

AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assemblymember Hector De La Torre, Chair

MONDAY, APRIL 4, 2005, 4PM
STATE CAPITOL, ROOM 447

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ITEMS ON CONSENT

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 1: ELECTRONIC DEATH REGISTRATION SYSTEM

The budget proposal is to expend \$225,000 from the Health Statistics Special Fund to deploy the Electronic Death Registration System (EDRS) and to train system users to ensure the successful integration of EDRS into local registration/business processes. The funding comes from the Health Statistics Fund and no fee increase is required to implement the program. The program will contract with the University of California – Davis for the deployment of the system and for training the local government users of the system.

AB 2550 (Nation, Chapter 857, Laws of 2002) mandated the development and implementation of an EDRS in California. The legislation was part of a package of legislation to improve vital records administration and combat identity theft and fraud. The legislation established funding for the development, implementation, maintenance and operation of the EDRS through an increase in the disposition permit fees. The fees were raised from \$7 to \$13 in 2003. In January 2005 the fees declined by \$2, leaving the remaining \$4 increase to fund the maintenance and operation of the Electronic Death Registration System. The University of California, Davis Health System, developed the Electronic Death Registration System software for the State.

Today, Californians do not receive timely death information to settle estates or to claim insurance or survivor benefits. Five states have an EDRS system in place: Maryland, Montana, Minnesota, New Hampshire and South Dakota. California selected the Minnesota model for the development and deploying of the system. The EDRS system was designed, developed and tested in two pilot counties. As a result of the deployment of the system: families of deceased persons will be able to get death certificates sooner; funeral directors will spend less time with government paper work; coroners will be able to quickly file amended cause of death information after an investigations are complete; local registrars will be able to process death certificates more accurately; the state will benefit from timely, accurate data; and the general public will benefit from research done using timely, accurate data.

The development and implementation of the EDRS was the result of the legislation referenced above and enacted in 2002. The Davis Administration sponsored the bill as part of a package of legislation that would improve vital records administration and combat identity theft and fraud. The base budget for EDRS in 2004-2005 was \$1.463 million. The funding was for the final activities necessary to begin the rollout and for maintenance and operation activities.

The proposed funding for 2005-2006 is for deployment of the system and training of system users. System development and testing as proposed in the Finance Letter in the 2003-2004 Fiscal Year was accomplished through a Standard Agreement between the Department and the University of California - Davis, Health System.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 2: PROPOSITION 50 INTERAGENCY AGREEMENT

The budget proposes an increase in funding, \$125,000 from Proposition 50 funds, for the Division of Drinking Water and Environmental Management within the Department of Health Services to fund an Interagency Agreement with the California Bay-Delta Authority.

The California Bay-Delta Authority (CBDA) has the responsibility to carry out the Bay-Delta Program. CBDA, using resources from the Department of Health Services interagency agreement, will contract out for a water quality program manager for the Department of Health Services. The Department is a participating member of the CBDA and is required under the provisions of Senate Bill 1653 (Costa, Chapter 812, Statutes of 2002) and its CBDA Memorandum of Understanding to implement a CBDA Drinking Water Quality Program. Proposition 50 contains provisions which require any projects that will wholly or partially assist in the fulfillment of one or more of the goals of the CALFED Bay-Delta Program to be consistent with the CALFED Programmatic Record of Decision.

CBDA will provide assistance and general guidance to the Department of Health Services in establishing, coordinating and administering the Drinking Water Quality Program for the California Bay-Delta Program. CBDA has the responsibility to carry out the Bay-Delta Program and employs staff to accomplish the work. CBDA will contract out with the Santa Clara Valley Water District for a Water Quality Program Manager, who will oversee and coordinate the Drinking Water Quality Program for the Department of Health Services.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 3: CANNERY INSPECTION PROGRAM FUND SHIFT

Pursuant to Assembly Bill 3027 (Committee on Agriculture, Chapter 314, Statutes of 2004) the budget proposes to shift funding, \$1.6 million, for the Cannery Inspection Program to a newly created special fund, Cannery Inspection Fund, from the General Fund (reimbursable). Also, the proposal would transfer the appropriation authority for nine Senior Food and Drug Investigators and the funding for a contract with UC Davis. Finally, beginning January 1, 2005 canneries will begin to be billed in advance for cannery licensing activities occurring after July 1, 2005.

Cannery inspection frequency varies by the amount of product produced. Some canneries are inspected daily to release products produced within the last 24 hours and others may only produce products seasonally or once to twice per year. The Department of Health Services conducts inspections of the firm's process controls and production records to support the release of each batch of product produced. Annual inspections of the facility look very closely at all aspects of the licensee's operations. Currently there are 160 licensed canners.

The program was the model that the US Food and Drug Administration used when they developed federal regulations for low acid canned foods and acidified foods. Many other

process authorities look to California as the lead in establishing new process parameters to control botulism toxin production.

All advanced billings for services to be provided through June 30, 2005 are still being deposited into the General Fund, since the General Fund reimbursement positions were funded through June 30, 2005. On July 1, 2005 those positions will be transferred to the cannery inspection fund. Advanced billings for services to be provided July 1, 2005 forward will be deposited into the Cannery Inspection Fund. The amount of the July billing is unknown at this time.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 4: KEN MADDY CANCER REGISTRY PROGRAM

The budget proposes to reduce the appropriation in the Department of Health Services' Breast Cancer Research Account by \$239,000 to align expenditures with the projected revenue level. The funding reduction will eliminate support for two full time equivalent Research Scientist I contract positions that conduct epidemiological research.

As a result of decreasing sales of cigarettes and tobacco products in California, the amount of the revenue for the state collected from such sales is declining. For Fiscal Year 2005-2006, the Department of Finance projects the Breast Cancer Research Account funds will decrease in total revenues from \$16.324 million in the 2004-2005 Fiscal Year to \$14.195 million in Fiscal Year 2005-2006, a reduction of \$2.129 million.

