AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 21, 2022

2:30 PM, STATE CAPITOL, ROOM 444

We encourage the public to provide written testimony before the hearing. Please send your written testimony to: BudgetSub1@asm.ca.gov. Please note that any written testimony submitted to the committee is considered public comment and may be read into the record or reprinted. All are encouraged to watch the hearing from its live stream on the Assembly's website at https://www.assembly.ca.gov/todaysevents.

The hearing room will be open for attendance of this hearing. Any member of the public attending a hearing is strongly encouraged to wear a mask at all times while in the building. The public may also participate in this hearing by telephone after all witnesses on all panels and issues have concluded, and after the conclusion of member questions.

To provide public comment, please call toll-free:
877-692-8957 / Access Code 131 54 44

ITEMS TO BE HEARD

NON-PRESENTATION ITEMS

LIST OF PANELISTS IN ORDER OF PRESENTATION

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

PANEL 1 (ISSUES 1-2): EMERGENCY MEDICAL SERVICES AUTHORITY

PANEL 1 - PRESENTERS

- **Rick Trussell**, Chief of Administration, Emergency Medical Services Authority

PANEL 1 – Q&A ONLY

- **Louis Bruhnke**, Chief Deputy Director, Emergency Medical Services Authority
- **Craig Johnson**, Chief Disaster Medical Services, Emergency Medical Services Authority
- **Steven McGee**, Chief Legal Counsel, Emergency Medical Services Authority
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

PANEL 2 (ISSUE 4): COMMUNITY BENEFITS PROPOSAL

PANEL 2 – PRESENTERS

- **Susan Fanelli**, Chief Deputy Director of Policy and Programs, California Department of Public Health
- **Scott Christman**, Chief Deputy Director, Department of Health Care Access and Information
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Dr. Kevin Barnett**, DrPH, MCP, Program Director, Center to Advance Community Health and Equity, Public Health Institute
- **Kiran Savage-Sangwan**, MPA, Executive Director, California Pan Ethnic Health Network
- **Dr. Muntu Davis**, M.D., M.P.H., Health Officer, Los Angeles County
- **Genoveva Islas**, MPH, Founder & CEO, Cultiva la Salud

PANEL 2 – Q&A ONLY

- **Julie Nagasako**, Deputy Director, Strategic Development and External Relations Fusion Center, California Department of Public Health
- **Ty Christensen**, Health Program Audit Manager II, Department of Health Care Access and Information
- **Sheila Tatayon**, Attorney III, Department of Health Care Access and Information
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

PANEL 3 (ISSUES 5-6): CORE PUBLIC HEALTH INFRASTRUCTURE

PANEL 3 – PRESENTERS

- **Dr. Thomas Aragon**, Director and State Public Health Officer, California Department of Public Health
- **Susan Fanelli**, Chief Deputy Director of Policy and Programs, California Department of Public Health
- **Brandon Nunes**, Chief Deputy Director of Operations, California Department of Public Health
- **Dr. Erica Pan**, State Epidemiologist and Deputy Director, Center for Infectious Diseases, California Department of Public Health
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California
- **Julio Ramirez**, Public Health Microbiology Supervisor I, SEIU

PANEL 3 – Q&A ONLY

- **Tricia Blocher**, Deputy Director, Emergency Preparedness Office, California Department of Public Health
- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health
- **Dr. Kathleen Jacobson**, Public Health Medical Admin I, Division of Communicable Disease Control, California Department of Public Health
- **Sonya Harris**, Senior Advisor, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PANEL 4 (ISSUE 7): DISEASE SURVEILLANCE READINESS, RESPONSE, RECOVERY, AND MAINTENANCE OF IT OPERATIONS

PANEL 4 – PRESENTERS

- **Dr. James Watt**, Assistant Deputy Director, Center for Infectious Diseases, California Department of Public Health
- **John Roussel**, Acting Deputy Director, Information Technology Services Division, California Department of Public Health
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 4 – Q&A ONLY

- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PANEL 5 (ISSUES 8-10): OFFICE OF HEALTH EQUITY PROPOSALS

PANEL 5 – PRESENTERS

- **Dr. Rohan Radhakrishna**, Deputy Director, Office of Health Equity, California Department of Public Health
- **Linda Helland**, Climate Change and Health Equity Section Chief, California Department of Public Health
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 5 – Q&A ONLY

- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PANEL 6 (ISSUES 11-15): CENTER FOR HEALTHY COMMUNITIES PROPOSALS

PANEL 6 – PRESENTERS

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, Center Operations, California Department of Public Health
- **Dr. Diana Ramos**, Assistant Deputy Director, Center for Healthy Communities, Chronic Disease Prevention, California Department of Public Health
- **Dr. Harold Goldstein**, Executive Director, Public Health Advocates

PANEL 6 – Q&A ONLY

- **Terri Sue Canale**, Acting Deputy Director, Center for Healthy Communities, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PANEL 7 (ISSUES 19-23): CENTER FOR FAMILY HEALTH PROPOSALS

PANEL 7 – PRESENTERS

- **Christine Sullivan**, Division Chief, Center for Family Health, Women, Infants and Children Division, California Department of Public Health
- **Richard Olney**, Division Chief, Center for Family Health, Genetic Disease Screening Program, California Department of Public Health
- **Diane Lindsey**, Division Chief, Center for Family Health, Maternal, Child & Adolescent Health Division, California Department of Public Health
- **Kristi Foy**, Executive Director, California Clinical Laboratory Association

PANEL 7 – Q&A ONLY

- **Dr. Connie Mitchell**, Deputy Director, Center for Family Health, California Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center for Family Health, California Department of Public Health
- **Catherine Lopez**, Assistant Division Chief, Center for Family Health, Women, Infants and Children Division, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PANEL 8 (ISSUE 26): CENTER FOR HEALTH STATISTICS AND INFORMATICS PROPOSAL

PANEL 8 – PRESENTERS

- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health

PANEL 8 – Q&A ONLY

- **Michelle Miles**, Interim Branch Chief, Center for Health Statistics and Informatics, Vital Statistics Branch, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PANEL 9 (ISSUES 33-35): CENTER FOR HEALTH CARE QUALITY PROPOSALS

PANEL 9 – PRESENTERS

- **Cassie Dunham**, Deputy Director, Center for Health Care Quality, California Department of Public Health

PANEL 9 – Q&A ONLY

- **Scott Vivona**, Assistant Deputy Director, Center for Health Care Quality, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ITEMS TO BE HEARD

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

PANEL 1 – EMERGENCY MEDICAL SERVICES AUTHORITY

OVERVIEW

This panel covers two of EMSA's three budget change proposals: 1) California Poison Control System Funding Augmentation; and 2) Paramedic Disciplinary Review Board (AB 450).

PANEL 1 – PRESENTERS

- **Rick Trussell**, Chief of Administration, Emergency Medical Services Authority

PANEL 1 – Q&A ONLY

- **Louis Bruhnke**, Chief Deputy Director, Emergency Medical Services Authority
- **Craig Johnson**, Chief Disaster Medical Services, Emergency Medical Services Authority
- **Steven McGee**, Chief Legal Counsel, Emergency Medical Services Authority
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 1: CALIFORNIA POISON CONTROL SYSTEM FUNDING AUGMENTATION BCP

PROPOSAL

The Emergency Medical Services Authority (EMSA) requests a Local Assistance augmentation of $1,056,000 General Fund in 2022-23, $1,470,000 General Fund in 2023-24, and ongoing funding of $1,715,000 General Fund and $349,000 Reimbursements to support the California Poison Control System (CPCS). This augmentation is being requested due to increased salaries and benefit expenses resulting from negotiated union bargaining agreements and will continue stable funding for day-to-day operations of the CPCS and continued statewide access to poison center services in the event of an emergency.

BACKGROUND

The CPCS is a statewide 24/7 hotline available to the public, health care providers, and emergency services, run through four centers. The CPCS also operates an education and outreach program targeted at high-risk populations.

CPCS's General Fund support was reduced from $6.9 million in 2007-08 to $5.9 million in 2008-09 before being further reduced to $2.95 million in 2009-10.

The federal government, in 2009, approved an amendment to the state's S-CHIP state plan which incorporated CPCS into the California's S-CHIP as a Public Health Initiative, and also approved California to use S-CHIP funds, within the 10 percent federal administrative expenditures cap allowed for states.

The Family First Coronavirus Response Act (FFCRA; P.L. 116-127) provides a 6.2-percentage-point increase to the regular FMAP rates for all states, the District of Columbia, and the territories. The FFCRA FMAP increase began on January 1, 2020 (the first day of the calendar quarter in which the COVID-19 public health emergency period began), and the FFCRA FMAP increase is set to end on the last day of the calendar quarter in which COVID-19 public health emergency period ends.

The federal HRSA grant funding is only available to nationally-certified poison control centers, and all four of California's centers are certified. According to the administration, this BCP will enable the CPCS to maintain the minimum level of service required to maintain national accreditation and federal funding. The CPCS cannot opt out of either union or UC required pay increases. Because these mandatory increases are base building, expenses compound yearly.

Increasing personnel and benefit costs are a direct result of mandatory pay increases in collective bargaining agreements negotiated by the UC Office of the President. Approximately 74 percent of CPCS staff are represented under a collective bargaining agreement. Each of CPCS's four call centers employs eleven clinically trained Specialists in Poison Information: 43 are licensed pharmacists, one is a registered clinical nurse, and seven are pharmacy technicians—all are unionized, and receive contracted pay increases twice a year for an annual average increase of 4.1 percent to base pay.

To fill funding gaps in prior years, CPCS has been able to use carryover of HRSA grant funds and leverage existing General Fund via increased FMAP rates. Beginning in 2021-22, no carryover HRSA grant funds or additional S-CHIP funding will be available to offset CPCS's budget deficits in 2022-23, 2023-24, or 2024-25. The requested General Fund augmentation will be used to leverage additional S-CHIP funding in order to meet the increased salaries and benefit expenses resulting from negotiated union bargaining agreements and will provide stable funding for day-to-day operations of the CPCS.

According to EMSA, if the funding augmentation is not approved, EMSA will require CPCS operational reductions which will result in significant reduction of CPCS staff and critical poison prevention services to the California population that may lead to the closure of one or more of the four PCCs. Without sufficient staffing levels, the CPCS may not be able to meet federal and state mandated performance requirements, in which case the CPCS would lose accreditation and federal funding, ultimately resulting in the closure of the CPCS

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 2: PARAMEDIC DISCIPLINARY REVIEW BOARD (AB 450) BCP

PROPOSAL

EMSA requests three positions and $703,000 Emergency Medical Services Personnel (EMSP) Fund in 2022-23 and $665,000 EMSP Fund in 2023-24 and ongoing to implement AB 450 (Gonzalez, L., Rodriguez, Chapter 463, Statutes of 2021) which establishes the Paramedic Disciplinary Review Board (Board) to take disciplinary action against a paramedic (EMT-P) license holder, review and revise the criteria for the revocation or suspension of an EMT-P license, the probation of EMT-P personnel, the appeal of a licensure decision by EMSA, and hear appeals regarding the denial of licensure by EMSA.

BACKGROUND

AB 450 created a seven-member appointed independent Paramedic Disciplinary Review Board (the Board) within EMSA, which is statutorily authorized to do the following:

- Review and determine whether to adopt, modify, or reject and return for further hearing proposed decisions from Administrative Law Judges;
- Take disciplinary action against a California paramedic license holder;
- Hear and act on applicants' appeals following EMSA's denial of licensure;
- Develop criteria for the Board to suspend, place on probation, or revoke a license;
- Develop criteria to aid in making final determinations regarding appeals of licensure actions; and
- Review and revise existing criteria for the suspension of a paramedic license.

EMSA phased in an overall fee increase of $50 per license type over the course of FY 2020-21 and FY 2021-22. Current fees for initial issuance or reinstatement of a paramedic license is $300 and $250 to renew a paramedic license. To implement the requirements of AB 450, a paramedic licensing fee increase of $65 per license type will need to be effectuated by January 1, 2023. Specifically, EMSA requests resources for:

- One Career Executive Officer (C.E.A.), Level A ($238,000)
- Associate Governmental Program Analyst (AGPA) ($167,000)
- Attorney I, Range D ($249,000)
- Board Member Expenses ($49,000) - $28,000, or $1,000 per Board member per quarterly meeting, annually, for per diem and in-state travel costs; meeting room rentals, EMSA will require $4,000 annually, or $1,000 per meeting.
- EMSA will require $17,000, or $2,425 per board member - The estimated costs for secure equipment, representing expenses for the Board to meet four times annually.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 3: REPLACEMENT AND UPGRADE OF AGING VEHICLE AND RADIO FLEET ASSETS BCP

PROPOSAL

EMSA requests a General Fund augmentation of $8,664,000 in Fiscal Year 2022-23 and $50,000 in 2023-24 and ongoing. The one-time funding will be utilized to replace aging fleet assets. The ongoing request for $50,000 is necessary to fund the California Radio Interoperability System's (CRIS) subscription fees required for the requested radio equipment. The resources will fund EMSA emergency medical response fleet and equipment upgrades by addressing identified safety and operational gaps experienced during recent wildfire, earthquake, and pandemic disaster responses.

BACKGROUND

EMSA and the California Department of Public Health (CDPH) jointly coordinate all statewide medical and health disaster response activities in California under the State Emergency Plan (SEP) Emergency Support Function (ESF) 8 using the Standardized Emergency Management System (SEMS). The EMSA Disaster Medical Services (DMS) Division is responsible for all state-level disaster medical response, recovery, mitigation, and preparedness and maintains a large cache of emergency response medical equipment, biomedical equipment, mobile medical shelters, emergency response vehicles, communications equipment, and wrap-around support equipment.

During "steady-state" day-to-day operations, EMSA DMS is tasked with disaster medical response planning, preparedness, and mitigation to quickly mobilize to support federal, state, regional, and local stakeholders. Day-to-day operations include maintaining all medical, biomedical, and nonmedical assets at EMSA warehouses, writing and updating state and federal emergency response plans, disaster medical training and exercising, and building systems and teams to quickly mobilize response personnel when needed for disaster medical response.

During disasters in California, EMSA DMS, working with local, regional, state, and federal partners, has a broad response charter. When requested, EMSA DMS is responsible for coordinating and deploying the following assets and personnel:

- EMSA Agency Representative personnel to various federal, state, regional, and local coordination centers
- California Medical Assistance Teams (CAL-MAT)
- Mission Support Teams (MST)
- Mobile Medical Shelters (e.g., medical tents, HVAC, generators)
- Disaster Medical Support Unit (DMSU) vehicles
- Medical caches, supplies, and restock

- Biomedical equipment (ventilators, IV infusion pumps, Invacare hospital beds, 02 concentrators, 02 cylinders, high-flow nasal cannulas).
- Pharmaceuticals
- Communications Caches (e.g., radios, information technology (IT), audio visual (AV))

According to EMSA, over the past six to seven years, the EMSA DMS Division has responded to an increasing number of statewide disaster responses, including extreme weather events, drought, wildfires, earthquakes, and infectious disease responses. EMSA's major disaster responses in the past seven years have included the 2014 6.0 Napa Earthquake, the 2014 Ebola Epidemic, the 2015 Valley Fire, the 2016 Clayton Fire, the 2017 North Bay Fires, the 2018 Carr, Camp, and Mendocino Complex Fires, the 2019 7.1 Ridgecrest Earthquake, the 2019 Kincade Fire, the 2019 Public Safety Power Shutdowns (PSPS), the 2020 COVID-19 pandemic, the 2020 August Complex Fires, and the 2021 River and Dixie Fires. Over the past several years, the mandated, disparate, lengthy, and complex disaster responses have pushed the EMSA DMS Division beyond its safe and capable limits. EMSA states that the responses frequently placed EMSA and CAL-MAT logistics and field staff in unsafe and compromising positions utilizing old and ineffective equipment, inappropriate supplies, and inadequate communications tools.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests EMSA present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

4140 DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION
4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

PANEL 2 – ISSUE 4: COMMUNITY BENEFITS PROPOSAL

PANEL 2 – PRESENTERS

- **Susan Fanelli**, Chief Deputy Director of Policy and Programs, California Department of Public Health
- **Scott Christman**, Chief Deputy Director, Department of Health Care Access and Information
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Dr. Kevin Barnett**, DrPH, MCP, Program Director, Center to Advance Community Health and Equity, Public Health Institute
- **Kiran Savage-Sangwan**, MPA, Executive Director, California Pan Ethnic Health Network
- **Dr. Muntu Davis**, M.D., M.P.H., Health Officer, Los Angeles County
- **Genoveva Islas**, MPH, Founder & CEO, Cultiva la Salud

PANEL 2 – Q&A ONLY

- **Julie Nagasako**, Deputy Director, Strategic Development and External Relations Fusion Center, California Department of Public Health
- **Ty Christensen**, Health Program Audit Manager II, Department of Health Care Access and Information
- **Sheila Tatayon**, Attorney III, Department of Health Care Access and Information
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Joseph Donaldson**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

The Administration proposes to require non-profit hospitals to allocate 25 percent of their community benefit funds to local public health efforts, including community-based organizations (CBOs). The administration explains that this proposal is intended to direct these funds to address social determinants of health, by linking hospitals to communities so that community benefits reflect the needs and priorities of communities.

Through the 2021 budget process, the Legislature approved of an annual $115 million grant program for CBOs, tribes, and health clinics to address social determinants of health. The Legislature's goal with this funding was to increase health equity and racial justice in the state, by investing significant funding directly into communities to be spent in accordance with priorities and needs identified by communities throughout the state that typically experience significant levels of health disparities. This funding was not included in the final 2021 Budget Act.

STAFF COMMENTS/QUESTIONS

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

- What do hospitals spend these funds on now? I.e., who will no longer be the beneficiary of these funds if this proposal is approved and implemented?

- Representatives of hospitals have stated that they already work closely with communities on the development of their community benefits spending plans, and therefore that their community benefits already reflect community priorities; can you confirm or deny this information?

- How would the state ensure that community benefits funds are reaching all high-needs communities in the state, even where there is no non-profit hospital nearby?

The Subcommittee requests HCAI describe their proposed role in monitoring and enforcement of this new policy.

Finally, the Subcommittee requests the stakeholders on this panel provide feedback on this proposal and recommendations on how the state can best address health equity and racial justice through CBOs.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

4265 CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

PANEL 3: CORE PUBLIC HEALTH INFRASTRUCTURE

OVERVIEW

This panel covers proposals related to the state's core public health infrastructure, including: issue 5, the Foundation for the Future of Public Health Proposal, and issue 6 on COVID-19 Emergency Response and Operations.

