

AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER SHIRLEY N. WEBER,PH.D., CHAIR

MONDAY, MARCH 3, 2014

4:00 P.M. - STATE CAPITOL ROOM 126

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ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: DEPARTMENT OVERVIEW

The Department of Public Health (DPH) is dedicated to optimizing the health and well-being of the people in California, primarily through population-based programs, strategies, and initiatives. The DPH's goals are to achieve health equities and eliminate health disparities; eliminate preventable disease, disability, injury, and premature death; promote social and physical environments that support good health for all; prepare for, respond to, and recover from emerging public health threats and emergencies; improve the quality of the workforce and workplace; and promote and maintain an efficient and effective organization.

DPH Budget

As summarized in the table below, the Governor's proposed 2014-15 budget provides approximately \$3 billion overall, representing a \$472 million (total funds), or 13.6 percent, reduction from the current year DPH budget. This reduction largely reflects the proposed transfer of the Drinking Water Program out of the DPH to the State Water Resources Control Board.

General Fund dollars make up just 3.7 percent of the department's total budget while federal funds make up approximately 57 percent of the total budget.

Of the total funds, \$683.3 million is for State Operations, while the remaining \$2.3 billion is for local assistance.

DEPARTMENT OF PUBLIC HEALTH (Dollars In Thousands)					
Fund Source	2012-13 Actual	2013-14 Projected	2014-15 Proposed	BY to CY Change	% Change
General Fund	\$129,474	\$115,182	\$110,629	(\$4,553)	(3.9%)
Federal Funds	1,785,473	1,888,068	1,732,974	(155,094)	(8.2)
Special Funds & Reimbursements	1,154,866	1,480,387	1,167,562	(312,825)	(21.1)
Total					
Expenditures	\$3,069,813	\$3,483,637	\$3,011,165	(\$472,472)	(13.6%)
Positions	3,493.2	3,795.7	3,541.4	(254.6)	(6.7)

The following table shows the proposed expenditures by program area:

Program	2012-13 Actual	2013-14 Projected	2014-15 Proposed
Public Health Emergency Preparedness	87,891	98,015	97,598
Emergency Preparedness	87,891	98,015	97,598
Public and Environmental Health	2,813,729	3,182,743	2,707,523
Chronic Disease Prevention and Health Promotion	272,326	310,420	294,244
Infectious Diseases	624,053	597,508	592,727
Family Health	1,600,095	1,675,208	1,691,936
Health Statistics and Informatics	23,967	28,154	28,031
County Health Services	13,729	16,685	17,078
Environmental Health	279,559	554,768	83,507
Licensing and Certification	168,193	202,879	206,044
Licensing and Certification	158,836	189,443	192,773
Laboratory Field Services	9,357	13,436	13,271
Administration	27,733	34,158	33,798
Distributed Administration	-27,733	-34,158	-33,798
Total Expenditures (All Programs)	\$3,069,813	\$3,483,637	\$3,011,165

BACKGROUND

The overall structure of DPH is as follows (for a full list of all 313 DPH programs, please see Attachment A):

Department Director / State Public Health Officer

- Civil Rights
- California Conference of Local Health Officers
- Office of Health Equity
- Office of Quality Performance and Accreditation
- Administration and Public Affairs

Policy and Programs

- Emergency Preparedness Office
- Center for Health Statistics and Informatics
- Legislative and Governmental Affairs
- Office of State Laboratory Director
- Laboratory Field Services

Center for Chronic Disease and Health Promotion

- Chronic Disease and Injury Control
- Environmental and Occupational Disease Control
- Office of Problem Gambling

Center for Environmental Health

- Drinking Water and Environmental Management
- Food, Drug, and Radiation Safety

Center for Family Health

- Family Planning
- Genetic Disease Screening Program
- Maternal, Child, and Adolescent Health
- Women, Infants, and Children

Center for Health Care Quality

- Healthcare Association Infections Program
- Licensing and Certification

Center for Infectious Diseases

- AIDS
- Communicable Disease Control
- Binational Border Health
- Office of Refugee Health

STAFF COMMENTS/QUESTIONS

The Subcommittee requests the DPH to provide an overview of the department and its proposed budget, and to respond to the following:

Please describe DPH programs and how the department sets public health priorities for the state.

Staff Recommendation: This is an informational item and no action is necessary.

ISSUE 2: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE

The proposed 2014-15 ADAP budget includes total funding of \$409.6 million, a \$9.4 million decrease from the revised current year budget of \$419 million. This \$9.4 million decrease primarily reflects savings resulting from the implementation of the Affordable Care Act (ACA). The proposed budget also includes a current year (2013-14) increase in ADAP funding authority of \$12.7 million over the 2013 Budget Act. Finally, the budget proposes a \$3.3 million increase in funding authority for ADAP in the budget year.

BACKGROUND

ADAP provides HIV/AIDS drugs for individuals who could not otherwise afford them (up to \$50,000 annual income). Drugs on the ADAP formulary slow the progression of HIV disease, prevent and treat opportunistic infections, and treat the side effects of antiretroviral therapy.

ADAP LOCAL ASSISTANCE BUDGET (In Thousands)					
Funding Source	2013-14 Budget	2013-14 Revised	2014-15 Proposed	BY to CY Change	% Change
General Fund	0	0	0	0	0
Federal Fund	79,141	103,488	98,727	(4,761)	(4.6%)
Special Fund	260,809	307,232	259,769	(47,463)	(15%)
Reimbursements	66,339	8,315	51,126	42,811	(514%)
Total Expenditures	\$406,289	\$419,036	\$409,622	(\$9,413)	(2.2%)

The historical increase in expenditures within ADAP is no longer occurring due to two recent key policy changes: 1) the transition of ADAP clients to the Low Income Health Program; and 2) the transition of ADAP clients to Medi-Cal and Covered California as a result of the implementation of the ACA.

The following are the significant changes to the ADAP budget since adoption of the 2013 Budget Act:

2013-14 Changes

- Increase in ADAP Rebate Fund expenditure authority of \$46.4 million primarily due to the federal requirement to spend rebate funds prior to federal funds.
- Increase in the drug rebate rate from 60 to 65 percent based on the past four quarters of actual rebates received.
- Increase in federal funds of \$24.3 million due to additional grant awards.
- Decrease in the use of reimbursement funds (Safety Net Care Pool) of \$58 million due to the federal requirement to spend all rebate revenue first.

2014-15 Changes

- Per DHCS, \$53.6 million in reimbursement funds (Safety Net Care Pool) are available to ADAP. The ADAP expenditure need is \$51.1 million, resulting in a \$2.5 million surplus.

The following major assumptions formed the basis for the ADAP estimate:

1. *Medi-Cal Expansion.* For 2013-14, savings as a result of the Medi-Cal expansion are estimated to be \$74,021,110 for 5,401 clients. For 2014-15, savings from the expansion are estimated to be \$128,212,057 for 9,520 clients.
2. *Covered California.* Savings as a result of ADAP clients transitioning to Covered California, coverage is estimated to be \$1,228,421 in 2013-14 and \$10,351,472 in 2014-15.
3. *2013 Ryan White Grant Adjustments.* ADAP will receive a \$24.3 million increase in federal grants, due to various adjustments.
4. *Low Income Health Program (LIHP).* LIHP back-billing is the timeframe between when drugs are dispensed and when they qualify for reimbursement from LIHPs. LIHP back-billing was delayed until July 1, 2013 due to administrative barriers, which shifted savings in 2012-13 to 2013-14. For 2014-15, LIHP back-billing was further delayed until July 15, 2013 and the estimate updates the estimated savings of \$43.3 million in 2013-14.
5. *The Office of AIDS Pre-Existing Conditions Program (OA-PCIP).* The OA-PCIP pays monthly PCIP premiums for eligible clients. OA-PCIP also provides assistance with AIDS drug deductibles and co-pays. The estimate includes savings from the first six months of 2013-14 of \$760,478.
6. *Methodology Change.* The estimate includes various updates and modifications to the monthly expenditures for the linear regression model.
7. *Increased Pharmacy Benefit Manager (PBM) Costs.* The ADAP PBM contract is estimated to be \$103,342 in 2013-14 and \$220,025 in 2014-15 due to various updates and changes to federal requirements.