State statute mandates that the Cancer Surveillance Section be allocated ten percent of the Breast Cancer Research Account funds annually for the purposes of breast cancer-related data collection and epidemiological research. The current allocation to the Cancer Surveillance Section from the Breast Cancer Research Account is \$1.657 million and the original budget year allocation was \$1.659 million. Based on the adjusted revenue projections, the budget year allocation to the Cancer Surveillance Section from the Breast Cancer Research Account will be \$1.420 million, a \$239,000 reduction from the 2004-2005 Fiscal Year base.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 5: NEWBORN SCREENING PROGRAM

The Department proposes to expend \$15.016 million from the Genetic Disease Testing Fund and the authority for 3 new full time permanent positions for an expansion of the Newborn Screening Program by adding Tandem Mass Spectrometry (MS/MS) and Congenital Adrenal Hyperplasia (CAH) screening.

The Health Trailer bill for the 2004-2005 Fiscal Year, SB 1103, authorized the Department to increase the expansion of the Newborn Screening Program from 39 conditions to 76 conditions by adding tandem mass spectrometry and Congenital Adrenal Hyperplasia. The

program is administered by the Genetic Disease Branch and fulfills the public need of producing screening and treatment for prevention of these genetic disorders.

The Newborn Screening Program screens over half a million newborns a year (99 percent of the annual births in the state) in 325 maternity hospitals. The Program uses a unique public-private partnership which obtains laboratory services by competitive bids from eight private laboratories and contracts with private institutions to conduct follow-up activities. Any positive test or unsatisfactory specimen are noted and electronically transmitted to one of seven regional Newborn Screening Program test follow-up centers that track the case until evidence of a proper referral and treatment is received. Referral is to the California Children Services (CCS) approved Special Care Centers.

Reimbursement for the Newborn Screening Program testing of newborns is made by hospitals which pay the Genetic Disease Branch the full screening fee for newborn screening and obtain third-party reimbursement from the family's source of payment for the delivery. For Medi-Cal births, hospitals are reimbursed by Medi-Cal either as a part of their managed care capitation rate or, for fee-for-service eligibles at their negotiated rate. The on-going impact to the General Fund, based on the projected number of births funded by Medi-Cal is \$2.1 million.

MS/MS is a broad, complicated blood analysis that has 46 different values and patterns of value that require interpretation. MS/MS requires the addition of expensive new machines to the laboratories and staff to maintain, monitor, and interpret test results.

Currently, the Department of Health Services staff maintains the existing analytic equipment high pressure liquid chromatography system for 27 hemoglobin and immunochemical auto analyzer to thyroid and galactokinase for the newborn screening program. An additional Public Health Chemist is proposed to standardize and develop quality control and proficiency assays for the MS/MS reference laboratory and the CAH reference laboratory. This includes performing secondary testing using a different MS/MS analysis on borderline CAH positives to reduce false positives and immediately notify a follow up coordinator of any urgent results. The Department is requesting a public health chemist and research scientist to maintain and monitor the new equipment and monitor the test results. In addition the Department is proposing a position that would provide administrative, operational, and business support services necessitated by the implementation of MS/MS

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 6: UNSERVED/UNDERSERVED SERVICES – BATTERED WOMEN'S SHELTERS

The budget proposes a restoration of \$1.1 million (\$350,000 Nine-West Settlement Agreement Fund, \$235,000 Domestic Violence Training and Education Fund and \$515,000 General Fund) for the Unserviced/Underserved (U/U) program to retain funding at its present level of \$2.25 million. In the 2003-2004 Fiscal Year, the U/U program was mistakenly identified as a General Fund "outreach program" instead of a "direct service" program and was reduced 50 percent (\$1.1 million).

The U/U program is the only component of the Battered Women's Shelter Program (BWSP) that assists BWSP-funded shelters to serve, in culturally sensitive ways, communities of color, teens and disabled women that traditionally do not seek shelter services but are at high risk for domestic/intimate partner relationship violence.

The current Domestic Violence (DV) program was established as the BWSP by the Battered Women Protection Act of 1994 (AB 167, Chapter 140 Statutes of 1994 as amended by AB 801, Chapter 599, Statutes of 1994). As legislatively mandated, BWSP began primarily as a shelter-based program that expanded existing services, established 17 new shelters statewide, and funded creative and innovative service approaches such as community response teams. The 1999-2000 Fiscal Year budget provided \$2.5 million augmentation to focus services on "unserved/underseved" populations, with emphasis on cultural and ethnic populations, so that groups experiencing DV but not traditionally seeking assistance through the BWAP would also be able to receive assistance.

Goals of the Battered Women's Shelter Program

- Provide comprehensive shelter-based domestic violence services to battered women and their children.
- Prevent domestic violence in California.

Problem

- Domestic violence is the leading cause of injury to women between ages 15 and 44 in the U.S.
- In 2002, husbands, ex-husbands, or boyfriends killed 128 women in California.
- California law enforcement received 196,569 domestic violence calls in 2002 of which 119,850 involved weapons, including firearms and knives.

Program Activities

- Shelter-based services include emergency shelter, transitional housing, legal assistance, counseling, and community response teams.
- Meet the comprehensive needs of battered women and their children and ensure access to unserved/underserved populations, e.g. teens, women with disabilities, lesbians, multicultural populations.
- Funding of non-profit agencies to implement innovative, community-specific projects, which prevent domestic violence, such as programs for local community awareness, teenagers, and preschool children.
- Statewide technical assistance and training to shelter staff and other domestic violence service providers.
- A data collection and evaluation system of domestic violence service providers.
- Comprehensive programs to decrease community tolerance of domestic violence. Shelter-based services include emergency shelter, transitional housing, legal assistance, counseling, and community response teams.

Who Provides Services?

- Dedicated staff and trained volunteers in 146 programs: 96 (two shelters combined into one organization) shelters providing direct services to battered women and their

children, 15 shelters and community-based partner agencies funded to reach unserved/underserved populations, 32 agencies conducting community domestic violence prevention programs, 1 agency providing statewide technical assistance and training, and 1 contractor conducting evaluation and data collection.

