Preventive Health and Health Services Block Grant: FFY 2023 State Plan

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Executive Summary 2
Program Descriptions 2
Advancing Climate Change and Health Programs at LHDs, tribes and within CDPH 6
California Asylum Seeker Health Surveillance and Linkage to Care 18
CA Behavioral Risk Factor Surveillance System (BRFSS) Program 27
Cardiovascular Disease Prevention Program 33
Emergency Medical Services (EMS) Prehospital Data and Information Services and Quality Improvement Program 49
Emergency Medical Services (EMS) Systems Operations, Planning, and Specialty Care 56
Health in All Policies 80
Healthy People 2030 Program 88
Injury Prevention Program 95
The Office of Policy and Planning 117
Public Health Accreditation 128
Rape Prevention Program 134
Surveillance Sampling of Leafy Greens 140
Toxicological Outbreaks Program 146
Tuberculosis Free CA 153
Workforce Development: Preventive Medicine Residency (PMR) and CA Epidemiologic Investigation Service (Cal-EIS) Fellowship 166

Executive Summary

This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Fiscal Year 2023. 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.	$604,515
CA Asylum Seeker Health Surveillance and Linkage to Care	This program is an active surveillance and rapid public health response program for individuals seeking asylum and intending to reside in CA. Active surveillance increases early identification of infectious diseases of public health significance, and services facilitate linkage to healthcare services and disease control.	$230,477
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.	$283,213
Cardiovascular Disease Prevention Program	This program aims to increase the number of adults successfully controlling their high blood pressure to reduce illness and death associated with heart disease and stroke. The program utilizes Comprehensive Medication Management's team-based care approach, linking attending physicians, community pharmacists, stroke coordinators, and community health workers to help post-stroke patients achieve better hypertension control and reduce the risk of stroke recurrence. This program also promotes cardiovascular health through collaboration with the Healthy Hearts California alliance members via biannual webinars and is updating California's Master Plan for Heart Disease and Stroke Prevention and Treatment.	$831,847

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.	$1,207,869
EMS Systems Operations, Planning, and Specialty Care	Emergency Medical Services Authority, through its EMS Systems Division is mandated to provide oversight of EMS systems, the statewide Trauma System, Stroke and ST-Elevation Myocardial Infarction (STEMI) Systems, EMS for Children, and the CA Poison Control system. The EMS Systems Division has statutory and regulatory oversight responsibility of the EMS system for the State of CA and promulgates regulations for use by local EMS agencies and EMS providers, reviews and approves annual local EMS system a plans 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.	$1,450,242
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.	$578,875
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.	$816,704

Injury Prevention Program	This Program seeks to maintain and strengthen injury prevention as a core public health function and ensure capacity to address on-going and emerging cross-sector issues through programming, surveillance, and strategic planning for a range of topics including: 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 impact and increase longevity and well-being through evidence-based prevention strategies	$1,108,074
The Office of Policy and Planning	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.	$943,753
Public Health Accreditation Program	CDPH has been accredited by the Public Health Accreditation Board (PHAB) since 2014. The Public Health Accreditation Program (PHA) coordinates all internal activities relating to maintaining CDPH's accreditation status, and provides technical assistance and support to all California Local Health Jurisdictions (LHJs) that are pursuing or considering PHAB accreditation or reaccreditation.	$58,596
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.	$825,408
Surveillance Sampling of Leafy Greens	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
Toxicological Outbreaks Program	This program supports the administrative and technical infrastructure at CDPH to conduct non-infectious toxicological disease outbreak investigations.	$122,074

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.	$585,958
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.	$672,281

Advancing Climate Change and Health Programs at LHDs, tribes and within CDPH

Healthy People 2030 Objective

EH-D02 Reduce diseases and deaths related to heat

Health Objective

Between July 1, 2023 and June 30, 2024, 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: $513,838
- 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: 3.50

Position #1	
Position Title:	Health Program Specialist I
Staff Name in Position:	Osamu Kumasaka
Total FTE [% time]:	100

Position #2	
Position Title:	Health Program Manager I
Staff Name in Position:	Elizabeth Rhoades
Total FTE [% time]:	100

Position #3	
Position Title:	Health Program Specialist I
Is this position vacant?	Yes
Total [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	Program has interviewed candidates and is checking references on the selected candidate. Barring any barriers, position will be filled by May or June 2023.

Position #4	
Position Title:	Associate Governmental Program Analyst
Is this position vacant?	Yes
Total FTE [% time]:	50
Briefly describe the recruitment/hiring plan to fill the vacant position:	Program experienced a failed recruitment for this position. The RPA for the re-posting was created March 16, 2023. Program aims to have it filled by July 1, 2023, barring any problems with hiring.

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, floods, 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 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, 2000-2020 (https://trackingcalifornia.org/heat-related-illness/heat-related-illness-summary-tables)

Date key indicator baseline data was last collected: 2020

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. Local health departments
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*: American Community Survey 2022
- *Number of people served:* 39,029,342
- *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 07/2023 and 06/2024, Program will increase the number of CDPH and CalHHS programs that incorporate climate change considerations into their health programs, plans, policies, or communications from 15 to 18.

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 incorporate climate change into state agency health programs and plans. 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, American Public Health Association, CDPH, and journal articles

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:* 15
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 03/15/2023
- *Interim target value to be achieved by the Annual Progress Report:* 16
- *Final target value to be achieved by the Final Progress Report:* 18

Target Population

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

Activity 1

Host Cross-CDPH Climate Change Collaboration Meetings. Between 07/2023 and 06/2024, Program will meet at least three (3) 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 07/1/2023 and 06/30/2024, 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 07/2023 and 06/2024, Program will provide technical assistance to 18 CDPH programs regarding climate change in the forms of communications, fact sheets, health warnings, and program objectives.

Description of Activity: Between 07/1/2023 and 06/30/2024, the Health Program Manager I will be responsible to provide technical assistance to 18 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 07/2023 and 06/2024, Program will provide technical assistance to 3 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 07/1/2023 and 06/30/2024, the Health Program Manager I will be responsible to provide technical assistance to 3 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 07/2023 and 06/2024, Program will increase the number of LHDs that incorporate climate change considerations into their health programs, plans, policies, or communications from six (6) to nine (9).

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 help LHDs incorporate climate change into health programs, plans, and policies. 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: APHA's "Climate Change, Health & Equity: A Guide for Local Health Departments

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:* 6
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 03/15/2023
- *Interim target value to be achieved by the Annual Progress Report:* 7
- *Final target value to be achieved by the Final Progress Report:* 9

Target Population

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

Activity 1

Support LHDs to Conduct Environmental Scans. Between 07/2023 and 06/2024, Program will provide technical assistance to at least six (6) LHDs to conduct environmental scans of local climate change planning activities, possible partners, gaps, and opportunities.

Description of Activity: Between 07/01/2023 and 06/30/2024, the Health Program Specialist I will provide technical assistance to at least six (6) 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 07/01/2023 and 06/30/2024, Program will provide technical assistance to at least six (6) LHDs to utilize data tools and local knowledge to assess local vulnerability to the health impacts of climate change.

Description of Activity: Between 07/1/2023 and 06/30/2024, the Health Program Specialist I will provide technical assistance to at least six (6) 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 07/2023 and 06/2024, Program will 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 four (4) to six (6). 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 help six (6) Tribes integrate climate and health-related programs and plans. Program will provide technical assistance to six (6) Tribes, Tribal-serving organizations, 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 integrate climate and health programs and plans
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 4
- *Data source for baseline value:* Program reported data
- *Date baseline was last collected:* 03/15/2023
- *Interim target value to be achieved by the Annual Progress Report:* 5
- *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*: 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 & non-federally recognized Tribal territories, clinics, & health organizations in 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

Activity 1

Technical assistance to Tribes with climate and health planning and programs. Between 07/2023 and 06/2024, the Tribal Program Specialist will assist two (2) 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 07/2023 and 06/2024, the Tribal Program Specialist will assist two (2) 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

Support a Community of Practice for Tribes or Tribal health organizations. Between 07/2023 and 06/2024, the Tribal Program Specialist will facilitate at least (3) communication strategies 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 07/2023 and 06/2024, 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 (3) 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

California Asylum Seeker Health Surveillance and Linkage to Care

Healthy People 2030 Objective

AHS-04: Reduce the proportion of people who can't get medical care when they need it

Health Objective

Between July 1, 2023 and June 30, 2024, 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: $230,447
- Amount of funding to local agencies or organizations: $230,447
- 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. 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: 0

Data source for key indicator baseline: Program FY 2023

Date key indicator baseline data was last collected: 7/1/2023

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

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, March 2023
- *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, 2023 and June 30, 2024, 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

Active disease surveillance data collection. 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 07/2023 and 06/2024, 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:* 0
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 07/01/2023
- *Interim target value to be achieved by the Annual Progress Report:* 70
- *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.

Activity 1

Asylum Seeker Active Surveillance. Between 07/2023 and 06/2024, 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 07/2023 and 06/2024, 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 07/2023 and 06/2024, Program will review data in the asylum seeker health surveillance system database (ASHS database) quarterly (4 times annually) for completeness and accuracy. Data 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 and reviewed for completeness and accuracy. 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: July 1, 2023 and June 30, 2024, 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.

Problem for this Objective: **Health surveillance for asylum seekers is largely not available.** 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: 7/1/2023

Intervention Information

Program will analyze asylum seeker health surveillance data and publish report. Between 07/2023 and 06/2024, 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
- *Unit of measurement:* 1 report completed
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 07/1/2023
- *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.

Activity 1

Surveillance Data Analysis. Data Analysis. Between 07/2023 and 06/2024, Program will analyze annual data from 150 asylum seekers collected from the ASHS database to identify disease prevalence and trends among asylum seekers in 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 07/2023 and 06/2024, Program will produce one (1) report summarizing disease prevalence and trends among asylum seekers in Southern California.

Description of Activity: Program will produce one (1) report summarizing disease prevalence and trends among asylum seekers in Southern California between 07/2023 and 06/2024.

- *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 07/2023 and 06/2024, 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. 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:* 0
- *Data source for baseline value:* Current programmatic outcomes
- *Date baseline was last collected:* 07/01/2023
- *Interim target value to be achieved by the Annual Progress Report:* 70
- *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.

Activity 1

Linkage to Health Services. Between 07/2023 and 06/2024, LHJ programs will provide one-on-one case management services for linkage to healthcare to 150 asylum seekers.

Description of Activity: Between 07/2023 and 06/2024, 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 07/2023 and 06/2024, LHJ program will provide case management for 150 referrals to health providers for asylum seekers in California.

Description of Activity: Between 07/2023 and 06/2024, 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 in public health

Health Objective

To enhance the use of California BRFSS data in public 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: State Health Department
- 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 Factor Surveillance Program
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Issue/Problem

BRFSS data are used for directing program planning, evaluating programs, establishing program priorities, developing specific intervention and policies, assessing trends, and targeting relevant population groups. CA BRFSS provides mission critical data to CDPH and meets CDPH block grant funding criteria. 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. BRFSS data supports core public health programs and services representing all foundational area of CDPH. The data are used for directing program planning, evaluating programs, establishing program priorities, developing specific interventions and policies, assessing trends, and targeting relevant population groups towards meeting Health 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: 1

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: 06/20/2022

Program Strategy

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

Is this program specifically addressing a Social Determinant of Health (SDOH)?: 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, 2017-2021 American Community Survey 5-Year Estimates
- *Number of people served:* 30,462,921
- *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: Program will manage the integration of processes and services to the data collection call center to collect at least 8,000 BRFSS surveys from July 1, 2023 to June 30, 2024.

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

Monitoring processes and services of survey call center. Between July 1, 2023 and June 30, 2024, 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.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: Monitoring the number of collected surveys 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:* 06/20/2022
- *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.

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, 2023 to June 30, 2024.

Description of Activity: Between July 1, 2023 and June 30, 2024, 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 one (1) data set to external and internal BRFSS data users from July 1, 2023 to June 30, 2024.

Description of Activity: Program will provide one (1) BRFSS data set to external and internal BRFSS data users by September 1, 2023.

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

Activity 3

Analyze BRFSS Data. Program will analyze data from questions covering fifteen (15) core modules of the BRFSS and make available to public and programs from July 1, 2023 to June 30, 2024.

Description of Activity: Between July 1, 2023 and June 30, 2024, Program will analyze data collected from questions covering fifteen (15) core modules 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 4

Produce Four Factsheets. Between July 1, 2023 and June 30, 2024, Program will, upon completion of analysis, produce four (4) factsheets.

Description of Activity: Between July 1, 2023 and June 30, 2024, Program will upon completion of analysis, produce four (4) 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

Activity 5

Host BRFSS users Webinars. Between July 1, 2023 and June 30, 2024, Program will host a biannual (2) BRFSS users webinar.

Description of Activity: Between July 1, 2023 and June 30, 2024, Program will host a biannual BRFSS users webinar. Webinars scheduled in August/September 2023 and February/March 2024 will highlight user findings of BRFSS data, updates on survey collection and data.