PANEL 3 – PRESENTERS

- **Dr. Thomas Aragon**, Director and State Public Health Officer, California Department of Public Health
- **Susan Fanelli**, Chief Deputy Director of Policy and Programs, California Department of Public Health
- **Brandon Nunes**, Chief Deputy Director of Operations, California Department of Public Health
- **Dr. Erica Pan**, State Epidemiologist and Deputy Director, Center for Infectious Diseases, California Department of Public Health
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Michelle Gibbons**, Executive Director, County Health Executives Association of California
- **Julio Ramirez**, Public Health Microbiology Supervisor I, SEIU

PANEL 3 – Q&A ONLY

- **Tricia Blocher**, Deputy Director, Emergency Preparedness Office, California Department of Public Health
- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health
- **Dr. Kathleen Jacobson**, Public Health Medical Admin I, Division of Communicable Disease Control, California Department of Public Health
- **Sonya Harris**, Senior Advisor, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 5: FOUNDATION FOR THE FUTURE OF PUBLIC HEALTH PROPOSAL

PROPOSAL

CDPH requests 404 positions and General Fund expenditure authority of $300 million annually to modernize California's public health system with the goal of protecting and improving the health of all Californians. Of these resources, $200.4 million would support California's 61 local health jurisdictions and $99.6 million would support statewide public health priorities at CDPH.

BACKGROUND

Decades of Underinvestment in Public Health. Public health is invisible. Many of the advances in civilized society Californians take for granted are made possible by the efforts of public health workers operating in the background of their lives. Public health workers monitor and track outbreaks of infectious diseases, most notably and recently the COVID-19 pandemic, but also outbreaks of measles, hepatitis A, and sexually transmitted infections (STIs). Public health workers make sure the food Californians eat is free of food-borne pathogens and other dangerous contaminants. Public health workers regulate the quality of health facilities, including hospitals, clinics, and nursing homes to ensure the places Californians go to seek medical care are safe, clean, and are capable of providing high-quality services. Public health engages in a wide variety of population health interventions, from the Black Infant Health programs that seek to reduce vast disparities in maternal and infant morbidity and mortality, to Childhood Lead Poisoning Prevention programs that ensure California's kids have a safe place to grow up, to tobacco prevention programs that reduce smoking and lung-related diseases.

Public health becomes visible to policymakers and the public when it is unsuccessful: an uncontrolled disease outbreak, a failure to protect the food supply, or the persistence of health disparities. As a result, there is a limited constituency to advocate for maintaining adequate funding for essential public health services, often public health workers themselves, healthcare providers, or community-based organizations focused on public health or health disparities. For decades, the level of public investment in public health at the national, state, and local level has been significantly below what is needed for a truly equitable public health system that can keep Californians healthy and safe.

California's Public Health System. California's Department of Public Health delivers a broad range of public health programs. Some of these programs complement and support the activities of local health agencies in controlling environmental hazards, preventing and controlling disease, and providing health services to populations who have special needs. Others are primarily state-operated programs, such as those that license health care facilities.

In addition to the state department, 61 local health jurisdictions from each of California's 58 counties and from three cities (Berkeley, Long Beach, and Pasadena) support public health interventions at the local level. Local health jurisdictions are funded by 1991 Realignment funds, local county General Fund, and a variety of state and federal funding streams for specific programs.

Public Health Workforce Shortages. The COVID-19 pandemic has laid bare the decades-long underinvestment in public health in California, the nation, and the world, particularly in developing the public health workforce. Two years into the pandemic, many public health officers identify additional staff resources as the most important resource they would have wanted to be available before the pandemic began. According to the California Future Health Workforce Commission, 61 percent of managers and supervisors, and 44 percent of non-supervisory staff at the California Department of Public Health are eligible for retirement, and the department estimates two-thirds of its workforce will retire in the next five years. At the local level, county and city health departments report challenges in recruiting and retaining well-qualified workers, citing a lack of tools for recruiting, limited options for advancement, and instability of funded positions. The instability of funding is a particular problem the Legislature attempted to address in its public health infrastructure package in last year's joint Senate-Assembly budget proposal, but delayed for a year in the final budget agreement. Most local public health funding is categorical, tied to specific programs or activities, with no flexibility to support comprehensive public health strategies. The Legislature also attempted to appropriate ongoing funding to develop public health workforce development programs at the Department of Health Care Access and Information (HCAI, formerly OSHPD). There are currently few workforce development programs to recruit, train, or retain qualified public health professionals. In particular, local health departments have identified the need for public health nurses, laboratory staff, epidemiologists, health equity staff, and data analysts.

2021 Joint Legislative Budget Proposal

During the 2021-22 budget process, the Senate and the Assembly approved a joint legislative budget proposal, which included ongoing General Fund expenditure authority of $403 million to support investments in public health infrastructure. The proposal included the following primary components:

Local Public Health Investments - $200 million

- Local health jurisdictions would have received an annual investment of $200 million General Fund, subject to certain planning, transparency, and accountability requirements, and distributed to counties based on a formula that took into account population, health disparities and the overall burden of preventable mortality and morbidity.

- Local health jurisdictions would have been required, as a condition of receiving state public health investment dollars, to submit a triennial plan to CDPH that outlined strategies to reduce preventable causes of mortality and morbidity, as well as reduce health disparities.
- Local health jurisdictions would also have been required to conduct workforce analysis and planning.

Health Equity and Racial Justice Innovation - $115 million

- The Office of Health Equity would have administered an annual $115 million grant program to address health disparities. Clinics, community-based organizations, and tribes would have applied for grants and would have been required to demonstrate how funding would be used to ameliorate existing or emerging health disparities, including metrics for success.

Public Health Workforce Development - $35 million

- CDPH, in collaboration with the Department of Health Care Access and Information (HCAI) and local health jurisdictions, would have administered an annual $35 million workforce development program to recruit, expand, and retain a modern public health workforce, including training, scholarships, apprenticeships, and other programs targeted to local health jurisdictions and communities with significant health disparities. The program would have supported training of epidemiologists, disease investigators, information and data analytics specialists, public health nurses, community health workers, medical social workers, outreach specialists, multilingual health educators, health equity leaders, environmental health specialists, laboratory staff, food safety professionals, dietitians, quality improvement coordinators, and physical and occupational therapists.

CDPH – Statewide Coordination and Planning - $40 million

- CDPH would have received an appropriation of $40 million annually to support statewide coordination and planning of the activities funded by the components of this proposal, including:

    - Technical Assistance - Technical assistance to local health jurisdictions, particularly in small counties or cities, for preparation of the triennial public health plan.
    - Learning Collaboratives – Facilitation of learning collaboratives to share best practices regarding specific interventions to address causes of preventable morbidity and mortality, or health disparities.
    - Effective Public Health Communications - Communication support for public information officers in local health jurisdictions to ensure effective delivery of public

health messages, particularly in smaller counties or cities, as well as access to media and other messaging resources.

- Effective IT Systems to Support Public Health - Ongoing information technology upgrades and improvements to support communicable and chronic disease surveillance, testing, case investigation, contact tracing, identification and monitoring of health disparities, and other public health priorities.
- Public Health Workforce Gap Analysis - A triennial gap analysis of public health workforce needs in the state, to align with and inform the preparation of local health jurisdictions' triennial public health plans and inform the development and implementation of the $35 million public health workforce development program.
- Annual Health Disparities Reporting – A population-based health status report including:
    - ✓ Indicators of chronic disease prevalence and management, including, but not limited to, statistics on asthma and asthma management, obesity, diabetes, and cardiovascular disease;
    - ✓ Maternal and infant mortality;
    - ✓ Social determinants of health, including, but not limited to, access to nutritious foods, safe and affordable housing and neighborhoods, income and poverty rates; educational opportunities, evidence of racism and discrimination.
    - ✓ Environmental factors, such as exposure to polluted air and water, exposure to lead and gun violence;
    - ✓ Prevalence of infectious diseases, including respiratory and sexually transmitted diseases;
    - ✓ Access and proximity to health care, including rates of uninsured and timely access to health, dental, vision and behavioral health services;
    - ✓ Tobacco product use and availability;
    - ✓ Substance use disorders and drug overdose prevalence.
- Health Disparities Reduction - Statewide Coordination and 2030 Goal – A goal of reducing health disparities among children by 50 percent statewide by December 31, 2030.
- Annual State of the State's Public Health – An annual report on the State of the State's Public Health, that would identify the most prevalent existing causes of morbidity and mortality in California, emerging causes of morbidity and mortality in California, statewide or regional health disparities based on its annual reporting, as well as policy recommendations and fiscal estimates for addressing these issues.
- Annual State of the County's Public Health – As a condition of receipt of state funding, county public health officers would also have been required to annually prepare a report on the State of the County's Public Health. The county public health officer would present this report annually to the county's Board of Supervisors.

Public Health Infrastructure Study - $3 million

- CDPH would coordinate with local health jurisdictions, community-based organizations, healthcare providers, and other public health stakeholders to conduct a study to identify specific needs to develop an agile and flexible public health infrastructure at the local and statewide level. The study would be informed by two or more public stakeholder meetings and would be used by local health jurisdictions, in collaboration with CDPH and local stakeholders, to develop and implement the triennial public health plan beginning July 1, 2022.

The 2021 Budget Act ultimately included no resources in 2021-22 for investments in public health infrastructure, but a commitment to annual General Fund expenditure authority of at least $300 million beginning in 2022-23. The 2021 Budget Act did include General Fund expenditure authority of $3 million to support a public health infrastructure study, which the Administration indicated would inform its proposed spending plan for public health investments in 2022-23.

The Future of Public Health Work Group

The Administration convened stakeholders, including representatives of state departments and agencies, local health jurisdictions, tribal health officials, and community advocacy organizations to develop a memo, titled "Future of Public Health Work Group: Investments and Capabilities Needed for the Future Public Health System", which was published in September 2021. The work group memo identified the need for investments in the following foundational public health services:

- *Workforce*. To respond effectively to the next set of public health challenges, California's state and local public health system would need to:
  - Attract a diverse and talented workforce with the relevant skills and experiences, and that reflects the communities they serve.
  - Create opportunities to grow and develop current and future employees into leaders
  - Implement a robust and agile talent model to ensure the workforce is able to adapt to the state's changing public health needs, from data science, technology, and disease surveillance to marketing and communications.
  - Promote creativity, flexibility, and innovation to ensure an effective and inclusive working environment and culture.

  According to the memo, these workforce goals would require two major investments: 1) funding to support expansion of the workforce, filling known gaps to ensure there is sufficient capacity to deliver on system demands; and 2) augmenting state and local workforce development capabilities required to attract, develop, and retain the public health workforce of the future.

- *Emergency Preparedness and Response*. To create a ready and sustainable structure that can rapidly identify hazards and deploy the state would invest in:
  - Ensuring early detection of infectious, biological, chemical, environmental, and radiological agents to prevent adverse impacts.
  - Improving the timeliness of response to threats and improving average times to respond to a hazard to as close to real-time as possible.
  - Address inequities by developing nimble interventions for groups experiencing disproportionate impacts.
  - Sustaining regular public health operations while engaging in an active response, including ensuring continuity of local emergency preparedness operations and reducing the number of redirected state emergency staff during a hazard event.

  According to the memo, several initiatives were identified to support these efforts, including: 1) developing a 24 hour intelligence hub focused on proactive and real-time hazard detection; 2) establishing a dedicated core team to support planning, training, and tabletop exercises; 3) building a regional resourcing model to support critical emergency preparedness capabilities; 4) establishing a Public Health Reserve Corps consisting of approximately 1,000 public health volunteers trained centrally, but managed and deployed locally in the event of a large hazard event; and 5) establishing community recovery units to set community recovery guidance, ensure efficient cost recovery, and minimize the impact of social, economic, and physical and mental health impacts.

- *Information Technology (IT), Data Science, and Informatics*. State and local public health departments should expand data access and interoperability to enable data driven decision making and advanced analytics to explain, predict, and prevent disease spread by:
  - Building decision intelligence capabilities to analyze data and information using modern data science to inform and optimize decisions, solve problems, and improve performance.
  - Responding quickly and effectively to evolving public health circumstances with forecasting and scenario analysis to determine appropriate public health measures.
  - Conducting retrospective assessments following public health events and assessing and evaluating the impact of policy on decision making.
  - Using technology to engage partners and the community to increase participation in public health and help policymakers assess the impact of policy and interventions.

  According to the memo, initiatives could include: 1) building a flexible and scalable backbone for dynamic public health activities using cloud-based, secure, and scalable platforms needed for data sharing and management; 2) streamlining data in disease surveillance and licensing systems to create one-stop shops for disease and environmental surveillance information; 3) enabling more efficient public health

business processes and reducing manual burden to facilitate more efficient tracking and impact assessments; 4) integrating and accessing new data streams to enable public health analyses including electronic health records, social determinants of health, and environmental data; 5) enhancing system-wide data governance and standards; 6) building analytics workspaces to query data, run, iterate, and share models on key public health use cases; 7) enabling access to accurate and timely data for city and county health jurisdictions and stakeholders; 8) building IT, data, and informatics capacity, skillsets, and knowledge sharing to improve decision making; and 9) establishing an enterprise-wide IT, data science, and informatics project office to ensure successful delivery of these initiatives.

- *Community Partnerships*. Creating a holistic partnership network, engaged to support state and local public health efforts would enable public health systems to:
  - Engage a broad range of partners in holistic and inclusive collaborations and use a data-backed approach to assess our existing relationships.
  - Enable a high level of proactive coordination with partners so that partnerships can be mobilized as needs arise
  - Tap into the power of coalitions by strategically assessing the functions that community partners could take and activating them to play roles where they are uniquely positioned to have impact.

  According to the memo, initiatives to develop community partnership infrastructure could include: 1) developing a community partnership strategy to outline roles and intended capabilities of community partners in supporting California's public health mission; 2) hiring dedicated community engagement personnel to ensure personalized outreach and uptake of an overarching community partnership strategy; 3) establishing a community partner relationship management system to achieve a broader outreach pipeline in local communities, strengthen existing partnerships, and address equity goals; and 4) launching a public health community funding matchmaking infrastructure connecting community partners with appropriate funding sources and ensuring funds are allocated to a diverse network of organizations through a dedicated team and system.

- *Communications and Public Education*. Developing a proactive, personalized, and highly coordinated communication strategy and operations would include:
  - Effectively and equitably driving systemic change that encourages healthy behavior and empowers Californians and other stakeholders to improve health and environment.
  - Shifting public participation from being informed and consulted to actively collaborating on public health priorities based on scientific evidence.
  - Advancing health equity by ensuring that all communications and public engagements are culturally competent and linguistically accessible.

- Promoting a shared narrative and vision for improving public health in California rooted in core public health values and with the aim of building a culture of health and respect.
- Ensuring all Californians have an equal voice and the opportunity to shape the direction of public health activities.
- Engaging Californians at all levels, including business communities, elected leaders, schools, and other institutions.

According to the memo, initiatives for communication and public education could include: 1) creation of a core public health communication strategy and deployment plan which defines an overall public health narrative to promote healthy behavior and informs specific actions and priorities; and 2) ensuring operational capabilities and adequate capacity to effectively disseminate communications across a variety of channels and field requests from Californians in a linguistically and culturally competent manner.

- *Community Health Improvement*. Developing a comprehensive community health improvement strategy that emphasizes life course approach, resiliency, equity, and prevention could be achieved by:
  - Enabling systematic and comprehensive efforts focused on community health improvement, including needs assessment, targeted public health program designs and implementation, and monitoring of outcomes.
  - Effectively convening and collaborating with state and local agencies, upstream partners, providers, communities, and other stakeholders.
  - Strategically directing efforts and resources to areas of need and importance, addressing health behaviors and a broad range of health factors, reducing health disparities, and focusing on community-wide prevention and resiliency.

  According to the memo, improvements to community health could include the following initiatives: 1) a comprehensive community health strategy that emphasizes life course approach to health and public health prevention; 2) a dedicated community health improvement team; 3) standardized and aligned community health data; and 4) community health improvement plans informed by community-driven health risk assessment models.

2022 Spending Plan for Public Health Infrastructure Investment

Based on the work of the Future of Public Health Work Group and the memo published in September 2021, the Administration released its Spending Plan for Public Health Infrastructure Investment along with the Governor's January budget. In the spending plan, CDPH requests 404 positions and General Fund expenditure authority of $300 million annually to modernize California's public health system with the goal of protecting and improving the health of all Californians. Of these resources, $200.4 million would support California's 61 local health jurisdictions and $99.6 million would support statewide public health priorities at CDPH. The specific components of the proposal are as follows:

State Operations Spending Plan - $99.6 million

The Administration's proposed expenditures for state operations are categorized similarly to the six foundational services identified in the Future of Public Health Work Group memo. CDPH would receive 404 positions and $99.6 million in the following areas:

- *Workforce*. CDPH requests 270 positions and General Fund expenditure authority of $58 million annually to increase staffing capacity and to attract, develop, and retain a diverse, multi-disciplinary public health workforce. According to CDPH, these positions and resources would support the following initiatives:
  - A multi-channel, proactive, and digitally-enabled recruitment and hiring functions to attract top talent that reflects the diversity of California's population.
  - A simplified, aligned job classification system within CDPH that can be used as a model for local health jurisdictions.
  - A holistic organizational culture transformation at CDPH and at the local level to promote inclusiveness and support employees, incentivizing them to stay and grow into leadership through development support, career pathways, sufficient staffing, salary and non-salary incentives.
  - A culture of growth and learning via a well-structured, up-to-date, and highly accessible training program.
  - A comprehensive competency-based performance management system to define necessary competencies across public health roles, asses gaps in skillsets, and track competency development along career progression pathways.
  - An operational planning function to develop staffing benchmarks, make sure minimum recommended staffing standards are met at the state and local level, and support agile, strategic workforce deployment based on need.
  - An Office of Policy and Planning to conduct strategic planning to address current and emerging threats to public health, be accountable for effective and efficient use of funds, establish clear and quantifiable performance targets, and ensure actions are aligned with strategic priorities and increased equity.

- *Emergency Preparedness and Response*. CDPH requests 77 positions and General Fund expenditure authority of $27.6 million annually for a scalable and sustainable structure that can rapidly identify hazards and deploy resources to mitigate and contain public health threats. This resource request is aligned with four of the five initiatives in this category outlined in the memo including the following:
  - Developing a 24 hour intelligence hub and surveillance network
  - A dedicated core team to support regular refreshes of planning, training, and exercises
  - Developing a regional resourcing model to support regional coordination with Regional Disaster Medical Health Specialists.
  - Developing a dedicated recovery unit to establish public health recovery guidance after public health events.

- *IT, Data Science, and Informatics*. CDPH requests three positions and General Fund expenditure authority of $548,000 to expand the California Birth Defects Monitoring Program. CDPH has a separate proposal for $235.2 million to support maintenance and operations of information technology systems established during the COVID-19 pandemic (see Issue 7: Disease Surveillance Readiness, Response, Recovery, Maintenance of IT Operations).

- *Communications and Public Education*. CDPH requests 26 positions and General Fund expenditure authority of $4.5 million annually to achieve a proactive, personalized, and highly coordinated communication strategy that meets the varying demands of California's diverse population and provides capacity to tailor messages to effectively reach all Californians. These positions and resources are aligned with the two initiatives outlined in the memo in this category, including the following:
  - Creation of a core public health communications strategy and deployment plan.
  - Bolster operational capabilities and adequate capacity to effectively disseminate communications.

