

**AGENDA****ASSEMBLY BUDGET SUBCOMMITTEE NO. 1  
ON HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR****MONDAY, FEBRUARY 26, 2018****2:30 P.M. - STATE CAPITOL ROOM 126**

<b>ITEMS TO BE HEARD</b>		
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<b>4120</b>	<b>EMERGENCY MEDICAL SERVICES AUTHORITY</b>	
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## LIST OF PANELISTS IN ORDER OF PRESENTATION

### 4120 EMERGENCY MEDICAL SERVICES AUTHORITY

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#### ISSUE 1: DEPARTMENT OVERVIEW AND PROPOSED BUDGET

- **Howard Backer**, MD, MPH, FACEP, Director, California Emergency Medical Services Authority
- **Dan Smiley**, Chief Deputy Director, California Emergency Medical Services Authority
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

#### *Public Comment*

#### ISSUE 2: INCREASED INFORMATION TECHNOLOGY SECURITY RESOURCES BUDGET CHANGE PROPOSAL

- **Howard Backer**, MD, MPH, FACEP, Director, California Emergency Medical Services Authority
- **Dan Smiley**, Chief Deputy Director, California Emergency Medical Services Authority
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

#### *Public Comment*

### 4265 DEPARTMENT OF PUBLIC HEALTH

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#### ISSUE 3: DEPARTMENT OVERVIEW AND PROPOSED BUDGET

- **Brandon Nunes**, Chief Deputy Director of Operations, Department Of Public Health
- **Susan Fanelli**, Assistant Director, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

#### *Public Comment*

**ISSUE 4: CENTER FOR CHRONIC DISEASE OVERVIEW AND PROGRAM UPDATES**

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment*****ISSUE 5: TOBACCO TAX (PROPOSITIONS 99 AND 56) FUNDING ADJUSTMENTS**

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment*****ISSUE 6: ALZHEIMER'S DISEASE PROGRAM GRANT AWARDS BUDGET CHANGE PROPOSAL**

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment*****ISSUE 7: CHILDHOOD LEAD POISONING BUDGET CHANGE PROPOSAL (AB 1316)**

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 8: LEAD CONSTRUCTION CERTIFICATION PROCESSING DELAYS OVERSIGHT ISSUE**

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment*****ISSUE 9: SAFE COSMETICS PROGRAM ADVOCATES' PROPOSAL**

- **Janet Nudelman**, Director of Program and Policy, Breast Cancer Prevention Partners, Director, Campaign for Safe Cosmetics

***Public Comment*****ISSUE 10: HYPERTENSION AWARENESS ADVOCATES' PROPOSAL**

- **Dr. Alan Shatzel, D.O.**, Board President, American Heart Association, Sacramento Chapter

***Public Comment*****ISSUE 11: CENTER FOR ENVIRONMENTAL HEALTH OVERVIEW AND PROGRAM UPDATES**

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment*****ISSUE 12: PUBLIC BEACHES – INSPECTION FOR CONTAMINANTS (SB 1395)**

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

**ISSUE 13: CENTER FOR HEALTH CARE QUALITY OVERVIEW, PROGRAM UPDATES, AND LICENSING AND CERTIFICATION ESTIMATE**

- **Jean Iacino**, Deputy Director, Center for Health Care Quality, DPH
- **Scott Vivona**, Acting Deputy Director, Center For Health Care Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Health Care Quality, DPH
- **Benjamin Menzies**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment*****ISSUE 14: LOS ANGELES COUNTY CONTRACT BUDGET CHANGE PROPOSAL AND TRAILER BILL**

- **Jean Iacino**, Deputy Director, Center for Health Care Quality, DPH
- **Scott Vivona**, Acting Deputy Director, Center For Health Care Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Health Care Quality, DPH
- **Angelo Bellomo**, Deputy Director for Health Promotion, Los Angeles County Department of Public Health
- **Benjamin Menzies**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

## ITEMS TO BE HEARD

### 4120 EMERGENCY MEDICAL SERVICES AUTHORITY

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#### ISSUE 1: DEPARTMENT OVERVIEW AND PROPOSED BUDGET

##### PANELISTS

- **Howard Backer**, MD, MPH, FACEP, Director, California Emergency Medical Services Authority
- **Dan Smiley**, Chief Deputy Director, California Emergency Medical Services Authority
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

##### *Public Comment*

##### OVERVIEW

The Emergency Medical Services Authority's (EMSA) mission is to coordinate emergency medical services (EMS) statewide; develop guidelines for local EMS systems; regulate the education, training, and certification of EMS personnel; and coordinate the state's medical response to any disaster.

The EMSA is comprised of the following three divisions:

- ***Disaster Medical Services Division.*** The Disaster Medical Services Division coordinates California's medical response to disasters. It is the responsibility of this division to carry out the EMS Authority's mandate to provide medical resources to local governments in support of their disaster response, and coordinate with the Governor's Office of Emergency Services, Office of Homeland Security, California National Guard, California Department of Public Health, other local, state, and federal agencies, private sector hospitals, ambulance companies and medical supply vendors to improve disaster preparedness and response.
- ***EMS Personnel Division.*** The EMS Personnel Division oversees licensure and enforcement functions for California's paramedics, personnel standards for pre-hospital emergency medical care personnel, trial studies involving pre-hospital emergency medical care personnel, first aid and CPR training programs for child day care providers and school bus drivers.

- **EMS Systems Division.** The EMS Systems Division oversees EMS system development and implementation by the local EMS agencies, trauma care and other specialty care system planning and development, EMS for Children program, California's Poison Control System, emergency medical dispatcher standards, EMS Data and Quality Improvement Programs, and EMS communication systems.

<b>PROPOSED BUDGET</b>
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The Department's proposed budget is summarized in the table below. For 2018-19, the Governor's Budget proposes \$37.4 million for the support of EMSA. Of this amount, approximately \$16.5 million is budgeted for State Operations, while the remaining is for Local Assistance. The proposed budget reflects a 0.5 percent increase from the current year budget.

The primary source of funding for this department is federal funds, which is included in the lines below labeled "Federal Trust Fund" and "Reimbursements," as those are federal funds that come through other departments first, namely the Departments of Health Care Services and Public Health.

<b>EMERGENCY MEDICAL SERVICES AUTHORITY</b>					
<i>(Dollars In Thousands)</i>					
Fund Source	2016-17 Actual	2017-18 Projected	2018-19 Proposed	CY to BY Change	% Change
<b>General Fund</b>	<b>\$8,385</b>	<b>\$8,866</b>	<b>\$9,223</b>	<b>\$</b>	<b>%</b>
Emergency Medical Services Training Program Approval Fund	\$189	\$217	\$217	\$0	0%
Emergency Medical Services Personnel Fund	\$2,122	\$2,747	\$2,608	(\$139)	-5.1%
Federal Trust Fund	\$4,652	\$6,313	\$6,290	(\$23)	-0.4%
Reimbursements	\$12,117	\$17,518	\$17,520	\$2	0.01%
Trauma Care Fund	\$38	\$0	\$0	\$0	0%
Emergency Medical Technician Certification Fund	\$1,362	\$1,553	\$1,554	\$1	0.06%
<b>Total Expenditures</b>	<b>\$28,865</b>	<b>\$37,214</b>	<b>\$37,412</b>	<b>\$198</b>	<b>0.5%</b>
<b>Positions</b>	71.8	68.9	69.9	1	1.5%

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests EMSA to provide an overview of the Department and its proposed budget. Please also provide a description of significant changes or activities of the department over the past year, including related to California's fires.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 2: INCREASED INFORMATION TECHNOLOGY SECURITY RESOURCES BUDGET CHANGE PROPOSAL****PANELISTS**

- **Howard Backer**, MD, MPH, FACEP, Director, California Emergency Medical Services Authority
- **Dan Smiley**, Chief Deputy Director, California Emergency Medical Services Authority
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

**Public Comment****PROPOSAL**

EMSA is requesting 1.0 permanent position and \$356,000 General Fund in 2018-19, which includes one-time funding of \$196,000 for IT infrastructure improvements, and on-going funding of \$189,000 in 2019-20. The additional resource will be utilized to provide adequate staffing levels to strengthen the Department's Information Technology (IT) infrastructure and compliance with State policy and procedural requirements.

**BACKGROUND**

In accordance with California State Code 11549.3, as amended on January 1, 2016, EMSA underwent an Independent Security Assessment (ISA) by the California Military Department's Cyber Network Defense Team (CND) in December 2016. The CND conducted the Independent Security Assessment (ISA) using three general categories which are used to gain an understanding of the cyber-hygiene program implementation across EMSA's enterprise. The categories assessed included policy reviews, logical implementation and practices, and vulnerability/risk awareness.