8. *Safety Net Care Pool.* The Medicaid 1115 Waiver allows DHCS to use ADAP expenditures as Certified Public Expenditures to draw down federal funds. ADAP estimates utilizing only \$8.4 million of the \$66.3 million available for 2013-14 due to the federal requirement to spend all available rebate funds prior to spending federal funds. For 2014-15, ADAP will receive approximately \$53.6 million in SNCP funds. \$51.2 million is needed for ADAP .

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the ADAP estimate and describe its major components.

Staff Recommendation: Staff recommends holding this item open until after the release of the May Revision, in order to consider updates and changes.

ISSUE 3: RYAN WHITE DATA MATCH PROPOSAL

The Office of AIDS (OA) is proposing trailer bill language in order to obtain statutory authority to allow the California Franchise Tax Board (FTB) to share tax data with OA.

BACKGROUND

The OA states that the ability to obtain and utilize tax data will further ADAP's compliance with state and federal Ryan White income eligibility requirements. Specifically, the OA will be able to cross-reference client data with tax data in order to verify eligibility for the program. Currently, the OA verifies client income eligibility using a variety of client provided documents, including pay stubs, employment affidavits, bank statements, and tax returns. The ADAP estimate states that if a client's tax information shows federal adjusted gross income above \$50,000, the client would be required to provide additional documentation proving that their income has decreased to \$50,000 or below, or else they will be disqualified from the ADAP.

The OA explains that they have made requests for this data to the FTB, which has denied the requests citing their lack of statutory authority to disclose tax data to the OA, despite their existing statutory authority to share tax data with the Departments of Child Support Services, Health Care Services, and Social Services.

DPH explains that the FTB would actually provide the data to the Office of Technology Services (OTech), which would conduct the match; hence, the OA would never actually be in possession of the data. The OA is also working on development of a data sharing confidentiality model.

The proposed trailer bill language:

1. Authorizes the department to disclose the name and taxpayer identification or social security number to the FTB for this purpose;
2. Authorizes the FTB to inform the department of all income information about such clients; and
3. Requires the FTB to destroy the information received from the department after exchanging data.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal and respond to the following:

1. Does the OA believe that ADAP is currently unable to accurately determine the income eligibility of applicants, or will the ability to data match with the FTB simply make the process more efficient?
2. Does the OA believe that this will lead to the disqualification of a substantial number of ADAP clients? If so, is there a savings estimate associated with this proposal?

Staff Recommendation: Staff recommends holding this item open to allow for more time for consideration and public input.

ISSUE 4: ADAP ELIGIBILITY & FAMILY SIZE PROPOSAL

Advocates have submitted a proposal to the Subcommittee to adjust eligibility for the Office of AIDS Health Insurance Premium Payment (OA-HIPP) program and ADAP:

- From the current standard of federal adjusted gross income, with no consideration of family size, to be consistent with the eligibility for other health programs (modified adjusted gross income (MAGI) and family federal poverty levels); and
- From the existing income limit of \$50,000, regardless of household size, to a cap of 500% Federal Poverty Level (FPL) -- \$57,450 for a single individual and \$97,650 for a three-person household.

BACKGROUND

Financial eligibility for OA-HIPP and the AIDS Drug Assistance Program (ADAP) are the same. Currently the programs serve individuals with incomes up to \$50,000 annually based on federal adjusted gross income with no regard for family size. The result is that a single individual is treated the same as a person with dependents. Historically, ADAP served primarily single men with no dependents. Changes in the epidemic and in marriage and family rights, as well as new insurance coverage opportunities through the Affordable Care Act, have resulted in a more diverse ADAP caseload, thereby creating the need to modernize the programs' eligibility standards. Advocates assert that these changes also will allow better coordination with Medi-Cal and Covered California standards and ensure comparable benefits for single people and those with families.

The existing eligibility cap of \$50,000 is estimated to be 447% of Federal Poverty Level (FPL). This proposal is to increase the cap to 500% of FPL, or \$57,450 for a single individual and \$97,650 for a three-person household. Advocates state that estimates indicate that this would increase the program's caseload by less than 1%. Currently five other high-income states operate programs with this income eligibility, including Maine, Maryland, Massachusetts, New Jersey and the District of Columbia.

STAFF COMMENTS/QUESTIONS

Subcommittee staff requests the LAO to present this proposal and to provide any reactions and cost estimates they may have related to the proposal.

Subcommittee staff requests DPH to provide a response to this proposal, and a cost estimate as soon after the hearing as possible.

Staff Recommendation: Staff recommends holding this item open pending development of a cost estimate.

ISSUE 5: OFFICE OF AIDS HEALTH INSURANCE PREMIUM PAYMENT PROPOSAL

Advocates have submitted a proposal to the Subcommittee to require the Office of AIDS' Health Insurance Premium Payment (OA-HIPP) program to cover all co-pays, co-insurance and deductibles incurred by eligible people living with HIV/AIDS who are enrolled in private health insurance through Covered California. Currently, OA-HIPP covers private coverage premiums and co-pays and deductibles for ADAP formulary drugs.

BACKGROUND

Currently, OA-HIPP pays for monthly health, dental and vision care premiums up to a maximum amount of \$1,938 for individuals who qualify for ADAP. OA-HIPP was designed to improve health outcomes by facilitating access to insurance coverage and to reduce costs in ADAP. The program is required to ensure that the insurance purchased includes a comprehensive drug benefit, thereby securing access to essential HIV medications for clients and also realizing significant savings for ADAP.

The population living with HIV is still responsible for substantial out-of-pocket costs associated with primary medical services, such as doctor visits, labs, urgent and emergency care, as well as any drugs that are not included on the ADAP formulary. According to supporters of this proposal, the cost of these services has been a barrier to people enrolling in insurance coverage.

Supporters of this proposal state that if OA-HIPP covers this additional health care cost burden for this population, more low-income people with HIV will be able to genuinely afford comprehensive coverage, thereby improving individual health and dramatically reducing risk of new infections. Effective HIV treatment is one of the most effective prevention tools currently available. Facilitating more ADAP clients to gain comprehensive coverage should also result in increased savings in the ADAP, consistent with the original purpose of the OA-HIPP.

DPH provided the following cost information in response to this proposal:

DPH notes that they consider this approach a part of a larger discussion on state-only programs and the impact on them of the implementation of the ACA.

DPH states that part of the cost depends on how many HIV+ clients have already enrolled in Covered CA vs. how many additional clients would enroll if OA paid the costs of medical expenses. If a relatively low percentage of HIV+ clients have enrolled already, but more enroll as a result of implementation of this policy proposal, then this proposal would generate savings. However, if a high percentage of HIV+ clients have already enrolled in Covered CA, then this proposal could generate additional costs to the State.

Based on ADAP's experience transitioning clients to the Low Income Health Program, OA estimates that between 25 and 33 percent of eligible ADAP-only clients would enroll in Covered CA in the first year of implementation of this proposed policy change compared to an estimated 7.2% of ADAP-only patients who will enroll in Covered CA in FY 2015-16 if medical out of pocket costs are not covered.