- *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 control of high blood pressure in adults

Health Objective

From 07/01/2023 to 6/30/2024, hypertension control will be increased by a 3 (3) point percentage, from 58% to 61%, 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: 6
- Number of FTEs in this program funded by the PHHS Block Grant: 2.09

Position #1	
Position Title:	Health Program Specialist II_CVD Lead
Staff Name in Position:	Tiffany Richards
Total FTE [% time]:	100

Position #2	
Position Title:	Health Program Specialist I_CHW Lead
Staff Name in Position:	Lizbeth Martinez
Total FTE [% time]:	100

Position #3	
Position Title:	Research Scientist III
Staff Name in Position:	Dharma Bhatta
Total FTE [% time]:	30

Position #4	
Position Title:	Associate Governmental Program Analyst Contract
Staff Name in Position:	Lisa Pulido
Total FTE [% time]:	25

Position #5	
Position Title:	Associate Governmental Program Analyst Fiscal
Staff Name in Position:	Bryan Meade
Total FTE [% time]:	24

Position #6	
Position Title:	Research Scientist Supervisor I
Staff Name in Position:	Nana Tufuoh
Total FTE [% time]:	10

Issue/Problem

Heart disease and stroke remain the first and sixth leading causes of death and disability in California (CA) and the Cardiovascular Disease Prevention Program (CDPP) works to increase hypertension control in adults to reduce the morbidity and mortality associated with cardiovascular disease (CVD) in CA. Heart disease and stroke are the first and sixth leading causes of death in CA and a major cause of disability. In 2021, an estimated 65,471 Californians died from heart disease and 18,364 from stroke (CDC Wonder, 2021). 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 $52 billion (Economic Burden of Chronic Disease in California, 2018. California Department of Public Health). The 2021 age-adjusted prevalence rate of hypertension in adults 18 and older was 24.6% (California Health Interview Survey [CHIS 2021], any heart disease 6.2% percent [CHIS 2021], and stroke 2.5% (Behavioral Risk Factor Surveillance System [BRFSS 2021]).

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: Prevalence (HDS-05): California Health Interview Survey and Behavioral Risk Factor Surveillance System. Mortality (HDS-02 and HDS-03): CDC WONDER. California Vital Statistics Data. California Department of Healthcare Access and Information (HCAI), Patient Discharge Data, 2019.

Baseline value of the key indicator described above: Heart Disease (HDS-02): 85.8 per 100,000; Blood Pressure (HDS-05): 24.6; Stroke (HDS-03): 42.1 per 100,000; stroke hospitalization: 2.2%.

Data source for key indicator baseline: Prevalence (HDS-05): California Health Interview Survey and Behavioral Risk Factor Surveillance System. Mortality (HDS-02 and HDS-03): CDC

WONDER. California Vital Statistics Data. California Department of Healthcare Access and

Date key indicator baseline data was last collected: 2021

Program Strategy

Goal: Increase blood pressure control in adults with hypertension in order to reduce deaths from coronary artery disease and reduce the risk of stroke recurrence in post-stroke patients thereby decreasing 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: CDPP implements several strategies to reach the program's goal of increasing the number of adults with controlled hypertension. These strategies include implementing Comprehensive Medication Management (CMM), disseminating research and best practices to public health professionals in the Healthy Hearts California (HHC) alliance, and updating the State Plan for Heart Disease and Stroke Prevention and Treatment.

CDPP's promotion and implementation of CMM currently focuses on a pilot project of post-stroke patients in Riverside County. The pilot links post-stroke patients leaving the hospital with attending physicians, community pharmacists, stroke coordinators, and community health workers (CHWs) to help patients achieve better hypertension control by improved medication management. Better hypertension control can reduce the risk of a recurrent stroke event and, as a result, reduce the number of deaths from coronary artery disease and strokes.

CDPP presents best practices and protocols to the HHC alliance using a variety of communication strategies. CDPP will host a biannual webinar; convene an in-person event; and distribute biannual email communications to share current research, new reports and studies, and updates to protocols and practices. These strategies aim to improve the reach of information to public health professionals across different settings, thereby decreasing silos, and broadening and strengthening the existing HHC alliance.

As the largest public health department in the country, it is imperative that California Department of Public Health provide and disseminate current and relevant best practices, data, and resources. The State Plan for Heart Disease and Stroke Prevention and Treatment was released in 2007 and is past due for an update. CDPP will release an initial draft of an updated CVD State Plan by the end of June 2024 to ensure access to the most current information possible.

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)

Internal:

1. Cardiovascular Health Program (CDC 2304 Grant)
2. California Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMEN)
3. Chronic Disease Control Branch Future of Public Health Program
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 will evaluate the implemented annual activities for progress and outcomes on a yearly basis. This evaluation includes 1) Post-webinar evaluation of HHC collaboration; and 2) Evaluation of team-based care CMM pilot project for control of hypertension 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), 2021; CA Health Interview Survey (CHIS), 2021
- *Number of people served:* 9,780,537
- *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:

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

Objective: Between 07/2023 and 06/2024, CDPP staff and partners will use CMM to increase hypertension control in approximately 60% (30 people) of post-stroke adults discharged from hospital care, thereby reducing stroke recurrence.

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 hypertension control in post-stroke patients can increase risk for a recurrent stroke**. People who survive a stroke are at high risk for a recurrent stroke event and other chronic CVD. After a 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 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

Data source for key indicator baseline: Percentage of HCAI Patient Discharge Data (2%)

Date key indicator baseline data was last collected: 2021

Intervention Information

Coordinate a pilot project to provide CMM to improve post-stroke patient care in Riverside County. CDPP staff will coordinate a CMM pilot with a minimum of 30 post-stroke adults from DRMC in Riverside County. Patients are referred to CMM to receive supervised care from a multidisciplinary patient care team including an attending physician, community pharmacist, stroke coordinator, and community health worker. The CMM pilot is carried out by CDPP staff in collaboration with USC-CRMC, IEHP-Riverside County Managed Care Organization, and

DRMC. The pilot includes formal data/database use agreements with DRMC, AHA-Get with the

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 - evidence-based intervention, Health Care Quality Measures approved by Nat'l 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
- *Unit of measurement:* Number of post-stroke patients referred to CMM
- *Baseline value for the item to be measured:* 2
- *Data source for baseline value:* De-identified post-stroke patient data from DRMC under hospital's data use agreement with CDPH
- *Date baseline was last collected:* 2/6/2023
- *Interim target value to be achieved by the Annual Progress Report:* 12
- *Final target value to be achieved by the Final Progress Report:* 30

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
- *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

Convene CMM Pilot Subcommittee Meetings. Between 7/2023 and 6/2024, CDPP will convene a minimum of twelve (12) CMM Pilot Subcommittee Meetings to discuss pilot implementation among collaborating partners.

Description of Activity: CDPP staff will convene twelve (12) CMM pilot project subcommittee meetings to discuss the implementation of the CMM pilot project in Riverside County. The deliverables for this activity will be a) meeting minutes and b) a document outlining the process and workflow of CMM referral to improve control of hypertension in post-stroke patients.

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

Activity 2

Convene CMM Statewide Implementation Meetings. Between 7/2023 and 6/2024, CDPP will convene four (4) quarterly CMM Statewide Implementation Meetings to discuss CMM implementation across CA with various partners and stakeholders.

Description of Activity: Between 07/2023 and 06/2024, CDPP staff will convene four (4) quarterly CMM Statewide Implementation Meetings to share best practices on CMM implementation and solicit technical assistance from experts. The deliverables for this activity are meeting minutes and recordings.

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

Activity 3

Conduct CMM Webinar. By 6/2024, CDPP will conduct a minimum of one (1) CMM Webinar to present CMM Pilot results to stakeholders across the State.

Description of Activity: By 06/2024, with contracted support from California State University, Sacramento (CSUS), CDPP will conduct a minimum of one (1) CMM webinar to present the CMM Pilot's implementation, results, and learnings to stakeholders across the State. The deliverables for this activity are the webinar agenda and recording.

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

Activity 4

Implement Hospital CMM Referral System for Post-Stroke Patients upon Discharge. Between 07/2023 and 06/2024, CDPP will implement a Hospital CMM Referral System for Post-Stroke Patients upon Discharge and will generate one (1) common findings report.

Description of Activity: CMM-based patient care team including an attending physician, stroke coordinators, community pharmacist, and CHWs will be responsible for this activity. 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 as per outlined in the process and workflow of CMM referral. By 06/2024, CDPP will collaborate with USC and DRMC to develop a common findings report outlining the CMM Pilot's results using GWTG-S data. The deliverable for this activity is the common findings report.

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

Objective 2:

Title: Communicate cardiovascular health best practices to HHC members through various methods

Objective: Between 07/2023 and 06/2024, CDPP will communicate cardiovascular health best practices to HHC members through various methods including one (1) webpage update, one (1) live webinar, one (1) in-person convening, and two (2) email distributions.

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

Communicate cardiovascular health best practices to HHC members through various methods. Through collaborative and collective action, HHC is a driving force behind reducing the risk and prevalence of heart disease and stroke in CA. HHC members include 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. CDPP facilitates communication and shared ideas among this collaborative group while looking through the Social Determinants of Health (SDOH) lens and leveraging resources to support programs that improve cardiovascular health outcomes. HHC also addresses factors that contribute to heart disease and stroke and works to eliminate health disparities. Coordination with HHC members to present webinars and in-person sharing of best practices 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.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Best Practice Initiative (U.S. Department of Health and Human Services)
- Guide to Clinical Preventive Services (Task Force on Community Preventive Services)
- MMWR Recommendations for Reports (Centers for Disease Control and Prevention)
- Other: protocols, and team-based care models among statewide stakeholders

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. CDPP facilitates communication and shared ideas among this collaborative group while looking through the Social Determinants of Health (SDOH) lens and leveraging resources to support programs that improve cardiovascular health outcomes. HHC also addresses factors that contribute to heart disease and stroke and works to eliminate health disparities.

- *Item to be measured:* Number of 1) webinars, 2) communication emails, 3) in-person convenings, and 4) webpage updates
- *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:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 5

Target Population

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

Activity 1

Update HHC Membership Database. Between 07/2023 and 06/2024, CDPP will review and update the existing HHC membership database, including conducting outreach to a minimum of five (5) email addresses that have previously bounced back.

Description of Activity: Between 07/2023 and 06/2024, CDPP will review and update the existing HHC membership database, including conducting outreach to a minimum of five (5) email addresses that have previously bounced back. The purpose of outreach is to identify potential new contacts for HHC Membership thereby broadening and strengthening the membership. The deliverable for this activity is the HHC membership database.

- *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. Between 07/2023 and 06/2024, CDPP will review and update one (1) HHC membership packet.

Description of Activity: Between 07/2023 and 06/2024, CDPP will review and update one (1) HHC membership packet to ensure links are active and health resources and fact sheets are current. This review will also include ensuring alignment with the Healthy People 2030 goals. The deliverable for this activity is the HHC membership packet.

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

Activity 3

Convene Healthy Hearts California (HHC) Webinar. Between 07/2023 and 06/2024, CDPP, in coordination with AHA, will develop and convene one (1) webinar to present best practices protocols on CVD prevention and management to HHC.

Description of Activity: Between 07/2023 and 06/2024, with contracted support from CSUS, CDPP, in coordination with AHA, will develop and convene one (1) webinar to present best practices and protocols to HHC. Sharing best practices protocols and promoting utilization of team-based care models, including CMM, supports effective treatment, management, and control of hypertension and aligns with the CDPP goal of increasing hypertension control. The deliverables for this activity are webinar agendas and recordings.

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

Activity 4

Conduct Evaluation of HHC In-Person Event and Webinar. By 06/2024, CDPP will produce one (1) evaluation summary report outlining the HHC in-person event and webinar attendance and impact.

Description of Activity: By 06/2024, CDPP will produce one (1) evaluation summary report outlining HHC in-person event and webinar attendance and impact. This evaluation will inform the planning and offerings of future in-person events and webinars as well as membership needs. The deliverable for this activity is the evaluation reports.

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

Activity 5

Promote CVD Awareness and Communicate Best Practices to HHC Members via Email. Between 07/2023 and 06/2024, CDPP will communicate cardiovascular health best practices to HHC members via two (2) email distributions.

Description of Activity: Between 07/2023 and 06/2024, CDPP will communicate cardiovascular health best practices to HHC members via two (2) email distributions. Information will include the latest research and newly published reports and studies; upcoming meetings, trainings, and webinars; and other relevant information as appropriate. The deliverable for this activity is copies of the email communications.

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

Activity 6

Review and Update CDPP Webpage. Between 07/2023 and 06/2024, CDPP will review and update one (1) CDPP webpage on the CDPH website to ensure links are active and health resources and fact sheets are current.