EMSA states that the assessment demonstrates that there are insufficient resources currently being dedicated to EMSA's IT infrastructure responsibilities. The assessment also included estimates of the resources needed for remediation which includes one-time purchases of mitigating hardware and/or software in the amount of \$196,000 and that the majority of the remediation efforts could be achieved by dedicating more staff time (3,418 hours) to IT infrastructure responsibilities.

Government Code Section 11549.3, and SAM Section 5300.2, requires all State entities to comply with the information security (IS) and privacy policies, standards, and procedures issued by the California Information Security Office (CISC). All State

agencies are required to designate an Information Security Officer (ISO) to oversee the agency's compliance with IS requirements to protect the reliability, integrity, and confidentiality of data, and safeguard information assets. Currently, only one staff member is assigned to perform the ISO function within EMSA which is handled part-time as an ancillary duty. Over the years, state policy and procedural requirements have led to increased workload in the following areas:

- Responding to increased oversight and accountability requirements for mandated reporting and mitigation tracking;
- Monitoring and reporting of cyber threats (network intrusions, viruses, cyber-attacks, etc.);
- Monitoring and reporting of tangible security risks;
- Researching, analyzing, and implementing more sophisticated encryption technologies;
- Mandates from the State Chief Information Security Office regarding technological changes, such as, the immediate removal of certain encryption technologies;
- Deployment and support of a broader array of personal electronic, mobile equipment, or software applications for both employees and the public;
- Maintaining safe wireless technologies;
- Conducting risk analysis on critical IT infrastructure systems;
- Responding to new standards for protecting and transmitting data; and
- Attendance of the CIO and support staff at more conferences and outside meetings to keep up with legislative, technological, and policy changes.

A recent draft publication by the State ISO entitled "Information Security Program Guide for State Agencies" identified the following areas for information security:

- Risk Management;
- Policy Management;
- Organizing Information Security;
- Asset Protection;
- Human Resource Security;
- Physical and Environmental Security;
- Communication and Operations Management;
- Access Control;
- Information Systems Acquisition, Development and Maintenance;
- Incident Management;
- Disaster Recovery Management; and
- Compliance.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests EMSA to present this budget change proposal and respond to any questions.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**4265 DEPARTMENT OF PUBLIC HEALTH**

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**ISSUE 3: DEPARTMENT OVERVIEW AND PROPOSED BUDGET****PANELISTS**

- **Brandon Nunes**, Chief Deputy Director of Operations, Department Of Public Health
- **Susan Fanelli**, Assistant Director, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

***Public Comment***

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

***DPH Budget***

The Governor's proposed 2018-19 budget provides DPH approximately \$3.2 billion overall, representing a very small \$2.4 million (total funds), or 0.1 percent, decrease from the current year DPH budget. General Fund dollars of \$138 million make up just 4.3 percent of the department's total budget while federal funds make up approximately 50 percent of the total department budget. The \$10.4 million reduction in General Fund primarily reflects one-time General Fund augmentations to the department in 2016 as follows:

- \$5 million one-time General Fund to prevent the spread of sexually transmitted diseases
- \$3 million one-time General Fund to distribute Naloxone kits to prevent drug overdose fatalities
- \$2.5 million one-time General Fund to support Alzheimer's early detection efforts
- \$1.4 million one-time General Fund to prevent the spread of hepatitis
- \$1 million one-time General Fund to support the work of the Biomonitoring Program

<b>DEPARTMENT OF PUBLIC HEALTH</b>					
<i>(Dollars In Thousands)</i>					
<b>Fund Source</b>	<b>2016-17 Actual</b>	<b>2017-18 Projected</b>	<b>2018-19 Proposed</b>	<b>CY to BY \$ Change</b>	<b>CY to BY % Change</b>
<b>General Fund</b>	<b>\$139,510</b>	<b>\$148,300</b>	<b>\$137,923</b>	<b>(\$10,377)</b>	<b>-7.1%</b>
<b>Federal Funds</b>	\$1,564,234	\$1,566,944	\$1,589,349	\$22,405	1.4%
<b>Special Funds &amp; Reimbursements</b>	\$387,673	\$664,320	\$634,641	(\$29,679)	-4.5%
<b>Licensing &amp; Certification</b>	\$128,007	\$152,809	\$156,153	\$3,344	2.2%
<b>Genetic Disease Testing Fund</b>	\$122,019	\$132,382	\$132,924	\$540	0.4%
<b>WIC Manufacturer Rebate Fund</b>	\$218,348	\$233,307	\$230,852	(\$2,455)	-1.1%
<b>AIDS Drug Assistance Program Rebate Fund</b>	\$211,939	\$293,824	\$307,651	\$13,827	4.7%
<b>Total Expenditures</b>	<b>\$2,771,730</b>	<b>\$3,191,886</b>	<b>\$3,189,493</b>	<b>(\$2,393)</b>	<b>-0.07%</b>
<b>Positions</b>	3,456.7	3,563.7	3,608.2	44.5	1.2%

The following table shows the proposed expenditures by program area. The \$40.5 million reduction in Chronic Disease Prevention and Health Promotion primarily reflects the reduction from five to four quarters of Proposition 56 funding, and the \$39.5 million increase to Infectious Disease Control reflects increased caseload and costs in the AIDS Drug Assistance Program, which will be discussed in more detail at the Subcommittee's hearing on March 12, 2018.

<b>DPH Program Expenditures</b>					
<i>(In Thousands)</i>					
<b>Program</b>	<b>2016-17 Actual</b>	<b>2017-18 Estimate</b>	<b>2018-19 Proposed</b>	<b>CY to BY \$ Change</b>	<b>CY to BY % Change</b>
Emergency Preparedness	\$87,765	\$93,865	\$96,030	\$2,165	2.3%
Chronic Disease Prevention & Health Promotion	\$290,527	\$529,064	\$488,531	(\$40,533)	-7.7%
Infectious Disease	\$607,926	\$629,495	\$668,981	\$39,486	6.3%
Family Health	\$1,420,713	\$1,492,999	\$1,485,332	(\$7,667)	-0.5%
Health Statistics & Informatics	\$24,692	\$29,556	\$30,112	\$556	1.9%
County Health Services	\$201	\$4,064	\$4,095	\$31	0.8%
Environmental Health	\$94,277	\$125,750	\$124,008	(\$1,742)	-1.4%
Health Facilities	\$232,868	\$272,557	\$277,766	\$5,209	2.0%
Laboratory Field Services	\$12,761	\$14,536	\$14,638	\$102	0.7%
<b>Total Expenditures</b>	<b>\$2,771,730</b>	<b>\$3,191,886</b>	<b>\$3,189,493</b>	<b>(\$2,393)</b>	<b>-0.07%</b>

<b>BACKGROUND</b>
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The overall structure of DPH is as follows:

**Department Director / State Public Health Officer**

- Civil Rights
- California Conference of Local Health Officers
- Office of Health Equity
- Office of Quality Performance and Accreditation
- Administration and Public Affairs
- Center for Health Statistics and Informatics
- Emergency Preparedness Office
- Office of the State Public Health Laboratory Directors

**Policy and Programs**

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

**Center for Chronic Disease Prevention and Health Promotion**

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

**Center for Environmental Health**

- Environmental Management
- Food, Drug, and Radiation Safety

**Center for Family Health**

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

**Center for Health Care Quality**

- Healthcare Association Infections Program
- Licensing and Certification

**Center for Infectious Diseases**

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

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to provide an overview of the department and its proposed budget and provide highlights of major public health issues that involved the department over the past year.

Additionally, Subcommittee staff has discussed with the department the Legislature's need to receive regular, up-to-date public health data on major causes of morbidity and mortality and trends associated with those health conditions. This information is critical

to the Legislature's ability to make sound policy and fiscal choices that address the major causes of morbidity and mortality in California effectively. The Subcommittee would like to explore with the department feasible strategies for the department to provide this information, in the form of a public presentation to the Subcommittee and in a written report, on an annual basis. This "State of the State's Public Health" would provide 3-5 year incidence, prevalence and trend analysis on key causes of illness, injury and death, such as the following (as examples):

- What are the rates of sexually transmitted diseases and what are the trends?
- How many cases of hepatitis A and how many deaths from hepatitis A have there been each year for the past 5 years?
- How many children drown and in what types of situations (i.e., backyard pool? ocean?) did they drown?
- How many people die of cancer and what are the leading types of cancer deaths, by age, gender, race, etc.?
- How many people die from heart disease?
- What are the vaccination rates?
- What conditions do you see increasing? Decreasing?

The Subcommittee requests the department to share its assessment of what additional resources the department would need, if any, to meet this request on an annual basis, and to provide the following data at this hearing:

Over the past 5 years:

1. How many school shootings have there been in California? When? How many children died at each one?
2. How many deaths have there been from any gun violence in California?
3. How many opioid overdose deaths have there been in California?