Given these assumptions, OA projects that the cost of paying medical out-of-pocket expenses in this proposal would range from \$1.8 - \$2.4 million in FY 2015-16 but would result in a net other fund savings of \$6.3 - \$9.4 million in FY 2015-16. These estimates assume the current rebate return rate.

As for allowable fund sources to cover the cost of this proposal, ADAP Special Funds (rebate funds) may be eligible to cover the cost for the Third Party Administrator to operationalize these changes. Also, per federal HRSA requirements, rebate (special) funds would cover the cost of the medical deductibles. If no rebate funds were available, then federal funds could cover these costs – similar to how OA currently pays for ADAP drug costs.

Finally, DPH explains that this estimate assumes the payment of medical out of pocket expenses would start January 1, 2016. In order to implement this programmatic change, OA would need to develop a request for proposals and enter into a new contract with a third party administrator to pay for premiums and eligible medical out-of-pocket expenses. It is not clear at this time whether additional administrative costs would be incurred for this approach and whether there would be other costs to other state programs and departments.

STAFF COMMENTS/QUESTIONS

Subcommittee staff requests the LAO to present this proposal and to provide any reactions and cost estimates they may have related to the proposal.

Subcommittee staff requests DPH to provide a response to this proposal.

Staff Recommendation: Staff recommends holding this item open pending refinement of a cost/savings estimate.

ISSUE 6: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

The Genetic Disease Screening Program (GDSP) consists of two programs—the Prenatal Screening Program and the Newborn Screening Program. Both screening programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided as part of the fee payment. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund—Genetic Disease Testing Fund. The total GDSP proposed 2014-15 local assistance budget is \$88.6 million, a small increase (\$1.6 million or 2%) over the current year (2013-14) budget of \$86.9 million.

The budget proposes a 2014-15 increase in expenditure authority of \$907,000, attributable to a proposed \$45 fee increase in the Prenatal Screening Program. The proposed fee increase would bring the total fee to \$207. The DPH explains that the fee increase is necessary to correct for the historic overstatement of caseload and inadequate fee revenue in recent years leading to insufficient funding to cover program costs. The proposed fee increase is discussed in more detail below.

BACKGROUND

Prenatal Screening Program (PNS). This program provides screening of pregnant women who *consent* to screening for serious birth defects. The fee paid for this screening is about \$150. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester. Women who are at high risk based on the screening test results are referred for follow-up services at state-approved “Prenatal Diagnosis Centers.” Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

Newborn Screening Program (NBS). This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is \$113. Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers the fee for its enrollees. The NBS screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions, and referral information is provided where applicable.

GDSP Local Assistance Costs			
	2013-14 Estimate	2014-15 Proposed	CY to BY Change
Prenatal Screening Program			
Local Assistance	\$47,517,413	\$48,956,537	\$1,439,124 (3%)
Newborn Screening Program			
Local Assistance	\$39,449,242	\$39,697,367	\$248,125 (0.6%)
TOTAL	\$86,966,655	\$88,653,904	\$1,687,249 (2%)

The GDSP estimate incorporates the following new assumptions:

PNS Contract Increase. Historically, the rate for the first trimester screen has been significantly lower than for the second trimester screen. However, new lab contract rates provide the same rate for first and second trimester screens, thereby increasing lab costs by approximately \$1.34 million.

Lab Consolidation. The GDSP is in the process of reducing the seven laboratory contracts to five contracts, with the expectation that this will yield long-term cost savings of approximately \$1.7 million annually. The DPH states that they do not expect this reduction in contracts to have any negative impact on the program.

Caseload Projection. The program is projecting a slight 1.3 percent increase in caseload, as shown in the table below. Historically, caseload projections for both the NBS and PNS have been overestimates due to inaccurate methodologies. For the NBS, the estimate used 100 percent of the estimated birth rate, not accounting for the small portion of the population that opts out of the program. Going forward, the estimate will be based on an average of actual participation over the prior three years.

GDSP Caseload			
	2013-14 Estimate	2014-15 Proposed	CY to BY Change
Prenatal Screening Program	371,497	376,249	4,752 (1.3%)
Newborn Screening Program	498,722	505,102	6,380 (1.3%)
TOTAL	870,219	881,351	11,132 (1.3%)

Fee Increase. The GDSP is planning to implement a PNS program fee increase of \$45, effective July 1, 2014, bringing the total fee to \$207. The administration states that this fee increase is necessary to correct for: 1) the historic overstatement of caseload; and 2) revenue reductions resulting from reductions to the Medi-Cal reimbursement rate. This fee is paid by either the patient or health insurance coverage, and covers the cost of the blood test and any follow-up services for women with positive screening results. Medi-Cal covers approximately 45 percent of the women participating in the PNS. From the fee paid, \$10 is paid to the California Birth Defects Monitoring Program to support the Prenatal Specimen Biobank.

DPH states that GDSP has not collected sufficient revenue to cover expenditures since 2010-11. The DPH explains that the GDSP regularly experiences a cash flow challenge in that the program began operating prior to the actual receipt of fee revenue. In other words, the program is constantly struggling to cover its costs due to the time lag in fee revenue. They believe that increasing the fee revenue will help alleviate this cash flow

problem. DPH states that the program has authority to increase the fee through regulations, and statutory authority is not required.

Medi-Cal Reimbursement Rate

DPH states that the fee increase is needed, in part, as a result of Medi-Cal rate reductions. According to DPH, DHCS applied the 10 percent Medi-Cal provider rate reduction contained in AB 97 (Committee on Budget), Statutes of 2011, to the GDSP consistent with applying AB 97 to lab rates in general. As a result, the GDSP has received a 10 percent rate reduction for GDSP participants enrolled in Medi-Cal. However, DPH has negotiated a change to this policy with DHCS, which will end this reduction and provide the GDSP with a refund. The following describes recent Medi-Cal rate reductions in recent years that have had an impact on this program:

TIME PERIOD	REDUCTION
July 2008 – February 2009	10% reduction (AB X3 5)
March 2009 – December 2011	Prior 10% reduced to 1% reduction
January 2012 – November 2013	10% reduction to lab services (AB 97)
December 2013 -	No reduction and GDSP expects a refund for June 2011 to November 2013

STAFF COMMENTS/QUESTIONS

The justification for a fee increase is not clear, given that the DPH describes that the fee increase is meant to address three primary issues: 1) a cash flow problem; 2) reduced Medi-Cal rates; and 3) an inaccurate caseload estimate methodology. It may not be usual or reasonable to increase a fee in order to address a cash flow problem. Moreover, the insufficient revenue resulting from reduced Medi-Cal rates have been addressed by DHCS agreeing to restore the rate cut and refund the reduction already taken. Finally, the GDSP has improved its caseload estimate methodology, and therefore caseload should no longer be overestimated.

The Subcommittee requests DPH to present the GDSP estimate and respond to the following:

1. Please explain the justification for the proposed fee increase.
2. What if any impact could a fee increase have on program participants?
3. Please explain the difficulty the program has experienced in collecting this fee from private insurers. Has DPH sought assistance from the Department with Managed Health Care with this issue?

Staff Recommendation: Staff recommends holding this item open to allow for further consideration and public input.

ISSUE 7: TOBACCO CONTROL PROGRAM REDUCTIONS

The Governor's proposed 2014-15 budget includes a decrease of \$2.7 million in Proposition 99 Health Education Account funding for the California Tobacco Control Program. This reduction includes a \$1.4 million decrease to state operations for the Media Campaign, and a \$1.3 million decrease in Competitive Grants.