- *Community Partnerships*. CDPH requests five positions and General Fund expenditure authority of $2.9 million to achieve a holistic partnership network engaged to support California's state and local public health efforts. These positions and resources are aligned with two of the four initiatives outlined in the memo, including the following:
  - Development of a community partnership strategy and plan to outline roles and intended capabilities of community partners in supporting California's public health mission.
  - Dedicated community engagement personnel to deliver personalized outreach and uptake of an overarching community partnership strategy.

- *Community Health Improvement*. CDPH requests 23 positions and General Fund expenditure authority of $6.1 million annually to provide a comprehensive community health improvement strategy that emphasizes a life-course approach, resiliency, equity, and prevention. These positions and resources are aligned with two of the four initiatives outlined in the memo and adds a third, including the following:
  - Community health financing strategies that emphasize a life-course approach to health and public health prevention.
  - Dedicated community health improvement team to support policy making across agencies.
  - Development and implementation of a behavioral mental health program to address the current behavioral and mental health crisis in the state.

Local Assistance Spending Plan - $200.4 million

The Administration proposes to provide local assistance funding of $200.4 million to local health jurisdictions annually. These resources would be distributed based on the following methodology: 1) $350,000 for each local health jurisdiction; 2) 50 percent of remaining funds based on population data; 2) 25 percent of remaining funds based on poverty data; and 3) 25 percent of remaining funds based on population data for Black/African-American/Latino/or Native Hawaiian/Pacific Islanders. Local health jurisdictions would be required to allocate 70 percent of funding to support staff to fill critical public health positions, including those where gaps were identified during the pandemic. In addition, local health jurisdictions would be required to submit a plan by July 1, 2023, and every three years thereafter, tied to its Community Health Assessment and Community Health Improvement Plan, including proposed evaluation methods and metrics. Funding may also be used to establish regional public health partnerships between multiple local health jurisdictions.

STAFF COMMENTS/QUESTIONS

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

- The Administration's spending plan includes significant funding for hiring new staff at both the state and local level. What is the Administration's strategy to ensure there is an adequate pool of qualified candidates to fill those positions?
- How would the Administration's significant investment in state public health staff allow it to support local health jurisdictions with technical assistance and facilitating dissemination of best practices, particularly for smaller jurisdictions with funding and resource challenges?
- How does CDPH propose to ensure that counties do not shift existing realignment funding away from public health and backfill with this new state funding?

The Subcommittee requests CHEAC provide feedback on this proposal, share any ongoing concerns regarding the future ability of California's counties to perform more than adequate public health functions for the state, and respond to the following:

- Please describe how local health jurisdictions would be likely to use the local assistance resources proposed in the Administration's spending plan.
- How could CDPH better support local health jurisdictions to improve population health, particularly in smaller jurisdictions with funding and resource challenges?
- What are local health jurisdictions doing to ensure there is an adequate pool of qualified candidates to fill public health positions? How are jurisdictions retaining staff who are under significant stress and often face threats and harassment?

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 6: COVID-19 EMERGENCY RESPONSE AND OPERATIONS BCP

PROPOSAL

CDPH requests $760.8 million General Fund in 2022-23 to continue the state's efforts to protect public health and safety against the spread of COVID-19 by providing vaccinations (including boosters), diagnostic testing, contact tracing, health staff support for facilities in need, operations support, and emergency response activities at the border. CDPH will re-evaluate this proposal later in the spring as COVID evolves. These proposed funds will support pandemic response efforts through December 31, 2022. Specifically, CDPH requests the following:

- $158.6 million would support school testing activities, providing specimen collection, as well as procurement and distribution of test supplies.
- $130.6 million would support vaccine and booster outreach, education, and appointment assistance campaigns.
- $90 million would provide specimen collection services through various modalities including fixed, drive-through, mobile, at-home, and traveling teams.
- $77.7 million would support diagnostic testing services at the Valencia Branch Laboratory.
- $46.7 million would support interagency agreements with the Department of General Services, the Emergency Medical Services Authority, and the Department of Social Services to support border response activities.
- $23.6 million would provide end-to-end administration and management services of vaccine sites and strike teams.
- $16.1 million would provide vaccine mobile units rotating across counties and local health jurisdictions to provide pop-up clinic services.
- $14.5 million would provide health screening or testing services for state agencies to comply with the Governor's vaccine mandate for stat staff.
- $5.2 million would provide support to the vaccine task force.

Areas of Expenditure and Funding Requested

Areas of Expenditure [i]	2022-23 Governor's Budget	
Vaccinations (including boosters)	$	182,323,000
Testing	$	361,934,000
Contact Tracing	$	18,284,000
Staffing Deployments	$	124,309,000
Border Activities	$	73,900,000
TOTALS	***$***	***760,750,000***

[i] *Resources for 2022-23 IT Activities are being requested through a separate proposal: Disease Surveillance Readiness, Response, Recovery, and Maintenance of IT*

BACKGROUND

CDPH provided the following background information:

Vaccinations. As of February 2022 California has administered nearly 71 million vaccine doses with nearly 74 percent of Californians over age five fully vaccinated. In addition, over 13.6 million booster shots have been administered. The state's Vaccinate All 58 campaign conducts outreach, education, and appointment assistance in all 58 counties. The campaign has built partnerships with community-based organizations, faith-based organizations, ethnic media, and others to empower trusted messengers with timely, accurate, and culturally relevant information, and to encourage vaccine confidence and appointment booking through highly interactive peer-to-peer engagement, events, and media. CDPH reports the campaign has canvassed over 700,000 households and provided appointment assistance to more than one million individuals in the hardest-hit communities in California.

Testing. As of February 2022 California has performed nearly 144 million COVID-19 diagnostic tests since the beginning of the pandemic. CDPH reports it has implemented various strategies to meet demand and make testing costs sustainable, including opening the Valencia Branch Laboratory and implementing comprehensive antigen testing.

Contact Tracing. As of January 2022, CDPH and other state departments redirected 268 state staff to local health jurisdictions as a part of the California Connected contact tracing program. These staff are trained to serve as case investigators, contact tracers, outbreak investigators, and contract tracing school specialists. CDPH is also seeking volunteers to join the Public Health Reserve Corp, a unit of trained strike teams to provide emergency response support in the case of a state of emergency that poses a risk to public health.

Health Staffing. During the Omicron surge, more than 2,000 health care workers have been deployed to support health care facilities, expand surge capacity, and support vaccine administration.

Border Activities. CDPH reports it has, in partnership with federal, local, and non-profit partners, provided support and services to newly arriving migrants at the border in Imperial, San Diego, and Riverside Counties, including testing, temporary shelter, vaccines, and coordination for safe onward travel. Six intake hubs have been established across these three counties to serve up to 2,000 migrants per day.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

PANEL 4 – INFORMATION TECHNOLOGY SERVICES DIVISION

ISSUE 7: DISEASE SURVEILLANCE READINESS, RESPONSE, RECOVERY, AND MAINTENANCE OF IT OPERATIONS BCP

PANEL 4 – PRESENTERS

- **Dr. James Watt**, Assistant Deputy Director, Center for Infectious Diseases, California Department of Public Health
- **John Roussel**, Acting Deputy Director, Information Technology Services Division, California Department of Public Health
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 4 – Q&A ONLY

- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Shelina Noorali**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

CDPH requests 130 positions and General Fund expenditure authority of $235.2 million in 2022-23, ten additional positions and General Fund expenditure authority of $156.1 million in 2023-24, and $61.8 million annually thereafter to maintain and operate the technology platforms and applications necessary to support both COVID-19 response activities and other potential disease outbreaks. CDPH also requests General Fund expenditure authority of $165 million in 2022-23, $109.2 million in 2023-24, and $13.1 million annually thereafter for contract resources to support these IT projects.

BACKGROUND

According to CDPH, multiple information technology systems have been improved or created to support public health efforts during the COVID-19 pandemic. These systems include the following:

CA Notify – CA Notify provides notification if a person receives a positive test result for certain highly infectious diseases and accelerates initiation of contact tracing.

CAIR2 Message Broker – The California Immunization Registry 2 (CAIR2) message broker is a secure gateway to hospitals and labs for exchanging reportable vaccination records with CDPH. CDPH believes this tool will be useful for supporting data exchange for a variety of vaccines in the future.

CalCONNECT – The California Confidential Network for Contact Tracing (CalCONNECT) is California's contact tracing system used to manage case and contact records and notify individuals of possible exposure to people who test positive for infectious diseases. This system provides the foundation for developing future contact tracing capacity for other diseases.

CalREDIE/HIE Gateway – The California Reportable Disease Information Exchange (CalREDIE) is CDPH's infectious disease reporting and surveillance system of record, and is used statewide by 61 local health jurisdictions and over 350 laboratories for reporting notifiable conditions via the Health Information Exchange (HIE) Gateway.

CERT (emergency) – The CDPH Employee Redirection Tracker (CERT) enables human resources staff to receive, assign, redirect, and manage departmental requests for staff resources where an unmet business need exists due to emergency and rapid response.

CCRS – The California COVID-19 Reporting System (CCRS) is an integrated software-as-a-service (SaaS) that provides 24 hour processing of lab results for all reportable infectious diseases. CCRS maintains the flow of information to sustain the operations of downstream systems, including CalREDIE, Los Angeles and San Diego County disease surveillance systems, and Office of AIDS. Collectively, these systems provide information regarding COVID-19 testing, infection, hospitalization, death, and vaccinations rates needed to support the Governor's Blueprint for a Safer Economy.

Enterprise Infrastructure/Security – Maintenance and operations of remote access services, and new rapid response cloud services applications, including ongoing licensing and software for various services and software solution tools to address the foundational, operational and governance needs for cloud providers such as Salesforce, Azure, and Amazon Web Services (AWS).

LIMS – The Laboratory Information Management System (LIMS) provides for the management, processing, and collection of samples and associated data on public health risks.

LTM – The Lab Testing Metrics (LTM) application provides a platform for CDPH's Lab Field Services (LFS) to collect and manage a variety of public health data from laboratories.

myCAvax (Vaccine Management, My Turn, and DVR) – Vaccine Management is a suite of applications that allows for: 1) myCAvax, which is the enrollment and approval application for vaccine providers, vaccine allocation, vaccine ordering, and vaccine reporting; 2) My Turn Clinic, which enables providers and local health jurisdictions (LHJs) to run vaccination clinics, including mobile vaccination clinics, school vaccination clinics, mass vaccination clinics, and standard vaccinations clinics; 3) My Turn Public, which enables Californians to find and book vaccination appointments, including walk-in

appointments and scheduled appointments; 4) Digital Vaccine Record (DVR), which is the state's secure proof of vaccination tool.

REDCap – Research Electronic Data Capture (REDCap) is a survey tool used to respond to disease cluster and outbreak investigations to rapidly build, share, and manage standardized questionnaires and databases in a secure web application to assist with reporting to California LHJs, the CDC, and partner states.

IT OPS Center – Provides 24 hour IT support, monitoring, rapid response, and problem resolution of all DPH disease surveillance systems. This center was established to provide tracking and oversight of the many interoperable IT systems to ensure timely delivery of health data to downstream dashboards.

CDPH has leveraged approximately $250 million of one-time emergency funding from a variety of sources to implement these systems in response to the COVID-19 pandemic, including necessary IT staff. CDPH indicates it believes these systems are critical to the state's ability to respond to emergencies and infectious disease outbreaks and support three foundational health services and priorities in California: 1) assessment and surveillance, 2) emergency preparedness and response, and 3) policy development and support.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

PANEL 5 – OFFICE OF HEALTH EQUITY PROPOSALS

This issue covers three Office of Health Equity budget change proposals, including issues: 8) Homelessness: California Interagency Council on Homelessness (AB 1220); 9) Climate and Health Surveillance Program; and 10) Public Health Regional Climate Planning.

PANEL 5 – PRESENTERS

- **Dr. Rohan Radhakrishna**, Deputy Director, Office of Health Equity, California Department of Public Health
- **Linda Helland**, Climate Change and Health Equity Section Chief, California Department of Public Health
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office

PANEL 5 – Q&A ONLY

- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 8: HOMELESSNESS: CALIFORNIA INTERAGENCY COUNCIL ON HOMELESSNESS (AB 1220) BCP

PROPOSAL

CDPH requests 2 positions and $389,000 from the General Fund in 2022-23 and ongoing to provide CDPH program coordination, data analytics, and technical assistance to the California Interagency Council on Homelessness and to embed public health interventions in State strategies to maximize population health benefits and healthcare cost savings by ending homelessness in California.

BACKGROUND

According to CDPH, prior to 2021 there was no statutory requirement for the department to address housing or homelessness as a public health issue. CDPH conducted an environmental scan in 2019 of its housing and homelessness activities and found that, although the department engages in various aspects of supporting healthy housing and homelessness prevention services, these programs are dispersed throughout the department, are narrowly scoped, and supported with categorical funding. Because of this gap, the CDPH Office of Health Equity hired a staff person with subject matter expertise in housing and homelessness to support its Health in All Policies (HiAP) program.

AB 1220 (Rivas, L., Chapter 398, Statutes of 2021) requires the participation of leadership from 20 unique state agencies, departments, and other bodies of government on the California Interagency Council on Homelessness. These agencies have jurisdictions across various sectors ranging from transportation, housing, social services, healthcare, veteran affairs, aging, workforce, and education. AB 1220 requires the council to meet at least quarterly and its goals include the following:

- Identify mainstream resources, benefits, and services that can be accessed to prevent and end homelessness in California.
- Create partnerships among state agencies and departments, local government agencies, federal partners and agencies, nonprofit entities working to end homelessness, homeless services providers, and the private sector, for the purpose of arriving at specific strategies to end homelessness.
- Promote systems integration to increase efficiency and effectiveness and focus on designing systems to address the needs of people experiencing homelessness.
- Coordinate existing funding and applications for funding.
- Make policy and procedural recommendations to legislators and other governmental entities.
- Identify and seek funding opportunities for state entities that have programs to end homelessness.

- Broker agreements between state agencies, departments, and local jurisdictions to align and coordinate resources, reduce administrative burdens, and foster common applications for services, operating, and capital funding.
- Serve as a statewide facilitator, coordinator, and policy development resource on ending homelessness in California.
- Report to the Governor, federal Cabinet members, and the Legislature on homelessness and work to reduce homelessness.
- Ensure accountability and results in meeting the strategies and goals of the council.
- Identify and implement strategies to fight homelessness in small communities and rural areas.
- Create a statewide data system or warehouse to collect and match data on homelessness programs to programs impacting homeless recipients of state programs, such as Medi-Cal and CalWORKs.
- Set goals to prevent and end homelessness among California's youth.
- Improve the safety, health, and welfare of young people experiencing homelessness.
- Increase system integration and coordinating efforts to prevent homelessness among youth involved or formerly involved in the child welfare or juvenile justice systems.
- Lead efforts to coordinate a spectrum of funding, policy, and practice efforts related to young people experiencing homelessness.
- Identify best practices to ensure homeless minors who may have experienced maltreatment are referred to the child welfare system.

CDPH states that it is an active member of the council and participates in working groups on State Funding and Programs, Racial Equity, Youth and Young Adults, Employment, Re-entry or Transitions.

This broad representation on the council, which includes the CalHHS Secretary and CDPH Director, is required to drive progress in key Action Areas of the Action Plan. The most relevant Action Areas to CDPH include:

- Action Area 1: Strengthening Our Systems to Better Prevent and End Homelessness in California.
- Action Area 2: Equitably Addressing the Health, Safety, and Services Needs of Californians Experiencing Unsheltered Homelessness.

Specifically, Action Area 1 activities are focused on pursuing racial equity in response to homelessness and housing instability; engagement and partnership with people with lived expertise from experiences of homelessness; supporting interjurisdictional and regional planning; partnerships to strengthen outcomes related to education, employment, income, and assets; disaster preparedness and response; and communications and public awareness.

Action Area 2 activities are focused on addressing health and safety needs and increasing access to State supported services and programs for people who are experiencing unsheltered homelessness.

This proposal seeks to:

1. Support coordination of interagency workgroups and to provide public health and equity technical assistance and policy recommendations to the ICH, as established under AB 1220.
2. Provide public health data analytical support and technical assistance for local and state grantees and participants of the U.S. Department of Housing and Urban Development's Continuum of Care Program.
3. Provide technical assistance on public health interventions to State strategies to maximize population health benefits and healthcare cost savings by ending homelessness in California.
4. Provide policy and programmatic recommendations on homelessness prevention to the CDPH Director and Secretary of CalHHS.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 9: CLIMATE AND HEALTH SURVEILLANCE PROGRAM BCP

PROPOSAL

The CDPH Office of Health Equity (OHE) requests 30 positions and $10 million in 2022-23 and ongoing in State Operations from the General Fund to initiate Climate Change and Health Surveillance to provide near real-time notification for public health departments, first responders, and the community for emerging or intensified climate-sensitive diseases. Surveillance will provide early warnings of heat-related illness cases and may also provide early detection of health effects from wildfire smoke, climate-sensitive vector-borne diseases such as West Nile virus, water-borne diseases such as Vibrio, food-borne Salmonella or E. coli O157, dust-borne Valley fever (coccidioidomycosis), and mental health impacts.

In addition to the 30 requested positions, CDPH requests General Fund expenditure authority of $4.7 million annually to support the following contract resources:

- $400,000 would support Databricks processing and support, to make incoming data ready for analytics.
- $420,000 would support a Tableau server upgrade and Tableau desktop licenses to display data.
- $100,000 would support FiveTran, a consumption-based software as a service for ingesting data into Databricks.
- $2,400,000 would support a contracting team of seven resources to set up and manage analytics workspaces, train research scientists on use of the workspaces, provide data science technical expertise, ingest and manage new data streams, and develop and manage Tableau dashboards and reporting. The team consists of 1 data scientist, 4 data engineers, 1 informatics data analyst, and 1 project manager.
- $400,000 would support a feasibility study of innovative forms of early surveillance for climate-sensitive conditions, such as Internet searches, purchase records, 211 calls, or Artificial Intelligence or Big Data technologies that can detect climate health impacts even before someone goes to the emergency room.
- $954,000 would support the fees that hospital emergency departments must pay to their Electronic Health Records vendors to establish the connection to the National Syndromic Surveillance Program BioSense platform.

BACKGROUND

The Climate Change and Health Equity Section (CCHES) in CDPH's Office of Health Equity (OHE) was launched when $330,000 and three positions funded by the Air Pollution Control Fund (3237) were included in the 2010 Budget Act. This allocation established a small infrastructure of CDPH staff to support the implementation of AB 32

(Núñez, Chapter 488, Statutes of 2006) and AB 32-related activities of the California Climate Action Team's Public Health Workgroup.

This BCP proposes to initiate surveillance across California to detect climate change-related health conditions early, in near-real time, in order to plan and mobilize local first responders and other resources to reach vulnerable people and prevent further illness, injury, or death.