Description of Activity: Between 07/2023 and 06/2024, CDPP will review and update one (1) CDPP webpage on the CDPH website to ensure links are active and health resources and fact sheets are current. The intent of the CDPP webpage is to increase public awareness of CVD through resources and information. The deliverable for this activity is screenshots of updates to 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 7

Convene HHC In-person Event. Between 07/2023 and 06/2024, CDPP, in coordination with CDCB staff, will develop and host one (1) in-person event to present best practices to statewide contractors and partners.

Description of Activity: Between 07/2023 and 06/2024, with contracted support from CSUS, CDPP, in coordination with CDCB staff, will develop and host one (1) in-person event to present best practices and address works to reduce health disparities in cardiovascular health to contractors and partners involved. Sharing best practices protocols supports effective treatment, management, and control of hypertension and aligns with the CDPP goal of increasing hypertension control. The deliverable for this activity is a final report of the event outcomes.

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

Objective 3:

Title: Update State Plan for Heart Disease and Stroke Prevention and Treatment

Objective: Between 07/2023 and 06/2024, CDPP will coordinate with subject matter experts to update the State Plan for Heart Disease and Stroke Prevention and Treatment (2007-2015) based on new research and cardiovascular health data, practices, and guidance by conducting at least four (4) meetings with stakeholders.

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

Convene State Plan Update Task Force Meetings & Subcommittee Meetings to Update Existing State Plan. The State Plan for Heart Disease and Stroke Prevention and Treatment was published in 2007 with data from 2004 and earlier. With heart disease and stroke remaining the first and sixth leading causes of death for Californians, it is imperative that the CVD State Plan be updated to include current guidance and recommendations including current data and best practices from subject matter experts.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: As a result of these stakeholder meetings, the updated CVD State Plan will be used as the roadmap by various stakeholders with the goal to improve cardiovascular disease throughout California.

- *Item to be measured:* Number of Task Force committee meetings
- *Unit of measurement:* Number of Task Force committee meetings
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Vital Statistics, CDC WONDER, CA BRFSS and CHIS, Literature, Task Force Meeting Minutes
- *Date baseline was last collected:* 2022
- *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.

Activity 1

Convene Plan Update Task Force Meetings. Between 7/2023 and 6/2024, with contracted support from CSUS, CDPP staff and the Task Force Chair will plan, organize, and convene a minimum of two (2) CVD State Plan Update Task Force meetings to bring together stakeholders and review the original CVD State Plan for needed updates.

Description of Activity: By Between 7/2023 and 6/2024, CDPP staff, with contracted support from CSUS, will plan, organize, and convene a minimum of two (2) CVD State Plan Update Task Force meetings to bring together stakeholders and review the original CVD State Plan for needed updates. Each of the updated CVD State Plan's ten goals has an accompanying subcommittee and, during these meetings, subcommittees will provide updates on progress for each of the CVD State Plan's ten (10) goals. The deliverables for this activity are meeting minutes and recordings.

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

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

Activity 2

Convene Task Force Chair Planning Meetings. Between 7/2023 and 6/2024, CDPP staff will plan, organize, and convene a minimum of twelve (12) Task Force Chair Planning Meetings with the Task Force Chair to internally discuss the CVD State Plan update.

Description of Activity: Between 7/2023 and 6/2024, CDPP staff will plan, organize, and convene a minimum of twelve (12) Task Force Chair Planning Meetings with the Task Force Chair to internally discuss the CVD State Plan update, the progress of the ten subcommittees, quarterly Task Force Meeting preparation, and other CVD State Plan-related items. The deliverable for this activity is meeting minutes.

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

Activity 3

Convene Task Force Subcommittee Meetings. Between 7/2023 and 6/2024, CDPP staff will plan, organize, and convene a minimum of three (3) Task Force Subcommittee Meetings for each subcommittee so Task Force members and advisors can review and discuss updates for their assigned goal/topic.

Description of Activity: Between 7/2023 and 6/2024, CDPP staff will plan, organize, and convene a minimum of three (3) Task Force Subcommittee Meetings for each subcommittee. During these meetings, subcommittees will review existing content, identify gaps, and make recommendations for new and updated content. The deliverable for this activity is meeting minutes.

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

Activity 4

Coordinate and Attend Regular Meetings with State Plan Editor/Writer. Between 7/2023 and 6/2024, CDPP staff will coordinate and attend a minimum of four (4) meetings with the CVD State Plan Editor/Writer.

Description of Activity: Between 7/2023 and 6/2024, CDPP staff will coordinate and attend a minimum of four (4) meetings with the State Plan Editor/Writer. In order to create an accessible, high-quality, user-friendly end product document, CDPP has secured, with contracted support from CSUS, a professional CVD State Plan Editor/Writer to consolidate experts' feedback and draft updated content for the new CVD State Plan. CDPP will meet with the CVD State Plan Editor/Writer to ensure alignment with recommendations, forward progress, etc. The deliverables for this activity are meeting minutes.

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

Activity 5

Complete Draft Update to the State Plan for Heart Disease and Stroke Prevention and Treatment. By 06/2024, CDPP staff will complete and submit an initial draft of one (1) CVD State Plan for Heart Disease and Stroke Prevention and Treatment.

Description of Activity: By 06/2024, CDPP staff, with support from the CVD State Plan Editor/Writer and the CVD State Plan Update Task Force Chair and Members, will complete and submit an initial draft of one (1) CVD State Plan for Heart Disease and Stroke Prevention and Treatment, including current recommendations and data. The deliverable for this activity is a draft of the updated CVD State 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 with access to necessary electronic information

Health Objective

Between 07/2023 and 06/2024, 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: 4.50

Position #1	
Position Title:	Staff Services Manager I
Staff Name in Position:	Adrienne Kim
Total FTE [% time]:	100

Position #2	
Position Title:	Associate Governmental Program Analyst
Total FTE [% time]:	Michelle McEuen
Jurisdiction-level FTE	50

Position #3	
Position Title:	Research Program Specialist I
Staff Name in Position:	Victoria Lupinetti
Total FTE [% time]:	100

Position #4	
Position Title:	Associate Governmental Program Analyst
Is this position vacant?	Yes
Total FTE [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	The duty statement and justification have been submitted to CDPH for review. The next step is for the position to be posted online, review the applications and set up interviews.

Position #5	
Position Title:	Health Program Manager II
Staff Name in Position:	Tom McGinnis
Total FTE [% 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 and refine 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 look 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 services that includes lights and/or sirens response, and 911 requests for services that includes 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: 32

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2022

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, 2022
- *Number of people served:* 39,029,342

- *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 07/2023 and 06/2024, 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:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *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.

Activity 1

Develop the Core Quality Measures Process Manual. Between 07/2023 and 06/2024, Program will develop one (1) Core Quality Measures Process Manual.

Description of Activity: Between 07/2023 and 06/2024, Program will develop one (1) 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 07/2023 and 06/2024, Program will produce one (1) 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 07/2023 and 06/2024, Program will develop one (1) 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 07/2023 and 06/2024, Program will produce one (1) 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 07/2023 and 06/2024, Program Staff will compile and analyze 100% of one (1) EMS data set submitted by LEMSAs into the CEMSIS database and develop the annual CY 2022 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 (34 letters in all) that outlines the previous year's data submission, providers based on LEMSA's EMS Plans, and previous year’s data submissions.

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 07/2023 and 06/2024, Program will publish one (1) Data Matching Report on the EMSA Website.

Description of Activity: Between 07/2023 and 06/2024, Program staff will publish one (1) report on EMSA’s website detailing the successes and outcomes of matching EMS data with an outside data source.

- *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 people who can't get medical care when they need it

Health Objective

Between 07/2023 and 06/2024, The Emergency Medical Services (EMS) 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: 7.50

Position #1	
Position Title:	Health Program Manager II
Staff Name in Position:	Tom McGinnis
Total FTE [% time]:	50

Position #2	
Position Title:	Staff Services Manager I
Staff Name in Position:	Angela Wise
Total FTE [% time]:	100

Position #3	
Position Title:	Management Services Technician
Staff Name in Position:	John Skarr
Total FTE [% time]:	100

Position #4	
Position Title:	Health Program Specialist II
Is this position vacant?	Yes
Total FTE [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	Job applications are currently under review.

Position #5	
Position Title:	Health Program Specialist II
Staff Name in Position:	Farid Nasr, MD
Total FTE [% time]:	100

Position #6	
Position Title:	Health Program Specialist I
Staff Name in Position:	Mark Olivas
Total FTE [% time]:	100

Position #7	
Position Title:	Health Program Specialist I
Is this position vacant?	Yes
Total FTE [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	Job applications are currently under review.

Position #8	
Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Lori O'Brien
Total FTE [% 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: Emergency Medical Services Authority, through its EMS Systems Division is mandated to provide oversight of EMS systems, the statewide Trauma System, Stroke and ST-Elevation Myocardial Infarction (STEMI) Systems, EMS for Children, and the CA Poison Control system. The EMS Systems Division has statutory and regulatory oversight responsibility of the EMS system for the State of CA and promulgates regulations for use by local EMS agencies and EMS providers, reviews and approves annual local EMS system plans 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.

Baseline value of the key indicator described above: 34

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2023

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
- Other: Local EMS Agencies

Target Population of Program

- *Target population data source*: US Census Bureau, July 1, 2022
- *Number of people served:* 39,029,342
- *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 07/2023 and 06/2024, Program will maintain one (1) 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 Information System (CEMSIS) data to establish quality-improvement measures, EMSA will evaluate additional needs for LEMSAs to enhance their EMSC programs. Review of at least eight (8) 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: 2023

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:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *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 sub-set of the Program.

- *Target population data source*: US Census Bureau, July 1, 2022.
- *Number of people served:* 8,742,573
- *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 07/2023 and 06/2024, Program will provide education on trends in emergency medical care of pediatric patients by conducting one (1) California EMSC Educational Forum.

Description of Activity: Between 07/2023 and 06/2024, Program will conduct one (1) California EMSC Educational Forum to provide educational opportunities for EMS and hospital providers

related to medical treatment of pediatric patients. 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?* No
- *Does the data collection involve public health data?* No

Activity 2

Provide Technical assistance to EMSC Programs. Between 07/2023 and 06/2024, Program will provide technical assistance to at least four (4) LEMSAs who have or are developing EMSC plans.

Description of Activity: Between 07/2023 and 06/2024, Program will provide technical assistance to at least four (4) 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

Activity 3

Review EMS Plans. Between 07/2023 and 06/2024, Program will review at least eight (8) EMS Plans to ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California.

Description of Activity: Between 07/2023 and 06/2024, Program will review of at least eight (8) EMS Plans to ensure compliance with EMSC regulations to provide continuity and conformity of EMSC programs throughout California.

- *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 07/2023 and 06/2024, Program will maintain one (1) 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.

Problem for this Objective: **Injuries from trauma and traumatic illness is a leading cause of death for Californians.** In California, a 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 78 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

Develop, implement, and review local trauma systems to ensure timely access to optimal trauma care. 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 78 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 Systems 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:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *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.

Activity 1

Review and Analyze Trauma Plan Status Updates (TSSRs). Between 07/2023 and 06/2024, Program will review and analyze at least twenty (20) LEMSA Trauma Plan Status Updates submitted to EMSA.

Description of Activity: Between 7/2023 and 6/2024, Program will analyze a minimum of twenty (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 07/2023 and 06/2024, Program will provide oversight of one (1) trauma registry data collection.

Description of Activity: Between 07/2023 and 06/2024, Program will oversee and coordinate the overall data collection of one (1) trauma registry into CEMSIS-Trauma from 78 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. Between 07/2023 and 06/2024, Program will create and host a one-day (1), virtual Trauma Summit.

Description of Activity: Between 07/2023 and 06/2024, Program will create a one-day (1) virtual Trauma Summit 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 07/2023 and 06/2024, Program will facilitate four (4) quarterly meetings with State Trauma Advisory Committee meetings to promote the development of the state trauma system with trauma stakeholders.

Description of Activity: Between 07/2023 and 06/2024, Program will facilitate four (4) 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 3:

Title: Maintain EMS Partnership for Injury Prevention and Public Education

Objective: 07/2023 and 06/2024, Program will maintain one (1) 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 50 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.

Problem for this Objective: **The mortality rate for injury deaths in California is the highest in the U.S.** California historically has the highest number of injury deaths in the country. California also has the highest number of unintentional injury deaths. 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.

Key indicator affected by this program: Inclusion of an EMS role in statewide prevention and public-education initiatives, programs, and policies will be used to recognize EMS as a vital part of prevention and public-education activities. The key indicators are the number of EMS partners attending the Injury Prevention workshops at the Annual Trauma Summit.

Baseline value for the key indicator: 650

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 10/06/2022

Intervention Information

Increase access to and effectiveness of rapid prehospital EMS by providing statewide injury-prevention training and initiatives with local EMS providers and stakeholders. Increase access to and effectiveness of rapid prehospital EMS by providing statewide injury-prevention training 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, "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:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *Interim target value to be achieved by the Annual Progress Report:* 25
- *Final target value to be achieved by the Final Progress Report:* 50

Target Population

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

Activity 1

Maintain EMS Partnership for Injury Prevention and Public Information Program webpage. Between 07/2023 and 06/2024, Program will maintain one (1) injury and illness-prevention web page on the EMSA website.

