaumont Public Health National Center for Innovations Research Brief October 2021, state and local governmental PH departments need an 80% increase in their workforce to provide a minimum set of PH services to the nation. California's state PH workforce is small relative to its population: California has fewer than 10 FTE per 100,000 population, compared to an average of 23 FTE per 100,000 among large states. Nationwide, the average age of state PH employees is 48.3; the median age is 49. As older PH physician and epidemiologist leaders retire, there is a need to replace them with a more diverse cohort that better represents the California population and has novel perspectives and insights into methods of meeting current PH challenges. PMR and Cal EIS ensure a steady supply of critically needed diverse, well-trained PH physicians and epidemiologists to assume leadership positions in state and local PH agencies in California. These positions include Local Health Officers, state agency Medical Directors, Data Directors and Division/Branch/Section Chief physicians and epidemiologists. California needs trained experts ready to respond to PH emergencies that result in illness, injury, deaths and inequity, such as influenza, COVID, floods and wildfires, as well as to respond to the alarming rise in chronic and behavioral conditions that decrease life expectancy.

Public health program was prioritized as follows:

- Conducted, monitored, or updated a jurisdiction health assessment (e.g., state health assessment)
- Conducted a topic- or program-specific assessment (e.g., tobacco assessment, environmental health assessment)
- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan
- Other: State and local health department priority, research and educational institution priority

Key Indicator(s) affected by this problem: Number of PH physicians and epidemiologists that graduate each year; ready and able to be employed at state and local PH agencies in California.

Baseline value of the key indicator described above: 13

Data source for key indicator baseline: Annual count of residents and fellows that graduate

Date key indicator baseline data was last collected: 2021

Program Strategy

Goal: The California Department of Public Health (CDPH) will conduct PH professional training through the PMR and the Cal EIS to develop the PH workforce pipeline and graduate diverse qualified physicians and epidemiologists to be employed in California PH agencies.

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

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

Summary of Program Strategy: PMR and Cal EIS objectives align with the CDPH Strategic Map 2019-2022 “Empower the Public Health Workforce”. The programs strengthen California state and local health departments by developing a workforce of qualified diverse physicians and epidemiologists who possess the competencies needed to work as PH professionals. The program graduates are employed leading and facilitating the work of California PH state and local health departments. This priority relates to Healthy People 2030 Objective (PHI-R02) by expanding pipeline programs that include service learning or experiential learning components in PH settings.

Primary Strategic Partners

External:

1. California Conference of Local Health Officers
2. City of Berkeley
3. Department of Health Care Services
4. Department of Healthcare Access and Information
5. Los Angeles County Department of Public Health

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
- Other: Evaluation, site visits

Evaluation Methodology: Program goals and objectives are aligned with physician and epidemiologist national organization requirements and competencies. State health objectives are monitored and evaluated yearly. Monitoring tools include trainee milestone or competency progress, monthly/quarterly trainee reports, preceptor/trainee evaluations, site visits, Advisory Committee, Program Evaluation Committee, program policies and procedures, the American Board of Preventive Medicine resident pass rate and the type and location of employment after completing the program.

Program Settings:

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

Target Population of Program

- *Target population data source*: United States Census Bureau July 1, 2021
- *Number of people served:* 39,237,836
- *Ethnicity:* Hispanic or Latino/Not Hispanic or Latino

Race:

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

Age:

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

Sexual Orientation:

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

Gender Identity:

- Male
- Female
- Transgender

Geography:

- Urban
- Rural

Location:

- State of California

Occupation:

- All

Education Attainment:

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

Health Insurance Status:

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

Primarily Low Income: No

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

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

Objectives and Activities

Objective 1:

Title: Increase Number of Trainees Who Achieve Either Preventive Medicine and PH or Epidemiology Competencies.