The primary mechanism for early detection of climate change-related health conditions will be to participate in the CDC's BioSense National Syndromic Surveillance Program (NSSP). Staff will work with the approximately 275 emergency department facilities in California not yet reporting health surveillance data to enroll and train them to report data through NSSP, providing intensive technical assistance and support. Every "chief complaint" and "discharge diagnosis" from the emergency department will enter the system within about 24 hours of the patient visit. Funds will be used to upgrade systems for data reporting, ingesting, analysis, display, and communication, to automate data transfer, analysis, and sharing as much as possible with state and local health departments and the public. Additionally, data coming from the NSSP's ESSENCE platform will be further analyzed, transformed, and displayed in user-friendly ways through the development of workspaces for Tableau and Databricks. Staff will provide intensive technical assistance to local health departments to support them in accessing, viewing, analyzing, and acting on their local data showing how often and to which populations climate change-related health conditions are occurring.

CDPH will use the results to develop predictive analytic models of potential future incidence of conditions such as heat-related illnesses and deaths, collaborate with others to enact policies and develop programs to prevent these health impacts. CDPH will also conduct modeling to quantify potential reductions of harm from interventions. CDPH will employ a communications specialist to communicate results and actionable solutions to the public, health professionals, and policymakers, using a variety of communication media.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 10: PUBLIC HEALTH REGIONAL CLIMATE PLANNING BCP

PROPOSAL

The CDPH Office of Health Equity (OHE) requests $25 million ($1.25 million in State Operations and $23.75 million in Local Assistance) in one-time General Fund expenditure authority in 2022-23, with provisional language for the funds to be available until June 30, 2025 and to allow transfer of funds to State Operations, to establish a Climate Change and Health Resilience Planning Grant Program that funds local health departments, community-based organizations, and tribes to develop regional Climate and Health Resilience Plans (based on Public Health Officer Regions), which can bolster the actions of resource-limited local health departments and communities to more effectively prevent and reduce inequitable health impacts of climate change, including behavioral health risks. This is a companion BCP to a "Climate Change and Health Surveillance" BCP also submitted for the January 2022 budget.

In order to implement this program, CDPH will use existing position authority in 2022-23, 2023-24, and 2024-25 to establish eight positions, including:

- Resources equivalent to one Health Program Manager II position would set the direction for the Climate Change and Health Resilience Planning Grant Program and supervise local assistance program staff.
- Resources equivalent to one Health Program Specialist II position would lead the staff in outreach, training, and technical assistance to LHJs, tribes, and CBOs; provide direction on evaluation measures for the Plans; and resolve problems and assure quality control.
- Resources equivalent to four Health Program Specialist I positions would provide outreach, training, and technical assistance to LHJs, tribes, and CBOs, and help them develop and implement Climate Change & Health Resilience Plans.
- Resources equivalent to two Associate Governmental Program Analysts would process contracts, grant agreements, and invoicing for LHJs, tribes, community-based organizations, and technical assistance providers.

In addition to these resources, CDPH requests General Fund expenditure authority of $21,000 to support a contracted technical assistance and training provider for community engagement, communications, mental health, or evaluation.

At a later date, CDPH will assess if there is a need to expand this pilot planning program to fund additional counties, tribes, and community organizations, and for implementation of the resilience plans developed through this planning phase.

BACKGROUND

According to CDPH, taking action to address health impacts of climate change can reduce those threats and increase resilience while simultaneously reducing greenhouse gas emissions. Additionally, many California climate change policies and solutions aimed at lowering carbon emissions can also simultaneously address upstream determinants of health outcomes (e.g., housing, transportation, land use, economic development, jobs, and more), reduce health inequities, and foster community resilience to climate impacts. Such "no-regret" actions include reducing driving and increasing physical activity through building safe, appealing facilities for walking, cycling, and transit; reducing pollution through regulations, incentives, and equipment changes; prioritizing transit-oriented and infill development that reduces car-dependency, maintains affordability, and does not locate polluting uses near people; creating healthy local food systems; pursuing urban and community greening; and reducing building energy use through energy efficiency, weatherization, cool roofs, and water conservation.

CDPH currently has only eight staff positions in CCHES dedicated to addressing climate change and health, working to achieve a state where all Californians thrive in healthy and resilient communities. In addition to the local support described above, these staff provide technical assistance to other state agencies to embed health into their climate-related programs, policies, plans, and grant funding programs that affect land use, transportation, housing, energy, income and jobs, natural and working lands, emergency preparedness, and air and water quality.

CDPH OHE will support LHDs, community-based organizations, and tribes or tribal health programs (tribes) to establish regional climate change and health resilience plans with a planning process that includes:

1. Engage funded and non-funded community-based organizations, tribes, faith-based organizations, local government, and other stakeholders. Conduct robust community engagement at every step of plan development and implementation. Establish a "collaborative stakeholder structure" that details who will be engaged, roles, and decision-making methods.

2. Assess local vulnerability to health and equity impacts of climate change using available data and tools such as the CDPH Climate Change and Health Vulnerability Indicators for California, the State Cal-Adapt climate exposure tool, the California Healthy Places Index, and local health data and tools including Traditional Ecological Knowledge from tribes that wish to provide it.

3. Complete an environmental scan of local climate change planning, including:

    a) Resilience and adaptation planning and activities (e.g., Local Hazard Mitigation Plan or Safety Element of the General Plan);

b) Climate change mitigation planning and activities that reduce greenhouse gases and improve determinants of health such as physical activity, healthy food access, housing, and transportation (e.g., transportation and land use planning, Area Plans, General Plans, Bicycle and Pedestrian Plans, Climate Action Plans, California Climate Investment programs, and Sustainable Communities Strategies/Regional Transportation Plans with regional planning agencies);
c) Other groups or entities addressing climate change with whom to collaborate.

4. With technical assistance from CDPH, write a Climate Change and Health Resilience Plan that addresses priority climate change and health equity impacts identified in the vulnerability assessment, and that improves social determinants of health through climate change actions. Regional coalitions will choose interventions from a list of best practices provided by CDPH, including policy objectives to create long-term change that improves the health of entire populations. Regional Plans will include metrics to evaluate the effectiveness of process and outcomes, including engagement of the community in plan development and implementation.

5. If resources permit, begin implementation of the plan with training and technical assistance from CDPH.

According to the proposal, distribution of funds will be based on two main factors: 1) Public health officer regions throughout the state; and 2) population health equity factors. Funds will be distributed to each of five public health officer regions in California (see table below for geographic reference). The level of funding for each region will be based on a health equity frame, providing a baseline for each of the regions plus additional funding based on the size of both the overall population and the size of the population in the lowest, worst-off quartile of the California Healthy Places Index (HPI), indicating a combination of risk factors for harm from climate impacts, such as poverty, pollution, poor housing quality, lack of tree canopy and lack of access to transportation. CDPH OHE/CCHES plans to use a formula that starts with a baseline allocation plus an additional allocation based on weighting the overall size of the population in a region by 25 percent and the size of the population in the lowest HPI quartile at 75 percent. The formula would be adapted for LHD funding, for CBO funding, and for tribal funding.

CDPH Public Health Officer Regions

PUBLIC HEALTH OFFICER REGION	LOCAL HEALTH DEPARTMENTS IN REGION
Association of Bay Area Health Officers (ABAHO)	Sonoma, Napa, Solano, Marin, Contra Costa, Alameda, San Francisco, Santa Clara, San Mateo, Santa Cruz, Monterey, City of Berkeley
Rural Association of Northern California Health Officers (RANCHO)	Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen, Tehama, Glenn, Lake, Mendocino
Greater Sacramento Region Health Officers (GSRHO)	Plumas, Butte, Sierra, Nevada, Placer, Yuba, El Dorado, Alpine, Amador, Sacramento, Yolo, Sutter, Colusa
San Joaquin Valley Consortium (SJVC)	San Joaquin, Calaveras, Tuolumne, Stanislaus, Mariposa, Merced, San Benito, Madera, Fresno, Kings, Tulare, Kern
Southern California Health Officers (SCHO)	San Luis Obispo, Santa Barbara, Ventura, Los Angeles, Orange, San Diego, Imperial, Riverside, San Bernardino, Inyo, Mono, City of Long Beach, City of Pasadena

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

PANEL 6 – CENTER FOR HEALTHY COMMUNITIES PROPOSALS

This panel covers proposals and adjustments under the Center for Healthy Communities, including issues:

11. Air Quality (AB 619) BCP
12. Sexual Orientation and Gender Identity Data Collection Pilot Project (AB 1094) BCP
13. Alzheimer's Healthy Brain Initiative BCP
14. Fitness Council BCP
15. Tobacco Taxes (Propositions 99 & 56) Adjustments

PANEL 6 – PRESENTERS

- **Maria Ochoa**, Assistant Deputy Director, Center for Healthy Communities, Center Operations, California Department of Public Health
- **Dr. Diana Ramos**, Assistant Deputy Director, Center for Healthy Communities, Chronic Disease Prevention, California Department of Public Health
- **Harold Goldstein**, Executive Director, Public Health Advocates

PANEL 6 – Q&A ONLY

- **Terri Sue Canale**, Acting Deputy Director, Center for Healthy Communities, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 11: AIR QUALITY (AB 619) BCP

PROPOSAL

CDPH requests three positions and General Fund expenditure authority of $586,000 annually to create and maintain an air quality plan, pursuant to AB 619 (Calderon, Chapter 412, Statutes of 2021). Specifically, CDPH requests the following positions and resources:

- One Research Scientist II position would contribute to the development of the air quality plan guidance regarding the use of respiratory protection and other exposure control measures; provide language for tracking the supply of air filtration masks, respirators, and other protective equipment; provide guidance for counties on whether to maintain stockpiles of air filtration masks and other protective equipment and devices available for distribution; provide guidance on whether and when counties are to make these devices available to residents; respond to questions and provide recommendations to counties, contractor organizations, and the public on the use of protective equipment; develop and update specifications for air filtration masks and respirators as needed for stockpiles and state purchasing contracts; respond to questions from counties and the general public on protective strategies such as ventilation filters and selection and use of portable air cleaners; and provide guidance on mask fitting and appropriate use.

- One Research Scientist III position provide subject matter expertise and assist local health departments in developing their own air quality plans; analyze population vulnerabilities and estimate access and functional needs burdens for air quality planning; advise management on county resource needs; analyze air quality data and present data analysis information to management; research and provide expertise on associations between air quality events and respiratory illness; develop, incorporate stakeholder input, and advise on the Air Quality Health Plan; and summarize data and inform outreach.

- One Health Program Specialist II position coordinate air quality plan compilation, publication, and updates; provide language, edits, and review for the Air Quality Health Plan; schedule and coordinate meetings with other agencies and stakeholders; manage communication and act as liaison between DPH and various stakeholders; ensure produced materials are culturally and linguistically appropriate to meet the diverse educational needs of impacted disadvantaged communities; facilitate stakeholder meetings; act as programmatic contact; establish and maintain communication with required state agencies, medical professionals, local governments, hospitals, businesses, and advocacy organizations; update air quality planning guide as needed; and provide oversight of contracts, budgets, administrative components, communication, and outreach activities.

In addition, CDPH requests General Fund expenditure authority of $50,000 annually to support a contract for meeting facilitation, supplies, outreach, and education materials.

BACKGROUND

In August 2020, four wildfires were burning in California, including the largest in the state's history, the August Complex Fire in Tehama County, which burned over one million acres. In addition, the Santa Clara Unit (SCU) Complex Fires burned nearly 400,000 acres in Stanislaus, Santa Clara, Alameda, Contra Costa, and San Joaquin counties; the Sonoma-Lake-Napa Unit (LNU) Lightning Complex Fires burned over 363,000 acres in Sonoma, Lake, Napa, Yolo, and Solano counties; and the North Complex Fire burned over 300,000 acres in Butte, Plumas, and Yuba counties.

According to CDPH, wildfire smoke consists of a mixture of toxic air pollutants, with high levels of fine particulate matter of particular public health concern. Fine particulate matter is a known risk factor for cardiorespiratory morbidity due to its ability to travel deep into the lungs and the bloodstream. During wildfire smoke events, concentrations of fine particulate matter are significantly elevated, posing an increased risk of adverse health outcomes, such as asthma, chronic obstructive pulmonary disease (COPD), and other diseases. Hospitalizations and emergency department visits for respiratory conditions generally increase during wildfire smoke events and studies have found increases in hypertension, ischemic heart disease, heart attacks, and deaths from non-accidental causes during such events. Young children appear to be especially vulnerable, with one study finding a 70 percent increase in emergency department visits for asthma among very young children during a period of dense wildfire smoke.

AB 619 requires CDPH to develop a plan with recommendations and guidelines for counties to use in the case of a significant air quality event caused by wildfires or other sources. The plan must be developed in consultation with representatives from the Governor's Office of Emergency Services (CalOES), the California Air Resources Board, the Governor's Office of Planning and Research, the California Department of Aging, the Department of Developmental Services, the Office of Environmental Health Hazard Assessment, appropriate medical professionals, air pollution districts, cities and counties, hospitals, business organizations, and various advocacy organizations. The plan is required to address the following:

- Establishing policies and procedures that address the availability, use, and distribution of respiratory protection and other protective equipment and devices, particularly for vulnerable residents at greater risk for adverse health effects from wildfire smoke or other sources.

- Guidance on how a county informs its residents about unhealthy air quality, its impact on health, the acquisition and use of respiratory protection, and other mitigation options.

- Recommendations on outreach and education for the general public as well as vulnerable populations.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 12: SEXUAL ORIENTATION AND GENDER IDENTITY DATA COLLECTION PILOT PROJECT (AB 1094) BCP

PROPOSAL

CDPH requests General Fund expenditure authority of $541,000 in 2022-23 through 2024-25 to establish and administer a three-year sexual orientation and gender identity data collection pilot project, pursuant to AB 1094 (Arambula, Chapter 177, Statutes of 2021).

According to CDPH, based on its experience administering the California Violent Death Reporting System (CalVDRS) program, counties participating in the pilot program would require reimbursement for the cost of participating in trainings, implementing changes to current coroner and medical examiner tools and systems, and data entry activities. In addition, CDPH would use existing position authority to establish two positions for the duration of the pilot. Specifically, CDPH is requesting the following resources:

- Resources equivalent to one Research Scientist II position would develop and oversee the pilot, recruit and provide technical assistance to counties, ensure appropriate training and collection of sexual orientation and gender identity (SOGI) data, analyze data, provide applicable reports, and facilitate dissemination of relevant information by the department.

- Resources equivalent to one Associate Governmental Program Analyst would provide administrative support to the program, serve as liaison to participating counties and training entities, manage contracts and other program aspects, and support data collection, analysis, and dissemination efforts.

CDPH also requests General Fund expenditure authority of $212,000 in 2022-23 through 2024-25 for local assistance funding to reimburse counties for their costs to participate in the pilot project.

BACKGROUND

In 2018, 4,490 Californians died by suicide, including 544 young people between the ages of 10 and 24. Research conducted on data from the National Violent Death Reporting System (NVDRS) found that lesbian, gay, bisexual, transgender, or queer (LGBTQ) youth are more likely to die by suicide than non-LGBTQ youth. The data indicated that almost 25 percent of 12 to 14 year olds who died by suicide were LGBTQ. Members of the LGBTQ community are also at risk of experiencing violence based on their sexual orientation or gender identity.

Established in 2002, NVDRS is a surveillance system to gather data on all types of violent deaths, including homicides in suicides, in all settings for all age groups. NVDRS is represented in all states, and pools more than 600 unique data elements from multiple sources into a usable, anonymous database. The NVDRS system includes data fields for sexual orientation and transgender identity as well as a narrative section where further information on gender identity can be entered, tracked, and reported through text search functions. Since 2016, DPH has managed the CalVDRS with funding from the federal Centers for Disease Control and Prevention (CDC). Data elements are collected from multiple primary data sources, including death certificates, coroner or medical examiner reports, law enforcement reports, and toxicology reports. These data provide context about violent deaths such as relationship problems, mental health conditions and treatment, toxicology results, and life stressors. De-identified data from CalVDRS are entered into the NVDRS system.

AB 1094 requires CDPH to establish a three-year pilot program in up to six counties for training coroners and medical examiners on the identification and collection of SOGI information in cases of violent death. CDPH is required to develop a list of trainers with expertise in identifying and collecting SOGI clinical data as well as following best practices around cultural competency, respect for confidentiality, and other topics. At least one county must be chosen from the northern, southern, and central regions of California and CDPH must consider representation of urban, rural, and suburban areas. Participating counties would receive training from a list of approved training entities, begin standardized collection of SOGI data in cases of violent death, report the data to CDPH for inclusion in CalVDRS, and aggregate, de-identify, and annually report the data to the county's Board of Supervisors during each year of the pilot.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 13: ALZHEIMER'S HEALTHY BRAIN INITIATIVE BCP

PROPOSAL

CDPH requests General Fund expenditure authority of $10 million in 2022-23, available for encumbrance or expenditure until June 30, 2025 to allocate grants to six existing local health jurisdictions, and expand to up to six additional jurisdictions, to participate in the California Healthy Brain Initiative Pilot Program. CDPH would establish a competitive request for application process for local health jurisdictions, which would incorporate the principles of eliminating health disparities, collaborating across multiple sectors, and leveraging public and private resources for sustained impact. These local assistance resources would comprise $8.5 million over three years. CDPH is also requesting $1.5 million over three years for state operations to support the grant program.

In addition, CDPH requests General Fund expenditure authority of $45,000 over three years for an external evaluation consultant that would develop quantitative and qualitative data gathering strategies and tools to assess the California Healthy Brain Initiative local health jurisdictions' progress towards completing project activities and deliverables that are consistent with the Healthy Brain Initiative Road Map to evaluate whether the projects are effective in meeting their goals and objectives; evaluate the projects' progress towards advancing cognitive health; assess from the data gathered by CDPH the progress of the California Healthy Brain Initiative local health jurisdictions' pilot projects towards building capacity to report on process and outcome indicators; and assist CDPH with developing draft and final project evaluation reporting templates and tools; and assist CDPH with evaluating quarterly and bi-annual progress reports from the California Healthy Brain Initiative local health jurisdictions.

BACKGROUND

The 2019 Budget Act included General Fund expenditure authority of $5 million to allocate grants for up to six local health jurisdictions to support activities consistent with the Healthy Brain Initiative, an initiative implemented by the federal Centers for Disease Control and Prevention (CDC). According to CDPH, the Alzheimer's Disease Program awarded grant funding to the following local health jurisdictions: Los Angeles, Placer, Sacramento, San Diego, Santa Clara, and Shasta. The project activities included the following:

- Monitoring data and evaluating programs to contribute to evidence-based practice.
- Education and empowerment of the public with regard to brain health and cognitive aging.

- Mobilizing public and private partnerships to engage local stakeholders in effective community-based interventions and best practices.

- Ensuring a competent workforce by strengthening the knowledge, skills, and abilities of health care professionals who deliver care and services to people with Alzheimer's disease and other dementias and their family caregivers.

CDPH indicates the six funded pilots demonstrate success in creating programs that meet the needs of specific jurisdictions. Placer County developed a partnership with first responders to implement Project Lifesaver, a search and rescue program to find wandering dementia patients. San Diego County has implemented a mobile application for physicians to use in assessment of patients with cognitive impairment. Santa Clara County has partnered with the Alzheimer's Association to educate the public in Spanish, Vietnamese, Chinese, and English to education on the signs, symptoms, and prevention of Alzheimer's disease.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 14: FITNESS COUNCIL BCP

PROPOSAL

CDPH requests three positions and General Fund expenditure authority of $10 million in 2022-23, available for encumbrance or expenditure until June 30, 2025 to support the Governor's Advisory Council on Physical Fitness and Mental Well-Being, established by the Governor in June 2021. CDPH indicates it would use existing position authority to establish three positions between 2022-23 and 2024-25 to support the program activities. The remaining funds ($8.6 million) would support a comprehensive social marketing campaign.