BACKGROUND

The DPH cites long-term decreasing smoking rates, and therefore decreasing Proposition 99 revenue to the state. In 2013, there was an unexplained \$3 million blip in Proposition 99 revenue, however Department of Finance projects that this blip was a one-time, one-year event, and that overall trends continue to show decreasing smoking rates and correlating decreasing revenue. Therefore, the administration proposes to absorb this year's reduction by ending or reducing activities that were funded with last year's one-time increase in funding. The table below shows current year and budget year Proposition 99 revenue and expenditure projections:

Proposition 99 Tobacco Tax Revenue (In Thousands)						
	2013-14 Estimate			2014-15 Proposed		
Proposition 99 Account	Available Funding	Total Expenditures	Remaining Balance	Available Funding	Total Expenditures	Remaining Balance
Health Education (20%)	\$72,097	\$65,210	\$6,947	\$65,684	\$62,400	\$3,284
Hospital Services (35%)	118,864	93,206	25,658	111,836	108,024	3,812
Physicians' Services (10%)	27,519	26,732	787	25,409	25,403	6
Research (5%)	17,479	15,866	1,685	16,351	15,533	818
Public Resources (5%)	16,594	14,293	2,363	14,677	13,943	734
Unallocated (25%)	75,629	60,668	14,975	70,393	67,499	2,894
TOTAL	\$328,182	\$275,975	\$52,415	\$304,350	\$292,802	\$11,548

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

Staff Recommendation: Staff recommends holding this item open to allow more time for public input.

ISSUE 8: PUBLIC HEALTH REINVESTMENT

Historically, California's investment in public health has been minimal; nevertheless, it also experienced a drastic decline over the past five years. The General Fund in the DPH has been reduced dramatically over the past few years. In 2008-09, the DPH budget included approximately \$350 million in General Fund, as compared to the currently proposed \$110 million, a 69 percent reduction. Through the state's recent fiscal crisis, funding for many DPH programs was either reduced or eliminated. Descriptions of these programs, the reductions to them, and new public health proposals are described in this item below.

The following table provides a sampling of programs (primarily, though not entirely, at DPH) that experienced either reduced or eliminated funding within the past few years, and approximate reduction amounts for those programs:

Public Health Program Reductions	
Program	Reduction (In Millions)
Early Mental Health Initiative	\$15
Maternal, Child, Adolescent Health Programs	\$41
Dental Disease Prevention Program	\$3
Asthma Public Health Initiative	\$1
Injury Control	\$10
Lab Aspire (Lab Training) Program	\$2
HIV/AIDS Programs	\$86

There are additional programs, or public health issues, for which funding was not reduced simply because funding had never been provided, such as for the school-based health centers grant program (described in more detail below). Similarly, the state has invested little to no General Fund in strategies to combat childhood obesity, despite the urgency and severity of the problem.

PANEL 1

- Aaron Fox, Director of State Health Equity & Public Policy, L.A. Gay & Lesbian Center Highland Annex
- Eileen Espejo, Director, Media & Health Policy, Children Now
- Redahlia Kilson, Participant, Sacramento County Black Infant Health Program
- Matthew Marsom, Vice President for Public Policy & Programs, Public Health Institute
- Bruce Pomer, Executive Director, Health Officers Association of California
- Rusty Selix, Executive Director, California Council of Community Mental Health Agencies
- Laura Thomas, MPH, MPP, Deputy State Director, Drug Policy Alliance

PANEL 2

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office

BACKGROUND

The following is a summary of many of the programs that experienced significant funding reductions since 2008, and new proposals related to restoring funding and rebuilding public health infrastructure in California:

Maternal, Child and Adolescent Health

Black Infant Health Program (BIHP). Funding for the BIHP was cut by \$3.9 million in 2009. The BIHP was created in 1989 to address a disproportionately high infant mortality rate for Black infants. In 2011, the preterm birth rate for Black mothers was 13.5 percent, as compared to the state preterm birth rate of 9.8 percent. The BIHP seeks to address the complex factors related to infant mortality and preterm births for the population at greatest risk. BIHP provides health education, social support, individualized case management, home visitation and referrals to other services. The BIHP still operates in 15 local health jurisdictions in California. The Subcommittee has received numerous letters of support for restoring funding to this program.

Adolescent Family Life Program (AFLP). Funding for the AFLP was reduced substantially in 2009. The AFLP addresses the social, health, educational, and economic consequences of adolescent pregnancy by providing comprehensive case management services to pregnant and parenting teens and their children. The AFLP emphasizes promotion of positive youth development, focusing on and building upon adolescents' strengths and resources to work towards:

- Improving the health of the pregnant and parenting teen, thus supporting the health of the baby;
- Improving graduation rates;
- Reducing repeat pregnancies; and
- Improving linkages and creating networks for pregnant and parenting teens.

HIV/AIDS Care and Prevention

The overall reduction to HIV/AIDS public health programs was approximately \$86 million, resulting in the elimination of all of the programs with the exception of ADAP. The following table shows the breadth of funding and programs in recent prior years.

State of California AIDS/HIV Program Funding Detail
Department of Public Health (DPH) and Department of Health Care Services (DHCS)
2009 Budget Act
(\$ In Thousands)

Funding Category	2007-08 (Actual)				2008-09 (Estimated)				2009-10 (Budgeted)			
	General Fund	Federal Funds	Special Fund	Total	General Fund	Federal Funds	Special Fund	Total	General Fund	Federal Funds	Special Fund	Total
Support												
DPH Office of AIDS (OA) ^W	\$5,728	\$12,089	\$1,268	\$19,085	\$6,599	\$13,401	\$1,088	\$21,088	\$3,643	\$14,197	\$1,164	\$19,004
DPH Other Programs ^W	0	529	0	529	0	529	0	529	0	529	0	529
DHCS Audits and Investigations ^W	0	64	147	211	0	127	127	254	0	144	144	289
TOTAL SUPPORT ^W	\$5,728	\$12,682	\$1,415	\$19,825	\$6,599	\$14,057	\$1,215	\$21,871	\$3,643	\$14,870	\$1,308	\$19,821
Local Assistance (DPH OA) ^W												
Education & Prevention ^{W, D}	\$30,478	\$6,188	\$0	\$36,666	\$24,628	\$6,416	\$0	\$31,044	\$0	\$6,416	\$0	\$6,416
HIV Counseling and Testing	8,825	1,635	0	10,460	8,225	2,534	0	10,759	0	2,534	0	2,534
Epidemiologic Studies/Surveillance	9,051	1,592	0	10,643	8,651	1,578	0	10,229	7,651	1,578	0	9,229
Early Intervention	8,133	6,703	0	14,836	7,433	6,983	0	14,416	0	6,983	0	6,983
Therapeutic Monitoring Program	8,000	0	0	8,000	8,000	0	0	8,000	0	0	0	0
AIDS Drug Assistance Program (ADAP) ^W	90,564	88,513	133,629	312,706	96,349	88,446	171,507	356,302	70,849	92,927	250,257	414,033
Housing	1,215	3,460	0	4,675	1,093	3,540	0	4,633	0	3,540	0	3,540
Home and Community Based Care	6,727	5,062	0	11,789	6,327	5,426	0	11,753	0	5,426	0	5,426
CARE/Health Insurance Premium Payment	0	1,983	0	1,983	0	1,700	0	1,700	0	1,700	0	1,700
Care Services (Consortia)	3,300	16,871	0	20,171	0	15,173	0	15,173	0	15,339	0	15,339
Planning/Technical Assistance	0	916	0	916	0	1,309	0	1,309	0	2,881	0	2,881
TOTAL OA LOCAL ASSISTANCE	\$166,293	\$132,923	\$133,629	\$432,845	\$160,706	\$133,105	\$171,507	\$465,318	\$78,500	\$139,324	\$250,257	\$468,081
TOTAL OA (SUPPORT + LOCAL ASST)	\$172,021	\$145,641	\$134,897	\$442,459	\$167,305	\$147,035	\$172,595	\$486,935	\$82,143	\$154,060	\$251,421	\$487,614
FFS Medi-Cal (DHCS) ^W	\$274,021	\$274,021	\$0	\$548,042	\$253,214	\$359,784	\$0	\$612,998	\$247,225	\$396,423	\$0	\$643,648
Estimated Part D (DHCS) ^W	48,884	0	0	48,884	51,702	0	0	51,702	56,395	0	0	56,395
TOTAL FFS and PART D MEDI-CAL (DHCS)	\$322,905	\$274,021	\$0	\$596,926	\$304,916	\$359,784	\$0	\$664,700	\$303,620	\$396,423	\$0	\$700,043
TOTAL AIDS/HIV FUNDING	\$494,926	\$419,626	\$135,044	\$1,049,596	\$472,221	\$506,946	\$172,722	\$1,151,889	\$385,763	\$550,617	\$251,565	\$1,187,945