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ISSUE 7: RICHMOND LAB PHASE III

The Department of Health Services is requesting a \$1.989 million, \$265,000 one time, augmentation to the budget to provide the resources necessary to operate the Richmond Phase III Office Building. In Fiscal Year 2005-2006 the majority of staff will be moved from various leased space in the East Bay Area. The Department believes that six new positions and additional operating expenses and one-time equipment purchases are required to support the programs. The Department proposes to fund the new positions on the retirement of current leases when the programs are relocated to the Richmond Campus. The savings from the leases would be \$3.6 million annually.

The expenditures proposed by the Department of Health Services would be broken down to: \$391,000 for salaries and benefits; \$1.455 million for contracts; and \$143,000 for equipment and other operating expenses. Of the \$1.455 million for external contracts, \$327,000 is for security services, \$288,000 is for janitorial services and \$125,000 for fire protection/alarm system maintenance.

Laboratory Central Services provides centralized, professional and technical support to the public health laboratories at the DHS Richmond Laboratory Campus. These services include: receiving, processing and routing medical and environmental samples and specimens; developing, evaluating and performing decontamination protocols on medical waste; washing and preparing glassware and instruments; purchasing, breeding, maintaining a variety of laboratory animals and maintaining animal facilities; providing teleconferencing services to Department of Health Services laboratories.

When operational, the 200,000 square foot, \$50 million building will require support in the form of maintenance/administrative staff and other facilities related services.

ITEMS TO BE HEARD

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 1: BIOTERRORISM

The Department of Health Services has proposed an expenditure of, \$8.2 million in Federal Funds, and the continuation of 94.8 limited term positions for two years to continue the implementation of the cooperative agreements with the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA) for activities relating to bioterrorism preparedness and response. The federal government has proposed funding for both the CDC and HRSA grants but the funds have not been allocated to the states for the 2005-2006 Fiscal Year.

The current funding cycle for CDC and HRSA cooperative agreements contains numerous required critical benchmarks and activities that the Department of Health Services believes is necessary to continue the staffing levels for both grants. The Federal grants support 104.8 positions, 10 permanent, 94.8 limited term. 86 of the positions, including the 10 permanent positions, are dedicated to CDC related activities and 18.8 positions are dedicated to HRSA related activities.

The CDC cooperative agreement funding is to enhance the California public health system's preparedness and response to bioterrorism, outbreaks of infectious diseases and other public health threats and emergencies. The grant is charged with public health management and coordination of the State's public health response to potential terrorist attacks. In administering the CDC funds, the Department has five goals which are coordinated through its Emergency Preparedness Office; establish a centrally managed public health bioterrorism response system for California; develop and coordinate all state, local and federal public health-related resources; coordinate with areas of the Department and private sector to increase and improve state and local capacity to support early recognition of and response to bioterrorism events; develop and train state and local public health workers for incident response and public information and risk communication related to bioterrorism events; and develop and implement preventive strategies where feasible. CDC requires an in-depth planning and preparedness response, focused on building public health infrastructure at the state and local levels to rapidly respond to bioterrorism, disease outbreaks and public health emergencies.

The HRSA grant provides hospitals clinics and Local Emergency Services Agencies an opportunity to focus on bioterrorism and preparedness issues in a coordinated manner. Each county has a coalition of hospitals, clinics, and Local Emergency Service Agencies develop a plan. There is a need however for inter-hospital or regional planning to manage a bioterrorism incident. Failure to develop the inter-hospital and regional planning may lead to non-standardized plans that may conflict or be unable to mesh with the county or regional approach to incidents. The HRSA grant provisions include regional healthcare planning and preparedness – a critical element in the state's ability to respond to, manage and recover from bioterrorism incidents.

Of the \$108.776 million in expenditure authority \$70.102 million is for the Centers for Disease Control and Prevention (CDC) co-operative agreement and \$38.774 million is for the Health Resources and Services Administration (HRSA) co-operative agreement. Of the CDC funding, \$23.308 million is for state operations and \$47.064 is for local assistance. Of the HRSA grants the Department adopted funding \$13.574 million for state support and \$25.2 million in local assistance.

The administration submits annual budget requests to the Legislature for authority to spend additional federal grant funds. These budget requests, however, do not generally describe the status of the prior-year grants, how those prior-year funds were spent, or what additional homeland security goals the administration hopes to achieve in the budget year. The LAO recommends the Subcommittee adopt placeholder trailer bill language to require the Department to develop a statewide strategic plan for the use of federal homeland security and bioterrorism funds by all departments and local jurisdictions. Also, the Department would be required to report to the Legislature expenditures of federal homeland security and bioterrorism funds. Finally, the Department would be required to conduct audits of local government cost reports to determine if expenditures of local governments conform to federal standards.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 2: AIDS DRUG ASSISTANCE PROGRAM

The Department requests, as a result of caseload growth, an increase in funding for the program, \$56.191 million total funds, \$24.63 million General Fund. Program totals for the AIDS Drug Assistance program are projected to be \$263.565 million, \$91.178 million General Fund, \$100.826 million federal funds and \$71.561 million from the ADAP Rebate Fund. Also, the budget requests authority to establish two permanent positions to negotiate drug price discounts with pharmaceutical drug manufacturers, \$230,000 from the ADAP Rebate Fund.

The AIDS Drug Assistance program was legislatively established in October 1987 to provide drugs to individuals with HIV/AIDS who could not otherwise afford them. The objectives of ADAP are to provide AIDS drugs that have been determined to prolong life and prevent deterioration of health in individuals with HIV or AIDS. The ADAP caseload has grown from 10,000 clients served in 1995-1996 to over 27,000 served in the 2003-2004 fiscal year.