Specifically, CDPH requests the following resources:

- Resources equivalent to one Health Program Specialist II position would oversee the coordination of the council, support high-level facilitation and cross-sector communications, provide high-level content expertise to support council development and engagement activities, oversee contracts for both event planning and social marketing campaigns, oversee preparation of an annual report, and collaborate with the Governor's Office and all appropriate state agencies and departments.

- Resources equivalent to one Health Program Specialist I position would provide advertising, public relations, and community engagement expertise; support day-to-day activities of the council's outreach and social marketing campaign; and provide overall support to staff and the council with meeting and contractor communications.

- Resources equivalent to one Associate Governmental Program Analyst would provide oversight of the interagency agreement and social marketing campaign contract, and all fiscal and contract reporting and deliverables.

In addition to the established position resources, CDPH requests General Fund expenditure authority of $8.6 million, available over three years, to support a comprehensive social marketing campaign in designated media markets and in communities statewide. CDPH would execute a contract with an experienced vendor to support formative research, social marketing plan development, concept and creative development, and implementation of all established communication activities. CDPH indicates it may enter into contracts for subject matter expertise or other technical assistance for this purpose.

BACKGROUND

On June 16, 2021, Governor Newsom announced the formation of the Governor's Advisory Council on Physical Fitness and Mental Well-Being, a new advisory council tasked with exploring health strategies to ensure Californians can thrive. With a special emphasis on child physical and mental health, the council will be led and convened by First Partner Jennifer Siebel Newsom and Pro Football Hall of Fame inductee and former San Francisco 49ers cornerback Ronnie Lott. The council will include representatives from health and wellness organizations, youth sports programs, education, the entertainment and fitness industry, and others from around the state. The council's activities will include:

- Advising on the development of physical activity and wellness goals for Californians of all ages

- Advising on methods to increase awareness among all age groups, particularly children and youth, about how physical activity, sport, nutrition, and mental wellness contribute to healthy and productive lives

- Encouraging inter-generational physical fitness activities including the use of physical activity and sport to strengthen families

- Facilitating collaboration among federal, state, and local agencies, education, business, industry, the private sector, and others in the promotion of physical activity and mental wellness.

According to CDPH, councils of this type have been convened under several previous governors, beginning in 1993 with an Executive Order from Governor Pete Wilson. The 1993 council was charged with developing fitness goals for school children and Californians of all ages, creating public awareness campaigns, and encouraging coordination between governments, education, and the private sector in the promotion of physical fitness. In 2005, Governor Arnold Schwarzenegger launched a new council as a non-profit organization that would raise funds and hire its own staff. The goal of the 2005 council was to promote physical activity for all Californians, with an emphasis on children and youth, to reduce the risk of diseases such as type 2 diabetes and obesity and to contribute to academic success.

STAFF COMMENTS/QUESTIONS

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

- Has any research been done to prove the efficacy of promoting physical activity via public awareness campaigns?

- According to research, what are the most common barriers to people engaging in physical activity? How does a public awareness campaign address those barriers?

The Subcommittee requests Dr. Harold Goldstein provide feedback on the proposal to fund a public awareness campaign to promote physical activity, and respond to the following:

- According to the most recent research, what do experts believe to be the most effective, evidence-based strategies for promoting physical activity, particularly among children and youth in low-income communities?

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 15: TOBACCO TAXES (PROPOSITIONS 99 & 56) ADJUSTMENTS

ADJUSTMENTS

The Governor's Budget reflects the following adjustments to Propositions 99 and 56 (tobacco taxes) revenue and related funding for CDPH Center for Healthy Communities programs:

***Proposition 99 Health Education Account (*-$11,834,000)**
The Governor's Budget reflects a decrease of $10.4 million in Proposition 99 Health Education Account State Operations and $1.4 million Proposition 99 Health Education Account Local Assistance as a result of updated Proposition 99 revenue projections. The decrease includes $2.4 million in State Administration, $2.5 million in Media Campaign, $2 million for Evaluation and $4.9 million in Competitive Grants ($3.4 million for State Operations and $1.4 million for Local Assistance). The revenues are used for programs associated with prevention and reduction of tobacco use, primarily among children, through school and community health education programs.

***Proposition 99 Research Account (*-$1,884,000)**
The Governor's Budget reflects a decrease of $1.9 million in Proposition 99 Research Account State Operations as a result of updated Proposition 99 revenue projections. The decrease includes $685,000 in State Administration and $1.2 million in External Contracts. The revenues are used for tobacco-related disease research.

***Proposition 99 Unallocated Account (*-$434,000)**
The Governor's Budget reflects a decrease of $434,000 in Proposition 99 Unallocated Account State Operations as a result of updated Proposition 99 revenue projections. The decrease includes $251,000 in State Administration, $76,000 in External Contracts and $107,000 for the California Health Interview Survey. The revenues are used to support tobacco education, tobacco prevention efforts, tobacco-related programs, tobacco-related healthcare services, environmental protection, and recreational resources.

***Proposition 56 State Dental Program Account (*$1,726,000)**
The Governor's Budget reflects an increase of $908,000 in State Dental Program Account State Operations and $818,000 in State Dental Program Account Local Assistance as a result of updated Proposition 56 revenue projections. The funds are used for the state dental program for the purpose and goal of educating about, preventing, and treating dental disease, including dental diseases caused by use of cigarettes and other tobacco products.

***Proposition 56 Tobacco Prevention and Control Programs Account (*$21,323,000)**
The Governor's Budget reflects an increase of $3.9 million in Tobacco Prevention and Control Programs Account State Operations and an increase of $17.4 million in Tobacco Prevention and Control Programs Account Local Assistance as a result of updated

Proposition 56 revenue projections. The increase includes $5.4 million in Media Campaign, $2.2 million in State Administration, $6.3 million in Competitive Grants (a decrease of $3.2 million in State Operations and an increase of $9.5 million in Local Assistance), a $1 million decrease in Evaluations, and an $8.4 million increase in Local Assistance for Local Lead Agencies. The funds are used for tobacco control programs by providing funds to state and local government agencies, tribes, universities, colleges, community-based organizations, and other qualified agencies for the implementation, evaluation, and dissemination of evidence-based health promotion and health communication activities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present these adjustments and respond to the following:

- Please describe any programmatic impacts of these adjustments.

- The 2021 Budget Act approved of an ongoing General Fund backfill for reductions in Proposition 56 revenue dedicated to the State Dental Program. Please explain how that action affects this year's State Dental Program budget.

- Stakeholders report that CDPH intends to reduce funding for the California Cancer Registry (CCR) by $1.8 million due to reductions in Proposition 99 revenue; is this accurate? If so, what will be the impact on the CCR of this reduction?

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 16: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE

ESTIMATE

The Office of AIDS within CDPH administers the AIDS Drug Assistance Program (ADAP), which provides access to life-saving medications for Californians living with HIV and assistance with costs related to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) for Californians at risk of acquiring HIV. Clients are eligible for ADAP services if they meet the following criteria:

1. Are HIV infected;
2. Are a resident of California;
3. Are 18 years of age or older;
4. Have a Modified Adjusted Gross Income that does not exceed 500 percent of the Federal Poverty Level; and
5. Are not fully covered by or eligible for Medi-Cal or any other third-party payer.

ADAP Programs

ADAP provides services to its "clients" through support for medications, health insurance premiums and out-of-pocket costs. Clients generally fall into one of five categories:

1. Medication-only clients are people living with HIV who do not have private insurance and are not enrolled in Medi-Cal or Medicare. ADAP covers the full cost of prescription medications on the ADAP formulary for these individuals, who only receive services associated with medication costs.

2. Medi-Cal Share of Cost clients are persons living with HIV enrolled in Medi-Cal who have a share of cost for Medi-Cal services. ADAP covers the share of cost for medications for these clients, who only receive services associated with medication costs.

3. Private insurance clients are persons living with HIV who have some form of health insurance, including through Covered California, privately purchased health insurance, or employer-based health insurance and who receive services associated with medication costs, health insurance premiums and medical out-of-pocket costs.

4. Medicare Part D clients are persons living with HIV enrolled in Medicare and have purchased Medicare Part D plans for medication coverage. This group of clients receives services associated with medication co-pays, medical out-of-pocket costs, Medicare Part D health insurance premiums, and has the option for premium assistance with Medigap supplemental insurance policies, which cover medical out-of-pocket costs.

5. Pre-exposure prophylaxis (PrEP) Assistance Program (PrEP-AP) clients are individuals who are at risk for, but not infected with, HIV and have chosen to take PrEP, or post-exposure prophylaxis (PEP), as a way to prevent infection. For insured clients, PrEP-AP pays for PrEP- and PEP-related medical out-of-pocket costs and covers the gap between what the client's insurance plan and the manufacturer's co-payment assistance program pays towards medication costs. For uninsured clients, PrEP-AP only provides assistance with PrEP- and PEP-related medical costs, as medication is provided free by the manufacturer's medication assistance program.

ADAP tracks caseload and expenditures by client group. CDPH estimates ADAP caseload and expenditures for 2021-22 and 2022-23 will be as follows:

Caseload by Client Group	2021-22	2022-23
Medication-Only	11,000	9,499
Medi-Cal Share of Cost	101	103
Private Insurance	10,872	10,893
Medicare Part D	7,520	7,537
PrEP Assistance Program	5,250	5,656
TOTAL	**34,743**	**33,687**

Expenditures by Client Group	2021-22	2022-23
Medication-Only	$333,979,452	$270,831,264
Medi-Cal Share of Cost	$1,460,097	$1,182,264
Private Insurance	$108,668,555	$108,944,692
Medicare Part D	$23,322,112	$29,225,130
PrEP Assistance Program	$2,950,264	$7,083,988
TOTAL	**$470,380,480**	**$496,050,788**

Costs for administration of ADAP are estimated to be $8.6 million in 2021-22 and $5.6 million in 2022-23. Costs for administration of PrEP-AP are estimated to be $567,749 in 2021-22 and $659,805 in 202223. Enrollment costs are estimated to be $8 million in 2021-22 and $7.3 million in 2022-23. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which includes a payment floor and variable payments dependent on new client medication enrollment, client bi-annual self-verification, client annual re-enrollment, client insurance assistance enrollment and re-enrollment, and PrEP client enrollment and re-enrollment.

In addition, ADAP's pharmacy benefit manager, Magellan Rx Management, contracts with a safety net recovery vendor, Health Management Systems (HMS) to pursue recovery of paid claims when a liable third party is identified post-payment. CDPH estimates recoveries of $12.2 million in 2021-22 and $12.2 million in 2022-23.

Program Updates in the 2022-23 ADAP Estimate

According to CDPH, ADAP is implementing the following significant changes to existing programs or new programs:

- *Medicare Part C Payment Program*. ADAP currently pays private health insurance premiums and outpatient medical out-of-pocket costs for clients in OA-HIPP, Medicare Part D Premium Payment Program (MDPP), and the Employer Based Health Insurance Premium Payment Program (EB-HIPP). When clients become eligible for Medicare, they are no longer eligible for OA-HIPP, but can receive payment for Medicare Part D costs. ADAP proposes to utilize ADAP rebate funds to establish the Medicare Part C Premium Payment Program, which would pay premiums and out-of-pocket costs for Medicare Part C (also referred to as Medicare Advantage), to encourage ADAP clients to enroll in comprehensive coverage, and reduce medication costs for ADAP in other categories.

- *Medicare Part B Extra and Innovative Benefits*. Certain Medicare Part B supplemental plans offer "extra" or "innovative" benefits to cover services outside base medical coverage, such as hearing aids, vision exams, Silver Sneaker gym memberships, and nurse consultations. ADAP currently pays Medicare Part B supplemental medical plan premiums through MDPP, but requires clients to cover the cost of extra or innovative benefits. ADAP proposes to utilize ADAP rebate funds to pay premiums for supplemental plans including extra and innovative benefits.

- *ADAP Pilot Program for Jails*. Prior to 2008, 36 local county jails participated in ADAP to provide medication assistance to qualifying detainees. However, the program was terminated in 2008 due to the recession and the subsequent General Fund shortfall. In 2018, the Health Resources and Services Administration (HRSA) released guidance that permitted the use of HRSA funds for detainees in county jails not yet convicted of a crime or not covered by federal or state health benefits during incarceration. Orange County requested ADAP to provide services at their county jail, allowing the jail to serve as an ADAP enrollment site, clients to access medications at the jail pharmacy, and prescription refills for clients scheduled for release. ADAP is considering expanding the ADAP jail pilot program to other interested county jails in 2022-23, including Los Angeles, Marin, Riverside, San Francisco, San Luis Obispo, and Siskiyou). According to CDPH, the net fiscal impact from the ADAP Rebate Fund of the Orange County pilot is $719,000 ($1.1 million in expenditures offset by $354,000 in rebates) for 123 eligible clients in 2021-22, and $317,000 ($933,000 in expenditures offset by $616,000 in rebates)

for 107 eligible clients, in 2022-23. CDPH estimates the net fiscal impact of the expansion would be $11.7 million ($17.4 million expenditures offset by $5.7 million in rebates) for 1,998 eligible clients in 2021-22, and $5.1 million ($15.1 million in expenditures offset by $10 million in rebates) for 1,733 eligible clients in 2022-23.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present the ADAP estimate and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 17: SEXUALLY TRANSMITTED DISEASE: TESTING (SB 306) BCP

PROPOSAL

CDPH requests 3 positions and $475,000 General Fund in 2022-23 and ongoing. The requested funding and positions are needed to manage the increased workload related to the requirements of SB 306 (Pan, Chapter 486, Statutes of 2021), allowing Human Immunodeficiency Virus (HIV) test counselors to perform any HIV, hepatitis C virus (HCV), or other sexually transmitted disease (STD) test that is classified as waived under the federal Clinical Laboratory Improvements Act (CLIA).

BACKGROUND

Nearly all states allow the use of federal Food and Drug Administration (FDA)-approved, CLIA waived tests by trained non-medical personnel and defer to federal requirements. California is one of only a handful of states with additional training requirements above and beyond federal law. Prior to bill enactment, HSC section 120917 allowed HIV test counselors trained by OA or its agents to perform CLIA-waived rapid tests for HIV and HCV or, if FDA-approved and CLIA-waived, combination HIV/HCV tests. SB 306 amended HSC section 120917 to allow HIV test counselors to perform CLIA-waived tests for all STDs if they have completed a training course approved by OA. This change enables CDPH to train test counselors on new CLIA-waived HIV, HCV, or STD tests as they become available without having to change state law or issue regulations. This flexibility allows for changing public health priorities, and because new STDs can arise, as HIV did in the 1980s, at any time requiring a rapid public health response.

These modifications also carry with it increased workload for CDPH, as staff will be interfacing more heavily with the public and stakeholders, including LHJs, community-based organizations, health care providers, and pharmacists to provide increased technical assistance and informational materials. Additionally, staff will need to develop new curricula and train HIV test counselors to perform herpes simplex virus (HSV) and trichomonas infection testing – and other tests which may be approved in future.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 18: PUBLIC HEALTH: COVID-19 (SB 336) BCP

PROPOSAL

CDPH requests General Fund expenditure authority of $307,000 in 2022-23 and 2023-24 to operate and maintain an e-mail distribution list for organizations, communities, nonprofits, and individuals to receive information regarding COVID-19 public health orders, pursuant to the requirements of SB 336 (Ochoa Bogh, Chapter 487, Statutes of 2021). CDPH indicates it will use existing position authority and requests two Associate Governmental Program Analysts to coordinate the addition and removal of recipients on the email distribution list, maintain updated health officer orders from each local health officer (LHO), distribute changes to heath officer orders through the list, and assist local health districts with their own distribution lists.

BACKGROUND

SB 336 requires CDPH, or a LHO, when taking measures to protect the public against the threat of COVID-19, to publish those measures and the date they take effect on their internet website. In addition, CDPH or a LHO is required to provide organizations, communities, nonprofits, and individuals an opportunity to sign up for an email distribution list which will relay changes to public health orders.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

PANEL 7 – CENTER FOR FAMILY HEALTH PROPOSALS

This panel covers the following Center for Family Health program estimates and budget change proposals, including issues:

19. Genetic Disease Screening Program Estimate
20. WIC Program Estimate
21. eWIC Post-Implementation Support BCP
22. California Home Visiting Expansion BCP
23. Black Infant Health BCP

PANEL 7 – PRESENTERS

- **Christine Sullivan**, Division Chief, Center for Family Health, Women, Infants and Children Division, California Department of Public Health
- **Richard Olney**, Division Chief, Center for Family Health, Genetic Disease Screening Program, California Department of Public Health
- **Diane Lindsey**, Division Chief, Center for Family Health, Maternal, Child & Adolescent Health Division, California Department of Public Health
- **Kristi Foy**, Executive Director, California Clinical Laboratory Association

PANEL 7 – Q&A ONLY

- **Dr. Connie Mitchell**, Deputy Director, Center for Family Health, California Department of Public Health
- **Leslie Gaffney**, Assistant Deputy Director, Center for Family Health, California Department of Public Health
- **Catherine Lopez**, Assistant Division Chief, Center for Family Health, Women, Infants and Children Division, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 19: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

ESTIMATE

The November 2021 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $145.9 million ($34.5 million state operations and $111.4 million local assistance) in 2021-22, and $175 million ($34.5 million state operations and $140.5 million local assistance) in 2022-23.

BACKGROUND

The Genetic Disease Screening Program (GDSP) performs the following tasks:

- Screens newborns and pregnant women for genetic and congenital disorders. The screening programs provide testing, follow-up, and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.
- Ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance.
- Fosters informed participation in its programs in an ethical manner through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.
- Provides ongoing critical review, testing, and evaluation of existing programs to ensure program objectives and goals are being met.
- Develops programs to adopt new methods and implement new services that further enhance the effectiveness and efficiency of current and future prevention programs.
- Promotes use of high-quality consumer education materials on genetic disorders, screening for birth defects and genetic services.

GDSP operates two primary screening programs: the Newborn Screening Program and the Prenatal Screening Program. Caseload and expenditures for these programs are reflected in the GDSP Estimate along with operational support costs for the programs.