Recognizing that the epidemic has changed over the past several years, stakeholders and advocates are not proposing to restore these programs as they were, but instead propose support for the following:

Pre-Exposure Prophylaxis (PrEP). Advocates propose \$3 million for three demonstration projects exploring the cost, benefit and health outcomes of offering (PrEP) to residually uninsured individuals in high impact areas. PrEP is a promising new FDA-approved drug that prevents HIV infection in at-risk individuals. It is critically important for people who are in communities experiencing significant spikes in new HIV infections. If used correctly, PrEP is 96% effective in preventing new infections.

Advocates state that these demonstration programs would allow the state to explore the feasibility of delivering this effective new HIV prevention technology to at-risk individuals with no other source of coverage. They believe that a successful project could also dramatically lower HIV prevalence in these communities, thereby also reducing new infections.

Demonstration Projects. Advocates propose \$2 million (General Fund) to support at least three public health demonstration projects to allow for innovative, evidence based approaches to outreach, screening, and linkage to, and retention in, care for the most vulnerable Californians living with and at risk for HIV disease. In light of the increasing rates of new HIV infections in particularly vulnerable communities, the National HIV/AIDS Strategy encourages outreach to the tens of thousands of individuals who are HIV infected yet do not know their status, to encourage testing and to help link people to

quality health care. Advocates point out that while the ACA will help in this effort due to its emphasis on preventive services, including HIV screening, there remains a critical need to reach out to those with no ties to the established health care system. Advocates believe that the proposed demonstration projects have the potential to improve health outcomes and reduce disparities in vulnerable populations.

Post-Exposure Prophylaxis (PEP) and PrEP education. Advocates propose \$3 million (General Fund) for PEP and PrEP education. PEP and PrEP represent two proven and effective ways to reduce HIV infections, according to supporters of this proposal. However, there are many missed opportunities to use these technologies. National studies have documented a lack of knowledge among providers and low uptake among people at risk.

Syringe Access Programs. Advocates propose \$5 million (General Fund) for clean syringe access programs, stating that they are the longest standing evidence-based intervention to prevent HIV and hepatitis C among injection drug users. Syringe programs have proven to dramatically reduce infection rates among active injection drug users. Advocates argue that, due to the long-standing ban on federal funding coupled with a lack of state funding, the effectiveness of this proven intervention has been diminished in California.

Teen Pregnancy Prevention

Advocates propose to restore \$10 million (General Fund) to teen pregnancy prevention efforts, by funding the Community Challenge Grant (CCG) program. The CCG funds a variety of community-based teen pregnancy prevention programs to help adolescents avoid unintended pregnancy and sexually transmitted infections. In 2006-07, CCG programs served approximately 166,749 youth and families through direct, face-to-face interventions, and age-appropriate, culturally sensitive, comprehensive sex education. Supporters of this proposal cite research showing that California's teen birth rate dropped 53 percent between 1991 and 2005, and attribute this significant drop to California's financial investment (prior to significant reductions) in family planning services, comprehensive sex and health education, and teen pregnancy prevention programs such as CCG.

Injury Control

In 2008, the Governor vetoed \$841,000 General Fund in salaries for staff in the Epidemiology and Injury Control (EPIC) section of DPH. EPIC is responsible for the state's injury prevention efforts, including intentional and unintentional injuries, as well as surveillance and epidemiology. DPH stated that all injury control activities would discontinue as of July 1, 2009.

Intentional (violence) and unintentional injuries represent a more significant health threat, and cost to the state, than many people realize. Each year, injuries in California cause approximately 17,000 deaths, 248 hospital visits, and 2,000,000 emergency room treatments. For people 1 – 44 years of age, injury-related deaths outnumber those from all natural causes combined. Historically, only one quarter of all people hospitalized for

injuries have private insurance. Approximately 22,000 brain and spinal cord injuries per year result in permanent disabilities requiring support from Medi-Cal or Medicare. 126,000 seniors are taken to emergency rooms each year for fall-induced injuries, 40 percent of whom are injured so severely that they are never able to return home. The federal Centers for Disease Control and Prevention (CDC) estimates that the total cost of injuries in California in 2006, including both direct medical costs and lost productivity, was \$67 billion. EPIC's nationally recognized work covered the following:

- Child passenger safety
- Violence prevention (including child abuse, domestic violence, sexual assault)
- Elder fall prevention
- Pedestrian safety
- Safe and active communities conducive to walking and biking
- Alcohol and drug surveillance to assist alcohol-related programs across the state interpret and apply data
- California Violent Death Report System, a nationally recognized child abuse and neglect surveillance program
- Web-based, user-friendly injury surveillance table-builder
- Office on Disability and Health (OHD) to increase health promotion opportunities and prevent secondary conditions for people with disabilities

Asthma Public Health Initiative

The California Asthma Public Health Initiative (CA PHI) provided local assistance to ten community health centers serving a combined population of approximately 9,000 children with asthma in underserved communities. Approximately \$1 million in funding was eliminated for CA PHI. The program also administered a local assistance program with central valley health departments designed to reach as many people with asthma, of all ages, as possible. Specifically, the program worked with five counties: Fresno, Stanislaus, Kern, Tulare, and Madera.

The program also conducted four clinical collaboratives to promote improved pediatric asthma care. DPH stated that these collaboratives directly impacted over 25,000 children resulting in significant clinical care improvements, reduced morbidity, and decreased emergency visits and hospitalizations. Finally, CA PHI provided statewide asthma clinical expertise to health care providers and individuals affected by asthma.

Oral Health

Dental Disease Prevention Program (DDPP). From 1980 to 2009, the DDPP provided school-based oral health prevention services to approximately 300,000 low-income school children in 32 counties in California. Approximately \$3.2 million (General Fund) was eliminated from this program. Participating sites provided:

- Fluoride supplementation
- Dental sealants
- Plaque control
- Oral health education

- Oral health advisory committee
- Dental screenings

Supporters of restoring funding for the DDPP cite research that supports all of the following:

- Poor dental health can disrupt normal childhood development and seriously damage overall health
- Dental disease can have a negative impact on a child's ability to learn and succeed in school.
- In 2007, more than half a million school-aged children in California missed at least one school day due to a dental problem – a total of 874,000 missed school days and a statewide average loss of nearly \$30 million in attendance-based school district funding.
- For every dollar spent on oral health prevention, between \$8 and \$50 are saved in subsequent treatment costs.
- In 2007, there were over 83,000 emergency room visits for preventable dental problems at a cost of \$55 million.

Supporters also cite the following program achievements:

- The DDPP was the only comprehensive school-based dental prevention program.
- In its last year of operation, local programs leveraged \$2.1 million in additional funding.
- Nearly 7,000 children in the program in 2008-09 were alerted to the need for urgent care and were referred for dental services.
- More than 14,000 children received dental sealants in 2008-09.
- Over 200,000 children per year received fluoride treatments.