Since the advent of Highly Active Antiretroviral Therapy (HAART) in fiscal year (FY) 1995-96, ADAPs nationwide have experienced increased enrollment due to people living longer and aggressive outreach efforts, increased utilization of combination therapies and drugs to treat the toxicity and side-effects of HAART, and ever increasing drug prices. The convergence of these factors has resulted in expenditures in ADAP outpacing Federal appropriations. The economy has greatly reduced state tax revenues and resulted in state fiscal crises that limit the ability of states to meet the gap between federal appropriations and the needs of uninsured/underinsured people living with HIV/AIDS.

Nationally, ADAPs have had to implement cost-containing strategies, including closed enrollment to new clients, limited access to antiretroviral (ARV) and other treatments, changes in eligibility criteria, and reduced drug formularies. Through the annual budgetary process, California ADAP has also had to consider similar cost-containing options.

In response to this situation, California ADAP took a key leadership role in the creation of the ADAP Crisis Task Force (ACTF) by convening a meeting in California of state ADAP representatives in 2002 to discuss and formulate potential negotiating strategies. From this meeting, the ACTF was formed and became a national-level drug discount negotiating body representing all ADAPs in the country. The ACTF is comprised of ADAP/AIDS directors from eight key states, including California. The ACTF membership represents approximately 75% of the national ADAP expenditures.

Beginning in March 2003, the ACTF began negotiations with all the major ARV drug manufacturers (Abbott Laboratories, Boehringer Ingelheim, Bristol Myers-Squibb, Gilead Sciences, GlaxoSmithKline, Roche, Merck, and Pfizer Inc.) to pay ADAP rebates above those mandated by federal law. Each drug manufacturer came to the table individually to enter into confidential supplemental rebate agreements with the ACTF, and by October 2003 the negotiations were completed. The outcomes of these pricing negotiations were critical to the ability of ADAPs nationally to keep ADAPs open and provide continuing access to medications required for quality HIV/AIDS health care.

As the terms of the initial supplemental agreements were nearing expiration, the ACTF began re-negotiating the drug manufacturer agreements in October 2004. The ACTF has successfully re-negotiated one- to two-year agreements with all the major ARV manufacturers. Additionally, the ACTF is negotiating with a number of non-ARV drug manufacturers for supplemental rebates.

ACTF activities are ongoing for 2005, including negotiations with more non-ARV drug manufacturers and generic drug manufacturers. Activities include:

- Weekly ACTF conference calls (e.g. discussions on updates on drug price increases, expiring agreements, strategy discussions, and data review to ensure manufacturers are honoring their agreements).
- Calls with drug manufacturers to address unresolved details of negotiations.
- Meet with manufacturers of other expensive drugs to negotiate rebates on these products. Two-day face to face meetings are generally held quarterly.

As the largest ADAP in the country, California's participation/presence at most of these discussions is critical to the credibility and strength of the ACTF negotiations.

The continuing success of ACTF negotiations is particularly significant to California, as 85% of ADAP expenditures are for ARV drugs alone. The proposed budget for BY 05-06 includes \$71.6M in drug rebates (27.3% of the total budget). Approximately 15% of the rebates now collected are due to supplemental rebate agreements.

ADAP now relies heavily on the additional rebates, as federal funding has not kept up with steadily increasing program demand. It is equally critical that ADAP assure every rebate dollar owed the program is accurately and effectively invoiced, received and tracked by drug manufacturer. All rebate dollars received are dedicated solely for the purchase of additional

ADAP drugs. Additional staff (MST position) to support this increasingly important function is essential to the ADAP rebate collection process.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 3: AIDS PREVENTION AND EDUCATION PROGRAM

DISCUSSION ONLY

Presently, approximately \$18.4 million is appropriated for HIV prevention and education in the 2004-2005 budget. This money is allocated to local health jurisdictions on the recommendation of the California HIV Planning Group (CHPG) and approval of the Office of AIDS (OA). This is the statewide planning group that is required by federal law in order to receive the Ryan White CARE money.

In February 2003, on the recommendation of the CHPG, the OA adopted a new funding formula for the allocation of the HIV prevention and education money for the 2003-2004 fiscal year. This change resulted in reductions for many jurisdictions. Thirty-six counties were placed in a category labeled historically "over-funded" for education and prevention funding. Seven jurisdictions were identified as being historically "under-funded." Eighteen were placed into a category called "floor" local health jurisdictions. These are rural counties, mostly in Northern California. When this formula was to be fully implemented, each of these counties were guaranteed floor funding of at least \$60,000 each year.

The Adopted Funding Formula Was As Follows:	
AIDS Cases Diagnosed in Prior Three Calendar Years	25%
Living AIDS Cases	25%
People of Color AIDS Diagnosed in Prior Three Calendar Years	15%
People of Color Living AIDS Cases	15%
People of Color in General Population	10%
People Living Below Federal Poverty Level	10%

In October 2004, OA adopted another formula and it was implemented for the 2005 – 2006 fiscal year. The formula was adopted in order to redirect education and prevention funds to those jurisdictions that have the greatest disease impact.

The new formula is as follows:	
HIV Prevalence/HIV Counseling and Testing (positives)/Living AIDS Cases	70%
Sexually Transmitted Diseases (Syphilis, GC, and Chlamydia in Men)	15%
People Living Below Federal Poverty Level	8%
People of Color in General Population	7%

HIV prevalence data will be excluded from the formula since this data is incomplete. The rationale for making this change is that "funding allocations (of prevention dollars) closely match disease impact. This tenet is a cost effective and prudent strategy to fight the epidemic." As a result of the adoption of this formula, all local health jurisdictions except for seven will see declines in their prevention and education dollars from their 2002 – 2003 fiscal year allocations. The seven health jurisdictions that will see increases from 2002 - 2003 are: Long Beach; Los Angeles; Orange; Riverside; San Bernardino; San Diego; and San Francisco.