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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## CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

### ISSUE 4: CENTER FOR CHRONIC DISEASE OVERVIEW AND PROGRAM UPDATES

#### PANELISTS

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

#### *Public Comment*

#### PROPOSAL

This is an informational item in order for the Subcommittee to: 1) learn more about the Center for Chronic Disease Prevention and Health Promotion; 2) receive updates on programs of interest to the Subcommittee; and 3) receive updates on programs within this Center for which augmentations were included in recent prior budget.

#### BACKGROUND

The Center for Chronic Disease Prevention and Health Promotion is organized into three major components: 1) Chronic Disease and Injury Control; 2) Environmental and Occupational Disease Control; and 3) Office of Problem Gambling (OPG). These are described in more detail below. The January budget proposes \$488,531,000 for this Center, approximately 15 percent of the department's overall budget.

#### **Chronic Disease and Injury Control**

*Nutrition Education and Obesity Prevention Branch.* Through statewide, regional and local partnerships, programs, and policy initiatives, this branch promotes healthy eating, physical activity, and food security with an emphasis in communities with the greatest health disparities.

*Safe and Active Communities Branch (SACB).* The SACB is the focal point for DPH injury prevention efforts, both epidemiological investigations and implementation of prevention programs to reduce intentional and unintentional injuries. Prevention efforts include epidemiological surveillance, planning and consensus building, interventions, policy development, professional education and training, and public information. SACB is made up of two major sections to carry out its mission: 1) State and Local Injury

Control Section (SLIC); and 2) Injury Surveillance and Epidemiology Section (ISES). The programs within this Branch include:

- Kids' Plates
- Older Adult Falls Prevention
- Child Passenger Safety (Vehicle Occupant Safety Program)
- Active Transportation Safety Program
- Domestic Violence/Intimate Partner Violence
- Sexual Violence
- Teen Dating Violence
- Child Maltreatment/Child Abuse Prevention
- California's Violent Death Reporting System (CalVDRS)
- Crash Medical Outcomes Data (CMOD) Project
- Prescription Drug Overdose Prevention

*Chronic Disease Surveillance and Research Branch (CDSRB).* The CDSRB collects statewide data about chronic disease and risk factors, conducts surveillance and research into the causes, cures, and controls of cancer, and communicates the results to the public. CDSRB coordinates these activities by directing, managing, and monitoring the state-mandated Ken Maddy California Cancer Registry (CCR), the Survey Research Group (SRG), California's Comprehensive Cancer Control Program (CCCP), and the California Lupus Surveillance Program.

*Chronic Disease Control Branch (CDCB).* The CDCB mission is to prevent and optimally manage chronic disease. The CDCB supports evidence-based programs that promote healthy behaviors, healthy communities, and improve the prevention, diagnosis, and management of chronic disease. It involves many partners and a spectrum of activities as the causes are multi-factorial and go beyond health care and traditional public health approaches. Chronic disease prevention includes preventing disease from occurring as well as decreasing the severity and impact of a condition once it occurs. The passage of the Patient Protection and Affordable Care Act provided an exciting opportunity to advance prevention, lower costs, provide better care and improve the patient experience. The CDCB includes the following programs:

- Alzheimer's Disease Program
- California Arthritis Partnership Program (CAPP)
- California Colon Cancer Control Program (C4P)
- California Epidemiologic Investigation Service (Cal-EIS) Fellowship Program
- California Heart Disease, Stroke, and Diabetes Prevention
- California Preventive Health and Health Services Block Grant (PHHSBG)
- California Stroke Registry
- California Wellness Plan Implementation

- Oral Health Program
- Preventive Medicine Residency Program (PMRP)
- Sodium Reduction Initiative
- WISEWOMAN

*Tobacco Control Program (TCP)*. The mission of the TCP is to improve the health of all Californians by reducing illness and premature death attributable to the use of tobacco products. Through leadership, experience and research, the TCP empowers statewide and local health agencies to promote health and quality of life by advocating social norms that create a tobacco-free environment. The goal of the TCP is to change the social norms surrounding tobacco use by “indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible.” To change tobacco-related social norms, the TCP funds a statewide media campaign and state and community interventions which focus on policy, system, and environmental change in four priority areas:

1. *Limit Tobacco Promoting Influences*. Efforts in this area seek to curb advertising and marketing tactics used to promote tobacco products and their use, counter the glamorization of tobacco use through entertainment and social media venues, expose tobacco industry practices, and hold tobacco companies accountable for the impact of their products on people and the environment.
2. *Reduce Exposure to Secondhand Smoke, Tobacco Smoke Residue, Tobacco Waste, and Other Tobacco Products*. Efforts in this area address the impact of tobacco use on people, other living organisms, and the physical environment resulting from exposure to: secondhand smoke, tobacco smoke residue, tobacco waste, and other non-combustible tobacco products.
3. *Reduce the Availability of Tobacco*. Efforts in this area address the sale, distribution, sampling, or furnishing of tobacco products and other nicotine containing products that are not specifically approved by the Food and Drug Administration (FDA) as a treatment for nicotine or tobacco dependence.
4. *Promote Tobacco Cessation*. Efforts in this area include the provision of free cessation assistance in six languages and for the hearing impaired through the California Smokers’ Helpline and efforts to improve awareness, access, and availability of cessation support offered by the health care system, health care plans, and employers.

**Environmental and Occupational Disease Control (EODC)**

The mission of EODC is to prevent or reduce disease and injury related to environmental and occupational factors. EODC employs a variety of methods to identify and understand health problems that may be caused or made worse by exposure to hazards in the workplace or in the environment. EODC tracks and investigates cases of illness and injury to understand contributing factors, develops prevention strategies, and shares what they have learned with community members and stakeholders. EODC also has a multidisciplinary Emergency Preparedness Team, whose goal is to identify and reduce risks from chemical releases and other hazards in California and to minimize their health impacts on workers, first responders, communities, and vulnerable populations.

*Childhood Lead Poisoning Prevention Branch (CLPPB).* The mission of the CLPPB is to eliminate childhood lead poisoning by identifying and caring for lead burdened children and preventing environmental exposures to lead. The CLPPB has six goals:

1. An informed public able to protect children from lead exposures;
2. Well-supported, effective local programs to detect, manage and prevent childhood lead poisoning;
3. Fully developed capacity to track lead exposure statewide and to monitor the management of lead burdened children;
4. Strong infrastructure enabling the prevention of children's exposure to lead through partnerships with government agencies, community-based organizations, and the private sector;
5. Full compliance with Federal and State statutory and regulatory requirements; and
6. Continued State and national leadership through research, policy development and standard setting.

*Environmental Health Investigations Branch (EHIB).* EHIB works to optimize the health of the people in California by studying how the environment affects health and by educating and informing the public. The EHIB includes programs and projects related to asthma, autism, biomonitoring, community health studies, drinking water, and fish.

*Environmental Health Laboratory Branch (EHLB).* The Environmental Health Laboratory (EHL) is responsible for analyzing environmental and biological samples for the presence and quantities of toxic substances. These include lead, air pollutants, pesticides, asbestos, and biological contaminants such as molds. The EHL serves as a reference laboratory for public health agencies and as a referee laboratory for chemical testing. It has a multidisciplinary staff of ~30 experts in chemistry, microbiology, ventilation engineering, epidemiology, and statistics. It conducts a wide variety of laboratory analyses and studies, including environmental and clinical analytical services; and it provides leadership in the development of laboratory methods. EHLB programs include:

- Biochemistry Section (including Biomonitoring and Lead Testing)
- Indoor Air Quality Section
- Outdoor Air Quality Section (including Chemical Emergency Response)

*Occupational Health Branch (OHB).* OHB works to prevent injury and illness on the job. They do this by:

- Identifying and evaluating workplace hazards;
- Tracking patterns of work-related injury and illness;
- Developing training and informational materials;
- Providing technical assistance to others to prevent work-related injury and illness;
- Working with partners to develop safer ways to work; and
- Recommending protective occupational health standard.

*Emergency Preparedness Team (EPT).* The ETP is a multi-disciplinary team, whose goal is to identify and reduce risks from chemical releases and other hazards in California and to minimize their health impacts on workers, first responders, communities, and vulnerable populations.

### **Office of Problem Gambling (OPG)**

The OPG is charged with developing and providing quality statewide prevention and treatment programs and services, to address problem and pathological gambling issues, to the people of California.

### **STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to provide an overview of this Center, updates on various programs, and respond to the following:

1. Please provide an update on the use of the increased funds provided in 2016 for Biomonitoring and Alzheimer's early diagnosis.
2. Please provide an update on the use of the \$3.7 million General Fund (over three years) for the foundational work for a Parkinson's Disease Registry. Please provide a cost estimate for establishing a full registry.
3. Please describe the Nutrition Education and Obesity Prevention Branch in detail.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 5: TOBACCO TAX (PROPOSITIONS 99 AND 56) FUNDING ADJUSTMENTS****PANELISTS**

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

**Public Comment****PROPOSALS**

This issue covers the changes to Proposition 99 and 56 revenue estimates, and proposed expenditures within DPH, most of which occur within the Center for Chronic Disease Control and Prevention. The Proposition 56 statute requires that Proposition 56 funds backfill any loss to Proposition 99 funds that results from the implementation of the increased tax created by Proposition 56.