Description of Activity: Between 07/2023 and 06/2024, Program will maintain one (1) 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 64 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 07/2023 and 06/2024, Program will attend three (3) TMAC General meetings to provide leadership in the coordination of injury prevention activities at the local and regional level.

Description of Activity: Between 07/2023 and 06/2024, Program will attend three (3) 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?* No
- *Does the data collection involve public health data?* No

Objective 4:

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

Objective: 07/2023 and 06/2024, EMSA Program will maintain one (1) 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 a STEMI Critical Care System, 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.

Problem 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 STEMI 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 key indicators are 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: 2023

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

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: AHA Guidelines' Mission Lifeline, the Ameri. College of Cardiology recs, Nat'l 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 a STEMI Critical Care System 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:* TA in interpretation of regulations, annual plan review, and other guidance provided to LEMSAs, etc.
- *Unit of Measurement*: Number of stakeholder engagements
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *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.

Activity 1

Provide Education on Current Trends for Optimal STEMI care. Between 07/2023 and 06/2024, California Emergency Medical Services Authority will conduct one (1) State STEMI Summit.

Description of Activity: Between 07/2023 and 06/2024, Program will conduct one (1) 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 07/2023 and 06/2024, the TAC meets in a regular basis to advise EMSA Director and the STEMI program on all aspects of the specialty care systems. Program staff facilitate and coordinate at least four (4) virtual meetings.

Description of Activity: Between 07/2023 and 06/2024, Program staff facilitate and coordinate at least four (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 Plans. Between 07/2023 and 06/2024, Program will analyze a minimum of 11 STEMI Critical Care System Annual Plans submissions from LEMSAs.

Description of Activity: Between 07/2023 and 06/2024, 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 07/2023 and 06/2024, EMSA Program will maintain one (1) 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

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.

Problem 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, Stroke Critical Care Systems are not yet implemented statewide. The LEMSAs that develop Stroke Critical Care Systems are obligated to follow state regulations. Program staff oversee implementation and interpret regulations to ensure LEMSAs are compliant with the state Stroke 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 System 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: 2023

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 Critical Care System 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, the public, and

approval. EMSA Program staff reviews annual plans to ensure the program is in compliant with

- *Item to be measured:* TA 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 plan reviews
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *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.

Activity 1

Provide education on Current Trends for Optimal Stroke care. Between 07/2023 and 06/2024, Program will conduct one (1) State Stroke Summit.

Description of Activity: Between 07/2023 and 06/2024, Program will conduct one (1) 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 07/2023 and 06/2024, Program staff will facilitate and coordinate at least four (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.

Description of Activity: Between 07/2023 and 06/2024, Program staff will 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 07/2023 and 06/2024, Program will analyze a minimum of 11 Stroke Critical Care System Annual Plans submitted to EMSA.

Description of Activity: Between 07/2023 and 06/2024, 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 07/2023 and 06/2024, EMSA Program will provide oversight to one (1) 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 one (1) annual report 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.

Problem for this Objective: **Statute & regulations mandate a CA poison control center (PCC) or regional PCC be designated by 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 237,166 total cases per year, with 71%% of the human exposure cases managed on site (caller/patient was able to remain at call location). Of the 81,748 cases involving children aged five and under, 87% were managed on site. Without CPCS services, emergency department visits would substantially increase.

Key indicator affected by this program: EMSA requires one (1) annual progress report 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: 0

Data source for key indicator baseline: EMSA

Date key indicator baseline data was last collected: 2022

Intervention Information

EMSA will conduct an assessment of one CPCS in order to monitor poison control service activities provided to Californians. EMSA will 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*: Annual report
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *Interim target value to be achieved by the Annual Progress Report:* 1
- *Final target value to be achieved by the Final Progress Report:* 1

Target Population

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

Activity 1

Collect and Review Annual Report Submission. Between 07/2023 and 06/2023, Program will collect and review one (1) annual report submission.

Description of Activity: Program will provide oversight to one (1) CPCS through coordination and technical assistance of one (1) annual report submission with the CPCS Business Director, in accordance with statutory and regulatory authorities and contractual requirements.

- *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 07/2023 and 06/2024, 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: CA Health and Safety Code, Division 2.5 and CA 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:* 0
- *Data source for baseline value:* EMSA
- *Date baseline was last collected:* 7/1/2023
- *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.

Activity 1

Collect EMS Plan Submissions. Between 07/2023 and 06/2024, Program will provide oversight to 100% of LEMSAs required to submit annual EMS plans through coordination of at least eight (8) EMS plan submissions with LEMSA Administrators, technical assistance, and EMS plan determinations, in accordance with statutory and regulatory authorities.

Description of Activity: Between 07/2023 and 06/2024, Program is responsible for providing coordination, technical assistance, and developing annual EMS plan determinations to LEMSA Administrators in accordance with statutory and regulatory authorities.

- *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 07/2023 and 06/2024, 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. Program will track and monitor by updating one (1) internal work-flow management application.

Description of Activity: Between 07/2023 and 06/2024, Program will keep current and update one (1) internal work-flow management application 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 07/2023 and 06/2024, Program will provide coordination and technical assistance to six (6) multicounty LEMSA Administrators.

Description of Activity: Between 07/2023 and 06/2024, Program will provide oversight to six (6) 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 07/2023 and 06/2024, 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. EMSA anticipates eight (8) EMS Plans with associated transportation components will be submitted for review during this time period.

Description of Activity: Between 7/2023 and 6/2024, 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. EMSA anticipates eight (8) EMS Plans with associated transportation components will be submitted for review during this time period.

- *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 07/2023 and 06/2024, Program will update one (1) internal service log to track contract start and end dates of the competitive processes.

Description of Activity: Between 07/2023 and 06/2024, Program will maintain one (1) 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 07/2023 and 06/2024, Program will review at least one (1) competitive process regarding EOAs for transportation, as they come in.

Description of Activity: Between 07/2023 and 06/2024, 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?* Yes
- *Does the data collection involve public health data?* No

Activity 7

Provide Technical Assistance. Between 07/2023 and 06/2024, Program will answer at least 32 requests for technical assistance with EMS transportation issues via email, phone calls, formal correspondence, and face-to-face inquiries.

Description of Activity: Between 07/2023 and 06/2024, Program will provide 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, formal correspondence, and face-to-face meetings. While it is

impossible to know how many requests for assistance will be received, based on previous years it is anticipated that there will be at least 32 instances of technical assistance provided.

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

Health in All Policies

Healthy People 2030 Objective

PHI-R09 Explore the impact of community health assessment and improvement planning efforts

Health Objective

Between 07/2023 and 06/2024, Program staff will advance health and racial equity by (1) embedding health and equity considerations into at least 10 local or state programs, policies, and processes that impact the social determinant of health; (2) build and maintain 10 new relationships and partnerships with stakeholders such as local health jurisdictions and community-based organizations who are advancing equity to achieve this objective.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $578,875
- 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: Supplement other existing funds
- Funding role of the PHHS Block Grant for this program: 10-49% - Partial source of funding
- Role of PHHS Block Grant Funds in supporting this program: Maintain existing program (as is)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: Yes
- Total Positions in this program funded by PHHS Block Grant: 3
- Number of FTEs in this program funded by the PHHS Block Grant: 3

Position #1	
Position Title:	Health Program Specialist I
Is this position vacant?	Yes
Total [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	Interviews have begun; onboard by June 2023.

Position #2	
Position Title:	Health Program Specialist II
Is this position vacant?	Yes
Total [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	Interviews have begun; onboard by June 2023.

Position #3	
Position Title:	Health Program Specialist II
Is this position vacant?	Yes
Total [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	Interviews have begun; onboard by June 2023.

Issue/Problem

California has long-standing health, racial, and social inequities that adversely impact population health, yet public health government agencies and departments must build trust to support trusted community partnerships that implement public health interventions. 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. As California moves towards an equitable recovery, the State has committed to making inclusive and trusted community partnerships among priority and vulnerable groups and populations. By improving community partnerships 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. Poverty is an important public health issue. It limits access to basic material necessities such as housing, food, education, jobs and transportation, and thereby impacts the ability to live a healthy life. 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%. The pandemic has exacerbated inequities. State life expectancy in California declined from 81.40 years in 2019 to 79.20 years in 2020 and 78.37 years in 2021. The gap in life expectancy between the richest and poorest percentiles increased from 11.52 years in 2019 to 14.67 years in 2020 and 15.51 years in 2021. Among Hispanic and non-Hispanic Asian, Black, and White populations, life expectancy declined 5.74 years among the Hispanic population, 3.04 years among the non-Hispanic Asian population, 3.84 years among the non-Hispanic Black population, and 1.90 years among the non-Hispanic White population between 2019 and 2021. Census tract–level income (poverty) and mortality data in California from 2015 to 2021 demonstrated a decrease in life expectancy in both 2020 and 2021 and an increase in the life expectancy gap by income level relative to the pre-pandemic period that disproportionately affected some racial and ethnic minority populations. The consequences of poverty include high rates of poorer health and lower life expectancy among vulnerable populations. It limits access to basic material necessities such as housing, food, education, and jobs, and thereby impacts the ability to live a healthy life.

Baseline value of the key indicator described above: 32.5% of overall population (2018).

Data source for key indicator baseline: Healthy Communities Data and Indicators Project, Income Insecurity.

Date key indicator baseline data was last collected: May 2019

Program Strategy

Goal: Explore the impact of community health assessment and improvement planning efforts on resource allocation, partnerships, community needs, and health outcomes by advancing equitable and inclusive community partnerships.

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)
- 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 community-based partnerships, Program will explore the impact of community health assessment and improvement planning efforts on resource allocation, partnerships, community needs, and health outcomes. Intentional and ongoing community engagement and partnerships are an essential component of public

health practice and are necessary to achieve the goals of racial and health equity. Program will effect long-lasting change and health improvements by mobilizing community partnerships to identify and solve problems and conduct community health assessments and interventions. Building infrastructure to support community partnerships will expand the state's capacity to tailor its approach to efficiently and effectively to reach populations with the greatest need. This will advance the public health system towards a culture of equity, antiracism, and health for all Californians. By improving equitable community partnerships 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. Strategic Growth Council
3. California Pan-ethnic Health Network
4. Government Alliance on Race and Equity
5. Local health departments and associated initiatives such as the Bay Area Regional Health Inequities Initiative and Public Health Alliance of SoCal

Internal:

1. Office of Policy and Planning (Fusion Center)
2. Center for Health Communities
3. Center for Infectious Diseases
4. Regional Public Health Office
5. Center for Family Health

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training

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
- Tribal nation or area
- University or college

Target Population of Program

- *Target population data source*: Poverty rate (200% FPL), Healthy Communities Data & Indicators Project, Income Insecurity
- *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, 2023 to June 30, 2024, Program will conduct (8) meetings, trainings, or one-on-one technical assistance (TA) sessions with CDPH programs, local health departments (LHDs), or community based organizations to increase the capacity of public health staff and community partners 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 and community partners to promote racial and health equity. Using equity best practices and community-based partnerships, Program will explore the impact of community health assessment and improvement planning efforts on resource allocation, partnerships, community needs, and health outcomes. Intentional and ongoing community engagement and partnerships are an essential component of public health practice and are necessary to achieve the goals of racial and health equity. Program will effect long-lasting change and health improvements by mobilizing community partnerships to identify and solve problems and conduct community health assessments and interventions. Building infrastructure to support community partnerships will expand the state's capacity to tailor its approach to efficiently and effectively to reach populations with the greatest need.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Racial Equity Alliance; Othering & Belonging Institute; COVID-19 Health Equity Playbook for Communities

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, local health department staff, and community partners who are trusted messengers 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, & consultations provided by Program
- *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:* 07/01/2023
- *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.

Activity 1

CDPH Equity Capacity. Between July 1, 2023 and June 30, 2024, Program will provide two (2) trainings or consultations to at least five (5) CDPH programs or local health jurisdictions to promote equity in Policies, Systems, and Environment.

Description of Activity: Between July 1, 2023 and June 30, 2024, Program will provide two (2) trainings or consultations to at least five (5) CDPH programs or local health jurisdictions to: (1) build public 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

Community Partner Capacity. Between July 1, 2023 and June 30, 2024, Program will provide trainings or technical assistance to at least three (3) community based organizations (CBO) to build community partner capacity to promote equity in Policies, Systems, and Environment.

Description of Activity: Between July 1, 2023 and June 30, 2024, Program will provide trainings or technical assistance to at least three (3) community based organizations (CBO) to: (1) build CBOs' 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 quality improvement as a way to increase efficiency and effectiveness in health departments

Health Objective

Between 07/2023 and 06/2024, 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: 5
- 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:	Yolanda Murillo
Total FTE [% time]:	25

Position #2	
Position Title:	Health Program Specialist II
Staff Name in Position:	Phu Hoang
Total FTE [% time]:	100

Position #3	
Position Title:	Health Program Specialist I
Staff Name in Position:	Amy Yan
Total FTE [% time]:	100

Position #4	
Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Matthew Herreid
Total FTE [% time]:	100

Position #5	
Position Title:	Staff Services Manager I
Is this position vacant?	Yes
Total [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	Program to start recruitment process.