Newborn Screening (NBS) Program

Newborn screening, recognized nationally as an essential preventive health measure, began in California in 1966 with the testing of infants for phenylketonuria (PKU). In 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and included a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added to the screening program, which allows for identification of related non-sickling hemoglobin disorders, including beta-thalassemia major, and Hb E/beta thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in

2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to CDPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2017, 18,920,529 babies were screened resulting in early identification of the following disorders:

Disorder	Cases
Phenylketonuria (PKU)	1,264
Primary Congenital Hypothyroidism	7,857
Galactosemia	1,018
Sickle Cell Disease and other clinically significant Hemoglobinopathies	5,006
Biotinidase Deficiency (BD)	209
Cystic Fibrosis (CF)	636
Congenital Adrenal Hyperplasia (CAH)	376
Metabolic Fatty Acid Oxidation Disorders	741
Metabolic Amino Acid Disorders (other than PKU)	203
Metabolic Organic Acid Disorders	518
Other Metabolic Disorders	62
Severe Combined Immunodeficiencies	75
X-Linked Adrenoleukodystrophy (ALD) and Other Peroxisomal Disorders	50
TOTAL	**18,015**

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan, Chapter 363, Statutes of 2016), two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be added to the NBS program screening panel within two years. The current fee for screening in the NBS program is currently $177.25. CDPH indicates the fee will increase by $33.75 to $211 to offset per case increases due to a declining birth rate.

NBS Caseload Estimate: The budget estimates NBS program caseload of 392,044 in 2021-22, a decrease of 19,430 or 4.7 percent, compared to 2020-21 actual total caseload of 411,474. The budget estimates NBS program caseload of 428,070 in 2022-23, an increase of 36,026 or 9.2 percent, compared to the revised 2021-22 estimate. These estimates are based on state projections of the number of live births in California. CDPH assumes 100 percent of children born in California will participate in the NBS program annually.

Prenatal Screening (PNS) Program

The Prenatal Screening (PNS) program offers prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant women in California to detect birth defects during pregnancy. The program offers 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:

- Sequential Integrated Screening – This screen combines first and second trimester blood test results with nuchal translucency (NT) ultrasound results, which measure the back of a fetus' neck. The first trimester blood specimen is drawn between 10 weeks and 13 weeks and six days of pregnancy. The nuchal translucency ultrasound is performed between 11 weeks and two days and 14 weeks and two days of pregnancy. The second trimester blood specimen is drawn between 15 weeks and 20 weeks of pregnancy. This measurement helps screen for Down syndrome (trisomy 21), trisomy 18, neural tube defects, and Smith-Lemli-Opitz Syndrome (SLOS).

- Serum Integrated Screening – This screen combines a first trimester blood test screening result (drawn between 10 weeks and 13 weeks and six days of pregnancy) with a second trimester blood test screening result (drawn between 15 weeks and 20 weeks of pregnancy). The results of the two blood tests are combined and the measurement helps screen for Down syndrome, trisomy 18, neural tube defects, and SLOS.

- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy helps screen for Down syndrome, trisomy 18, neural tube defects, and SLOS.

For women with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is $221.60.

PNS Caseload Estimate: The budget estimates PNS program caseload of 292,050 in 2021-22, a decrease of 19,460 or 6.2 percent, compared to the 2021 Budget Act. The budget estimates PNS program caseload of 309,025 in 2022-23, an increase of 16,975 or 5.8 percent, compared to the revised 2021-22 estimate. These estimates are based on state projections of the number of live births in California. CDPH estimates approximately 75 percent of mothers of children born in California will participate in the PNS program in 2021-22 and 73 percent will participate in 2022-23.

Cell-Free DNA Will Replace Current Screening Tests

Cell-free DNA (cfDNA) is a non-invasive screening test for fetal chromosomal abnormalities that relies on extraction of maternal and fetal cells from a pregnant individual's blood sample. cfDNA can detect the same chromosomal abnormalities as current PNS program screening (e.g. Down syndrome, trisomy 18, neural tube defects, and SLOS) and can additionally detect trisomy 13. cfDNA screening also results in fewer false positives and better accuracy resulting in fewer women being referred for diagnostic follow-up services.

CDPH indicates the PNS program plans to replace its current conventional biochemical screening tests for chromosomal abnormalities with cfDNA screening and a simpler biochemical screen for neural tube defects, beginning July 1, 2022. CDPH plans to increase fees in the PNS program from $221.60 to $232 to account for the cost of cfDNA screening. In addition, the new biochemical screen for neural tube defects will require a separate fee of $85. These fees will be established through the program's existing rulemaking authority and will be deposited in the Genetic Disease Testing Fund.

Clinical Laboratory Concerns

Clinical labs have raised several objections to the way that CDPH has implemented the new cfDNA testing, including:

- Through regulations, CDPH has prohibited a lab from offering a pregnant woman this type of prenatal test, unless the lab is in contract with the CDPH as a part of the PNS program. Labs argue that this eliminates a woman's ability to choose to be tested outside of the state's PNS program.

- The state regulations also mandate that all lab work be done within California; however, some labs are part of networks of labs that have locations outside of California that specialize in this type of testing.

- According to the labs, CDPH did not engage stakeholders at all on designing the implementation of this program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present the GDSP Estimate and respond to the concerns raised by labs.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 20: WIC PROGRAM ESTIMATE

ESTIMATE

The November 2021 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($976.9 million federal funds and $195 million WIC manufacturer rebate funds) in 2021-22 and $1.1 billion ($882.7 million federal funds and $182.9 million WIC manufacturer rebate funds) in 2022-23. The federal fund amounts include state operations costs of $59.2 million in 2021-22 and 2022-23.

Women, Infants, and Children (WIC) Funding Summary			
	2021-22	**2022-23**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$59,210,000	$59,210,000	$-
Local Assistance:	$917,706,000	$823,444,000	($94,262,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$195,028,000	$182,915,000	($12,113,000)
Total WIC Expenditures	**$1,171,944,000**	**$1,065,569,000**	**($106,375,000)**

BACKGROUND

The WIC program provides nutrition services and food assistance for pregnant, breastfeeding, and non-breastfeeding women, infants, and children up to their fifth birthday at or below 185 percent of the federal poverty level. WIC program services include nutrition education, breastfeeding support, assistance with finding health care and other community services, and vouchers for specific nutritious foods that are redeemable at WIC-authorized retail food outlets throughout the state. The WIC program receives federal funds from the United States Department of Agriculture (USDA) under the federal Child Nutrition Act of 1966. Specific uses of WIC Program funds are governed by federal laws and regulations, and CDPH must report funds and expenditures monthly.

The WIC program's food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant formula. As infant formula is provided to WIC recipients, the program receives a rebate from the manufacturer which is used to fund additional food expenditures. In addition to food expenditures, the program receives federal funds from the Nutrition Services and Administration (NSA) grant, which are used to contract with local agencies for direct services provided to WIC families including intake, eligibility determination, benefit issuance, nutrition education, breastfeeding

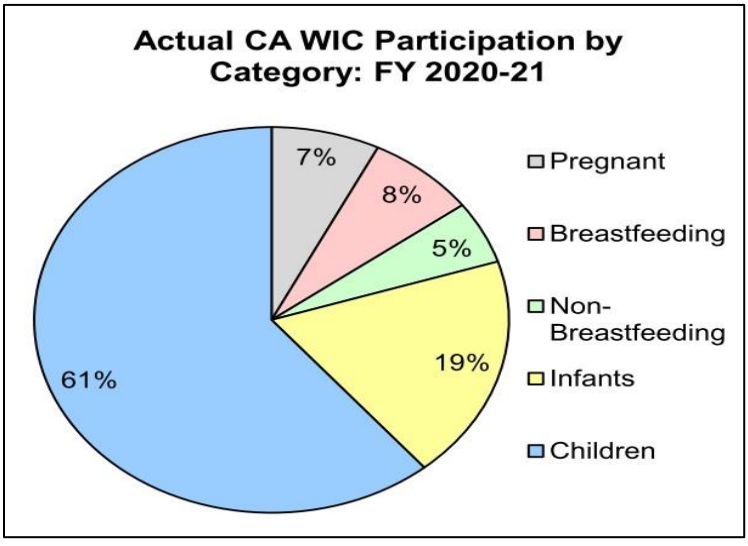
support, and referrals to health and social services. The NSA grant also funds state operations for administering the WIC program.

WIC Eligibility Categories

Food expenditures are divided into five participant categories, each with special nutrition needs that influence food costs:

- Pregnant women are eligible for the WIC program at any point in their pregnancy, and receive supplemental foods high in protein, calcium, iron, vitamin A, and vitamin C to support optimal fetal development.
- Breastfeeding women are eligible for benefits up to their infant's first birthday, and receive an enhanced supplemental food package with foods high in protein, calcium, iron, vitamin A, and vitamin C to support caloric needs during breastfeeding.
- Non-breastfeeding women are eligible for benefits up to six months after the birth of their infants, and receive a supplemental food package to help in rebuilding nutrient stores, especially iron and calcium, and achieving a healthy weight after delivery.
- Infants are eligible until one year of age. The WIC Program promotes breastfeeding as the optimal infant feeding choice due to its many health, nutritional, economical, and emotional benefits to mother and baby. Infants may also receive supplemental foods that are rich in protein, calcium, iron, vitamin A, and vitamin C during this critical period of development.
- Children are eligible from age one up to age five, and receive supplemental foods rich in protein, calcium, iron, vitamin A, and vitamin C. These nutrients have been shown to be lacking in the diets of children who qualify for WIC benefits and are needed to meet nutritional needs during critical periods of development. The food package also provides foods lower in saturated fat to reduce the risk of childhood obesity.

According to the WIC program Estimate, WIC participation by category, as of 2020-21, was as follows:



Caseload Estimates

The budget assumes 936,245 average monthly WIC participants in 2021-22, a decrease of 11,438 or 1.2 percent compared to the average monthly WIC participants in 2020-21. The budget assumes 930,482 average monthly WIC participants in 2022-23, a decrease of 5,763 or 0.6 percent from the revised 2021-22 caseload estimate.

Food Expenditures Estimate

The budget includes $798.5 million in 2021-22 for WIC program food expenditures, a decrease of $81.1 million or 9.2 percent, compared to the 2021 Budget Act. According to CDPH, the decrease in costs is due to a decline in participation, a decrease in food inflation, and lower than projected prior year expenditures, which serve as the basis for current year estimates. Of these expenditures, federally funded food expenditures are $603.5 million, a decrease of $86.2 million from the 2021 Budget Act, and WIC Manufacturer Rebate Fund food costs are $195 million, an increase of $5.1 million from the 2021 Budget Act.

The budget includes $692.1 million in 2022-23 for WIC program food expenditures, a decrease of $106.4 million or 13.3 percent from the revised 2021-22 food expenditures estimate. According to CDPH, this decrease in costs is also due to a decline in participation, as well as the elimination of the temporary federal increase for fruits and vegetables. Of these expenditures, federally funded food costs are $509.2 million, an increase of $94.3 million from the revised 2021-22 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $182.9 million, a decrease of $12.1 million from the revised 2021-22 food expenditure estimate.

Nutrition Services and Administration (NSA) Estimate

The budget includes $314.2 million for other local assistance expenditures for the NSA budget in 2021-22 and 2021-22, an increase of $10 million compared to the 2021 Budget Act. The budget also includes $59.2 million for state operations expenditures in 2021-22 and 2022-23, unchanged from the level assumed in the 2021 Budget Act.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present the WIC Estimate and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 21: eWIC POST-IMPLEMENTATION SUPPORT BCP

PROPOSAL

CDPH requests 25 positions and federal fund expenditure authority of $2.9 million annually to modernize services and provide ongoing support for a recently implemented management information system (WIC WISE), the WIC Electronic Benefit Transfer card, the WIC App, WIC Direct, as well as users of these technologies.

BACKGROUND

The federal Healthy, Hunger-Free Kids Act of 2010 required all state Women, Infants, and Children (WIC) programs to migrate from a voucher-based food benefit delivery system to an Electronic Benefit Transfer (EBT) system by October 1, 2020. With the assistance of the CalHHS Office of Systems Integration, the WIC program implemented its EBT system in March 2020 for all 83 local WIC agencies and approximately 500 clinic sites.

The new management information system, known as WIC WISE, supports the WIC EBT card, and implemented a new WIC smartphone application (WIC App) that provides services to WIC families through their smart phones. The WIC App helps WIC families find WIC-eligible foods and locate local agency offices and authorized vendors. According to CDPH, nearly 1 million WIC EBT cards have been issued and over 23 million WIC EBT card transactions have been processed as of July 1, 2021. WIC EBT card transactions are completed in real-time through a vendor's point of sale device to a system called WIC Direct. WIC Direct transmits information to WIC WISE, which ensures that purchases are reflected in the WIC family's remaining benefits. CDPH reports these new systems have provided important data to help WIC improve services and operations, including preventing, detecting, and responding to potentially fraudulent activities.

CDPH reports initial feedback from WIC families has been positive. A 2020 survey of California WIC families conducted by the University of California Nutrition Policy Institute and Public Health Foundation Enterprise estimated over 95 percent of WIC families reported satisfaction with the new WIC EBT card. The data also showed WIC families found the EBT card convenient and significantly reduced the stigma attached to using WIC benefits in stores. The survey also showed satisfaction with the WIC App, with families noting the ease of finding WIC-eligible foods and authorized vendors.

According to CDPH, the WIC program will require ongoing permanent support of the eWIC systems, including WIC WISE, the WIC EBT card, the WIC App, and WIC Direct, as well as assistance to users. CDPH believes these systems are essential to increase and retain participation of WIC families and requires positions and resources to support and modernize these systems, modernize communication strategies with WIC families, enhance data analysis, and expand program integrity efforts.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 22: CALIFORNIA HOME VISITING EXPANSION BCP

PROPOSAL

CDPH requests 19.7 positions and General Fund expenditure authority of $37.5 million annually to expand the California Home Visiting Program (CHVP), an evidence-based program that offers home visiting to pregnant and newly parenting families focused on building family resilience by promoting positive parenting and child development, increasing positive childhood experiences, and improving health and social outcomes.

BACKGROUND

The federal Patient Protection and Affordable Care Act of 2010 established the Maternal, Infant and Early Childhood Home Visiting Program (MIECHV), which supports evidence-based home visiting in states, territories, and tribal entities. In California, CDPH received MIECHV funding to establish the California Home Visiting Program (CHVP). In the 2021-22 federal fiscal year, the Health Resources and Services Administration awarded CDPH $19 million to support CHVP.

CHVP is an evidence-based, voluntary program offered to pregnant and newly parenting families, particularly those who face the greatest health and social inequities and are at risk for Adverse Childhood Experiences (ACEs), including child maltreatment, domestic violence, substance use disorder, and mental health-related issues. Home visiting provides parents health, social, and educational tools, and resources to raise their children independently and more confidently.

Evidence-Based Models for Service Delivery
As of 2018, CHVP home visiting services were provided to eligible families by 22 local health jurisdictions (LHJ). Each uses one of the following evidence-based models, based on the specific needs of the local area:

Healthy Families America (HFA)

- Serves low-income families who must be enrolled within the first three months after an infant's birth.
- A trained paraprofessional provides one-on-one home visits to parents and their babies primarily up to age three.
- Uses a strength-based approach.
- Uses motivational interviewing to build on the parents' own interests.

HFA Counties (8): Tehama, Butte, Nevada, Yolo, Merced, Madera, Imperial, Los Angeles*

Nurse Family Partnership (NFP)

- Serves low-income, first-time mothers who must be enrolled by the 28th week of pregnancy.
- A public health nurse provides one-on-one home visits to parents and their babies up to age two.
- Uses a strength-based approach.
- Uses motivational interviewing to build on the parents' own interests.

NFP Counties (15): Humboldt, Shasta, Sonoma, Solano, Sacramento, San Francisco, Contra Costa, Alameda, San Mateo, Stanislaus, Fresno, Kern, Riverside, San Diego, Los Angeles*

*Los Angeles offers services under both the HFA and NFP models.

2019 Budget Act Augmentation for CHVP

The 2019 Budget Act included General Fund expenditure authority of $23 million annually to support evidence-based home visiting services. According to CDPH, this funding allowed CHVP to expand participation to 29 counties and expand evidence-based home visiting models and expand to include an additional evidence-based option for home-visiting: Parents as Teachers (PAT). In addition, $5 million was set aside for innovative local practices in home visiting, supporting 10 innovative projects across 12 local health jurisdictions.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 23: BLACK INFANT HEALTH PROGRAM BCP

PROPOSAL

CDPH requests 7.3 positions and General Fund expenditure authority of $12.5 million annually to further expand the Black Infant Health (BIH) program, which provides group-based interventions for Black birthing parents to reduce maternal and infant disparities. According to CDPH, this funding would increase the number of BIH sites and participants and add strategies that support participant access and engagement. In particular, this funding would:

- Add counties where pockets of need exist;
- Engage more community-based organizations in counties which have close ties and established trust brokers within the Black community;
- Deepen the reach in counties that are currently funded to provide services to as many Black birthing people as possible; and
- Offer a virtual component of BIH to further reach and improve retention. A virtual component was implemented as an accommodation during the COVID-19 pandemic and may help decrease stress and isolation among participants when they are unable to attend in-person.

BACKGROUND

The BIH provides empowerment-focused group support services and case management to improve the health and social conditions for Black women and their families. Created in 1989 to address a disproportionately high infant mortality rate for Black infants, the program seeks to address the complex factors related to infant mortality and preterm births for the population at greatest risk. Black Infant Health providers offer participants health education, social support, individualized case management, home visitation and referrals to other services.

While the social support, stress management, and empowerment model of the Black Infant Health Program is an evidence-based intervention that reduces black infant mortality, the rate of black infant mortality has remained twice that of any other group. Other interventions that have shown promise generally include a team-based approach to care that couples social interventions with medical interventions. The Centering Pregnancy model is a group-based intervention that follows the recommended schedule of 10 prenatal visits, with each visit 90 minutes to two hours long. According to Centering Healthcare, which developed the model, pregnant women engage in their own care by taking their own weight and blood pressure and recording their own health data with private time with their provider for belly check. CDPH indicates that the group-based intervention in the BIH is partially derived from the Centering Pregnancy model.

Since its inception, the BIH has been funded by a combination of state General Fund and federal Title V Maternal and Child Health Service Block Grant funding. The Title V block grant, administered by the Health Resources and Services Administration, provides states with funds for programs to improve the health of mothers and children based on a statewide needs assessment.

In response to a significant General Fund deficit resulting from the 2007 recession, the 2009 Budget Act eliminated the $3.9 million General Fund appropriation for the program. Local programs still received funds allocated from the federal Title V block grant, but overall funding for these programs was reduced significantly. The 2014 Budget Act authorized the addition of $4 million of ongoing General Fund for the program, restoring the recession-era reductions.