**BACKGROUND****Proposition 56**

As of April 1, 2017, the 2016 Tobacco Tax Act increased the excise tax on cigarettes by \$2.00 per pack (based on a pack of 20 cigarettes) and imposed an equivalent excise tax on other tobacco products. A portion of the 2016 Tobacco Tax Act revenues are transferred into three newly created funds: the State Dental Program Account (Fund 3307), the Tobacco Law Enforcement Account (Fund 3308), and the Tobacco Prevention and Control Programs Account (Fund 3309).

The Proposition specifies allocations to various entities, including \$6 million annually for DPH to provide tobacco enforcement related activities and \$30 million annually for DPH's state dental program. Proposition 56 requires 82 percent of the remaining funds be transferred to the Department of Health Care Services. Of the remaining 18 percent, 13 percent is for DPH and the Department of Education for tobacco prevention, and 5 percent to the University of California for medical research.

The LAO provided the following chart in their 2017 brief on Proposition 56 (*The 2017-18 Budget: An Overview of the Governor's Proposition 56 Proposals*):

## How Measure Directs New Tax Revenue Be Spent

Program or Entity <sup>a</sup>	Amount	Purpose
<b>Step 1: Replace Lost Revenues</b>		
Existing Tobacco Tax Funds	Determined by BOE	To maintain tobacco-related revenues that tobacco tax funds would have received before this measure.
State and Local Sales and Use Tax	Determined by BOE	To maintain tobacco-related revenues the state and local governments would have received before this measure.
<b>Step 2: Pay for Tax Administration</b>		
State Board of Equalization (BOE)—administration	5 percent of remaining funds	For costs to administer the tax.
<b>Step 3: Allocate Specific Amounts for Various State Entities<sup>b</sup></b>		
Various state entities—enforcement <sup>c</sup>	\$48 million	For various enforcement activities of tobacco-related laws.
University of California (UC)—physician training	\$40 million	For physician training to increase the number of primary care and emergency physicians in California.
Department of Public Health (DPH)—State Dental Program	\$30 million	For education on preventing and treating dental disease.
California State Auditor	\$400,000	For audits of agencies receiving funds from new taxes, at least every other year.
<b>Step 4: Distribute Remaining Funds for State Health Programs</b>		
Medi-Cal—Department of Health Care Services	82 percent of remaining funds	For increasing the level of payment for health care, services, and treatment provided to Medi-Cal beneficiaries.
California Tobacco Control Program—DPH	11 percent of remaining funds	For tobacco prevention and control programs aimed at reducing illness and death from tobacco-related diseases.
Tobacco-Related Disease Program—UC	5 percent of remaining funds	For medical research into prevention, early detection, treatments, and potential cures of all types of cancer, cardiovascular and lung disease, and other tobacco-related diseases.
School Programs—California Department of Education	2 percent of remaining funds	For school programs to prevent and reduce the use of tobacco products by young people.

<sup>a</sup>The measure limits the amount of revenues raised that could be used to pay for administrative costs, to be

defined by the State Auditor through regulation, to not more than 5 percent for each recipient of funding.

<sup>b</sup>Predetermined amounts will be adjusted proportionately by BOE annually, beginning two years after the measure went into effect, if the BOE determines that there has been a reduction in revenues resulting from a reduction in the consumption of cigarette and tobacco products due to the measure.

<sup>c</sup>Funds distributed to Department of Justice (\$36 million), DPH (\$6 million), and BOE (\$6 million).

### **Proposition 99**

DPH Tobacco Control Branch (TCB) was established as a result of Proposition 99 (1988), which added a 25-cent excise tax per 20-cigarette pack and an equivalent tax increase on other tobacco products. DPH TCB administers funds to local health departments and competitively selected community-based organizations, runs a statewide media campaign, and completes comprehensive evaluation efforts.

#### *Proposition 99 Adjustments:*

<b>Proposition 99 (Tobacco Tax) Revenues 2018-19</b> <i>(Dollars in Thousands)</i>							
	<b>Health Education Account 20%</b>	<b>Hospital Services Account 35%</b>	<b>Physicians' Services Account 10%</b>	<b>Research Account 5%</b>	<b>Public Resources Account 5%</b>	<b>Unallocated Account 25%</b>	<b>TOTALS</b>
<b>Beginning Balance</b>	\$3,131	\$5,457	\$1,754	\$8,399	\$351	\$3,375	<b>\$22,468</b>
<b>Total Revenues</b>	\$51,479	\$74,101	\$21,164	\$12,924	\$5,477	\$47,850	<b>\$212,995</b>
<b>Totals Available</b>	<b>\$54,611</b>	<b>\$79,558</b>	<b>\$22,918</b>	<b>\$21,323</b>	<b>\$5,828</b>	<b>\$51,225</b>	<b>\$235,463</b>

The following chart shows just the information for the Health Education Account, primary funding for DPH, across three fiscal years:

<b>Proposition 99 Health Education Account</b> <i>(Dollars in Thousands)</i>					
	<b>2016-17 Actuals</b>	<b>2017-18 Estimate</b>	<b>2018-19 Proposed</b>	<b>CY to BY \$ Change</b>	<b>CY to BY % Change</b>
<b>Beginning Balance</b>	\$17,882	\$8,131	\$3,131	(\$5,000)	-61%
<b>Total Revenues</b>	\$60,221	\$52,463	\$51,479	\$984	1.9%
<b>Totals Available</b>	<b>\$78,103</b>	<b>\$60,594</b>	<b>\$54,611</b>	<b>(\$5,983)</b>	<b>-9.9%</b>



The following expenditure changes are proposed reflecting changing availability of Proposition 99 and 56 funding, primarily accommodating an overall steady decrease in tobacco tax revenue:

**Current Year (2017-18) Changes:**

Decrease Media Campaign (State Operations):	\$2,000,000
Decrease Competitive Grants (Local Assistance):	\$1,000,000
Decrease Evaluation (State Operations):	\$885,000
Decrease Local Lead Agencies (Local Assistance):	\$1,850,000

**Budget Year (2018-19) Changes By Prop 99 Account:**

***Research Account:***

Increase State Administration (State Operations):	\$1,424,000
Increase External Contracts (State Operations):	\$202,000

***Unallocated Account:***

Increase State Administration (State Operations):	\$208,000
Increase External Contracts (State Operations):	\$79,000
Increase California Health Interview Survey (State Operations):	\$106,000

***Tobacco Prevention Control Account (Prop 56):***

Decrease Media Campaign (State Operations):	\$5,496,000
Decrease Evaluation (State Operations):	\$3,864,000
Decrease Competitive Grants (Local Assistance):	\$4,195,000
Decrease Local Lead Agencies (Local Assistance):	\$5,401,000
Decrease Prop 56 (Local Assistance):	\$20,961,000

***State Dental Program Account (Prop 56):***

Decrease Prop 56 (State Operations):	\$3,000,000
Decrease Prop 56 (Local Assistance):	\$4,500,000

***Tobacco Law Enforcement Account (Prop 56):***

Decrease Prop 56 (State Operations):	\$1,500,000
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***Breast Cancer Research Account:***

Increase Breast Cancer Research Account (State Operations):	\$1,006,000
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**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to provide an overview of Propositions 99 and 56 funding within DPH, the dynamic interaction of the two funding sources, and the major adjustments being proposed in the January budget.

Please describe what one-time purposes were funded with the 5<sup>th</sup> quarter of Proposition 56 funding in the current year.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 6: ALZHEIMER'S DISEASE PROGRAM GRANT AWARDS BUDGET CHANGE PROPOSAL****PANELISTS**

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

**Public Comment****PROPOSAL**

The Alzheimer's Disease Program (ADP) requests an expenditure authority increase of \$3.2 million in 2018-19 (\$3.1 million General Fund and \$104,000 for the California Alzheimer's Disease and Related Disorders Research Fund (ADRDRF)) and \$2.9 million in 2019-20 and ongoing (\$3.1 million General Fund and a reduction of \$138,000 ADRDRF). These resources will allow DPH to fund research relating to the study of Alzheimer's disease and related disorders and fulfill contractual commitments.

**BACKGROUND**

The ADP was established pursuant to Assembly Bill 2225 (Chapter 1601, Statutes of 1984) and was expanded pursuant to Senate Bill 139 (Chapter 303, Statutes of 1988). The mission of ADP is to reduce the human burden and economic costs associated with Alzheimer's disease and related dementias, and ultimately to assist in discovering the cause and treatment of this disease. California has been a national leader in Alzheimer's disease research, and since 1985 the state has invested more than \$90.7 million in the California Alzheimer's Disease Centers (ADCs), which have leveraged the funds to raise more than \$544.5 million in federal and private research money (California State Plan for Alzheimer's Disease, 2011).