Overall, these jurisdictions will see a \$4.2 million increase in HIV prevention money over what they received for the 2002 – 2003 fiscal year, which means that the other jurisdictions will see a corresponding decrease.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 4: OFFICE OF BI-NATIONAL BORDER HEALTH

The budget proposes to eliminate General Fund support, \$604,000, for the California Office of Bi-national Border Health. The Office of Bi-national Border Health contractor would be given at least 30 days notice of the contract termination.

The California Office of Bi-national Border Health (COBBH) was established by statute (AB 63) in January 2000. The Office is located in San Diego.

The main charges of the Office are to:

- Convene a voluntary community advisory group of representatives of border community-based stakeholders to develop a strategic plan with short-term, intermediate, and long-range goals and implementation action.
- Develop and share recommendations from the strategic plan in consultation with the California appointees to the United States-Mexico Border Health Commission.
- Prepare and submit an annual border health status report to the Director of DHS, the Legislature, and the Governor.

The roles of the Office are to:

- Act as liaison to Baja California and Mexico state health officials and health professionals;
- Foster bi-national partnerships that improve health conditions for border and/or bi-national communities;
- Assess public health status of border and bi-national communities;
- Promote health policy and program development for bi-national cooperation;
- Inform and educate about bi-national and border health priorities to encourage health officials, professionals and individuals toward action; and
- Function as an information clearinghouse about border/bi-national health information, programs, projects and strategies.

The budget proposal states that coordination between Mexico and California health officials on the issues above will continue through established program liaisons in the various public health programs rather than the single point of contact that the Office provides.

However, according to the Public Health Institute, one important aspect of international health policy projects are the relationships that are important to beginning and sustaining any kind of work involving other countries. The relationship between Mexico and the United States is important because the porous border increases the potential for public health threats including the spread of communicable disease. The loss of the California Office of Bi-national Border Health would cause the demise of many relationships, formal and informal, that played an important public health role.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 5: CALIFORNIA ASTHMA PUBLIC HEALTH INITIATIVE

Asthma is a chronic inflammatory lung disease that results in partially reversible constriction of the airways. The condition is characterized by episodes of wheezing, shortness of breath, or coughing that may occur at anytime, but most often during the night or in the early morning. Asthma is considered to be a critical public health issue due to its negative impact on quality of life, increased morbidity and mortality, and substantial economic impact.

Funding for both the California Asthma Public Health Initiative programs, Childhood Asthma Initiative and the California Asthma Among the School Aged will expire on June 30, 2005. The programs received approximately \$13 million in Fiscal Year 2004-2005.

Significant Facts

- According to the 2001 California Health Interview Survey (CHIS), an estimated 11.9 percent of Californians (3.9 million adults and children) have been diagnosed with asthma. Nearly 75 percent (2.9 million) of these individuals experienced asthma symptoms during the prior 12 months.
- Asthma prevalence varies considerably by race and ethnicity. In California, asthma prevalence is highest among American Indians and Alaska Natives, Native Hawaiians and other Pacific Islanders, and African Americans.
- Asthma disproportionately affects children and young adults. In California, prevalence is highest among children 12 - 17.
- Asthma is a leading cause of school absenteeism in children and results in missed workdays and lost productivity in adults.
- Emergency room visits and hospitalizations for asthma are a significant burden in California and throughout the nation. Significant disparities exist in hospitalization rates by race and ethnicity. Overall, African Americans experience considerably higher rates than any other group.

- Asthma related deaths are not common, but the mortality rate from asthma in California is higher than the national rate. In 1999, asthma was responsible for 561 deaths in California, and of these, 19 deaths occurred among children 0 - 19. The mortality rate due to asthma among adults 65 and older is significantly higher compared to all other age groups. African Americans and Asian/Pacific Islanders experience the highest age-adjusted mortality rates from asthma.
- The direct and indirect economic impact of asthma was estimated to cost California \$1.27 billion dollars in 1998. In 2000, hospitalizations represented the largest direct medical expense related to asthma; the average cost per hospitalization was \$13,000.

Programs of the Department of Health Services

- The mission of the California Asthma Public Health Initiative (CAPHI) is to improve the quality of life for all children and adults with asthma through implementation of effective programs and policies in asthma education, management, and prevention. CAPHI seeks to reduce preventable asthma morbidity and mortality, and to eliminate disparities in asthma practices and outcomes through coordinated approaches and partnerships with communities, state and local organizations, health care providers, health departments, foundations, and academic institutions.
- The Childhood Asthma Initiative (CAI) is a four-year project funded by the California Children and Families Commission (CCFC) to address asthma in children 0 - 5 and to reduce its negative impact on families and school readiness. It is a collaborative project between the California Department of Health Services' (CDHS) Chronic Disease Control Branch, Children's Medical Services Branch, and the Environmental Health Investigations Branch. CAI has three components, which include Community Asthma Intervention Projects, Asthma Treatment Services, and a survey of childcare center site directors and childcare center staff.
- The California Asthma Among the School-Aged (CAASA) Project aims to provide high quality asthma care to children 5 - 18. This three-year project is funded through a grant from The California Endowment. CAASA uses continuous quality improvement techniques to increase knowledge and awareness of asthma among health care providers, and to improve the delivery of asthma care in seven community-based programs.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES**ISSUE 6: IMPACT PROGRAM**

The Prostrate Cancer Coalition requests the Legislature appropriate \$6.5 million for the IMPACT (Improving Access, Counseling and Treatment for Californians with Prostate Cancer) Program.

Funding for the IMPACT Program is proposed to be discontinued in the 2005-2006 Fiscal Year.