State Dental Director. Oral health advocates and stakeholders propose to fill the position of State Dental Director within DPH. Advocates state that a dental director will be able to provide the leadership and vision necessary to improve the state's oral health status, including developing a state oral health plan, monitoring and evaluating oral health treatment, prevention and literacy projects, and applying for and managing federal and private grant programs to support oral health. Supporters argue that, "There is currently no leadership within state government to support, coordinate and fund oral health programs and policies. There is no state oral health plan, nor is there any evaluation of programs. Moreover, there is no capacity to provide consultation and support to local health agencies, health professions, or educational institutions."

Infectious Disease Control

Public Health Laboratory Training Program

The 2012 Budget Act eliminated \$2.2 million (General Fund) for the Public Health Laboratory Training Program. This program provided local assistance grants to subsidize training, support, outreach and education, and provided funding for doctoral candidate stipends and post-doctoral fellowships for individuals training for public health laboratory directorships. There are 36 local public health labs in California. Public health lab directors must meet state and federal requirements to run a lab, that tests

human specimens, and must have the leadership and public health training needed to oversee the functions of a laboratory that protect the health of the public. Federal law (the Clinical Laboratory Improvement Amendments of 1991) requires that public health lab directors have a doctoral degree, national board certification, and four years of supervisory experience post-doctorate. The Health Officers Association of California (HOAC) states that during the six years that this program received state funds, the program supported 13 students who graduated and became: 5 public health lab directors, 1 assistant lab director, 2 hospital directors, 1 UCLA faculty member, and several public health microbiologists.

HOAC supports restoring funding for this program, citing an ongoing insufficient supply of qualified lab directors in the state. Public health lab directors are required to hold a doctorate degree, board certification, California Public Health Microbiologist certification, and have at least four years of experience in a public health lab. Specifically, HOAC proposes to restore funding, but with modifications to the program such that assistance be limited to assistant lab directors employed in local public health labs. These individuals would be eligible for a four-year commitment to funds, thereby allowing them to accrue the four years of lab experience necessary to become a public health lab director. HOAC estimates the need for funding at approximately \$1 million.

Tuberculosis Trust Fund. HOAC proposes the creation of a Tuberculosis Trust Fund with \$8.8 million (General Fund) to ensure tuberculosis (TB) expertise through an augmented or dedicated position in all 61 local health jurisdictions. According to HOAC, while TB has been declining in California since 1993, a Californian dies with TB every other day and a child under five is diagnosed with TB every week in California. Approximately 2.4 million persons are infected with TB, and finding and treating those individuals is critical to preventing TB transmission and to eventually eradicating TB in California.

STD Prevention and Services. The California Family Health Council proposes \$2 million (General Fund) annually to provide free STD screening, testing and diagnosis, free Chlamydia and Gonorrhea treatment, and to support outreach and education. They propose the selection of three counties with high STD rates that lack sufficient resources and infrastructure to provide adequate STD services to the uninsured population. Funds would support outreach and education, evaluation, training, and program administration. These pilot programs would operate from July 1, 2014 through June 30, 2016.

School-Based Health Centers

Supporters of the *Public School Health Center Support Program* (an unfunded grant program already in statute) propose \$10 million General Fund to start the existing program that has yet to receive any funding. Proponents state that the program would support all of the following:

- Technical assistance for all school based health centers (SBHCs) to increase outreach and enrollment into Medi-Cal and Covered California.

- Planning grants for 10 new SBHCs in areas where the greatest numbers of uninsured children will remain after 2014.
- Start-up grants for 20 newly constructed SBHCs including those funded by the Affordable Care Act.
- Sustainability grants for 30 SBHCs to expand obesity/diabetes prevention or asthma management to reduce health care costs.
- Implementation of comprehensive programs to address trauma in 35 schools in communities most heavily impacted by violence.

California currently has 200 SBHCs, with over 40 more in development. More than 250,000 children in grades K-12 have access to a SBHCs. Children served by SBHCs live in many of the state's most distressed neighborhoods where children and families are uninsured, experience barriers to accessing preventive health care, have high rates of emergency room visits, obesity, asthma, and exposure to violence and trauma.

California's SBHCs have come to be an important part of the safety net, providing access to health care to thousands of underserved children and adolescents. They offer a range of primary care services, such as screenings, immunizations, and physicals. Many also play an important role in managing students' chronic illnesses, such as asthma and diabetes. Some SBHCs offer mental health, youth development, and dental services.

In 2006, Governor Schwarzenegger signed AB 2560 (Ridley-Thomas): The School Health Centers Act. It created the *Public School Health Center Support Program*, to be jointly administered by the Department of Health Services and the California Department of Education. The program was designed to collect data on SBHCs and facilitate their development. In 2008, Governor Schwarzenegger signed SB 564 (Ridley-Thomas): The School Health Centers Expansion Act, which added a grant program to the *Public School Health Centers Support Program*. This grant program was designed to provide technical assistance and funding for the expansion, renovation and retrofitting of existing SBHCs and the development of new SBHCs. Both AB 2560 and SB 564 were to be implemented only to the extent that funds were appropriated to DPH. As of 2013, these funds have not been appropriated, and thus the functions of the *Public School Health Center Support Program* have not been implemented.

Early Mental Health Initiative

Today, the State of California provides no funding for any type of programs or services that could be described as prevention within the mental health arena. For many years, until 2012, the state invested \$15 million General Fund into the Early Mental Health Initiative (EMHI), which sought to identify very young, school-aged, children who exhibited mental health risk signs, and provide those kids with various supportive services, provided by trained para-professionals, in order to stop or slow the progression of mental health challenges for these kids. The program had been operated through the former Department of Mental Health, until the elimination of that

department, at which time the program transferred to the Department of Education (CDE). CDE has never actually operated the program, however as all of the funding was eliminated the same year the program was transferred.

Drug Overdose Grant Program

The Drug Policy Alliance (DPA) has submitted a proposal to the Subcommittee for \$2 million (General Fund) for a grant program for local agencies and community-based organizations in order to reduce the rate of fatal drug overdose caused by prescription analgesics and other drugs. The DPA proposes to appropriate these funds to the California Health and Human Services Agency (CHHS) for grants, program administration and evaluation to commence in the 2014-2015 fiscal year and be completed by the 2017-2018 fiscal year. The CHHS would make grants to local agencies or community based organizations for any of the following purposes:

1. Drug overdose prevention, recognition, and response education projects with naloxone provision to reduce the rate of fatal drug overdose in the state. Programs and entities that may be eligible for such grants include: homeless programs, low-income housing programs, jails, prisons, drug treatment centers, syringe exchange programs, clinics, programs serving veterans or military personnel, and other organizations that work with or have access to persons who misuse prescription or illegal drugs.
2. Drug overdose recognition and response programs, including naloxone administration, for first responders, including but not limited to law enforcement and peace officers, emergency medical technicians, volunteer fire or voluntary emergency service providers.
3. Drug overdose prevention, recognition, and response training, including naloxone provision for patients prescribed opioids, their family members or other persons who reside with a patient.

DPA proposes that not more than five percent be available annually for administration of the program and not more than five percent be made available annually to a university or other research entity in California to evaluate the effectiveness of the programs awarded grants.

The Drug Policy Alliance has proposed that this grant program be operated by the Health and Human Services Agency, however, staff recommends that, should funding be approved for this purpose, that the program instead operate through the Department of Public Health, as it fits well with the department's public health mission.