In 1987, the California Revenue and Taxation (R & T) Code was amended to authorize taxpayers to contribute amounts on their tax returns, in excess of any tax liability, and to establish a fund for research related to Alzheimer's disease (R & T Code Sections 18761-18766), which is administered by DPH. From 1989 to 2009, the Alzheimer's Disease Research Awards were supported by both General Fund and the ADRDRF. In 2009, funding to the ADP was reduced, and the program discontinued General Fund research activities. Today, the research awards are solely dependent on donations made by California taxpayers on their state income tax forms. Pursuant to R & T Code Sections 18761-18766, the ADP is authorized to award funds for Alzheimer's Disease and Related Disorders research.

The California Health and Human Services Agency's Alzheimer's and Related Disorders Advisory Committee (Committee) worked collaboratively with the ADP to assess the impact of the Alzheimer's Disease Research Awards and determine areas of research that should be highlighted in the 2016 grant cycle. In March of 2015, the ADP conducted a survey to assess the impact of the Alzheimer's Disease Research Awards funded through the ADRDRF with past grant recipients. The survey results and literature review were presented to the Committee, which made recommendations on potential research grant categories. With the rising prevalence of Alzheimer's disease diagnoses and the associated strain on families and services, the 2016 research grant cycle was refined and the ADP recommended that caregiving, biomarkers and early detection, epidemiology (risk and preventive factors) and health disparities areas of research should be given priority. The Committee provided input on the Request for Application (RFA) document, provided suggestions for the RFA review process, and ultimately approved these four categories of study. A request for application addressing the four areas of research was released and applications were reviewed and scored by an expert panel in each of the four areas. The seven most competitive proposals were chosen for awards, and there were 15 applicants that were not funded during this grant cycle due to limited availability of funding. Unfortunately, DPH mistakenly awarded research grants, which exceeded budget authority for the ADRDRF during this grant cycle.

DPH states that it is taking internal systematic steps to prevent this error from reoccurring, and at this time is requesting a one-time increase in ADRDRF budget authority to spend an additional \$242,000 in Local Assistance for 2018-19 to honor the total research grant amounts. In 2019-20 and thereafter Local Assistance Budget Authority would return to \$539,000. Additionally, DPH would like to reduce ADRDR F State Operations Budget Authority by \$138,000 in 2018-19 and annually thereafter, to align expenditures with revenue projections.

The ADRDRF will sunset on December 1, 2020. By 2025, the population size of those aged 60 and older is projected to match the 0-19 aged population (both roughly 10 million), placing unprecedented demands on the shrinking workforce as the aging population swells. With age being the greatest risk factor for Alzheimer's, California is on track for a 33 percent increase in the population affected in less than a decade.

<b>STAFF COMMENTS/QUESTIONS</b>
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The Subcommittee requests DPH to present this proposal and explain how the \$2.5 million General Fund, included in the 2016 Budget Act for this program, was used.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 7: CHILDHOOD LEAD POISONING BUDGET CHANGE PROPOSAL (AB 1316)****PANELISTS**

- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

**Public Comment****PROPOSAL**

The Childhood Lead Poisoning Prevention Branch (CLPPB) requests 2 positions and expenditure authority of \$276,000 in State Operations from the Childhood Lead Poisoning Prevention (CLPP) Special Fund (Fund 0080). The resources are needed to develop new regulations and to carry out data analysis and reporting of the additional blood lead tests reported to CLPPB annually, as required by Assembly Bill (AB) 1316 (Quirk, Chapter 507, Statutes of 2017).

**BACKGROUND**

AB 1316 requires DPH to adopt regulations establishing a new expanded standard of care to determine whether a child is at risk for lead poisoning. AB 1316 requires that the new regulations developed by DPH include consideration of environmental risk factors for lead exposure including:

- Time spent in a home, school, or building built before 1978;
- Proximity to a former lead or steel smelter or an industrial facility that historically emitted or currently emits lead;
- Proximity to a freeway or heavily traveled roadway; and other potential risk factors for lead exposure and known sources of lead contamination.

AB 1316 requires that the regulations be developed by July 1, 2019, in consultation with medical experts, environmental experts, appropriate professional organizations, the public and others, as determined by DPH.

AB 1316 requires DPH, by March 1, 2019 and by every March 1 thereafter, to prepare and prominently post on its Internet website information that evaluates the department's progress in meeting the goals of the Childhood Lead Poisoning Prevention Act. AB

1316 requires that the information, to the greatest extent possible, include a list of the census tracts in which children test positive at a rate higher than the national average for blood lead, in exceedance of the CDC's reference level for elevated blood lead, based on the data and information received in the previous calendar year. In addition, AB 1316 requires that the data included in the information comply with all applicable state and federal laws for the protection of the privacy and security of data.

AB 1316 requires adopting new regulations to establish questions to be asked by health care providers, to assess risk of lead exposure, and will need to be developed in consultation with medical experts, environmental experts, appropriate professional organizations, and the public, as determined by DPH. Existing lead screening questionnaires have not been validated for screening at BLLs of 10 mcg/dL or below. The environmental risk factors and other potential sources of lead exposure, as specified in AB 1316, will need to be incorporated into the questionnaire. DPH anticipates the regulatory process will take a minimum of two years.

#### **STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present this proposal and respond to the questions below. Advocates provided data that shows that an estimated 88 percent of lead-poisoned kids are on Medi-Cal. All Medi-Cal-enrolled kids are required to be tested for lead exposure/poisoning twice by age three, yet only 28 percent of these kids are being tested.

1. Please confirm the information above; i.e., what percentage of Medi-Cal kids are being tested?
2. Please provide an overview of the impacts of the expansion to lower lead levels.
3. Please describe in detail how county allocations are determined.
4. Does compliance and testing levels vary by county? If so, for what reasons?
5. Statute requires DPH to provide biannual reports to the Legislature; is DPH in compliance with this mandate?

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 8: LEAD CONSTRUCTION CERTIFICATION PROCESSING DELAYS OVERSIGHT ISSUE****PANELISTS**

- **Jose Mejia**, Director, California State Council of Laborers
- **Monica Morales, MPA**, Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

**Public Comment****OVERSIGHT ISSUE**

The Childhood Lead Poisoning Prevention Branch (CLPPB) staff manages a program to ensure that construction activities involving lead are performed in a manner to eliminate existing lead hazards, and to avoid creating new lead poisoning hazards for children and other occupants, as well as the workers themselves. The primary activities include:

- Evaluating and accrediting training providers who teach lead specialists how to find and abate lead hazards.
- Evaluating the qualifications of applicants for lead certification, and granting certification to those qualified to perform lead-related construction work in an effective and lead-safe manner.

Assembly staff has received complaints from labor about the amount of time it takes DPH to certify individuals, thereby allegedly leading to significant delays in construction projects. According to DPH, the current average application turn-around time is approximately 60 days, while state regulations allow for up to 120 days. DPH also states that the program has 4.0 full-time equivalent positions and 3.0 full-time-equivalent contract positions, and no vacancies.

**BACKGROUND**

The following background information on the program was taken from the DPH website:

California's lead accreditation and certification program began in June 1994. At that time, new childhood lead poisoning prevention legislation (codified in [Health and Safety Code Section 105250 et seq.](#)) required the California Department of Public Health (CDPH) to create a program to certify lead-related construction trades-people and accredit lead-related construction training providers. Final regulations establishing this

program took effect April 5, 1995. Revisions to these regulations that established work practice standards for lead-related construction and amended the previously established accreditation and certification requirements went into effect in January 1999. These regulations were updated in April 2008.

Certification means that CDPH has evaluated and approved a person's qualifications to perform lead-related construction work in residential and public buildings. CDPH evaluates applicants to make sure they have completed State-approved training and have relevant experience and education to perform lead work.

CDPH grants five kinds of certificates:

- Lead Inspector/Assessor
- Lead Project Monitor
- Lead Sampling Technician
- Lead Supervisor
- Lead Worker

Each certificate has different training, education, and experience requirements. Certificates are granted to individual people, not to companies or businesses. Candidates for full lead Inspector/Assessor, Supervisor, and Project Monitor certification must also pass a State certification exam (in addition to the "end of course" exam). There are currently many situations which require lead-related construction professionals to be certified.

- State law requires certification for anyone doing lead hazard evaluations (inspections), lead clearance testing, lead abatement project design, or lead abatement work, in residential and public buildings in California.
- State law requires certification for workers conducting lead abatement activities in public elementary and pre-schools or public daycare centers.
- California OSHA regulations require training and certification for lead-related construction workers and supervisors who are exposed to airborne lead at or above the 8-hour permissible exposure limit (PEL) of 50 µg/m<sup>3</sup>.
- The U.S. Department of Housing and Urban Development (HUD) requires certification for those conducting pilot lead abatement projects.
- Lead inspections that are done to comply with the Federal real estate disclosure rules must be done by State certified inspector/assessors.