- In California, approximately 20,500 men will be diagnosed with prostate cancer in 2002, and over 3,000 men will die from the disease.
- Prostate cancer is the second leading cause of cancer death in men, exceeded only by lung cancer.
- Prostate cancer, more than any other form of cancer, is a disease associated with aging. About 75% of men are age 65 and older when diagnosed.
- African American men have the highest rates of prostate cancer. African American men are 60% more likely than White men to develop prostate cancer, twice as likely as Hispanic men, and three times more likely than Asian and Pacific Islander men.
- Prostate cancer in African Americans is more likely to be an aggressive form of the cancer and strike at an earlier age.
- Little is known about the causes of prostate cancer, though a diet high in fat increases the risk.
- Like most cancers, prostate cancer is most likely to be treated more successfully when found in its early stages. Unlike breast cancer, clinical trials have not clearly demonstrated a decrease in mortality following screening and there are many uncertainties about early detection of this disease. For example, prostate cancer often grows very slowly (unlike other cancers) and may never become life threatening. The American Cancer Society, American Urological Association and the National Comprehensive Cancer Network recommend doctors offer men age 50 and older the option of yearly screening tests for the disease using two tests, the Digital Rectal Exam (DRE) and the Prostate Specific Antigen (PSA), along with a discussion of the benefits and risks of both tests. Men at high risk, such as African Americans and men who have a first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age, should begin testing at age 45.
- Early detection may have an effect on survival. At least 70% of all prostate cancers are detected early (while confined to the prostate), with a five-year survival rate of 97%. If the prostate cancer is detected after it has spread to other parts of the body, the survival rate is 34%.

When Section 4.10 cuts were implemented in December 2003, the General Fund (GF) appropriation for the Prostate Treatment Program was reduced by \$4.457 million. Funding for direct services, administration, case management, outreach and evaluation provided through an external contract with UCLA was reduced by \$4.259 million. State administration was reduced by \$198,200. The reduction left \$545,000 for the revised budget for the fiscal year (FY) 2003-2004. The program suspended all new enrollments as well as re-enrollments of men needing continued treatment beyond the end of their currently authorized period of program eligibility.

The IMPACT Program provides free prostate cancer treatment to low-income Californians who are uninsured. To enroll in the program a man must be a California resident, have an income at or below 200 percent of the Federal Poverty Level, have no health insurance and be ineligible for Medi-Cal or Medicare. Since the enrollment was suspended a waiting list has been started. Men who are on the waiting list have been directed to seek treatment from the public healthcare systems in the counties in which they live.

In FY 2002-2003 budget the program was appropriated \$20 million. In the Mid-Year Reduction \$10 million of the appropriation was rescinded because of the lower than anticipated participation in the program. The funding was further reduced in FY 2003-2004 budget by \$5 million because of under-utilization in the program. In the Control Section 4.10 appropriation, reductions made at the end of December, the program was further reduced to the \$545,000.

DHS phase out and contract closure plans

- DHS instructed UCLA to close IMPACT enrollments effective February 11, 2005. Closing IMPACT enrollments on February 11, 2005 will ensure that all men enrolled receive prostate cancer treatment for a full 12 months and allow UCLA/IMPACT the time and the funding available for UCLA to complete required final administrative activities before the contract ends on March 31, 2006.
- DHS is amending the UCLA contract, set to expire June 30, 2005, to extend to March 31, 2006 (a full five year term) so that patients enrolled this fiscal year can receive a full 12 months of treatment. DHS will amend the contract to include all FY 2004-05 reappropriated funds and to include an amount for FY 2005-06 that is dependent on reappropriation language in the signed Budget Act of 2005.

Funding proposed for the 2005-2006 Fiscal Year

- DHS has proposed 2005 Budget Act language to authorize re-appropriation of unspent FY 2004-05 funds into FY 2005-06. The re-appropriation proposed in the 2005 Budget Act will be used for FY 2005-06 UCLA administrative activities required for patient treatment and contract close-out, and for DHS program oversight.

The Balance Of The Tobacco Settlement Funds That Were Re-Appropriated For The Program In The 2004-05 Budget Year	
Appropriation and Allocations:	
FY 2004-05 Budget Act Appropriation	\$6,529,954
FY 2004-05 UCLA contract amount	\$5,929,954
FY 2005-06 UCLA contract amount	\$301,609
DHS Funding For Contract Oversight:	
FY 2004-05	\$100,000
FY 2005-06	\$198,391
TOTAL	\$6,529,954

* Carryover funding for FY 2005-06 is contingent on an appropriation in the 2005 Budget Act.

Program Enrollment

- As of February 7, 2005, per UCLA data, 341 men are currently enrolled in the IMPACT program.
- UCLA reports that from program inception in 2001 to February 7, 2005, a total of 630 men have been enrolled.
- Eligible men are enrolled for 12 months of treatment.
- Until February 11, 2005, men can be re-enrolled for subsequent 12-month periods if continued treatment is required.

New enrollments

- No, new enrollments, they ceased on February 11, 2005.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 7: WIC SUPPLEMENTAL NUTRITION PROGRAM

The Women, Infants, and Children (WIC) Supplemental Nutrition Branch in the Department of Health Services is requesting seven additional positions for the 2004-2005 Fiscal Year and continuing them in the 2005-2006 Fiscal Year. Two of the positions are permanent and five are limited two year positions. The positions were administratively established on January 1, 2005 and as of March 4, 2005 five of the seven positions had been filled. Funding for the position would come from Federal Trust Funds of WIC and budgeted for Operating Expenses. The positions would be used to: resume functions that have been discontinued or reduced over the last three years; meet new federal requirements for cost containment and; implement a breastfeeding program funded by the U.S. Department of Agriculture.

The Department proposes to add one position for Local Agency Support. Four positions would be added for food cost containment and two would be added for Breastfeeding Support. One position for Food Cost Containment and one for local agency support would be permanent and the others would be limited term positions.

The Local Service Agency Support position would perform on-site monitoring evaluations, conduct on-site technical assistance in nutrition areas, review training and competency of local agency staff and monitor contracts. The staff for cost containment would develop and implement cost containment policies and procedures, monitor grocer redemption, identify and implement state regulations, identify and conduct on-going operational review and hire and oversee a contractor that would perform specialized item pricing services. Breastfeeding has been identified as a core public health effort due to its great potential to improve health and reduce the risk of disease. The staff for the Breastfeeding Peer Counseling are to support local WIC programs in hiring and training breastfeeding peer counselors, women who have successfully breastfed their babies and who are trained to support other breastfeeding mothers in their community. A portion of the authority will be needed to complete the vendor management changes, however there is sufficient authority remaining after funding is redirected for the requested positions.