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 remains 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 to address emerging public health issues including COVID-19, monkeypox, and climate change. 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 PHHSBG-funded Programs that have met or not met objectives and associated activities in the previous year.

Baseline value of the key indicator described above: 0

Data source for key indicator baseline: FFY 2022 Final APR

Date key indicator baseline data was last collected: 11/2022

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 well as communicating 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. Office of Quality Performance and Accreditation

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, 2022
- *Number of people served:* 39,029,342
- *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

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

Objectives and Activities

Objective 1:

Title: Provide Administrative Support to Ensure all Programmatic and Fiscal Deliverables are Met

Objective: Between 07/2023 and 06/2024, Program will provide administrative oversight and support to 16 PHHSBG funded programs to ensure programmatic and fiscal deliverables are met timely in accordance with CDC's guidelines. The oversight and support will include a series of webinars, technical assistance, and quality improvement models.

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

Utilize CDPH best practices, fundamentals of project management, and the QI Model- PDCA Cycle. Utilizing CDPH best practices and fundamentals of project management will ensure all CDC deliverables are met timely and accurately. 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.

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:* Objectives and Activities statuses and outcomes for 16 PHHSBG-funded programs
- *Unit of measurement:* Number
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* FFY 2022 Final APR
- *Date baseline was last collected:* 11/2022
- *Interim target value to be achieved by the Annual Progress Report:* 0
- *Final target value to be achieved by the Final Progress Report:* 16

Target Population

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

Activity 1

Perform QI Analysis of PHHSBG-Funded Programs. Between 07/2023 and 06/2024, Program will analyze the PHHSBG FFY 2022 Final APR to determine one (1) program that requires QI intervention most.

Description of Activity: Between 07/2023 and 06/2024, HPP 2030 Program Staff will analyze the PHHSBG FFY 2022 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 (1) Program for a QI analysis, utilizing the PDCA Model. Once candidate program is determined, HPP 2030 Program Staff will meet with candidate program for QI intervention and analysis.

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

Activity 2

Conduct Webinars and Provide Technical Assistance to Program Staff. Between 07/2023 and 06/2024, Program will provide at least ten (10) webinars and continuous Technical Assistance (TA) to all PHHSBG funded Program Staff.

Description of Activity: Between 07/2023 and 06/2024, HPP 2030 Program Staff will provide at least ten (10) webinars and continuous TA to all PHHSBG-funded Program Staff via email, phone, or virtual meetings, as appropriate.

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

Activity 3

Conduct Webinars and Provide Technical Assistance to Fiscal Staff. Between 07/2023 and 06/2024, Program will provide at least two (2) Webinar Trainings and continuous TA to all PHHSBG funded Fiscal Staff.

Description of Activity: Between 07/2023 and 06/2024, HPP 2030 Fiscal Staff will provide at least two (2) Webinar Trainings and continuous TA to all PHHSBG funded Fiscal Staff to ensure each program properly maintains their program budgets, report any changes or concerns throughout the State Fiscal Year, and upkeep their Monthly Expenditure Reports.

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

Activity 4

Communication of PHHSBG Outcomes and Achievements. Between 07/2023 and 06/2024, Program will implement two (2) communication strategies to effectively communicate the program outcomes and successes to all internal and external stakeholders.

Description of Activity: Between 07/2023 and 06/2024, Program will implement two communication strategies via email, webinars, or published documents on the Department's webpage to highlight program outcomes and successes to all internal and external stakeholders.

- *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 07/2023 and 06/2024, Program will strive to reduce by 5% the crude rate of total, unintentional, and intentional injury deaths in California from the current 2021 rates (69.8, 52.3 and 16.8 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: CDC Core SIPP funding as well as CA Office of Traffic Safety (OTS) 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: 11
- Number of FTEs in this program funded by the PHHS Block Grant: 4

Position #1	
Position Title:	Health Program Specialist I
Staff Name in Position:	Karissa Anderson
Total FTE [% time]:	75

Position #2	
Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Claudia Angel
Total FTE [% time]:	10

Position #3	
Position Title:	Health Education Consultant III
Staff Name in Position:	Kate Bernacki
Total FTE [% time]:	10

Position #4	
Position Title:	Research Scientist I
Staff Name in Position:	Colin Chew
Total FTE [% time]:	10

Position #5	
Position Title:	Health Education Consultant III
Staff Name in Position:	Elizabeth Jones
Total FTE [% time]:	10

Position #6	
Position Title:	Health Program Specialist I
Staff Name in Position:	Mary “Kit Lackey
Total FTE [% time]:	10

Position #7	
Position Title:	Health Program Specialist II
Is this position vacant?	Yes
Total [% time]:	100
Briefly describe the recruitment/hiring plan to fill the vacant position:	The position will be advertised and filled prior to the FY23-24 PHHSBG period commencing

Position #8	
Position Title:	Health Program Manager II
Staff Name in Position:	Jeffery Rosenhall
Total FTE [% time]:	30

Position #9	
Position Title:	Research Scientist III
Is this position vacant?	Yes
Total [% time]:	10
Briefly describe the recruitment/hiring plan to fill the vacant position:	The position will be advertised and filled prior to the FY23-24 PHHSBG period commencing

Position #10	
Position Title:	Research Scientist Supervisor I
Is this position vacant?	Yes
Total [% time]:	75
Briefly describe the recruitment/hiring plan to fill the vacant position:	The position will be advertised and filled prior to the FY23-24 PHHSBG period commencing

Position #11	
Position Title:	Research Scientist Supervisor I
Is this position vacant?	Yes
Total [% time]:	10
Briefly describe the recruitment/hiring plan to fill the vacant position:	The position will be advertised and filled prior to the FY23-24 PHHSBG period commencing

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 = 69.8 per 100,000; Unintentional = 52.3 per 100,000; Intentional = 16.8 per 100,000

Data source for key indicator baseline: EpiCenter: California Injury Data Online, available online at: https://skylab4.cdph.ca.gov/epicenter/.

Date key indicator baseline data was last collected: 2021

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 2010) to 20 per 100,000.

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 Policy and Planning
5. Health in All Policies Program

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training
- Resources/Job Aids

Evaluation Methodology: Injury numbers/rates overall and for specific injury types 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, data products created). Impact evaluation will assess immediate and intermediate outcomes of activities using multiple measures (e.g., surveys, evaluations).

Program Settings:

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

Target Population of Program

- *Target population data source*: California Department of Finance, state population estimate for 1/1/2022
- *Number of people served:* 39,185,605
- *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

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

Objective 1:

Title: School-based Health Center Support

Objective: Between 07/2023 and 06/2024, Program will provide six (6) multiple 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.

Problem for this Objective: **More School-Based Health Centers are needed where students receive wrap-around 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 (CSHA) estimates the need for SBHCs statewide at 500; there are currently just under 300. The activities within this objective should assist with increasing support for expanding SBHCs statewide.

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. 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.

Key indicator(s) affected by this program: 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.

Baseline value for the key indicator: 60

Data source for key indicator baseline: Percentage, National Survey of Children's Health, National Performance Measure 10

Date key indicator baseline data was last collected: 2020-2021

Intervention Information

IVPB will offer statewide technical assistance on School-Based Health Centers supporting expansion. 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 (3) and quarterly workgroup meetings (4)
- *Unit of Measurement*: Number of technical assistance (TA) activities
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Internal tracking
- *Date baseline was last collected:* 7/1/2023
- *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, 2021
- *Number of people served:* 7,626,917
- *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

School-Based Health Center Coordination. By June 2024, Program will improve coordination statewide by convening four (4) School-Based Health Center Statewide Collaborative Workgroup (Workgroup) meetings.

Description of Activity: Between 07/2023 and 06/2024, the School-Based Health Center Statewide Collaborative Workgroup will be convened quarterly by CDPH's IVPB staff. The Workgroup membership comprised of representatives from CDPH, CDE, MCAH, MHSOAC,

DHCS and the School-Based Health Center Alliance among others, 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 07/2023 and 06/2024 Program will review findings from two (2) 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?* Yes
- *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 07/2023 and 06/2024, IVPB staff will provide at least three (3) 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: CDPH will provide at least three (3) technical assistance events (e.g., webinars, presentations, fact sheets, etc.) to California's SBHCs and their partners on topics identified in the needs assessment work which may include: increasing enrollments of eligible students in Medi-Cal and suicide prevention. Technical assistance events will likely be in the form of webinars during the 12-month project year but may include in-person presentations if conditions allow.

- *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: Between 07/2023 and 06/2024, Program will conduct at least fifty-four (54) 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.

Problem for this Objective: **Children 0-19 are at risk for unintentional injuries and need caregivers, safe spaces, and policies.** According to the CDC, unintentional injury is the leading cause of death to children ages 1-19, and third most common for children under the age of 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

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 program support to unintentional childhood injury prevention staff in California. In partnership with the Kids' Plates program, which is used exclusively to fund 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:* 07/01/2023
- *Interim target value to be achieved by the Annual Progress Report:* 27
- *Final target value to be achieved by the Final Progress Report:* 54

Target Population

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

- *Target population data source*: California DOF Demographic Research Unit. Population Projections, 2010-2060 (Baseline 2019).
- *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 07/2023 and 06/2024, 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 07/2023 and 06/2024, Program will facilitate four (4) 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 07/2023 and 06/2024, 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 (6-10 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: Increase Capacity for Older Adult Unintentional Injury Prevention Program - Healthy Aging Initiative

Objective: Between 07/2023 and 06/2024, Healthy Aging Initiative (HAI) will provide at least forty-five (45) 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.

Problem for this Objective: **Disproportionate levels of chronic disease and death from other various diseases.** 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 and unintentional injuries. As such, we will track number and rate of older adult deaths. The total number of deaths from all causes for older adults aged 55 and older was 277,546 (2,437 per 100,000).

Baseline value for the key indicator: 285,203

Data source for key indicator baseline:

CHHS Statewide Death Data (https://data.chhs.ca.gov/dataset/statewide-death-profiles)

Date key indicator baseline data was last collected: 2021

Intervention Information

The HAI will provide TA to expand capacity for serving 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 prevention 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:* 07/01/2023
- *Interim target value to be achieved by the Annual Progress Report:* 20
- *Final target value to be achieved by the Final Progress Report:* 45

Target Population

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

- *Target population data source*: Department of Finance (2022)
- *Number of people served:* 11,919,077
- *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

California's Master Plan for Aging (MPA). Between 07/2023 and 06/2024, HAI will support implementation of the California MPA by strengthening the relationships with internal and external healthy aging partners through coordination and participation in at least twenty-five (25) related meetings.

Description of Activity: Between 07/2023 and 06/2024, HAI staff will strengthen relationships with healthy aging partners through collaboration with the California Department of Aging, California Department of Public Health's Office of Suicide Prevention and Alzheimer's Disease Program staff, as well as fall prevention partners in California. HAI will compile and complete all MPA related reporting requirements and co-create the annual Older Adult Suicide in California data brief with CDPH's Office of Suicide Prevention.

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

Activity 2

Age-Friendly Public Health System. Between 07/2023 and 06/2024, HAI staff will provide at least ten (10) coordination and outreach activities to key stakeholders, in collaboration with the Trust for America's Health, on Age-Friendly Public Health System activities.

Description of Activity: Between 07/2023 and 06/2024, HAI staff will provide coordination and outreach to key stakeholders, in collaboration with the Trust for America's Health, on Age-Friendly Public Health System activities. This will include convening 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 Age-Friendly Public Health Systems.

- *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. Between 07/2023 and 06/2024, HAI staff will provide ten (10) technical assistance consultations to advise state agencies, Local Health Jurisdictions (LHJ), community agencies, or members of the public on healthy aging related issues.

Description of Activity: Between 07/2023 and 06/2024, HAI staff will provide technical assistance consultations to state agencies, LHJs, 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: Between 07/2023 and 06/2024,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

Traffic and medical data will be used to provide health and traffic safety technical assistance. 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:* 07/01/2023
- *Interim target value to be achieved by the Annual Progress Report:* 3
- *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

Linking crash data with medical outcomes to make connections between injury & crash risk factors. Between 7/1/2023 and 6/30/2024, CMOD staff will contract with the University of Southern California's Children's Data Network (CDN) for the development of a probabilistic data linkage methodology, as well as support for the CMOD Research Scientists in using this method to link crash data with medical outcomes data for one (1) year.

Description of Activity: Probabilistic Data Linkage: California Crash Medical Outcomes Data (CMOD) Project is proposing to contract with the University of Southern California's Children's Data Network (CDN). The data scientists at CDN would develop a replicable probabilistic data linkage method using Chimera, and then support the CMOD Research Scientists in using this method to link crash data with medical outcomes data. This will allow program staff to look at the relationship between those outcomes and various risk factors and crash characteristics.