Objective: Between 07/2022 and 06/2023, Program will increase the number of trainees who, over the course of their training period, have satisfactorily achieved American College of Preventive Medicine (ACPM) competencies or Council of State and Territorial Epidemiologists (CSTE) competencies in state or local PH agency programs and/or completing academic coursework, from 122 residents and 221 fellows (343 total) to at least 125 residents and 232 fellows (357 total).

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

Intervention Information

Physicians and scientists will receive applied training to gain ACPM Competencies OR CSTE Competencies. Applied preventive medicine, public health and epidemiology training in which physicians and epidemiologists achieve ACPM or CSTE competencies to prepare them for employment in California PH agencies. Program will recruit, select, hire, place, monitor, teach and evaluate residents and fellows placed in state and local PH agencies under a doctoral level preceptor, with the curriculum and practical experience targeted to the achievement of the respective competencies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: ACGME Institutional, Common & Preventive Medicine Requirements for GME; ACPM and CSTE competencies.

Rationale for choosing the Intervention: To address the PH workforce need identified by the deBeaumont Foundation in 2021, California will train a diverse cohort of physicians and epidemiologists to achieve requirements and competencies that are the national standard. The Accreditation Council for Graduate Medical Education (ACGME) accredits all medical specialties, including Preventive Medicine, and has rigorous education and training requirements. Competencies developed by ACPM for Preventive Medicine physicians and by CSTE for epidemiologists are the benchmarks for the respective fields. These national organizations have a vested interest in the training and competence of those practicing in the discipline and have committees to determine the needed knowledge, skills and experience to meet their specifications. Therefore, adopting these requirements and competencies in the CDPH training programs assures that the graduates will be well qualified to practice independently in Preventive Medicine or epidemiology.

- *Item to be measured:* Number of residents and fellows achieving competencies.
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 343
- *Data source for baseline value:* Annual count of residents and fellows that achieve competencies
- *Date baseline was last collected:* 2021
- *Interim target value to be achieved by the Annual Progress Report:* 343
- *Final target value to be achieved by the Final Progress Report:* 357

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? Yes

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

Activity 1

Recruit and Interview Applicants for PMR and Cal EIS Positions. Between 07/2022 and 6/2023, The Program Director, PMR Coordinator and Cal EIS Coordinator are responsible for the recruiting, interviewing, and selecting the top applicants, who are then offered placement sites in the PMR and Cal EIS programs beginning 07/2023.

Description of Activity: Between 07/2022 and 06/2023, program will recruit and interview at least 5 PMR applicants and 10 Cal EIS applicants. The recruitment process includes distributing PMR and Cal EIS information to schools of PH, residency programs, local health agencies and posting on various websites, such as FREIDA Online, Electronic Residency Application Service and PH Employment Connection. The competitive selection process includes review of applications by the PMR and Cal EIS Advisory Committees and their recommendation of top candidates to interview, followed by interviews and choice of top candidates to offer a position in the PMR and Cal EIS programs.

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

Activity 2

Develop and Implement PH Practice Curriculum. Between 07/2022 and 06/2023, The Cal EIS Coordinator schedules presenters from CDPH, local health departments and universities to educate the residents and fellows; these PH/Preventive Medicine Seminars take place between 07/2022 and 06/202.

Description of Activity: Between 07/2022 and 06/2023, program will conduct at least 16 PH/Preventive Medicine Seminars for residents and fellows. These bi-monthly seminars address ACGME Milestones and ACPM/CSTE competencies and provide residents and fellows with knowledge, insights and resources that prepare them to enter the PH workforce..

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

Activity 3

Place Residents and Fellows in a PH Training Experience. Between 07/2022 and 06/2023, experienced preceptors will mentor and guide residents and fellows to meet competencies through applied state and local PH experiences, providing training needed to develop California's PH workforce.

Description of Activity: Between 07/2022 and 06/2023, program will train at least 14 individuals in the relevant competencies. Experienced preceptors will mentor and guide residents and fellows to meet competencies through applied state and local PH experiences, providing training needed to develop California's PH workforce.

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