California Perinatal Equity Initiative

The 2018 Budget Act included trailer bill language and General Fund expenditure authority of $8 million annually to expand the BIH to further the goal of reducing the disparities in infant mortality within the black community. The expanded program, the California Perinatal Equity Initiative, supports local programs that combine social interventions with medical interventions and other wrap-around services including, but not limited to, evaluation, personalized case management, educational programs, and wraparound care provided by home visitors and various medical personnel. According to CDPH, planning grants were awarded to the 13 county health departments currently operating BIH programs for the purpose of improving Black infant birth outcomes and reducing infant mortality. The planning grants contained the following key requirements of county health departments:

1. Conduct an environmental scan to identify gaps in perinatal health care and community services
2. Attend state-hosted community engagement meetings
3. Establish local Perinatal Health Equity Community Advisory Boards
4. Engage hospital partners to conduct black preterm birth chart reviews and focus groups with moms who delivered preterm to gain a deeper understanding of perinatal health care before, during and after delivery
5. Develop and implement a public health awareness campaign to bring focus to maternal and infant health disparities

2019 Budget Act Augmentation for BIH

The 2019 Budget Act included two positions and General Fund expenditure authority of $7.5 million annually to support expansion of the Black Infant Health Model, including adding strategies to support participant access and engagement and further expansion of sites and participants. According to CDPH, the additional support for the program included:

- Completing an implementation evaluation to examine the contextual challenges to implementing the program in local health jurisdictions using existing reports and conducting key informant interviews; assess impact of quality improvement efforts.
- Improving data collection measures to capture key outcomes such as stress or baseline depression.
- Implementing technical upgrades to the BIH data system in order to analyze:
  - Additional data not previously reported (e.g., depression, food insecurity, experiences of racism)
  - Participant satisfaction data
  - Outcomes as a function of group size and dosage of intervention o Associations between participation and birth outcomes
  - Comparison of outcome with other strategies such as home visiting, preconception counseling, and fatherhood engagement
- Convening a state advisory group with representation of experts in health disparities and shared learning with other efforts, and with specific inclusion through authentic community engagement so that no decisions about black family health are done without inclusion of black families and community leaders.
- Assessing alternative direct service models such as those outlined in the California Perinatal Equity Initiative.

In September 2021, CDPH released its evaluation of the BIH program outcomes between 2015 and 2018. CDPH measured the change in intermediate health outcomes focusing on 18 indicators. The evaluation reported 13 out of the 18 indicators showed significant positive change. The largest improvements were identified for six indicators:

- 60 percent decrease in participants reporting no practical and emotional support
- 51 percent decrease in smoking within the last month
- 45 percent decrease in food insecurity
- 38 percent increase in the use of yoga, deep breathing, or medication to manage stress
- 35 percent decrease in depressive symptoms
- 33 percent increase in intention to put baby to sleep on their back

Five indicators did not show change, including drinking soda fewer than three times in the last week, did not eat fast food, ate vegetables more than once a day, ate fruits more than once a day, or showed a negative change, including taking vitamins every day.

According to CDPH, an exploratory comparative analysis also identified multiple contextual conditions associated with BIH sites' ability to implement the program with greater fidelity, including: higher levels of supplemental funding, institutional leadership that values the importance of BIH to address disparities, short vacancies among key staff, culturally competent staff, consistent motivators for participants, ability to schedule group sessions outside of business hours, the use of social media to engage with participants,

presence of a Community Advisory Board, staff that believe in the program, and staff confidence in their work.

CDPH plans to utilize these resources to improve the BIH program through the following strategies:

- Support model fidelity through continuous quality improvement monitoring at new sites;
- Convene quarterly statewide stakeholder Birth Equity Council meetings in addition to local Community Advisory Boards; and
- Provide a rigorous evaluation of the multi-component BIH program that includes evaluating alternative direct service models such as those outlined in the Perinatal Equity Initiative to better assess and possibly recommend a menu of viable options for local implementation efforts to reduce perinatal disparities.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 24: BOOKS FOR LOW-INCOME CHILDREN BCP

PROPOSAL

CDPH requests General Fund expenditure authority of $10 million in 2022-23 to support Books for Low-Income Children, an early childhood literacy program for participants in the WIC program. CDPH plans to use these resources to overcome some of the barriers that prevent participation by some WIC agencies and would seek matching funds to increase the number of books provided to families from three books per child to between four and six books per child.

In addition, CDPH indicates it would need to continue to temporarily redirect two Health Program Specialist I positions, originally redirected to administer the 2021 Budget Act program funding, to prepare the request for application process for grant funding, manage the competitive award process, and provide technical assistance and oversight for the grant program.

BACKGROUND

Several pilot projects over the last thirty years have demonstrated the effectiveness of coupling WIC sites or pediatric offices with efforts to enhance the development of literacy and school readiness in young children. In pediatric settings, the Reach Out and Read model developed by Boston City Hospital promotes reading aloud as an integral part of routine preventive care, provides a picture book at each provider visit between age 6 months and 6 years, and provides waiting room volunteers to read aloud with children. These pilot projects have demonstrated clinically meaningful increases in preschool vocabulary, parent-reported literacy promoting attitudes and practices, identification of books as a favorite activity, reading aloud thought of as leading to school success, use of books at bedtime, and reading aloud three or more days per week. Parent involvement with early literacy, such as those encouraged by the Reach Out and Read model, has demonstrated significant positive impacts on future reading outcomes.

In February 2020, First 5 California conducted an online survey among 58 county First 5 Commissions to inventory literacy interventions, including key details and program designs. All First 5 Commissions support one or more literacy programs, including many that provide books to children either as the primary goal or bundled along with another effort. These efforts include the Little by Little program in Los Angeles, which provides books to children at WIC offices; the Dolly Parton Imagination Library, which provides free, high-quality books by mail to children at any income level between birth and the beginning of school; and the Kit for New Parents, which provides parenting resources for parents of newborns, and includes a free picture book.

In particular, the Little by Little program in Los Angeles has demonstrated success in improving literacy through its efforts at local WIC agencies. Little by Little was funded by First 5 Los Angeles in 2003 at six WIC centers and includes three components: 1) a brief individual counseling session regarding child development for WIC staff members, 2) a brief handout with information about developmental milestones and appropriate ways to interact with a child to encourage optimal development, and 3) gift of a children's book or developmentally appropriate toy (e.g. black, white, and red chart for newborns or building blocks for 2.5 year old children). The intervention begins in the mother's third trimester of pregnancy and continues until the child's fifth birthday, or the end of WIC eligibility. According to a controlled study published in the journal Pediatrics, the Little by Little intervention demonstrated statistically significant improvements in school readiness, particularly among Spanish-speaking WIC participants.

2021 Budget Act Included Resources to Provide Books at WIC Sites

The 2021 Budget Act included General Fund expenditure authority of $5 million in 2021-22 to support the Books for Low-Income Children program, which supports local WIC agencies to provide books to nearly 500,000 young children between zero to five years of age receiving WIC benefits. However, CDPH reports that 23 of the 84 local WIC agencies and nearly 25 percent of children ages zero to five are not participating in the program. CDPH contacted the non-participating agencies to identify the barriers that prevented them from participating. The department found many were still making operational adjustments due to the COVID19 pandemic, the agencies did not have enough staff, and many children receiving WIC benefits were not coming into the WIC agency in person to be able to receive the books.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 25: MATERNAL CARE SERVICES (SB 65) BCP

PROPOSAL

CDPH requests 16 positions and General Fund expenditure authority of $5.5 million annually to establish the California Pregnancy-Associated Review Committee to conduct a review of pregnancy-related deaths, analyze common causes of severe maternal morbidity, and make recommendations to prevent maternal mortality and morbidity, pursuant to SB 65 (Skinner, Chapter 449, Statutes of 2021).

BACKGROUND

SB 65, the "California Momnibus Act," requires CDPH to establish the California Pregnancy-Associated Review Committee to continuously engage in the comprehensive, regular, and uniform review and reporting of maternal deaths in California. The committee is required to do the following:

- Identify and review all pregnancy-related deaths, including the cause, contributing factors, and disseminating findings.
- Analyze common indicators of severe maternal morbidity to identify prevention opportunities and reduce near-miss experiences.
- Make recommendations on best practices to prevent maternal mortality and morbidity, such as addressing socioeconomic or environmental impacts.
- Examine racial disparities and make recommendations on the prevention of racial disparities.
- Track and examine disparities experienced by lesbian, bisexual, transgender, intersex, and gender-nonconforming individuals and report findings.
- Collect and review data from maternal death investigations and make recommendations about how to improve or streamline data collection and investigatory processes.

The committee is required to gather this information through the review of medical records, death certificates, other pertinent reports or documents and, for populations experiencing disparities, voluntary interviews with surviving family members or members of the medical teams involved in the deceased individual's care. The committee will publish its findings every three years as part of its report on severe maternal morbidity required pursuant to SB 464 (Mitchell, Chapter 533, Statutes of 2019), including recommendations on how to prevent severe maternal morbidity and mortality, and how to reduce racial disparities.

SB 65 requires in-depth reviews of all maternal deaths and systematic deliberation regarding the cause of over 7,000 cases of maternal morbidity. According to CDPH, its responsibilities under SB 65 will significantly expand in the following areas:

In-Depth Reviews of Maternal Mortality. CDPH expects a three-fold increase in the number of cases included in its current in-depth mortality review.

- *Family Member and Provider Interviews*. SB 65 requires the in-depth review of maternal mortality to include voluntary interviews with surviving family members and providers. CDPH expects to conduct up to 250 interviews annually, 150 with family members and 100 with providers.
- *Committee Meetings*. CDPH indicates it will need to prepare for and support two day-long meetings of the California Pregnancy-Associated Review Committee to discuss severe maternal morbidity data findings.
- *Data Processing and Analysis*. CDPH indicates the increase in data flow on maternal mortality and morbidity will require resources to process this new information so that it may be useful for the committee and stakeholders as they engage to improve health outcomes of birthing people and their infants.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

PANEL 8 – CENTER FOR HEALTH STATISTICS AND INFORMATICS

ISSUE 26: END OF LIFE (AB 380) BCP

PANEL 8 – PRESENTERS

- **Dana Moore**, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health

PANEL 8 – Q&A ONLY

- **Michelle Miles**, Interim Branch Chief, Center for Health Statistics and Informatics, Vital Statistics Branch, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

PROPOSAL

CDPH requests one position and General Fund expenditure authority of $151,000 in 2022-23 and $147,000 annually thereafter to manage an increase in processing of End of Life Act documents due to the reduced waiting period between initial and final requests implemented by SB 380 (Eggman, Chapter 542, Statutes of 2021). Specifically, CDPH requests one Associate Governmental Program Analyst to provide general assistance to providers on submission of End of Life Act forms, monitor participation in the End of Life Act, collect and analyze forms from providers, perform database entry, maintain confidential documents and database, and update and maintain the End of Life Act website.

In addition, DPH requests expenditure authority of $4,000 in 2022-23 for its Information Technology Services Division to remove the final attestation form from its web-based portal and update the interpreter form with gender neutral language.

BACKGROUND

ABX2 15 (Eggman, Chapter 1, Statutes of 2015, Second Extraordinary Session), established the End of Life Option Act, which authorizes an individual with the capacity to make medical decisions and with a terminal disease to request aid-in-dying drugs if the following conditions are satisfied:

- A physician has diagnosed the individual with a terminal disease.
- The individual has voluntarily expressed a wish to receive aid-in-dying drugs.

- The individual is a resident of California.
- The individual has the physical and mental ability to self-administer the aid-in-dying drugs.
- The individual documents his or her request by submitting two oral requests, a minimum of 15 days apart, and a written request to his or her physician.

ABX2 15 also requires the individual's physician to submit to CDPH the documentation of the End of Life Act process, including the individual's written request for aid-in-dying drugs, and associated physician checklists, follow-up, and other compliance documents. CDPH is also required to annually report certain information on how many individuals receive aid-in-dying drugs, how many died and the cause of death, the number of physicians providing aid-in-dying prescriptions, and various demographic information. In addition, CDPH is required to make available the physician compliance and follow-up documents on its website.

SB 380 Shortens Time Between Oral Requests for Aid-in-Dying Drugs
SB 380 amends the End of Life Option Act by allowing an individual to qualify for aid-in-dying drugs by reiterating the oral request after 48 hours, rather than 15 days. SB 380 also eliminates the final attestation form required to be filled out by the individual within 48 hours of self-administering the aid-in-dying medication, as well as including gender neutral language in the interpreter form submitted to CDPH. According to CDPH, the shortened time period after the initial request is likely to result in an increase in End of Life Act reporting forms received by the department.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 27: INDUSTRIAL HEMP PRODUCTS (AB 45) BCP

PROPOSAL

CDPH requests 18 positions and General Fund expenditure authority of $4 million in 2022-23, 7 additional positions and expenditure authority from the Industrial Hemp Enrollment and Oversight Fund of $5.2 million annually thereafter to allow CDPH to implement the regulation of industrial hemp products mandated by AB 45 (Aguiar-Curry, Chapter 576, Statutes of 2021). SB 115 (Skinner, Chapter 2, Statutes of 2022), recently approved by the Legislature, included 11 positions and General Fund expenditure authority of $1.6 million in 2021-22 to begin implementation of AB 45.

In addition to these positions, CDPH requests expenditure authority of $30,000 in 2021-22, $118,000 in 2022-23, and $222,000 annually thereafter for safety equipment for peace officers, Peace Officer Standards Training (POST) courses, and vehicle leases.

BACKGROUND

According to CDPH, over the last several years, cannabinoids derived from industrial hemp production, such as cannabidiol (CBD), have become popular additives to foods, beverages, and cosmetics. CBD, which is not psychoactive and does not produce a “high” in the consumer, is nonetheless considered by the federal Food and Drug Administration (FDA) to be an unapproved additive, not Generally Recognized as Safe (GRAS), and is the active pharmaceutical ingredient in an FDA-approved pharmaceutical product for the treatment of certain epileptic seizures, known as Epidiolex.

In 2018, federal legislation removed industrial hemp from the Schedule I Controlled Substances list and allowed it to be legally cultivated and transferred across state lines. However, there was no change to federal food and drug laws, and CBD is still not permitted to be used in food, drugs, or cosmetics. Despite the continued federal prohibition, several states, including California, have enacted their own laws to allow the sale of industrial hemp products.

AB 45 authorizes CDPH to establish a program regulating the use of industrial hemp and its cannabinoids, extracts, or derivatives in foods, beverages, cosmetics, and pet food products. AB 45 also prohibits the manufacture of industrial hemp inhalable products, except for the sole purpose of sale in other states. Industrial hemp products may be distributed or sold in the state if an independent testing laboratory certifies the concentration of the psychoactive component of cannabis, tetrahydrocannabinol (THC), does not exceed 0.3 percent, the product was tested for the hemp derivatives identified in the product label or associated advertising, and the product was produced in compliance with applicable state and federal laws. AB 45 requires CDPH to do the following:

- *Licensing and Registration*. CDPH must register and license industrial hemp processors, distributors, and inhalable manufacturers.
- *Inspections and Investigations*. CDPH must license and inspect industrial hemp manufacturers and processors to determine compliance with state and federal laws and regulations, including investigating consumer complaints and enforcement activities in coordination with the Department of Cannabis Control, the California Department of Food and Agriculture, and local law enforcement agencies.
- *Legal and Regulations*. CDPH is required to develop and promulgate regulations establishing the industrial hemp regulatory framework, including:

    - Setting initial regulations incorporating the requirements of AB 45
    - Additional regulations CDPH deems necessary for enforcement of AB 45
    - Imposing age requirements on purchase of industrial hemp products
    - Establishing record-keeping standards that will apply to transporters, manufacturers, and retailers
    - Addressing maximum serving size and number of servings per container for industrial hemp products
    - Establishing and revising the Industrial Hemp Enrollment and Oversight fees

- *Testing*. Under an interagency agreement with the Department of Cannabis Control, CDPH will be required to test industrial hemp products, ingredients, and hemp extracts to ensure manufacturer compliance and to conduct enforcement actions.
- *Coordination*. CDPH, in consultation with the Department of Cannabis Control and the California Department of Food and Agriculture, is required to, if necessary, develop a process to share license, registration, cultivar, and enforcement information to facilitate educating the regulated community, compliance, and taking action against unlicensed industrial hemp manufacturers or the sale of illegal industrial hemp.

CDPH reports that the uncertainty of the overall size and scope of the industrial hemp products market requires a phased-in approach to implement the statute over three fiscal years. In addition, AB 45 establishes the Industrial Hemp Enrollment and Oversight Fund, and allows CDPH to collect fees to support the new industrial hemp regulatory work. The first two fiscal years of regulatory work on industrial hemp would be supported by General Fund resources, while the Industrial Hemp Enrollment and Oversight Fund would support the ongoing regulatory work with fee revenue in the third year and annually thereafter.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 28: CANNERY INSPECTION PROGRAM ACTIVITIES BCP

PROPOSAL

CDPH requests expenditure authority from the Cannery Inspection Fund of $900,000 annually to allow CDPH to manage its cannery inspection workload. CDPH reports the Food Safety Fund has been absorbing some of the costs that should have been attributed to the Cannery Inspection Fund, and as a result its reserve is steadily declining. This request would attribute the appropriate workload to the appropriate special fund.

BACKGROUND

The CDPH Food and Drug Branch Cannery Inspection Program was implemented in the early 1920s in response to foodborne illness outbreaks, such as botulism, related to improperly commercially manufactured canned foods. The Cannery Inspection Act authorized the regulation of manufacturing of shelf-stable, low-acid canned foods. As a result, botulism from commercially manufactured foods has become extremely rare.

According to CDPH, prior to November 2019, all personnel in the department's food safety programs were supported by the Food Safety Fund, which was associated with most of their activities. However, after implementing a time accounting process for reporting time worked by personnel for each individual program, CDPH discovered that the workload in the Cannery Inspection Program attributable to the Cannery Inspection Fund was higher than anticipated. As a result, the existing appropriation from the fund is insufficient to support its activities. The Cannery Inspection Fund is supported by annual license and inspection fees paid by regulated canneries.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 29: FLUOROSCOPY: TEMPORARY PERMIT (AB 356) BCP

PROPOSAL

CDPH requests one position and expenditure authority from the Radiation Control Fund of $114,000 annually to issue temporary permits to operate or supervise the operation of fluoroscopic X-ray equipment, pursuant to the requirements of AB 356 (Chen, Chapter 459, Statutes of 2021). Specifically, CDPH requests one Program Technician II position to assist in implementing the temporary permit process, including developing procedures, tracking sheets, templates, nomenclature, training plans, application documents, deficiency letters, and information notices; review and process applications; issue temporary permits; and submit monthly reports.

BACKGROUND

The Radiologic Technology Act requires CDPH to certify and permit individuals as certified supervisors or operators, radiologic technologists, and limited-permit X-ray technicians. Certified individuals may provide X-ray services to the public in hospitals, clinics, physician offices, and in mobile settings. As part of its responsibilities under the Act, CDPH also issues renewable permits to licensed physicians to use and supervise the use of fluoroscopic X-ray equipment. Fluoroscopy uses X-rays to obtain real-time moving images of the interior of an object, such as contraction of heart muscles. Applicants must pass a fluoroscopy examination, which focuses on the broad knowledge, skills, and ability of a person to safely use fluoroscopic X-ray equipment.