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

Activity 2

Data Brief on traffic patterns, crashes, and medical outcomes. Between 07/2023 and 06/2024, Program will analyze data on traffic patterns, crashes, and medical outcomes and develop one (1) data brief to share relevant results.

Description of Activity: Between 07/2023 and 06/2024, 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 3

Technical assistance (TA) to support use of crash and medical outcomes data. Between 07/2023 and 06/2024, Program will provide at least six (6) Technical Assistance activities to

relevant entities focused on use of crash and medical outcomes data for injury prevention purposes.

Description of Activity: Between 07/2023 and 06/2024, 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: Statewide General Injury Surveillance System

Objective: By Between 07/2023 and 06/2024, Program will conduct one (1) statewide general injury surveillance system by (a) developing state-level injury death, hospitalization, and emergency department visit datasets for the 2022 calendar year, (b) making the new injury data publicly available on its EpiCenter online injury surveillance data dashboard, and (c) analyzing the new injury data to inform at least three injury prevention 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

Provide timely, accurate, and easy-to-access injury data. Accurate and up-to-date injury data are essential for planning and delivering evidence-based injury prevention activities. This objective will ensure that IVPB continues providing the foundational injury data that it and other injury prevention stakeholders require to work effectively. IVPB will develop the next year of injury surveillance data according to current national standards; make the injury data easily accessible via its online injury data dashboard, EpiCenter; and use the new data to inform its various injury prevention activities.

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 (https://www.cdc.gov/mmwr/pdf/other/su6103.pdf)

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, IVPB can support its own injury prevention work, as well as myriad practitioners across California, helping the state identify and respond to emerging injury and violence trends.

- *Item to be measured:* Most recent year of death, hospital, and ED visit data available on EpiCenter
- *Unit of measurement:* Surveillance system
- *Baseline value for the item to be measured:* 1
- *Data source for baseline value:* EpiCenter injury data dashboard (https://skylab4.cdph.ca.gov/epicenter/)
- *Date baseline was last collected:* 03/08/2023
- *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.

Activity 1

Develop State Injury Data. Between 07/2023 and 06/2024, Program will develop three (3) state injury datasets from the most recently available state death, hospital, and emergency department (ED) visit data.

Description of Activity: IVPB will maintain its data use agreement with the CDPH Center for Health Statistics and Informatics (CHSI) to continue receiving annual files for California deaths, hospital discharges, and emergency department visits from state partners. By June 30, 2024, IVPB will obtain these data sets for calendar year 2022. Also, by June 30, 2024, IVPB research staff will process these data according to guidance produced by the CDC's National Center for Injury Prevention and Control (NCIPC) to identify, classify, and extract injury-related deaths, hospitalizations, and ED visits.

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

Activity 2

Make State Injury Data Accessible to the Public. Between 07/2023 and 06/2024, Program will make three (3) calendar year 2022 state injury datasets accessible to the public through its online data dashboard and direct request.

Description of Activity: IVPB maintains EpiCenter, an online injury surveillance data dashboard (https://skylab4.cdph.ca.gov/epicenter/). Between 07/2023 and 06/2024, IVPB will update EpiCenter to include calendar year 2022 injury-related deaths, hospitalizations, and ED visits for the state. EpiCenter makes injury data insights quick and easy through customizable visualizations, enabling users to identify risk and protective factors and trends in injury and violence and help inform interventions. EpiCenter also allows users to build custom injury data tables and download them in Excel format. If/when the data available through EpiCenter do not meet users needs, IVPB will create and share custom injury data tables by request and within the limits of Agency data de-identification guidelines (see DMP for details). Finally, EpiCenter contains an extensive documentation section to facilitate appropriate interpretation of the injury

data. IVPB will update this documentation as appropriate to accommodate any changes in the calendar year 2022 data.

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

Activity 3

Analyze State Injury Data to Inform Prevention. Between 07/2023 and 06/2024, Program will analyze three (3) calendar year 2022 state injury datasets to inform at least three (3) of its injury prevention activities.

Description of Activity: IVPB uses a data-driven and evidence-based approach to injury prevention. State death, hospitalization, and ED visit injury data are fundamental to this approach. Between 07/2023 and 06/2024, IVPB will analyze calendar year 2022 state injury datasets to inform at least three of its injury prevention activities. Activities include, but are not limited to, the tracking of general injury surveillance indicators, internal strategic planning, analysis of proposed injury prevention legislation, and various population and/or cause-specific injury prevention programs (e.g., childhood injury prevention, pedestrian safety). For all analyses, methods will be documented and communicated to ensure appropriate interpretation of results.

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

The Office of Policy and Planning

Healthy People 2030 Objective

PHI-04: Increase the proportion of state and territorial jurisdictions that have a health improvement plan

Health Objective

Between 07/01/2023 and 06/30/2024, The Office of Policy & Planning (OPP) will strengthen the primary prevention focus and cross-program alignment of California's state and community health improvement plans. OPP 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 date, messaging and policy approaches incorporating social determinants of health, regional disparities, and performance analytics.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: No funding to local agency/organization
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? 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: 3.75

Position #1	
Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Kelly Kelley
Total FTE [% time]:	100

Position #2	
Position Title:	Health Program Specialist II
Staff Name in Position:	Leslie Stribling
Total FTE [% time]:	100

Position #3	
Position Title:	Research Data Analyst I
Staff Name in Position:	Jaspreet Kang
Total FTE [% time]:	100

Position #4	
Position Title:	Health Program Specialist I
Staff Name in Position:	Britt Higgins
Total FTE [% time]:	75

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. 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: The current baseline value is three (3) initiatives.

Data source for key indicator baseline: Program tracking is the data source for indicator on key initiatives integrated with SHIP

Date key indicator baseline data was last collected: 2022

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 OPP 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 Professional Development and Engagement
4. Office of Legislative and Governmental Affairs
5. Regional Public Health Office

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training

Evaluation Methodology: OPP 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. OPP also employs Results-Based Accountability approaches for specific efforts to track progress on performance measures designed to contribute to advancing population results.

Program Settings:

- State health department

Target Population of Program

- *Target population data source*: CDPH Vital Statistics Death Data (2022); Let's Get Healthy CA (2022); CA Health Interview Survey (2021)
- *Number of people served:* 40,000,000
- *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:

- 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 State Health Improvement Plan (SHIP) 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 (SHIP) builds on the SHA by defining shared priorities and indicators to track progress, establishing cross-cutting strategies, and identifying organizations that are responsible for implementing these strategies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Public health accreditation standards and CDCs 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:* 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.

Activity 1

Conduct and Enhance the Annual SHA. Between 7/01/2023 and 6/30/2024, Program will conduct two (2) activities to enhance the State Health Assessment (SHA).

Description of Activity: Conduct the annual SHA. Enhance the SHA by refining and improving the California Community Burden of Disease (CCB) condition grouping mapping system. The system maps ICD-10 death codes to meaningful groups for public health action and forms a backbone of CCB and the SHA Core Module. The mapping system will be enhanced by collaboration, review, and input from clinical partners, experts in the ICD-10 death coding process, and SHA stakeholders.

- *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 7/01/2023 and 6/30/2024, Program will conduct two (2) activities to enhance the State Health Assessment (SHA).

Description of Activity: Conduct analyses of the differences in mortality by community rurality status and include such data in the SHA Core Module. Engage with rural local health jurisdictions and other stakeholders to understand and plan to address their needs regarding rural mortality and morbidity data.

- *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 7/01/2023 and 6/30/2024, 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 SHA and State Health Improvement Plan (SHIP) 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 (SHIP) builds on the SHA by defining shared priorities and indicators to track progress, establishing cross-cutting strategies, and identifying organizations that are responsible for implementing these strategies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Public health accreditation standards and CDCs 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:* 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.

Activity 1

Shared Action Plans to Address Key Public Health Priorities. Between 07/2023 and 06/2024, Program will implement two (2) shared action plans to address key public health priorities.

Description of Activity: Work collaboratively with state and local partners to support execution, alignment, and integration of collective impact activities as part of the shared equity strategy and implementation plan under the SHIP. Facilitate strategic alignment opportunities with key CDPH initiatives, such as the strategic plan and equity technical assistance activities. Conduct ongoing engagement to highlight and integrate lessons learned and promising practices in ongoing action planning.

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

Activity 2

Enhance the SHIP to Center Equity and Align Around Shared Priorities and Measurement. Between 07/2023 and 06/2024, Program will conduct one (1) SHIP enhancement activity to center equity and align shared priorities.

Description of Activity: Enhance the SHIP to reflect new and modified topic areas, update indicator baseline and target values, complete an annual data update to track progress toward shared priorities, and implement strategies to center equity in the framework. Work collaboratively with partners to integrate with other related strategic initiatives and link population results and indicators with shared strategies and performance metrics to monitor impact of key efforts.

- *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 07/01/2023 and 6/30/2024, 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 the SHA and State Health Improvement Plan (SHIP) 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 (SHIP) builds on the SHA by defining shared priorities and indicators to track progress, establishing cross-cutting strategies, and identifying organizations that are responsible for implementing these strategies.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

- Other: Public health accreditation standards and CDCs 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:* 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.

Activity 1

Address Cross-Cutting Priorities Through Department-Wide Initiatives. Between 07/2023 and 06/2024, Program will facilitate one (1) collective action initiative, engaging internal, interdepartmental, and multisector partners.

Description of Activity: Collaborate with at minimum five internal CDPH partners to identify priorities and align messages to build collective impact around emerging public health issues related to behavioral health prevention, climate change, and violence prevention.

- *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 07/2023 and 06/2024, Program will implement one (1) engagement initiative with Local Health Jurisdictions (LHJs) – including providing tools, training, and technical assistance – to advance strategies and policy approaches.

Description of Activity: Conduct outreach and experience sharing to advance health equity and strengthen public health infrastructure with Local Health Departments. Collaborate to offer peer-learning opportunities for LHJs and provide resources through technical assistance to increase number of LHJs developing CHA/CHIP and/or achieving accreditation status with Public Health Accreditation Board.

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

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: 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? No
- Funding role of the PHHS Block Grant for this program: Total source of funding
- Role of PHHS Block Grant Funds in supporting this program: Enhance or expand the program

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: No

Issue/Problem

As an accredited state public health department, the California Department of Public Health (CDPH) is required to provide accreditation-related technical assistance (TA) and support to California local health departments (LHDs). Up to thirty-nine million people in California may receive public health services from local and tribal health departments. Accreditation requires a systematic review and evaluation of the effectiveness of health department systems in delivering the Ten Essential Public Health Services. Accreditation helps improve the provision of public health services and improve health outcomes for the communities served by these facilities. Many California local health departments do not have many resources to devote to the accreditation process. The PHA program provides them with needed technical assistance and support.

Public health program was prioritized as follows:

- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: Currently, of 61 local health departments in California (58 counties and 3 cities), 23 have achieved PHAB accreditation. All of these 23 accredited LHDs are either preparing for or in the process of reaccreditation. Another 30 LHDs have either started the process of initial 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 LHDs do not have adequate funding for the training and technical assistance (TA) required to meet PHAB accreditation standards and measures. CDPH provides accreditation-related training and TA to LHDs seeking accreditation or reaccreditation to help them meet PHAB requirements. The key indicator is how many LHDs seeking accreditation or reaccreditation receive 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 health department 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)? No

Summary of Program Strategy: Between 07/2023 and 06/2024, Program will provide training and TA services to increase accreditation readiness and capacity to at least three local health departments. These services will provide participating LHDs an opportunity to develop, complete, and/or implement a process or project conforming to Public Health Accreditation Board (PHAB) standards and measures, thereby demonstrating readiness and capacity for national public health accreditation or reaccreditation.

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
5. Training vendors

Internal:

1. California Conference of Local Health Officers
2. The Office of Policy and Planning
3. Office of Health Equity

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training

- Resources/Job Aids

Evaluation Methodology: PHA 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 estimate of California population as of 2022
- *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: Between 07/1/2023 and 6/30/2024 PHA program will provide accreditation-related training and technical assistance to at least three (3) Local Health Departments (LHDs) seeking Public Health Accreditation Board (PHAB) accreditation or reaccreditation.

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

CDPH will provide accreditation-related training and technical assistance to LHDs seeking accreditation or reaccreditation to help them meet PHAB standards and measures. CDPH will provide technical assistance and training to support LHDs with accreditation-related activities. This TA and training may include assistance with Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) development and alignment, PHAB document selection, and networking opportunities. CDPH will also facilitate specialized training and technical assistance on workforce development, quality improvement, strategic planning, health equity, and/or performance management, all of which are required for PHAB accreditation.

Type of Intervention: Innovative/Promising Practice

Rationale for choosing the Intervention: 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 LHDs do not have funding for the training and technical assistance required to meet PHAB accreditation standards and measures. CDPH provides accreditation-related training and TA to LHDs seeking accreditation or reaccreditation to help them meet PHAB requirements.