**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests Jose Mejia to explain the delays and challenges being experienced with this program, and DPH to describe this program and respond to the following:

1. Please describe the funding for this program.
2. What are some ways that DPH might be able to accelerate the certification timeline?

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 9: SAFE COSMETICS PROGRAM ADVOCATES' PROPOSAL****PANELISTS**

- **Janet Nudelman**, Director of Program and Policy, Breast Cancer Prevention Partners, Director, Campaign for Safe Cosmetics

**Public Comment****PROPOSAL**

The Breast Cancer Prevention Partners proposes approximately \$1.5 million (in proposed new fee revenue) in increased funding for the Safe Cosmetics Program within DPH, in order to enhance the effectiveness of the program, as described below.

**BACKGROUND**

The Breast Cancer Prevention Partners provided the following background:

In 2005, the Legislature passed the California Safe Cosmetics Act - Senate Bill 484 (Migden). SB 484 created the California Safe Cosmetics Program, requiring companies to report any cosmetic or personal care product sold in the state that contains chemicals known to the State of California to cause cancer or birth defects – this includes chemicals found on the Prop 65 list, or on any of the lists created by the scientific authoritative bodies that inform Proposition 65.

The law also gave California the authority to investigate the safety of ingredients in cosmetic and personal care products. California Attorney General Kamala Harris used this authority in 2010 to sue Brazilian Blow-out hair straightener for marketing a dangerous cosmetic product in California as “formaldehyde free” that contained 10% formaldehyde by weight. The purpose of the program is to give the Department of Public Health, and other state agencies, the information they need to better protect Californians from exposure to toxic chemicals in the cosmetics and personal care products they use every day.

The California Safe Cosmetics Program launched a searchable public database in January 2014 that presents the information companies must report to the Department of Public Health in a consumer-friendly way. Between 2009 and 2015, this public database reported that 552 companies had disclosed the sale of 65,506 cosmetic products in the state of California, containing 88 unique Prop. 65 carcinogens and reproductive toxicants. Full compliance with the Program is not being enforced, despite

existing enforcement authority within the Sherman Drug and Food Act, and the Program lacks the necessary resources to allow for full implementation of its statutory mandates. Since its enactment, state funding for this program has decreased annually. Originally funded at \$495,000, funding has decreased to approximately \$370,000, a 25% decrease.

Advocates propose increased funding to do the following:

1. Increase staffing of the program so it could fulfill its statutory mandates and fully implement the law;
2. Enable the program to address underreporting by manufacturers;
3. Enable the program to address the industry abuse of “trade secret” designations which businesses have used to conceal hundreds of toxic chemicals from public view;
4. Initiate investigations into the safety of ingredients and products;
5. Refer investigations that find potential harm to Cal/OSHA to better protect California’s salon workers;
6. Allow for increased awareness and use of the Safe Cosmetics Database and regular outreach to consumers and salon workers;
7. Require companies to report to the state’s database whether their products are intended for professional salon use or consumer use; and
8. Overhaul and modernize the SCP’s outdated platform to address database malfunctioning.

Current Activities	Increased Capacity	Additional Funding Required
<p>The California Safe Cosmetics Program (CSCP) collects information on hazardous and potentially hazardous ingredients in cosmetic products sold in California through an electronic registration system and makes the information available through a publicly accessible database.</p>	<p>Redesign and overhaul of outdated platform to address malfunctioning of database includes upgrading of software and hardware and personnel time – one-time cost.</p>	\$350,000 - 500,000
	<p>Project oversight by CA Dept. of Technology – one-time cost.</p>	\$250,000- \$400,000
	<p>Add a dedicated stream of ongoing IT support to house, maintain and trouble shoot database – annual cost.</p>	\$75,000 - \$100,000
<p>Rely on self-reported data from manufacturers</p>	<p>Regular audit of the accuracy and completeness of data reported. Investigate underreporting by manufacturers</p>	<p>Additional staffing required</p>
<p>No Enforcement of SCP Reporting Requirements</p>	<p>Create a staff position within the Food and Drug branch to support enforcement activities including collection of fines levied on companies for failure to disclose reportable ingredients.</p>	<p>Creation of an enforcement staff position</p>
<p>No enforcement by the Food and Drug branch for non-compliance</p>	<p>Create an account to receive fines that are assessed on non-reporting companies</p>	<p>Action by Food and Drug branch</p>
<p>No investigations into the safety of products or ingredients.</p>	<p>Initiate investigations into the safety of ingredients and products</p>	<p>Additional staffing required</p>
<p>Publishes database on website</p>	<p>Conduct public awareness and outreach to salon workers and consumers to increase their knowledge and use of the program</p>	<p>Creation of a Health Educator staff position required</p>

Allows manufacturers to check a box to self-designate if reportable ingredients are trade secrets	Investigate the industry abuse of "trade secret" designations. Follow-up requests for legally required trade secret documentation.	Additional staffing required
No supervisor on staff to manage the staff or the Safe Cosmetics program	Hire a supervisor scientist to supervise staff and manage the Safe Cosmetics Program	Creation of a Staff Scientist Supervisor position
No differentiation between retail and salon products in database	Re-program database and redesign reporting form to require companies to report to the state's database whether their products are intended for professional salon use or retail consumer use	Staff Programmer
No Universal Product Code (UPC) requested of companies	Re-program database and redesign reporting form to add UPC code to improve product identification and reduce errors related to user-generated data.	Staff Programmer
<b>Grand Total \$ 1,136,000 -- \$1,461,000</b>		

The California Safe Cosmetics Program (CSCP) collects information on hazardous and potentially hazardous ingredients in cosmetic products sold in California through an electronic registration system and makes the information available through a publicly accessible database. In the past 6 months alone, DPH shared that 270 database errors were reported by companies attempting to input their product data.

Redesign and overhaul of the SCP's outdated platform is needed to address malfunctioning of database plus the reporting form needs to be re-designed and database re-programmed. The one-time cost of approximately \$400,000 would also include upgrading of software and hardware and personnel time. Project oversight by the California Department of Technology would be required for the system overhaul at a one-time cost of approximately \$350,000. A dedicated stream of ongoing IT and programmer support is needed to house, maintain and trouble shoot database at an annual cost of approximately \$85,000.

***Proposed Database Performance and Management Summary***

- Redesign and upgrade the database + hardware and software - \$350,000 - \$500,000 (one-time cost)
- CA information office oversight - \$250,000 - \$400,000 (one-time cost)
- Dedicated IT stream to maintain the database \$75,000 - \$100,000
  - Grand total: \$675,000 - \$1 million

With only two full-time employees (one professional and one administrative staff), advocates state that the Safe Cosmetics Program lacks sufficient human resources to fully implement this law. By supplementing the existing 2 staff with 5 additional staff, the SCP would be able to: regularly audit the accuracy and completeness of data reported; investigate underreporting by manufacturers; initiate investigations into the safety of ingredients and products; conduct ongoing outreach and public education to raise salon worker and consumer awareness – and use - of the program; investigate the industry abuse of “trade secret” designations; and follow-up requests for legally required trade secret documentation.

The proposal states that staffing needs would cost and include:

1. A Research scientist supervisor - \$96,000 - Manage the staff and the overall Safe Cosmetics Program.
2. A Health Education Consultant - \$72,000 - Conduct public education activities for the program including outreach to cosmetology schools, creation of web-based resources, dissemination of publications, draft articles for industry publications, make videos for safe use by salon professionals, secure translation of information into multiple languages, raise overall consumer and salon worker– and use - of the program.
3. A senior scientist (research scientist 2) -- \$84,000 - Call in safety data when appropriate to conduct investigations into cosmetic product and ingredient safety; investigate unsafe salon worker exposures for possible referral to CalOSHA; collaborate with other relevant state and local agencies.
4. A junior scientist (research scientist 1- -\$72,000 - Analyze and apply data gathered by the program, conduct research projects, prepare annual data reports or updates, track trends and summarize changes to data gathered.
5. Associate Government Program Analyst (AGPA) - \$60,000 - Provide administrative support needed to produce annual mailings informing companies of their duty to report, provide technical support to companies, provide systematic data quality audits, verify changes in formulations reported by companies, confirm validity of trade secret claims, make corrections to and maintain data quality.

**Proposed Fee**

Advocates propose the creation of a fee to provide a dedicated stream of funding for this program. Under this proposed fee structure, companies would have to report annually the presence of Prop. 65 chemicals in products they sell in California. Annual re-registration, which would be a new requirement, will cause this number to fluctuate as new products are entered into the database and others are removed because they were re-formulated to remove chemicals of concern.