AB 356 authorized CDPH to issue a temporary permit authorizing use of fluoroscopic X-ray equipment to licensed physicians while completing the fluoroscopy examination process. To obtain the permit, the applicant must meet all of the following requirements:

- Holds an unrestricted physician and surgeon's or podiatric physician and surgeon's license
- Has applied to CDPH for a renewable fluoroscopy permit
- Attests to having at least 40 hours of experience using fluoroscopic X-ray equipment while not subject to the Radiologic Technology Act
- Submits a $58 application fee

AB 356 was implemented to allow newly licensed physicians from outside California who have experience with fluoroscopy to continue to provide these services while undergoing California's fluoroscopy examination process.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 30: PRIORITY INLAND WATER-CONTACT RECREATION SITES: WATER QUALITY MONITORING (AB 1066) BCP

PROPOSAL

CDPH requests General Fund expenditure authority of $195,000 in 2022-23 to co-chair a working group from the California Water Quality Monitoring Council to study water hazards at priority water-contact recreation sites, pursuant to the requirements of AB 1066 (Bloom, Chapter 711, Statutes of 2021). Specifically, CDPH requests resources equivalent to one Senior Environmental Scientist Specialist position who would represent CDPH as co-chair of the working group, and assist in writing and submitting the required report to the council on data and recommendations for priority water-contact recreation sites.

BACKGROUND

AB 411 (Wayne, Chapter 415, Statutes of 1995), required CDPH to establish minimum standards for sanitation and bacteria at public coastal beaches. The standards included testing requirements for microbiological contamination in the waters adjacent to public coastal beaches, including for coliform, fecal coliform, and enterococci bacteria. In addition, AB 411 required CDPH to establish procedures for closing and posting warnings to the public due to contamination that may cause illness at a public coastal beach. In addition to its regulation of public coastal beaches, California has also implemented standards to prevent disease or hazardous conditions associated with public swimming pools, spas, waterparks, and interactive water features. However, California does not have a testing and water quality monitoring and posting system for inland, bodies of freshwater that are used for body-contact recreation, including swimming.

SB 1070 (Kehoe, Chapter 750, Statutes of 2006), provided for the establishment of the California Water Quality Monitoring Council. The council, a collaboration between the California Environmental Protection Agency (CalEPA) and the California Natural Resources Agency, requires the boards, departments, and offices within those agencies to integrate and coordinate water quality and related ecosystem monitoring, assessment, and reporting. The council's membership includes representatives from the two agencies, who serve as co-chairs of the council, the California Drinking Water Program, CDPH, publicly owned treatment works, storm water management agencies, the California Department of Food and Agriculture, community monitoring groups, members of the public, academic and non-academic scientists, water suppliers, and the United States Environmental Protection Agency.

AB 1066 (Bloom, Chapter 711, Statutes of 2021), requires the California Water Quality Monitoring Council to establish a working group, co-chaired by the State Water Resources Control Board and CDPH, to study water recreation hazards at priority water-contact recreation sites, including any inland water that may be used for recreation that

involves body contact with the water. By July 1, 2023, the working group is required to submit a report to the council that includes:

- A summary of existing, readily available data that identifies water-contact recreation sites.
- A summary of existing, readily available data for specific water-contact recreation sites that indicates the timing and types of uses that involve body contact with the water and any demographic information about the users.
- Potential criteria for identifying priority water-contact recreation sites, with an emphasis on establishing equity-based criteria, such as the use of the site by one or more overburdened communities. An overburdened community includes a minority, low-income, tribal, or indigenous population, or geographic location that potentially experiences disproportionate environmental harms or risks.
- A discussion of potential water quality hazards at priority water-contact recreation sites.
- General recommendations for reducing water quality risks at priority water-contact recreation sites, including:
  - A risk-based water quality monitoring program
  - A public water quality safety education campaign
  - Posting and notification of water quality hazards at identified water bodies
  - Standards or criteria needed to better protect the public from water quality hazards.

AB 1066 requires the council, by December 31, 2023, to propose to the State Water Resources Control Board definitions and requirements for a priority water-contact recreation site monitoring program.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 31: COMMERCIAL FISHING: INSPECTION: CRAB TRAPS (SB 80) BCP

PROPOSAL

CDPH requests three positions and General Fund expenditure authority of $710,000 annually to review and approve crab evisceration food safety plans for commercial processors, establish labeling requirements for eviscerated crab, and issue evisceration orders to be followed by crab processors during elevated domoic acid events, pursuant to the requirements of SB 80 (McGuire, Chapter 757, Statutes of 2021).

BACKGROUND

Domoic acid is a neurotoxic amino acid that can accumulate in the visceral tissues of shellfish and other marine organisms that feed on certain phytoplankton. When concentrations of these phytoplankton are high in the surrounding waters, such as during algal blooms, concentrations of domoic acid in the tissues of shellfish, such as crabs, can reach levels that can be toxic to humans and other animals that consume them. Domoic acid simulates the action of the neurotransmitter glutamate, binding to glutamate receptors in the brain and damaging the hippocampus and amygdaloid nucleus. Domoic acid toxicity at low levels can lead to severe gastrointestinal symptoms, such as vomiting, abdominal cramps, diarrhea, and severe headache. Higher levels can lead to memory loss, known as amnesiac shellfish poisoning, seizures, and even death. An invasion of chaotic seabirds in Capitola and Santa Cruz in 1961, thought to be under the influence of domoic acid, was the inspiration for the Alfred Hitchcock film, *The Birds*.

CDPH and California Department of Fish and Wildlife Monitor Domoic Acid in Crab. The annual Dungeness crab fishing season begins in November and ends in July. CDPH and the California Department of Fish and Wildlife (CDFW) collaborate to collect samples of Dungeness crab, rock crab, and other marine organisms to be tested for domoic acid. CDPH's Richmond Laboratory tests the samples and, if the domoic acid level in the viscera or meat exceeds safe regulatory limits, CDPH consults with CDFW and the Office of Environmental Health Hazard Assessment (OEHHA) to determine whether the crab fishing season should open, be delayed, or closed entirely, and to issue health advisories and close fishing areas during an elevated domoic acid event. During the 2015-16 season, high domoic acid levels caused prolonged closure of Dungeness crab fishing areas, resulting reported economic losses of more than $48 million. According to CDPH, modeling and analysis from CDFW suggest that warmer waters, increased algal blooms, and higher hazardous biotoxin levels in shellfish will likely lead to continued increases in elevated domoic acid events.

SB 80 authorizes CDFW to open waters to Dungeness crab or rock crab fishing if CDPH issues an order requiring the evisceration of the crab prior to manufacture, sale, delivery, or offering for sale. Evisceration is a process that removes and discards the entire

intestinal tract, hepatopancreas, and all associated abdominal organs of the crab, which is often the location of accumulated domoic acid. CDPH can issue an evisceration order if the department determines crab viscera exceed the allowable levels of domoic acid, but the corresponding crab meat does not. Evisceration must be conducted by a licensed processor that has an approved Hazard Analysis Critical Control Point (HACCP) food safety plan, maintains written recall procedures, and adheres to certain labeling requirements. CDPH may impose a $350 fee on processors to support the cost of reviewing the HACCP. SB 80 also requires CDPH to consult with the Dungeness Crab Task Force to establish the criteria for the manufacture, sale, delivery, holding, or offering for sale of crab subject to an evisceration order.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 32: PROPOSITION 56 TOBACCO LAW ENFORCEMENT ACCOUNT

BUDGET ADJUSTMENT

The Governor's Budget reflects an increase of $3.2 million in Tobacco Law Enforcement Account State Operations and a decrease $2.6 million in Tobacco Law Enforcement Account Local Assistance as a result of updated Proposition 56 revenue projections, resulting in net increased expenditures of $556,000 (Proposition 56). The funds are used to support enforcement of state and local laws related to the illegal sales of tobacco to minors.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this Proposition 56 adjustment and respond to the following:

- What is the explanation for shifting funding from local assistance to state operations?
- What impact will this have on the Tobacco Law Enforcement Program?
- Does this adjustment reflect increasing Proposition 56 resources in this program? If so, please explain.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

PANEL 9 – CENTER FOR HEALTH CARE QUALITY PROPOSALS

This panel covers the Center for Health Care Quality Estimate (issue 33) and two budget change proposals: 1) Health Facilities Oversight (issue 34); and 2) Los Angeles County Contract Extension (issue 35).

PANEL 9 – PRESENTERS

- **Cassie Dunham**, Deputy Director, Center for Health Care Quality, California Department of Public Health

PANEL – Q&A ONLY

- **Scott Vivona**, Assistant Deputy Director, Center for Health Care Quality, California Department of Public Health
- **Sonal Patel**, Principal Program Budget Analyst, Department of Finance
- **Nick Mills**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Principal Fiscal and Policy Analyst, Legislative Analyst's Office
- **Mark Newton**, Deputy Legislative Analyst, Legislative Analyst's Office

ISSUE 33: CENTER FOR HEALTH CARE QUALITY ESTIMATE

ESTIMATE

The Governor's Budget includes expenditure authority for the Center for Health Care Quality of $398.8 million ($4.6 million General Fund, $104.1 million federal funds, and $290.1 million special funds and reimbursements) in 2021-22, an increase of $9.6 million or 2.5 percent compared to the 2021 Budget Act, and $432.9 million ($5 million General Fund, $107.2 million federal funds, and $320.7 million special funds and reimbursements) in 2022-23, an increase of $43.7 million or 11 percent compared to the revised 2021-22 budget. According to CDPH, the increase in 2020-21 is attributed to various baseline adjustments, while the increase in 2022-23 is attributed primarily to the $18.4 million one-year extension of the health facility certification contract with Los Angeles County and various other baseline adjustments.

CHCQ Funding Summary, November 2020 Estimate		
Fund Source	**2021-22**	**2022-23**
0001 – General Fund	$4,592,000	$4,990,000
0890 – Federal Trust Fund	$104,099,000	$107,165,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	$3,669,000	$3,671,000
State Health Facilities Citation Penalty Account	$2,144,000	$2,144,000
Federal Health Facilities Citation Penalty Account	$7,402,000	$7,134,000
0995 – Reimbursements	$13,396,000	$13,416,000
3098 – Licensing and Certification Program Fund	$263,469,000	$294,345,000
Total CHCQ Funding	**$398,771,000**	**$432,865,000**
Total CHCQ Positions	**1436.3**	**1493.9**

BACKGROUND

CDPH's Center for Health Care Quality, Licensing and Certification Program (L&C) is responsible for administering the licensure, regulation, inspection, and certification of health care facilities and certain health care professionals in California. The program is organized into 14 district offices and Los Angeles County, which operates under a contract with the L&C program. L&C staff conduct periodic inspections and investigation of complaints and entity-reported incidents to ensure health care facilities comply with state and federal laws and regulations. L&C also contracts with the federal Centers for Medicare and Medicaid Services (CMS), which provides federal funding to ensure that facilities accepting Medicare and Medi-Cal payments comply with federal laws and regulatory requirements. In addition to facility oversight, L&C oversees the certification of certified nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present the Center for Health Care Quality Estimate and respond to the following:

- Please provide an update on the most current timeliness metrics for investigation of complaints and entity-reported incidents.

- What impact has the pandemic had on the Licensing and Certification program, and how is CDPH addressing those impacts?

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 34: HEALTH FACILITIES OVERSIGHT BCP

PROPOSAL

CDPH requests two positions and expenditure authority from the Licensing and Certification Fund of $4 million in 2022-23 and $284,000 annually thereafter. If approved, these positions and resources would allow CDPH to increase infection prevention and to provide quality assurance in Nursing Home Administrator training. Specifically, CDPH requests the following positions and resources:

Healthcare Associated Infections (HAI) Program – Contract resources ($3.7 million)
CDPH requests expenditure authority from the Licensing and Certification Fund of $3.7 million in 2022-23 to provide a sustainable and permanent HAI prevention and response capability. CDPH indicates the expansion would allow the program to redistribute workload and expand infection prevention resources throughout the state, provide education on HAI prevention and serve additional facility types, particularly skilled nursing facilities.

Nursing Home Administrator Program – Two positions
Two Associate Governmental Program Analysts would perform quality assurance functions including monitoring AIT evaluations, issuing deficiency and follow-up letters, and conducting AIT and preceptor interviews.

BACKGROUND

Healthcare Associated Infections Program
SB 739 (Speier, Chapter 526, Statutes of 2006) required CDPH and general acute care hospitals to implement various measures related to disease surveillance and the prevention of health care associated infections. The CDPH Center for Health Care Quality administers the Healthcare Associated Infection (HAI) Program, which was established in 2009 to improve the quality of care and patient safety through the prevention of infections in health care facilities. The program collects quarterly reports of HAIs from health facilities, including methicillin-resistant Staphylococcus aureus (MRSA), clostridium difficile, and Vancomycin-resistant enterococcal bloodstream infection, as well as the number of inpatient days and the incidence of central line or various surgical site infections. The program contracts with infection preventionist staff at the University of California (UC) Davis to support prevention and response to unusual infectious disease occurrences and outbreaks in health care facilities.

According to CDPH, prior to the COVID-19 pandemic, the HAI Program exclusively monitored general acute care hospitals for infection rates. Since the pandemic, HAI has expanded to conducting site assessments of infection prevention protocols at hospitals, skilled nursing facilities, and other facility types not regulated by CDPH. The current UC Davis contract consists of ten infection preventionists, which CDPH indicates is

insufficient to support the increased infection prevention and control workload since the start of the pandemic.

Nursing Home Administrator Program

CDPH administers the nursing home administrator program, which licenses individuals charged with ensuring the safety and well-being of populations that live within skilled nursing facilities. Nursing home administrators (NHAs) qualify for the licensing exam after completing an Administrator-in-Training (AIT) program, which is administered by a preceptor approved by the program. Each approved AIT program is individualized for each applicant and is directly supervised by the approved preceptor. According to CDPH, the program's existing staffing levels are not sufficient to manage the program's workload.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 35: LOS ANGELES COUNTY CONTRACT EXTENSION BCP

PROPOSAL

CDPH requests expenditure authority from the Licensing and Certification Fund of $18.4 million annually to extend and augment the department's health care facility certification contract with the Los Angeles County Department of Public Health to account for updated indirect cost and employee benefit rates, personnel costs, and lease costs.

CDPH currently has expenditure authority from the Licensing and Certification Fund of $91.4 million in 2021-22 for the LA County contract. The extended contract in 2022-23 would result in expenditures of $124 million, including $18 million in federal resources and $106 million in Licensing and Certification Fund resources. CDPH indicates the request for $18.4 million in additional resources is necessary to fund salary and benefit increases for the LA County staff approved since the original contract was negotiated.

BACKGROUND

For over 30 years, CDPH has contracted with Los Angeles (LA) County to perform federal certification and state licensing surveys and to investigate complaints and entity-reported incidents for approximately 4,300 health care facilities in the LA County area. Approximately one third of licensed and certified health care facilities in California are located in LA County, and 25 percent of the long-term care complaints and entity-reported incidents received statewide each year are generated in LA County.

In July 2015, CDPH and LA County renewed the contract for a three-year term, ending June 30, 2018, for an annual budget of $41.8 million to fund 224 positions. The 2016 Budget Act authorized an additional $2.1 million in expenditure authority to fully fund LA County to conduct tier 1 and tier 2 federal workload, long-term care complaints and entity-reported incidents, and pending complaints and entity-reported incidents. The 2017 Budget Act approved an additional $1.1 million for general salary increases approved by the LA County Board of Supervisors for employees covered by the LA County contract after the negotiation of the contract renewal.

The 2018 Budget Act included resources to allow CDPH to extend the LA County contract for an additional year until June 30, 2019. The Legislature also approved trailer bill language to assess a supplemental license fee on facilities located in LA County to offset additional costs necessary to regulate entities in the county. The supplemental fee was intended to prevent the need to increase license fees on health care facilities statewide to absorb increasing contract costs and to allow health care facilities in LA County to receive services comparable to other health care facilities statewide.

The department and LA County negotiated a new three-year contract beginning July 1, 2019, that emphasizes pay for performance with defined quality, quantity, and service metrics, as well as penalties for failure to meet those metrics. According to CDPH, the new contract reflected a gradual increase for LA County workload and resources to hire necessary staff over three years to complete 100 percent of the mandated workload, including its existing tier 1 and tier 2 federal workload, complaint and incident investigations, as well as new tier 3 and tier 4 federal workload, state licensure activities, and responsibility for all complaints and entity-reported incidents in the county. The contract includes a total of 491 positions including 317 surveyor positions and 174 support and supervisory positions, which is an increase of 118 percent over the prior contract to fulfill the additional licensing and certification workload for LA County facilities.

According to CDPH, during the COVID-19 pandemic, LA County was allowed some flexibility to implement COVID-19 activities including mitigation plan and infection control onsite surveys and visits, daily outbreak monitoring and risk exposure assessments, training and discussion attendance, and collaboration with multiple emergency agencies.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.

ISSUE 36: PUBLIC HEALTH ELECTRONIC LICENSING PROGRAM FOR TISSUE BANKS AND BIOLOGICS FACILITIES BCP

PROPOSAL

CDPH requests six positions and expenditure authority of $3.6 million ($583,000 Tissue Bank License Fund and $3 million Clinical Laboratory Improvement Fund) in 2022-23, and $2 million ($583,000 Tissue Bank License Fund and $1.4 million Clinical Laboratory Improvement Fund) annually thereafter to allow CDPH to: 1) increase inspections and oversight of tissue banks, blood banks, and biologics facilities; and 2) establish the Electronic Tissue and Biologics System (ETABS) to migrate facility licensing processes from paper-based to an online platform.

In addition to these staffing resources, CDPH requests expenditure authority of $2.7 million in 2022-23 to establish the ETABS bank licensing project, and $1.1 million annually thereafter for maintenance and operations. In 2022-23, $1.9 million would support a vendor to develop the program, while $800,000 would be for the CDPH Information Technology Services Division (ITSD) to provide project management, testing, development, release management, code review, data quality management, and additional oversight activities. In 2023-24 and annually thereafter, $1.1 million would be for ITSD to provide ongoing maintenance and operations support.

BACKGROUND

CDPH's Laboratory Field Services Branch is responsible for the licensure and oversight of clinical and public health laboratories, licensure and oversight of clinical and public health laboratory personnel and training, and licensure and oversight of blood banks, tissue banks, biologics production facilities, and cytology personnel. CDPH reports that over the last 15 years, there has been a significant growth of interest in the therapeutic applications of stem cells, the precursor cells that develop into blood, brain, bones, and organs. Stem cell therapies, like other medical products, require approval from the federal Food and Drug Administration (FDA) before they can be marketed. Currently there is only one stem cell therapy proven safe and effective and approved by the FDA for use in patients.

According to CDPH, a 2016 study identified 351 U.S. businesses engaged in direct-to-consumer marketing of stem cell interventions offered at 570 clinics, with 113 clinics in California. A follow-up study showed the industry added 90 to 100 new businesses per year. The study authors catalogued a number of concerns about these businesses including: a lack of compliance with federal regulations, misleading claims about the safety and efficacy of advertised procedures, and high risk of physical, emotional, and financial harm to ill, injured, or vulnerable individuals.

While the FDA indicated in 2019 it plans to increase compliance actions against these businesses, CDPH reports it continues to have a responsibility to ensure the safety and efficacy of products and treatments of California businesses. CDPH is requesting staff resources to increase its enforcement activities to ensure the safety and efficacy of these products and protect the public from harm, as well as migrating from the current paper-based application process to an electronic method to review applications and give examiners more time for on-site inspections and enforcement actions.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests CDPH present this proposal and respond to any questions raised by the Subcommittee members.

Staff Recommendation: Hold open to allow for additional discussion and feedback.