- *Item to be measured:* Number of LHDs that receive technical assistance
- *Unit of measurement:* Number of LHDs
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* PHA Program
- *Date baseline was last collected:* 07/01/2023
- *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.

Activity 1

Provide Accreditation-related Technical Assistance and/or Training. Between 07/01/2023 and 06/30/2024, Program will provide accreditation-readiness TA and/or training to three (3) local health departments that are preparing for PHAB accreditation or reaccreditation.

Description of Activity: 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, health equity, and/or performance management-related training and/or technical assistance.

- *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, 2023, and June 30, 2024, Program will implement 11 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 to create environmental and community changes.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $825,408
- Amount of funding to local agencies or organizations: $678,502
- 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: 0.85

Position #1	
Position Title:	Health Program Manager II
Staff Name in Position:	Sara Mann
Total FTE [% time]:	20

Position #2	
Position Title:	Research Scientist Supervisor I
Staff Name in Position:	Katie Chun
Total FTE [% time]:	5

Position #3	
Position Title:	Office Technician
Staff Name in Position:	Joseph Kinkead
Total FTE [% time]:	25

Position #4	
Position Title:	Staff Services Manager I
Staff Name in Position:	Karol Simmons
Total FTE [% time]:	35

Issue/Problem

This program will prevent sexual violence perpetration and victimization among adolescents. This program will prevent sexual violence perpetration and victimization among adolescents. Rape victims often have long-term emotional and health consequences as a result of this "adverse experience," such as chronic diseases, emotional and functional disabilities, harmful behaviors, and intimate relationship difficulties (CDC, 2008). Adolescents are particularly at risk. According to the National Intimate Partner and Sexual Violence Survey conducted in 2015, 81% of women and 71% of men who reported a completed or attempted rape experienced the victimization before the age of 25.

Public health program was prioritized as follows:

- Identified via surveillance systems or other data sources
- Prioritize within a strategic plan

Key Indicator(s) affected by this problem: Rate of sexual violence among adolescents.

Baseline value of the key indicator described above: 19.2

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)
- 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 will implement 11 local prevention projects using community/societal-level prevention strategies by local rape crisis centers (RCC) that provide sexual offense prevention programs to victims, potential victims, and potential perpetrators, aligned with the resources of the Centers for Disease Control and Prevention (CDC) to prevent sexual violence.

Primary Strategic Partners

External:

1. *ValorUS*
2. *University of California, San Diego*
3. *California Partnership to End Domestic Violence*

Internal:

1. CDPH Domestic Violence Prevention Program
2. CDPH Violence Prevention Initiative
3. CDPH Essentials for Childhood

Evaluation Methodology: RPP implements a standardized evaluation process that includes collection of process and outcome data from local organizations. These 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
- Schools

Target Population of Program

- *Target population data source*: State of California, Department of Finance, Report P-3, June 2019.
- *Number of people served:* 11,090,453
- *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, 2023, and June 30, 2024, Program will implement 11 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 11 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:* 07/01/2023
- *Interim target value to be achieved by the Annual Progress Report:* 11
- *Final target value to be achieved by the Final Progress Report:* 11

Target Population

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

Activity 1

Fund Comprehensive Community-based Projects. Between July 1, 2023 and June 30, 2024, Program will provide funding for eight (8) local comprehensive community-based projects using a community mobilization strategy in order to image change at the community/societal level.

Description of Activity: Between July 1, 2023, and June 30, 2024, Program will fund eight (8) local comprehensive community-based projects using a community mobilization strategy. Through June 2024, Program, and partners (UCSD and VALORUS) will provide training and technical assistance to the 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 July 1, 2023 and June 30, 2024, Program will fund three (3) school-based projects using a strategy of healthy relationships, gender equity, or active bystander intervention in order to have an impact on community/societal-level change.

Description of Activity: Between July 1, 2023 and June 30, 2024, Program will fund 3 comprehensive school-based projects that use a strategy of healthy relationships, gender equity, or active bystander intervention in order to impact community/societal-level change. The Program and its partners (UC San Diego and VALORUS) will provide training and technical assistance to 3 local projects in order to create protective environments in schools through climate and policy change. The Program will meet monthly with its 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

Healthy People 2030 Objective

FS-D04 Reduce outbreaks of Shiga toxin-producing E. coli, Campylobacter, Listeria, and Salmonella infections linked to leafy greens

Health Objective

Reduce the incidence of illness caused by Listeria monocytogenes 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: 0.77

Position #1	
Position Title:	Research Scientist II
Staff Name in Position:	Eun-Jung Choi
Total FTE [% time]:	65

Position #2	
Position Title:	Environmental Scientist
Staff Name in Position:	Nik Storm
Total FTE [% time]:	12

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 Listeria monocytogenes 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

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 Listeria monocytogenes. 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 (https://www.cdc.gov/foodsafety/foodborne-germs.html)

Date key indicator baseline data was last collected: 02/08/2023

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 Listeria monocytogenes.

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 Listeria monocytogenes testing. If positive samples are identified, investigational work and product recalls may be initiated. Identification and removal of leafy greens contaminated with Listeria monocytogenes from the food supply will reduce the incidence of foodborne illness and injury.

Primary Strategic Partners

External:

1. *U.S. Food and Drug Administration*
2. *U.S. Centers for Disease Control and Prevention*
3. *Industry Trade Associations*

Internal:

1. CDPH, Division of Communicable Disease Control, Infectious Diseases Branch

Evaluation Methodology: Progress will be measured based on the number of samples collected and evaluated. 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
- Home
- State health department
- Work site

Target Population of Program

- *Target population data source*: U.S. Census Bureau 2022 for California
- *Number of people served:* 39,029,342
- *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 Listeria monocytogenes testing program in U.S. grown leafy greens

Objective: Between 7/1/2023 and 6/30/2024, Program will implement one (1) Listeria monocytogenes testing program in U.S. grown leafy greens.

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

Positive tests for Listeria monocytogenes will have regulatory follow-up to reduce foodborne illness. FDB staff will complete necessary regulatory follow-up pending any positive Listeria monocytogenes 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:* 7/1/2023
- *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.

Activity 1

Collect Samples of Leafy Greens. Between 7/1/2023 and 6/30/2024, 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 Listeria monocytogenes. Between 7/1/2023 and 6/30/2024, FDLB staff will test 300 samples of leafy greens for Listeria monocytogenes.

Description of Activity: Between 7/1/2023 and 6/30/2024, FDLB staff will test 300 samples of leafy greens for Listeria monocytogenes. 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 7/1/2023 and 6/30/2024, FDB staff will complete necessary regulatory follow-up pending any positive findings.

Description of Activity: Between 7/1/2023 and 6/30/2024, 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?* Yes
- *Does the data collection involve public health data?* No

Toxicological Outbreaks Program

Healthy People 2030 Objective

IVP-04 Reduce emergency department visits for nonfatal unintentional injuries

Health Objective

Reduce statewide morbidity and mortality associated with exposure to toxic substances by building capacity for CDPH and LHJs to identify and respond to toxicological outbreaks in an effective, coordinated, and timely manner.

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: 0.6

Position #1	
Position Title:	Research Scientist II
Is this position vacant?	Yes
Total [% time]:	60
Briefly describe the recruitment/hiring plan to fill the vacant position:	Position announcement post closed on February 26, 2023. Program is screened and is currently interviewing candidates. Position will be filled by May 1, 2023

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 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 agent 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 data infrastructure necessary for case finding of toxicological outbreaks. Key indicator: three data systems operationalized and/or institutionalized in support of case finding for toxicological outbreaks.

Baseline value of the key indicator described above: 0

Data source for key indicator baseline: Implementation of survey software, data management system platform, and efficient data sharing system

Date key indicator baseline data was last collected: 2021

Program Strategy

Goal: Improve identification of and response to outbreaks with a common toxicological source to reduce emergency department visits, hospitalizations, and deaths in California by the end of FY 23-24.

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

Summary of Program Strategy: The program uses multiple strategies to build capacity to identify and respond to toxicological outbreaks. 1). Build data infrastructure to facilitate outbreak identification and response; (2). Develop workflows and protocols to guide CDPH and LHJs in outbreak identification and response (3). Provide learning opportunities to increase knowledge and skills in outbreak identification and response; (4). Create partnerships to facilitate an effective and coordinated outbreak identification and response; (5). Provide TA, coordination, and leadership to identify and respond to outbreaks. For the '23-'24 fiscal year, the Block Grant will fund strategy 1.

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. *CalHHS*
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 objective and activities: 1) securing data-collection survey software; 2) acquisition and implementation of a data software management system; and 3) the number of meetings with stakeholders to operationalize and institutionalize an electronic platform to exchange medical data.

Program Settings:

- State health department
- Local health department

Target Population of Program

- *Target population data source*: 2020 U.S. Census Bureau (decennial), Census, and 2023 American Community Survey (annual)
- *Number of people served:* 39,100,000
- *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? No

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

Objectives and Activities

Objective 1:

Title: Build Toxicological Outbreak Surveillance & Response Data Related Capabilities

Objective: Between 07/2023 and 6/2024, Program will develop three (3) data-related capabilities to facilitate data collection, data analysis, data management, and data sharing.

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 secure survey software, establish a data management system, work with stakeholders to operationalize and institutionalize an effective process for sharing medical data. Program continues to work with ITSD to secure survey software and establish a data management system. Program continues to work with stakeholders to operationalize a process to share medical data.

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: Increase state and local 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 stakeholders to build capacity to identify and respond to toxicological outbreaks
- *Unit of measurement:* Activity

- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Meetings, survey software, and data server system
- *Date baseline was last collected:* 07/01/2023
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 3

Target Population

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

Activity 1

Acquire Data Collection Tool. From 7/1/2023 to 12/31/2023 RS II will acquire one (1) data collection tool that enables complex survey design and provides a centralized database.

Description of Activity: Program currently uses Microsoft forms to develop surveys and exports collected data to excel for analysis and storage. This approach is inefficient and impacts the program's ability to identify and respond to toxicological outbreaks in a timely manner.

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

Activity 2

Acquire and Configure Data Management System. From 7/1/2023 to 12/31/2023, RS II will acquire, develop, and implement one (1) data management system to store, centralize, and analyze data.

Description of Activity: Program currently uses Excel to store data. In the current method, data must first be located and then read into analytical programs, which is time consuming and cumbersome. The new data management system would store data centrally and therefore provide a more efficient and effective method to access data for analysis and reporting.

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

Activity 3

Process to Acquire and Exchange Medical Data Electronic Exchange Mechanism. From 1/1/2024 to 6/31/2024, the RS II will develop and implement one (1) medical data electronic exchange system, a process by which medical data can be electronically exchanged between the program and other parties (medical providers, internal partners, external partners).

Description of Activity: Program currently collects medical data related to potential toxicological outbreaks by rudimentary methods, such as fax and email. These cumbersome methods create logistical issues that impact the program's ability to identify cases and respond to toxicological outbreaks in a timely manner.

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

Tuberculosis Free CA

Healthy People 2030 Objective

IID-17 Reduce tuberculosis cases

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)

Positions Funded by PHHS Block Grant

- Positions funded by the PHHS Block Grant: No

Issue/Problem

TB disease in California occurs primarily in people with longstanding LTBI and could be prevented by treating LTBI; because LTBI is asymptomatic and no other statewide programs exist to specifically address LTBI, many patients do not seek testing or treatment. The incidence of TB disease in California is nearly twice the national incidence. Californians born outside the U.S., as well as racial and ethnic minorities, experience disproportionately high rates of TB disease. TB disease in California occurs primarily in people with longstanding LTBI, and because LTBI is asymptomatic, many patients do not seek testing or treatment. The goal of our program is to identify and treat those with LTBI, in order to prevent cases of TB disease in California. The TB Free California program aims to avert TB disease

based on evidence-based practices, which will in turn improve overall health status and health equity throughout California.

Public health program was prioritized as follows:

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

Key Indicator(s) affected by this problem: Our key indicator is the California TB case rate. Due to the long latency period of TB disease, and the fact that the vast majority of public health and medical efforts currently focus on TB control rather than prevention, we rely on intermediate outcomes for our yearly program evaluation (described in evaluation methodology).

Baseline value of the key indicator described above: 4.7

Data source for key indicator baseline: California Department of Public Health, TB Control Branch, TB in California: 2022 Snapshot

Date key indicator baseline data was last collected: 2022

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 2021, the TB rates among persons who were Asian, Black, and Hispanic born outside the U.S., were 52, 38, and 23 times greater, respectively than of U.S.-born white persons; 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. *Merced County Department of Public Health*

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*: CDPH TB Control Branch: Report on Tuberculosis in California 2021
- *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 Test Positivity and Treatment Practices

Objective: Between 07/2023 and 06/2024, Program will support analysis of TB laboratory data in at least two (2) local health departments to understand local LTBI test positivity and treatment practices.