Program Description

- The Women Infant and Children (WIC) Supplemental Nutrition Program is a supplemental food and nutrition program for low-income pregnant, breastfeeding, and postpartum women and children under age five who have a nutritional risk.

Program Goal

- The goal of the WIC program is to decrease the risk of poor birth outcomes and to improve the health of participants during critical times of growth and development. To meet this goal, WIC provides nutrition education, breastfeeding promotion, medical care referrals, and specific supplemental nutritious foods which are high in protein and/or iron. The specific nutritious foods provided to participants include peanut butter, beans, milk, cheese, eggs, iron-fortified cereal, iron-fortified infant formula and juices.

Program Description

- WIC is unique among federally administered programs in that it provides specific supplemental nutritious food and nutrition education to a specifically targeted population as a short term intervention and adjunct to ongoing health care. The supplemental foods provided by the WIC program are designed to meet the participants enhanced dietary needs for specific nutrients during brief but critical periods of physiological development. It is "short term", in that, on average, WIC participants receive services for approximately two years.

Program Eligibility

- WIC is available to low income pregnant, breastfeeding, and postpartum women and children under age five who are at nutritional risk and who are at or below 185 percent of the federal poverty level. The income guidelines for a family of four are \$33,485 annually or \$2,791 monthly (effective through June 30, 2003). Many people incorrectly

view WIC as a welfare program because participants must be members of a low-income family. In fact, over 50 percent of the women and children on WIC in California are members of a family where one or both parents work outside the home.

Program Effectiveness

- Numerous scientific studies show that pregnant women who participate in the WIC program seek earlier prenatal care and consume a healthier diet. The improved nutrition and nutrition education provided to enrolled women and children result in longer pregnancies, fewer and very low birth weight babies, and fewer fetal and infant deaths. This translates into enormous savings in health care dollars. Specifically, after reviewing 17 cost benefit studies, the U.S. General Accounting Office (GAO) published a report in 1992 that found that WIC saved \$3.50 for every \$1.00 spent on WIC. Most of the savings, or approximately \$2.89, was saved in the first year of life. The GAO also noted that additional savings could be realized if more pregnant women were enrolled on the program. They conservatively estimated an overall annual savings of \$51 million in federal and state health care funds if WIC served all eligible pregnant women. For example, it costs \$544 a year for a pregnant woman to participate in WIC. By contrast, it costs the tax payers \$22,000 per pound to nurture a low birth weight baby (less than 5.5 pounds) to the normal weight of 7 pounds in a neonatal intensive care unit. WIC prenatal care benefits reduce the rate of very low birth weight babies by 44 percent.

Program Outreach

- Working families are among the most unlikely to know of WIC services since they often believe they are not eligible because they work. The WIC program has used a media campaign in California to increase awareness of the WIC program among working families who may qualify for the program. Many of California's working families receive low wages that do not allow them to purchase sufficient healthy foods for themselves and their families or to adequately access preventive health care services such as immunizations. Our goal is to encourage these families to participate in WIC and to benefit from improved nutrition, nutrition counseling, and medical care referrals while saving taxpayer dollars.

Program Funding

- WIC receives federal funding from the U.S. Department of Agriculture. California contracts with 82 local county and private non-profit agencies to deliver WIC services at the local level through over 650 local WIC centers. WIC has been well received by policy makers over the last several years. Significant funding increases has allowed WIC to grow from serving 520,000 participants a month in 1991 to over 1.2 million participants per month in 1998. In the last few years, Congress has "level funded" the program and has provided no funding for program expansion. To maintain the level of services, the WIC program has entered into over \$200 million in innovative rebate contracts with juice, infant formula, and infant cereal manufacturers. This allows California WIC to serve about 400,000 additional women and children at no additional cost to the taxpayer.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES**ISSUE 8: BETTER STATE OF HEALTH**

The number of overweight people in California has been increasing over time. Being overweight is a significant factor in disease, disability, premature death, and to the burden of increasing health care costs. To address the health care aspects of the problem the Governor's budget includes approximately \$6 million in General Fund resources to implement a variety of proposals to promote healthy nutrition, increased physical activity, and obesity prevention. The Governor's initiative is outlined in the table below.

Figure 4		
Proposed Components of Anti-Obesity Initiative		
<i>(Dollars in Thousands)</i>		
	DHS Positions	General Fund
DHS coordinating office	1	\$371
Community action grants	1	3,029
Training and technical assistance	—	500
Enhanced health services for Medi-Cal children	—	1,408
Surveillance, evaluation, and research	—	500
Public relations	—	150
Miscellaneous OE&E expenses	—	76
Totals	2	\$6,034

Legislative Analyst Office

First, the funding would establish a new office and the proposed budget for 2005-2006 proposes to expend approximately \$371,000 for the coordinating office. The proposal would add one new staff person to Department and create within the Department a new office to coordinate the department's existing programs that promote nutrition and physical activity. The office is to (1) serve as the single point of contact for information regarding the development of public policies and scientific information related to obesity; (2) foster partnerships among programs within the department that have functions related to combating obesity; (3) coordinate the department's public health surveillance, training, and evaluation of obesity prevention efforts; and (4) carry out various other coordinating activities. The new office would be directed by a new medical officer who would report directly to the State Public Health Officer.

The proposal includes approximately \$3 million for grants to community organizations to implement projects involving schools and other local agencies and organizations to address various aspects of obesity prevention. A wide variety of grants is envisioned as being possible. A grant might be used to support a project to encourage the layout of new housing developments in designs that encouraged new residents to walk to stores and schools instead of driving to them. The Department estimates that 15 such projects would be funded through a competitive process with the funding that the administration is requesting. The

administration also is requesting \$500,000 for technical assistance and training for these regional and local obesity prevention efforts.