*Fee Estimate:*

<p>Fee assessed on the number of products reported (65,000)</p>	<p>\$30 fee for each product disclosed to the SCP with a reportable chemical.</p>	<p>\$1.95 million</p>
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**Proposed Fines**

Although there is existing authority within the Sherman Food and Drug Act to assess a fine on cosmetic companies found to be in non-compliance with the reporting requirements of the law, it has never been used. This proposal calls for the creation of a new enforcement position within the Food and Drug Branch focused on non-compliance with the Safe Cosmetics Act and the creation of an account to house the fines collected.

**Opposition to this Proposal**

The following organizations are opposed to this proposal: The Personal Care Products Council, California Chamber of Commerce, Household Commercial Products Association, ifra North America, California Manufacturers and Technology Association, and the American Chemistry Council. Generally, they assert that this program is outdated, ineffective, and duplicative of other state and federal programs and laws. Specifically, they state that manufacturers are committed to upholding U.S. Food and Drug Administration (FDA) regulations as required by the U.S. Food, Drug, and Cosmetic Act (FD&C Act). These organizations state the following:

"The law requires that every cosmetic and personal care product and its ingredients be substantiated for safety before going to market, and that they contain no prohibited ingredients. Federal regulations require ingredients to be listed on cosmetic product labels in descending order of concentration....All of the information being collected under the Safe Cosmetics Program is already found on products labels and disclosed to the FDA via the Voluntary Cosmetic Registration Program (VCRP).

"Since the Safe Cosmetics Act passed in 2005, the California Legislature enacted a sweeping Green Chemistry Law. The goal of the Safer Consumer

Products Program is to advance the design, development, and use of products that are chemically safer for people and the environment. The Safe Cosmetics Program is duplicative with the Safer Consumer Products Law which has just released its 2018-2020 draft three year priority product work plan which includes beauty, personal care and hygiene products."

<b>STAFF COMMENTS/QUESTIONS</b>
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The Subcommittee requests Janet Nudelman to present this proposal, respond to the allegations of the opposition that the program is duplicative of other state government programs, and respond to any questions.

The Subcommittee requests DPH to explain the difference between the Safe Cosmetics Program and the Safer Consumer Products Program (under the Green Chemistry Law).

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 10: HYPERTENSION AWARENESS ADVOCATES' PROPOSAL****PANELISTS**

- **Dr. Alan Shatzel**, D.O., Board President, American Heart Association, Sacramento Chapter

**Public Comment****PROPOSAL**

The American Heart Association (AHA) is requesting \$10 million to create a 3-5 county pilot program for hypertension awareness, education, prevention, and control. The pilot program would focus on the counties with the highest prevalence of hypertension and establishes best practices in participating health care systems (federally qualified health centers, rural health centers, and/or private providers). The money would be used for the following:

- Identify 5 counties with the highest prevalence of blood pressure. Using data from the 2016 CHIS, the counties with high prevalence, higher priority populations, and geographic and population-size diversity are Glenn, Los Angeles, Solano, Siskiyou, and Tulare.
- Increase utilization rates of blood pressure cuffs among participating Medi-Cal patients. Blood pressure equipment is a covered benefit, but the utilization rates are incredibly low. Participating providers are encouraged to consistently prescribe blood pressure cuffs for self-measured home blood pressure monitoring. Formalizing this best practice will empower patients to fully engage in their own self-care through home monitoring.
- Patients will record their own blood pressure readings daily and subsequently transfer their readings to a patients' electronic health record.
- The care team will require patients to return for a follow-up no later than three months after the initial diagnosis, ideally returning within one month.
- Harness the power of community health workers (CHW) to expand the care team to provide more comprehensive health care. CHWs will make home visits to high-risk patients to provide more education on blood pressure, ensure that patients are using the blood pressure cuffs properly, tracking their readings, and assist in lifestyle modification.

- The goal will be to increase the hypertension control rate to at least 70% of participating patients.

## BACKGROUND

The AHA provided the following background information:

Hypertension, also known as high blood pressure, is the force of blood in artery walls during circulation. Normal blood pressure levels are <120 mmHg systolic and <80 mmHg diastolic. When blood pressure increases and is sustained at  $\geq 130$  mmHg systolic and/or  $\geq 80$  mmHg diastolic, high blood pressure develops. In the United States, 46% of adults are identified as having high blood pressure. High blood pressure costs the nation \$48.6 billion each year, including the cost of health care services, medications to treat high blood pressure, and missed days of work.

Hypertension is a major and modifiable risk-factor contributing to heart disease and stroke, two of the leading causes of death in California and the world. High blood pressure, known as the silent killer, often has no signs or symptoms. Frequently, a person can live years without knowing that they have high blood pressure. In fact, seven in ten people having their first heart attack and eight in ten having their first stroke have high blood pressure.

In California, one in three adults have high blood pressure with some communities of color having significantly higher prevalence. In particular, hypertension disproportionately impacts the African-American and Native American communities. The prevalence of high blood pressure in African-Americans is the highest in the world and develops earlier in life. Among African-Americans age 20 and older, 45% of males and 46.3% of females have high blood pressure. In the Native American community, heart disease is the first and stroke is the sixth leading cause of death. According to recent California Health Interview Survey data, 43.4% of Native Americans adults have high blood pressure.

In November of 2017, high blood pressure was redefined for the first time in 14 years. Previously, having a reading of 140/90 was considered to show hypertension. Now, a person is hypertensive with a reading of 130/80. By lowering the definition of high blood pressure, the guidelines recommend earlier intervention to prevent further increases in blood pressure and the complications of hypertension, particularly heart disease and stroke. These new guidelines stress the importance of using proper techniques to measure blood pressure – the readings should be based on an average of two to three readings on at least two different occasions. Due to the new guidelines, it is imperative that California increase awareness for hypertension prevention.

**High Blood Pressure**

- About 85.7 million, or 34 percent, of American adults have high blood pressure. The race and gender breakdown are:
  - 34.5 percent of NH white males
  - 32.3 percent of NH white females
  - 45.0 percent of NH black males
  - 46.3 percent of NH black females
  - 28.9 percent of Hispanic males
  - 30.7 percent of Hispanic females
  - 28.8 percent of NH Asian males
  - 25.7 percent of NH Asian females
- Of the hypertensives, about 76 percent of those are using antihypertensive medication, but only 54.4 percent of those have their condition controlled.
- About 77 percent of people who have a first stroke have blood pressure higher than 140/90 mm Hg.
- Nearly half of people with high blood pressure (45.6 percent) do not have it under control.
- Projections show that by 2030, about 41.4 percent of US adults will have hypertension, an increase of 8.4 percent from 2012 estimates.

**STAFF COMMENTS/QUESTIONS**

The Subcommittee requests Dr. Shatzel to present this proposal and respond to any questions.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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## CENTER FOR ENVIRONMENTAL HEALTH

### ISSUE 11: CENTER FOR ENVIRONMENTAL HEALTH OVERVIEW AND PROGRAM UPDATES

#### PANELISTS

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

#### *Public Comment*

#### PROPOSAL

This is an informational item and the Subcommittee requests DPH to provide an overview of the Center for Environmental Health and its major programs. The January budget proposes approximately \$124 million for this Center, about 3.9 percent of the total budget of DPH.

#### BACKGROUND

The Center for Environmental Health administers programs that protect the public from unsafe drinking water; regulate the generation, handling, and disposal of medical waste; oversee the disposal of low-level radioactive waste; protects and manages food, drug, medical device, and radiation sources and licenses manufacturers of medical cannabis. The Center comprises the Division of Food, Drug, and Cannabis Safety and the Division of Radiation Safety and Environmental Management.

#### **Division of Food, Drug, and Cannabis Safety (DFDCS)**

The Division of Food, Drug and Cannabis Safety protects and improves the health of all Californians by assuring the safety of foods, drugs, medical devices, and manufactured cannabis products through investigation, inspection, and control of the sources of these products. DFDCS is comprised of the Food and Drug Branch, the Food and Drug Laboratory Branch and the Office of Manufactured Cannabis Safety.

- The Food and Drug Branch (FDB) assures that food, drugs, medical devices are safe and not adulterated, misbranded nor falsely advertised, and that drugs and medical devices are effective. FDB also conducts underage tobacco enforcement activities. FDB works in conjunction with the Food and Drug Laboratory Branch

(FDLB) to ensure proper analysis throughout the state and uses FDLB's test results to assess public health concerns.

- The FDLB provides services and leadership as a public health reference and research laboratory. To ensure the safety of all Californians, FDLB provides the necessary analytical support to screen for, identify, and quantify chemical and microbiological contaminants in food, drugs, and manufactured cannabis. FDLB also provides regulatory services for substances of abuse laboratories. All lab activities implement and support legislatively-mandated programs.
- The Office of Manufactured Cannabis Safety (OMCS) was created by the enactment of the Medical Cannabis Regulation and Safety Act of 2015. OMCS is currently developing statewide standards, regulations, and licensing procedures, and is addressing policy issues in support of cannabis manufacturers. OMCS is responsible for issuing licenses to manufacturers of cannabis products, as of January 1, 2018.