According to the federal Centers for Disease Control and Prevention (CDC):

- In 1999, there were 4,030 overdose deaths from opioids; in 2010, there were over 16,000 drug poisoning deaths involving prescription painkillers and 3,000 deaths involving heroin.
- Overdose deaths involving prescription painkillers have increased approximately 20 percent since 2006.
- More Americans are using and dying from prescription painkillers than from heroin.

STAFF COMMENTS/QUESTIONS

As reflected in the Assembly Democratic Caucus's 2014-15 Blueprint for a Responsible Budget, the Assembly may wish to consider the value of a renewed investment in California's public health infrastructure.

The Subcommittee requests the LAO to present this issue, and requests DPH to provide reactions to the stakeholder panel and the various proposals contained within this item. The Subcommittee also requests DPH to respond to the following:

1. Since 2008, what programs have been cut, by how much, and what has been the resulting programmatic changes and service reductions?
2. Does the department have a statement of priorities or strategic plan that would direct the use of future unrestricted funding, should such funding become available?

Staff Recommendation: Staff recommends holding this item open until updated state revenue information is available as a part of the May Revision.

Attachment A: Department of Public Health Programs

1. Administration - Program Support Branch
2. ADAP (AIDS Drug Assistance Program)
3. Adolescent Family Life Program (AFLP)
4. AIDS Drug Assistance Program (ADAP)
5. AIDS (OA), Office of
6. Alzheimer's Disease Program
7. Animal Use Approval Program
8. Arthritis Partnership Program (CAPP), California
9. Asthma Public Health Initiative (CAPHI), California
10. Autism and other Developmental Disabilities
11. Beach Safety (Regulations and Guidance)
12. Binational Border Health, California Office of
13. Biochemistry Section, Environmental Health Laboratory Branch
14. Biomonitoring Program
15. Biotoxin Monitoring (Marine)
16. Birth and Beyond California (BBC)
17. Birth Defects Monitoring Program (CBDMP), California
18. Black Infant Health Program (BIH)
19. Blue-Green Algae (Cyanobacteria)
20. Bottled and Vended Water Program
21. Breast Cancer Screening Program
22. Breastfeeding Program (BFP) (MCAH)
23. Breastfeeding Resources (WIC)
24. Breathing, Addressing Asthma from a Public Health Perspective, California
25. Bottled Water Manufacturer Registration and Inspection Program
26. Botulism Control (Cannery Inspection Program)
27. California Active Communities (CAC)
28. California Arthritis Partnership Program (CAPP)
29. California Asthma Public Health Initiative (CAPHI)
30. California Biomonitoring Program (CECBP)
31. California Birth Defects Monitoring Program (CBDMP)
32. California Breathing, Addressing Asthma from a Public Health Perspective
33. California Cancer Registry
34. California Center for Physical Activity
35. California Conference of Local Health Officers, (CCLHO)
36. California Diabetes Program
37. California Diabetes and Pregnancy Program (CDAPP) - Sweet Success
38. California Early Childhood Comprehensive System (CA-ECCS)
39. California Electric and Magnetic Fields Program (EMF)
40. California Electronic Violent Death Reporting System (CalEVDRS)
41. California Environmental Contaminant Biomonitoring Program (CECBP)
42. California Environmental Health Tracking Program
43. California Epidemiologic Investigation Service (Cal-EIS)
44. California Heart Disease and Stroke Prevention Program
45. California Influenza Surveillance Project, Viral & Rickettsial Disease Laboratory Branch
46. California Office of Binational Border Health
47. California Osteoporosis Prevention and Education (COPE) Program
48. California Project LEAN (Leaders Encouraging Activity and Nutrition)
49. California Obesity Prevention Program
50. California Safe Cosmetics Program
51. California Tobacco Control Program
52. California Youth Firearm Injury Reporting System (CYFIRS)
53. Cancer Detection Section (CDS)
54. Cancer Detection Programs: Every Woman Counts (CDP: EWC)
55. Cancer Prevention and Nutrition
56. Cancer Registry, California

57. Chronic Disease Surveillance and Research Branch (CDSRB)
58. Cannery Inspection Program
59. CAPHI (California Asthma Public Health Initiative)
60. CAPP (California Arthritis Partnership Program)
61. Care Program, HIV
62. Center for Chronic Disease and Health Promotion
63. Center for Environmental Health
64. Center for Family Health (CFH)
65. Center for Health Care Quality
66. Center for Health Statistics and Informatics
67. Center for Infectious Diseases (CID)
68. Center for Physical Activity, California
69. Cervical Cancer Screening Program
70. Certification Verification Application - Licensing & Certification
71. Chemical Laboratory Response Network (LRN-C)
72. Child Abuse
73. Child Maltreatment
74. Childhood Injury Prevention Program (CIPP)
75. Childhood Lead Poisoning Prevention Branch
76. Child Passenger Safety
77. Children's Dental Disease Prevention Program
78. Chronic Disease Control Branch (CDCB)
79. Civil Rights, Office of
80. Cold Storage Program
81. Colon Cancer Control Program (C4P)
82. Communicable Disease Control, Division of
83. Communicable Disease Emergency Response Branch
84. Community Challenge Grant Program (CCG)
85. Community Water Fluoridation Program
86. Comprehensive Perinatal Services Program (CPSP)
87. Conference of Local Health Officers (CCLHO), California
88. COPE (California Osteoporosis Prevention and Education) Program
89. Cosmetics - California Safe Cosmetics Program
90. County Medical Services Program (CMSP)
91. Cyanobacteria
92. Delta Watershed Fish Project
93. Department of Defense Radiologic Oversight Program
94. Devices for Water Treatment
95. Diabetes Program, California
96. Diabetes and Pregnancy Program (CDAPP), California
97. Disabilities Advisory Committee (DAC)
98. Disability and Health Program
99. Disease Investigations Section, Infectious Diseases Branch
100. Division of Communicable Disease Control (DCDC)
101. Division of Drinking Water and Environmental Management
102. Division of Environmental and Occupational Disease Control
103. Domestic Violence Training and Education Program
104. Drinking Water Program
105. Drug Manufacturer Licensing and Safety Program
106. Early Childhood Comprehensive System
107. eHealth Information
108. Emergency Medical Services Appropriation (EMSA)
109. Emergency Preparedness Office
110. Environmental and Occupational Disease Control, Division of
111. Environmental Health Investigations Branch (EHIB)
112. Environmental Health Laboratory Branch (EHLB)
113. Environmental Health Specialist Registration Program
114. Environmental Health Tracking