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

Problem for this Objective: **There are few estimates of LTBI testing and treatment practices in community healthcare settings.** Preventing cases of TB disease in California depends on identifying and treating LTBI, yet there are few estimates of LTBI testing and treatment practices in local health jurisdictions and community healthcare settings. As of 2022, local health departments in California have access to all results of interferon gamma release assay (IGRA), a test for TB infection, through electronic lab reporting (ELR). This ELR data can be used for direct public health action, such as identifying medical providers who have high proportion of positive tests for training of providing case management to patients who need LTBI treatment. Unfortunately, many local health departments lack capacity to manage and act on ELR data.

Key indicator(s) affected by this problem: Proportion of persons who test positive for TB infection who are prescribed LTBI treatment in California (16.6%, rounded below)

Baseline value for the key indicator: 17

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

Analyze electronic laboratory data to construct LTBI Care Cascades at two (2) local health jurisdictions in California. Key steps in LTBI screening, diagnosis, and treatment can be measured and represented in a LTBI Care Cascade; LTBI Care Cascades can be compared across clinical settings, used to identify points of attrition in care and used to prioritize outreach and interventions. Between 07/2023 and 06/2024, Program will create standardized data collection or management tools, help prioritize patient/provider outreach, and perform analysis and construction of LTBI Care Cascades in at least two (2) local health departments. Program will help local health jurisdictions identify gaps in their LTBI care cascade and problem-solve barriers to LTBI testing and treatment. Local health jurisdictions will be encouraged to use analyses for direct public health action, such as outreach and training for medical providers who have high proportion of positive tests, community outreach for populations with high test positivity, or case management for patients who need LTBI treatment.

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.

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 local health jurisdictions (LHJ) will allow LHJs to understand their local burden of disease and plan direct public health actions. Additionally, measurement of Care Cascades will inform work with state and national partners to build infrastructure to collect data on LTBI testing and treatment.

- *Item to be measured:* Persons with positive TB testing who receive appropriate follow-up and treatment
- *Unit of measurement:* Number of persons
- *Baseline value for the item to be measured:* 50
- *Data source for baseline value:* Merced County Public Health Department
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 100
- *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.

Activity 1

Technical assistance to LHDs in managing & analyzing electronic lab records for TB infection. Between 07/2023 and 06/2024, Program will assist with electronic lab data by creating

standardized data collection tools, helping prioritize patient/provider outreach, and/or performing analysis and construction of LTBI Care Cascades in at least two (2) local health departments.

Description of Activity: As of 2022, local health departments in California have access to all results of interferon gamma release assay (IGRA), a test for TB infection, through electronic lab reporting (ELR). This ELR data can be used for direct public health action, however many local health departments lack capacity to manage and act on ELR data. Between 07/2023 and 06/2024, Program will assist with ELR data by creating standardized data collection tools, helping prioritize patient/provider outreach, and/or supporting analysis, creation of LTBI Care Cascades and dissemination of results in at least two (2) local health departments. Analyses may support health education for particular communities or identification of providers who have high proportion of positive tests and pursue further collaboration. 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

Support Healthcare Clinics in Measuring LTBI Testing and Treatment. Between 07/2023 and 06/2024, Program will assist with data collection, management, and analysis at clinics with two (2) key metrics regarding LTBI testing and treatment.

Description of Activity: Between 07/2023 and 06/2024, 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 one (1) community clinic site. 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. 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

Objective 2:

Title: Engage Communities at Higher Risk for TB and Their Providers

Objective: Between 07/2023 and 06/2024, Program will partner with at least five (5) community clinics, community-based organizations (CBOs), or professional organizations serving patients at higher risk of TB infection to provide TB health education materials or community health worker training, in order to reach communities at higher risk and reduce TB health disparities.

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.** TB disease is a health disparity issue in California, disproportionately impacting non-U.S.-born and non-white persons. In 2021, nearly half (49%)

of California's TB cases occurred in Asian persons, and 41% of cases occurred in Hispanic/Latinx persons. 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. Outreach to communities at higher risk for TB infection, as well as the providers that serve them, is needed to motivate patients to seek appropriate testing and treatment for LTBI. Community Health Workers (CHW) and other similar professionals (e.g., promotoras, medical assistants) are usually trusted members of communities and could 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.

Key indicator(s) affected by this problem: Number of community organizations using a TB prevention curricula in California

Baseline value for the key indicator: 0

Data source for key indicator baseline: Interview with key informants, internet search, discussion with TB elimination partners.

Date key indicator baseline data was last collected: 2022

Intervention Information

Health education and linkage to care from a trusted source may help reduce TB health disparities. Program will work with community organizations to distribute culturally and linguistically appropriate health materials and provide outreach to educate patients about their TB risk and promote LTBI treatment. Additionally, Program will provide training and technical assistance to Community Health Workers (CHW) and other similar professionals (e.g., promotoras, medical assistants) to include TB prevention messaging in their work. 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.

Type of Intervention: Evidence-Based Intervention

Evidence Source of Intervention:

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

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 CBOs that already serve these communities are the optimal partners to provide this education and messaging.

- *Item to be measured:* Number of community organizations providing TB health education outreach in California.
- *Unit of measurement:* Number of organizations
- *Baseline value for the item to be measured:* 0
- *Data source for baseline value:* Interview with key informants, internet search, discussion with TB elimination partners
- *Date baseline was last collected:* 2022
- *Interim target value to be achieved by the Annual Progress Report:* 2
- *Final target value to be achieved by the Final Progress Report:* 5

Target Population

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

Activity 1

Community Health Worker curriculum to community health centers and community-based organizations. Between 7/2023 and 6/2024, Program will increase awareness of LTBI as a health issue among populations at higher risk for TB by distributing the CHW training curriculum and providing training to at least two (2) community health centers or community-based organizations.

Description of Activity: Between 7/2023 and 6/2024, Program Health Educator will provide CHW curriculum and training to at least two (2) community health centers or community-based organizations. Program Health Educator will use previously created 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. 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

Promote TB prevention education in clinics and CBOs that serve populations at higher risk of TB. Between 7/2023 and 6/2024, Program will partner with community organizations to distribute culturally and linguistically appropriate TB education materials and/or include TB prevention education in outreach efforts.

Description of Activity: Between 7/2023 and 6/2024, Program will partner with at least five (5) community organizations to distribute culturally and linguistically appropriate TB education materials and/or include TB prevention education in outreach efforts. Program will provide health education materials and technical assistance in planning outreach activities, in order reach communities at higher risk of TB infection and reduce TB health disparities. Program Health Educator, in collaboration with the corresponding local TB program, 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

Share best practices in TB prevention by creating and convening a community of practice. Between 7/2023 and 6/2024, Program will recognize and share best practices in TB prevention with community clinics and community-based organizations by convening one (1) regional community of practice, with a minimum of two (2) annual meetings.

Description of Activity: Between 7/2023 and 6/2024, Program will identify and share best practices in TB prevention on topics including patient and provider engagement, education and outreach strategies, quality improvement projects and/or clinic-level interventions throughout California by convening one (1) local or regional community of practice, with a minimum of two (2) annual meetings. Community clinics and community-based organizations will be invited to the meetings and have the opportunity to share their experience with TB prevention activities. Program Health Educator, in collaboration with the corresponding local TB program, 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 4

Maintain a centralized web location for provider and patient materials on latent TB infection. Between 07/2023 and 06/2024, Program will maintain a centralized web location for providers and patients to access materials on latent TB infection.

Description of Activity: Program will maintain a centralized web location for patients and providers to access materials on LTBI. Program will revise and update content as needed and upload new materials and resources as they are developed. Program Health Educator and Project Specialist are 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: LTBI Training, Clinical Reference Materials, & Clinical Consultation to Medical Providers

Objective: Between 07/2023 and 06/2024, Program will provide technical assistance in the form of training, clinical reference materials, or clinical consultation to at least ten (10) medical providers or clinics 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 "Guidelines for the Treatment of Latent Tuberculosis", however primary care providers remain unaware of guidance.** 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 risk assessments, 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. Percentage baseline (33%)

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 medical providers who request support (and at least ten (10) clinics/providers) to receive clinical consultation or training related to LTBI. Engage >90% of community clinics and/or provider groups who request support (and at least ten (10) clinics/providers) to receive clinical consultation or training related to LTBI. Between 07/2023 and 06/2024, Program will engage at least ten (10) 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:* 10

Target Population

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

Activity 1

Develop a Revised Risk Assessment Tool for Medical Providers. Between 07/2023 and 06/2024, Program will develop one (1) reference tool for medical providers regarding risk-based screening for TB infection in California patients.

Description of Activity: Between 07/2023 and 06/2024, Program will work develop one (1) new provider resource regarding risk assessment for TB infection in California patients. Informed by California epidemiologic data and experiences of working with partner clinics, Program will revise existing California TB Risk Assessment (last updated in 2018) and develop a concise tool to help identify TB infection in asymptomatic patients with known risk factors for infection. Program Clinician will be 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 07/2023 and 06/2024, Program will work in collaboration with local TB control programs, clinics, and civil surgeon groups to execute six (6) trainings on LTBI testing and treatment.

Description of Activity: Between 07/2023 and 06/2024, Program will work in collaboration with local TB control programs, clinics, and civil surgeon groups to execute a minimum of six (6) trainings on LTBI testing and treatment. Trainings will be completed at each site once or twice annually, depending on specific needs of site. Trainings will emphasize best practices for providers and will target providers who serve high-risk populations and patients at most risk for progression. Particular emphasis will be placed on use of interferon gamma release assay (IGRA) for non-U.S. born patients, and use of short-course regimens, including 12-dose once-weekly isoniazid-rifapentine or four months of rifampin, for LTBI treatment. Program Clinician 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

Expert Consultation to at least 10 Medical Providers who Request Support Regarding LTBI Care. Between 07/2023 and 06/2024, Program will provide clinical consultation and subject matter expertise on testing and treatment of TB infection for at least ten (10) medical providers in community and institutional settings.

Description of Activity: Between 07/2023 and 06/2024, 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 at least ten (10) 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 Clinician 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 07/2023 and 6/30/2024, program will increase the public health (PH) workforce by graduating at least 8 trainees from the Preventive Medicine Residency (PMR) or the California Epidemiologic Investigation Service (Cal-EIS), to become qualified PH physicians and epidemiologists who contribute to and/or lead efforts to improve the health of Californians.

Program Funding Details

- Amount of funding to population disproportionately affected by the program: $0
- Amount of funding to local agencies or organizations: $0
- Type of supported local agency/organization: Other: N/A - local agency/organization will not be funded
- Will PHHS Block Grant funds be used to respond to an emerging need or outbreak as part of the program? 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): State and 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: 3
- Number of FTEs in this program funded by the PHHS Block Grant: 2.50

Position #1	
Position Title:	Health Program Specialist II
Staff Name in Position:	Jami Chan
Total FTE [% time]:	100

Position #2	
Position Title:	Health Program Specialist II
Staff Name in Position:	Esther Jones
Total FTE [% time]:	100

Position #3	
Position Title:	Associate Governmental Program Analyst
Staff Name in Position:	Yuliya Kravtsov
Total FTE [% 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-19, 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 available to be employed at state and local PH agencies in California.

Baseline value of the key indicator described above: 19

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

Date key indicator baseline data was last collected: 2022

Program Strategy

Goal: The California Department of Public Health (CDPH) will conduct PH professional training through the PMR and 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 Building the Future of Public Health specifically, “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. Department of Health Care Access and Information
3. Alameda County
4. Marin County
5. Napa County

Internal:

1. California Tobacco Control Program
2. Environmental Health Investigations Branch
3. Maternal, Child and Adolescent Health Division
4. One Health, Center for Environmental Health
5. Substance and Addiction Prevention Branch

Planned non-monetary support to local agencies or organizations:

- Technical Assistance
- Training

- Resources/Job Aids
- Other: Evaluation, site visits, preceptor and trainee orientations, tutorial/refresher program

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, 2022
- *Number of people served:* 39,029,342
- *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 # trainees to achieve preventive medicine/public health/epidemiology competency

Objective: Between 07/2023 and 06/2024, 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 228 fellows (350 total) to at least 123 residents and 235 fellows (358 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/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 and 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:* 350
- *Data source for baseline value:* Annual count of residents and fellows that achieve competencies
- *Date baseline was last collected:* 07/01/2023
- *Interim target value to be achieved by the Annual Progress Report:* 350
- *Final target value to be achieved by the Final Progress Report:* 358

Target Population

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

Activity 1

Recruit and Interview Applicants for PMR and Cal EIS Positions. Between 07/2023 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; program will recruit and interview at least five (5) PMR applicants and fourteen (14) Cal-EIS applicants.

Description of Activity: Between 07/2023 and 06/2024, program will recruit and interview at least five (5) PMR applicants and fourteen (14) 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 07/2023 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 06/2023; program will conduct at least 15 PH/Preventive Medicine Seminars for residents and fellows.

Description of Activity: Between 07/2023 and 06/2024, program will conduct at least 15 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 07/2023 and 06/2024, 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. Program will train at least 8 individuals in the relevant competencies.

Description of Activity: Between 07/2023 and 06/2024, program will train at least 8 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