The proposal also would provide \$1.4 million to develop a demonstration project that would be targeted at improving the quality of health care provided to Medi-Cal children to prevent or address obesity problems. The project would consist of three types of activities: (1) the promotion of breastfeeding and the exclusion of other methods for feeding infants, (2) increased screening and counseling of children for obesity problems by primary care providers, and (3) improved referral and treatment services for children who are overweight or at risk of becoming overweight. The project would be implemented in up to six collaboratives made up of hospitals, clinics, and other medical service providers that serve significant numbers of Medi-Cal beneficiaries.

Also, the budget proposal includes \$500,000 for public health surveillance activities, program evaluation, and research into the design and development of effective public health initiatives to stem the rise in obesity. Finally, the initiative includes approximately \$150,000 for public relations materials and events intended to encourage the public to live healthier lifestyles and not be overweight.

Currently, DHS spends about \$1.2 billion annually from federal and private sources for a variety of programs that are intended to promote good nutrition and increased physical activity as a means to improve public health. Approximately 75 percent of the funding is for nutritious food provided to low-income families through the Women, Infants, and Children (WIC) program.) Other activities, the department's obesity prevention programs provide are nutrition education to low-income women and young children, promotion of physical activity and healthy eating behaviors through public media campaigns, help develop school nutrition policy, and provide technical assistance and training to other entities engaged in obesity prevention efforts. The Department has indicated that one of the functions of the proposed new state office is to assess how these existing programs could be better managed and focused on reducing obesity.

The Legislative Analyst Office urges the Administration to complete an assessment of the nutrition programs that are currently functioning before additional General Fund resources for new obesity prevention efforts are committed. The Legislative Analyst further notes that some overlap with existing activities appears evident. For example, the Epidemiology and Health Promotion section of the Chronic Disease Control Branch of DHS already operates a "California Obesity Prevention Initiative." This initiative, with an annual budget of \$275,000 in federal funds, embarks upon many activities, which appear to be similar to those described in the Governor's new budget request.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES**ISSUE 9 LOW LEVEL RADIOACTIVE WASTE**

SB 2065, Kuehl was passed and signed into law in 2002. The statute requires the Department of Health Services to maintain a file of all manifests of radioactive waste generators for wastes sent to a disposal facility or a Southwestern Low-level Radioactive Waste Compact facility. Also, the Department must maintain a file on all radioactive material generated stored for decay, transfer, treated or released directly into the environment or disposed of by a generator in the state, and specifies standards for the type and quantity of such information. In addition the Department must maintain a file on each generator's storage capacity as well as the nature, activity, and volume of the radioactive materials stored. The reporting procedures mentioned above must be established through a public hearing process and require generators to use the procedures for annual reporting of the information specified above. Finally, the Department must prepare an annual set of tables summarizing data collected from activities and maintenance of files specified under the bill's provisions, including information on the amount of low-level radioactive wastes generated by each generator broken out by half-lives, and additional data as specified.

The bill also required that all costs associated with the program were to be paid from the Radiation Control Fund. The Department is required to aggregate the information that is made available to the public by county in order to shield the identity or location of any specific site where LLRW is stored or used. Also, the Department of Health Services may also aggregate the information by multiple counties if necessary to protect public security. Public access to the to the underlying site-specific data in the annual report by explicitly barring application of the California Public Records Act to the report. The Department can only undertake the requirements of the act if an appropriation is made.

Since enactment, the program has not been funded because the Radiation Control Fund has been over-subscribed. However the budget shows that fee collections have been increasing. Collections in the 2003-2004 Fiscal Year were \$14.882 million. Collections for 2004-2005 are projected to be \$16.452 million and for 2005-2006 the fund is projected to receive \$19.592 million.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES**ISSUE 10: GENETICALLY HANDICAPPED PERSONS PROGRAM ACCOUNTING ADJUSTMENT**

The Legislative Analyst Office recommends the Department of Health Services report at budget hearings on its estimate of the fiscal effect of shifting the Genetically Handicapped Persons Program from an accrual to cash basis of accounting. The LAO believes such a change would bring the program in line with other Department of Health Services programs

operating under a similar basis of accounting and could achieve net onetime program savings of several millions of dollars in the General Fund.

The LAO notes that in recent years, the Legislature has approved various program accounting changes in order to achieve onetime state savings. The 2003-04 Budget Act and related legislation shifted the Medi-Cal Program from an accrual to a cash basis of accounting. The 2004-05 Budget Act adjusted the spending level for the mental health services component of the Early and Periodic Screening, Diagnosis and Treatment Program to reflect the use of the same accounting basis as the rest of Medi-Cal. These technical changes had the effect, on a onetime basis, of shifting a portion of the programs' budget for a particular year to the next fiscal year.

The Governor's budget proposes a similar accounting change for the Child Health and Disability Prevention Program (CHDP), a change that is estimated to achieve onetime General Fund savings of approximately \$500,000 in 2005-06. The department indicates that such a change is warranted because of CHDP's financial support for the gateway, a program that screens for and connects children who are otherwise eligible for or currently enrolled in Healthy Families Program or Medi-Cal to those programs. Most gateway funding comes from Medi-Cal, which, as noted earlier, is on a cash basis. The CCS program (a program that provides health care services to severely ill and medically fragile children) is already budgeted on a cash basis in part because of that program's close financial relationship with Medi-Cal. Notably, the Genetically Handicapped Persons Program (GHPP) (a program that provides comprehensive health care services to severely ill adults) is now budgeted on an accrual basis, which potentially complicates coordination of its "state only" component with Medi-Cal. The department has indicated that it might be possible to move this program to a cash accounting basis.

The LAO recommends that Department of Health Services report at budget hearings on its estimate of the fiscal effect of a shift of GHPP to a cash basis of accounting in order to make the program consistent with other DHS programs. The LAO estimates that such a shift would result in potentially several millions of dollars in General Fund savings on a onetime basis.