115. Environmental Laboratory Accreditation Program
116. Environmental Management Branch
117. EPIC (Epidemiology and Prevention for Injury Control Branch)
118. Epidemiology and Prevention for Injury Control (EPIC) Branch
119. Every Woman Counts (Breast and Cervical Cancer Screening Program)
120. Export Document Program
121. FACE (Fatality Assessment and Control Evaluation) Program
122. FCANS (Fatal Child Abuse and Neglect Surveillance Program)
123. Fall Prevention
124. Family Health (CFH), Center for
125. Family PACT Program (FamPACT)
126. Family Planning (OFP), Office of
127. Farmer's Market Nutrition Program, WIC
128. Fatal Child Abuse and Neglect Surveillance (FCANS) Program
129. Fatality Assessment and Control Evaluation (FACE) Program
130. Fetal and Infant Mortality Review Program (FIMR)
131. Fluoridation by Public Water Systems
132. Fogerty International Training, California and China Environmental Health Collaboration
133. Food and Drug Branch
134. Food and Drug Export Program
135. Food and Drug Laboratory Branch
136. Food and Drug Laboratory Chemistry Program
137. Food and Drug Laboratory Microbiology Program
138. Food Processing Industry Training and Education Program
139. Food Safety Industry Education and Training Program
140. Food Safety Inspection Program
141. Food Testing Program
142. Food, Drug and Radiation Safety
143. Forensic Alcohol Program
144. Frozen Food Program
145. Funding Opportunities for Public Water Systems
146. GCIP (Gynecologic Cancer Information Program)
147. General Food Safety Program
148. Genetic Disease Screening Program (GDSP)
149. Governor's Council on Physical Fitness and Sports
150. Grocers, WIC Authorized
151. Gynecologic Cancer Information Program (GCIP)
152. Healthcare Associated Infections (HAI) Program
153. Hazard Evaluation System and Information Service (HESIS)
154. Health Information and Research
155. Hearings, Office of Regulations and
156. Heart Disease and Stroke Prevention Program, California
157. Hepatitis Prevention, Office of Viral (OVHP)
158. HESIS (Hazard Evaluation System and Information Service)
159. HIV Care
160. Home Medical Device Retail Program
161. Home Visiting Program
162. HOPWA (Housing Opportunities for Persons with AIDS)
163. Human Stem Cell Research Program
164. Immunization Branch
165. Indoor Air Quality Program (IAQ)
166. Indoor Radon Program
167. Infant Botulism Treatment and Prevention Program
168. Infant Health
169. Infectious Diseases, Center for
170. Infectious Diseases Branch
171. Influenza Surveillance Project
172. Information and Education Program (I&E)

173. Injury Prevention
174. Institutions Program
175. Kids' Plates Program
176. Laboratory Animal Use Approval Program
177. Laboratory Central Services
178. Laboratory Field Services
179. Lead in Candy Program, Food and Drug Branch
180. Lead Poisoning Prevention, Childhood
181. Lead Poisoning Prevention Program, Occupational
182. Lead Related Construction Program
183. LEAN - California Project (Leaders Encouraging Activity and Nutrition)
184. Licensing and Certification
185. Licensing & Certification - Certification Verification Application
186. Legislative and Governmental Affairs, Office of
187. Local Health Department Maternal, Child and Adolescent Health Program (LHDMP)
188. Low Level Radioactive Waste Tracking Program
189. Male Involvement Program (MIP)
190. Mammography Program
191. Maternal Health
192. Maternal, Child, and Adolescent Health (MCAH) Program
193. Maternal, Child and Adolescent Health in Schools (MCAHIS)
194. Medical Device Manufacturer Licensing and Safety Inspection Program
195. Medical Marijuana Program (MMP)
196. Medical Waste Management Program
197. Medication Error Reduction Plan (MERP) Program
198. Methadone Program
199. Microbial Diseases Laboratory Branch
200. Network for a Healthy California
201. Newborn Screening Program
202. Nuclear Emergency Response Program
203. Nursing Home Administrator Program (NHAP)
204. Nutrition and Physical Activity Initiative (MCAH)
205. OA (Office of AIDS)
206. Obesity Prevention Program, California
207. Occupational Health Branch (OHB)
208. Occupational Health Surveillance and Evaluation Program (OHSEP)
209. Occupational Lead Poisoning Prevention Program (OLPPP)
210. Office of AIDS (OA)
211. Office of Binational Border Health, California
212. Office of Civil Rights
213. Office of Family Planning (OFP)
214. Office of Health Equity (OHE)
215. Office of Legislative and Governmental Affairs
216. Office of Oral Health (CDIC)
217. Office of Problem Gambling
218. Office of Public Affairs
219. Office of Regulations and Hearings
220. Office of State Public Health Laboratory Director (OSPHLD)
221. Office of Viral Hepatitis Prevention (OVHP)
222. Office on Disability and Health
223. OHB (Occupational Health Branch)
224. OHSEP (Occupational Health Surveillance and Evaluation Program)
225. Olive Oil Program
226. OLPPP (Occupational Lead Poisoning Prevention Program)
227. Operator Certification (Drinking Water Treatment and Distribution System)
228. Oral Health Program (MCAH)
229. Organic Processed Products Program
230. (OSPHLD) Office of State Public Health Laboratory Director

231. Osteoporosis Prevention and Education (COPE) Program, California
232. Outdoor Air Quality Section (OAQ)
233. Pet Food Licensing & Registration Program
234. Preconception Health and Health Care Program
235. Preharvest Shellfish and Marine Biotxin Monitoring Program
236. Prenatal Screening Program
237. Perinatal Hepatitis B Prevention Program
238. Perinatal Substance Use Prevention
239. Preventive Health Care for Adults
240. Preventive Medicine Residency Program (PMRP)
241. Privacy Office
242. Processed Food Registration and Inspection Program
243. Program Support Branch
244. Project LEAN (Leaders Encouraging Activity and Nutrition)
245. Proposition 50 - Funding for Public Water Systems
246. Proposition 84 - Funding for Public Water Systems
247. Prostate Cancer Treatment Program
248. Public Affairs, Office of
249. Public Health Informatics Branch
250. Public Health Policy and Research Branch
251. Public Swimming Pools and Spas
252. Radioactive Materials Licensing and Inspection Program
253. Radioactive Waste Tracking Program
254. Radiologic Health Branch
255. Radon Program
256. Rape Prevention and Education (RPE) Program
257. Recreational Health Programs
258. Refugee Health Program
259. Regional Perinatal Programs of California (RPPC)
260. Registered Environmental Health Specialist Program
261. Regulations and Hearings, Office of
262. Regulations for Drinking Water Systems
263. Rural Health Services (RHS) Program
264. Safe Drinking Water State Revolving Fund
265. Safe Routes to School
266. Sanitation and Radiation Laboratory
267. School Health Connections
268. Seafood and Shellfish Safety - Food and Drug Branch
269. Senior Injuries
270. Sexual Violence Prevention
271. Sexually Transmitted Diseases Control Branch
272. Shellfish Growing Areas
273. Shellfish Marketing Certificate - Food and Drug Branch
274. Skin Cancer Prevention
275. Smokers' Helpline
276. Stem Cell Research Program, Human
277. Stop Tobacco Access to Kids Enforcement (STAKE)
278. Sudden Infant Death Syndrome Program (SIDS)
279. Surveillance and Statistics Section, Infectious Diseases Branch
280. Survey Research Group
281. Sweet Success Program (CDAPP)
282. Syphilis Elimination Effort (SEE)
283. Technical, Managerial, and Financial Assistance for Water Systems
284. Teen Pregnancy Prevention Program (TPP)
285. TeenSMART Outreach Program (TSO)
286. Tobacco Control Program
287. Traffic Safety
288. Tuberculosis Control Branch

- 289. Vaccines for Children
- 290. Vector-Borne Disease Section, Infectious Diseases Branch
- 291. Vehicle Occupant Safety Program (VOSP)
- 292. Vended Water
- 293. Vendors, WIC Authorized
- 294. Veterinary Public Health Section, Infectious Diseases Branch
- 295. Violence Against Women Statewide Prevention Project
- 296. Violence Prevention
- 297. Violent Death Reporting System, California (CalVDRS)
- 298. Viral and Rickettsial Disease Laboratory Branch
- 299. Viral Hepatitis Prevention, Office of (OVHP)
- 300. Vital Records Issuance and Preservation Branch
- 301. Vital Records Registration Branch
- 302. Water
- 303. Water, Bottled
- 304. Water, Drinking
- 305. Water, Recycling
- 306. Water, Vended
- 307. Water Treatment Device Certification
- 308. West Nile Virus Surveillance
- 309. WIC (Women, Infants and Children)
- 310. WISEWOMAN Program
- 311. Women, Infants and Children (WIC)
- 312. X-Ray Machine Certification and Registration (Mammography Standards Program)
- 313. Youth Firearm Injury Reporting System, California (CYFIRS)