### **Division of Radiation Safety and Environmental Management (DRSEM)**

The Division of Radiation Safety and Environmental Management (DRSEM) protects and improves the health of all California residents through its environmental programs including radiation safety, inspection, laboratory testing, and regulatory activities. DRSEM is comprised of the Radiologic Health Branch, the Environmental Management Branch, and the Drinking Water and Radiation Laboratory Branch.

- The Drinking Water and Radiation Laboratory Branch (DWRLB) is the State's primary drinking water quality testing laboratory and is the only state laboratory capable of measuring chemical, microbiological, and radiochemical contaminants in drinking water and drinking water supplies. DWRLB is also the only State laboratory capable of measuring environmental radiation and radionuclides. Its primary mission is to provide analytical services, reference measurements, and technical support for RHB, EMB, and for the State Water Resources Control Board's Division of Drinking Water.
- The Environmental Management Branch (EMB) regulates the medical waste industry, pre-harvest commercial shellfish operations, and recreational health (public swimming pools, ocean beaches and organized camps); provides sanitary surveillance of state institutions; administers the Registered Environmental Health Specialist (REHS) program; oversees radiological cleanup at military base closure facilities, coordinates the State's Indoor Radon Program, the Medical Waste Management Program and CDPH's Nuclear Emergency Response Program.

- The Radiologic Health Branch (RHB) enforces the laws and regulations designed to protect the public, radiation workers, and the environment. RHB is responsible for providing public health functions associated with administering a radiation control program. This includes licensing of radioactive materials, registration of X-ray producing machines, certification of medical and industrial X-ray and radioactive material users, inspection of facilities using radiation, investigation of radiation incidents, and surveillance of radioactive contamination in the environment.

<b>STAFF COMMENTS/QUESTIONS</b>
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The Subcommittee requests DPH to provide an overview of this Center, including an overview and update on its cannabis-related work.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 12: PUBLIC BEACHES – INSPECTION FOR CONTAMINANTS (SB 1395)****PANELISTS**

- **Mark Starr, DVM, MPVM**, Deputy Director, Center for Environmental Health, Department of Public Health
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

**Public Comment****PROPOSAL**

DPH requests expenditure authority to finalize the implementation of mandated provisions of SB 1395 (Block, Chapter 928, Statutes of 2014), which requires the development of guidelines for approving the use of new rapid test methods at specific beaches so that they can be accepted as alternatives to the current conventional slower culture methods used for closing and opening public beaches.

DPH requests \$354,000 in 2018-19, \$242,000 in FY 2019-20, \$370,000 in 2020-21, and \$125,000 in 2021-22 and 2022-23 from the General Fund to fund staff that will be redirected from within DPH and equipment needed to complete this work. DPH requests expenditure authority for five additional years, and one-time equipment funding for an Auto Extraction Device to complete the laboratory workload.

**BACKGROUND**

Under the State's Beach and Bay Water Quality Monitoring Program, county public health departments perform beach water sampling and testing and close beaches or post warning signs if testing indicates water quality is below state standards. Currently approved tests are culture-based, involving a multiple sample standard for fecal contaminant indicators - total coliform, fecal coliform, and Enterococcus. Because of the time required for bacterial cultures to grow, laboratory results can take up to two days to determine if the beaches are safe. This means that if the water is contaminated, the public would be exposed to microorganisms that can make them ill during that time before the beach closure. Likewise, reopening of a beach after its water is no longer contaminated is also delayed up to two days.

In 2012, the United States Environmental Protection Agency (EPA) released a new rapid quantitative polymerase chain reaction (qPCR) method for detecting Enterococcus in recreational water, Method 1611. In 2014, US EPA released an improved version on the qPCR method, Method 1609. These new methods can return results in

approximately four hours, a significant improvement over the time required for culture-based methods. Rapid results are critical not only for beach management and public health protection decisions (i.e., opening/closing and public notification), but also because water quality can change quickly.

Since SB 1395 became law in 2014, US EPA has published another improved qPCR method, Method 1609.1, as well as criteria for site-specific approval of new methods for recreational water monitoring. Additionally, a new technology, known as droplet digital PGR (ddPCR) has become commercially available for use in public health laboratories. These developments are being incorporated into the laboratory studies currently underway at DPH.

SB 1395 requires DPH to develop guidelines for approving the use of the new rapid test methods at specific beaches so that they can be accepted as alternatives to the conventional slower culture methods. In 2015, DPH's Drinking Water and Radiation Laboratory Branch (DWRLB) received initial support for a three-year limited term position and funding to begin implementation of the mandated provisions of this law.

DPH has completed the following work to support SB 1395. The laboratory work products of the project include guidance documents on: 1) using PCR methods in public health practice; 2) validation criteria at specific beaches; 3) quality assurance requirements for PCR; 4) development of lab accreditation checklists (in cooperation with experts on PCR and beach monitoring such as the Southern California Coastal Water Research Project (SCCWRP); and 5) cooperative field studies with beach managers and stakeholders to study the performance of the PCR methods, validation criteria, and to provide practical data to inform the project and future regulations. DPH/DWRLB has worked with the SCCWRP and public laboratories, such as the San Diego County Public Health Laboratory, and San Diego County Environmental Health who have also conducted research on implementing new PCR-based water quality testing at California beaches. In addition, key work completed to support SB 1395 by DPH to date includes:

- Established laboratory tests for both culture-based and new rapid PCR methods to analyze *Enterococcus* indicator bacteria in beach water samples.
- Established proficiency in both culture-based and new rapid PCR methods for water quality monitoring methods.
- Organized and conducted a year-long study at Keller Beach in San Francisco, which is managed by the East Bay Regional Park District. The study obtained *Enterococcus* data for the new PCR methods.



- Developed detailed standard operating procedures for calibration of new PCR methods based on Enterococcus cultures.

This proposal will provide the resources for DPH to complete the work already started to develop guidelines and regulations for approving the use of new, rapid test methods that local health jurisdictions can utilize to determine overall microbiological contamination conditions in public beaches. The Keller Beach (on the San Francisco Bay - Sacramento/San Joaquin Estuary) study has provided important preliminary findings. However, California is a very large state with very different marine environments and beaches. The most widely used beaches in the highest population density areas are located in Southern California. Recognizing this, the next phase of DPH's plan is to now undertake a larger scale beach study with partners in San Diego County. DPH and San Diego are preparing to start a year-long study of 46 Southern California beaches using the new PCR methods (aka "46-beach study"). The environmental/ecological conditions in San Diego are very different than Keller Beach in San Francisco Bay. San Diego beaches are impacted by major discharges and sewage from the Tijuana watershed.

The development of modern beach water quality regulations in California will be informed by this critical study to ensure protection of California's beach visitors, resulting in practical and effective regulations with the cooperation of key stakeholders and other experts including SCCWRP. The San Diego Cooperative Beach Study will provide a substantial data set comparing the current culture-based methods for Enterococcus with the new rapid PCR methods, and will directly involve scientific experts from the SCCWRP laboratory, the San Diego County Public Health Laboratory, and DPH.

This funding will support the development of guidance documents on the use of new rapid PCR techniques for recreational water quality monitoring, the completion of the evaluation of the Keller Beach study data, applying the USEPA site validation criteria, and the analysis of several thousand water quality samples from the year-long Southern California beach study. The accumulated data from the 46-beach study will be evaluated against USEPA's site specific criteria. The funds will also support the development of training materials and provide training to laboratorians from local public health departments using the rapid PCR methods. Lastly, these resources will support the development of new regulations incorporating criteria for approval of new, rapid PCR testing methods.

As the laboratory work to implement this new and rapid testing technology is completed over the next three years, regulation development will begin in the third (overlap) year in order to incorporate flexible standards that can accommodate new technology. Beginning in 2020-21, funding will also support the drafting of regulations for public beaches and ocean water to address alternative microbial indicators used in combination with related test methods and protective standards, specify acceptable test methods used to analyze ocean water, and update the minimum protective

bacteriological standards for waters adjacent to public beaches. Additionally, these resources will support the preparation of guidance documents and outreach materials for local environmental health jurisdictions, and will support investigations of reported water borne illness events at monitored beach sites to determine if additional work is needed regarding approved microbiological analytical methods used to monitor the recreational water quality. This last phase will be completed by the end of 2022-23.

<b>STAFF COMMENTS/QUESTIONS</b>
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The Subcommittee requests DPH to present this proposal and respond to any questions.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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## CENTER FOR HEALTHCARE QUALITY

### ISSUE 13: CENTER FOR HEALTH CARE QUALITY OVERVIEW, PROGRAM UPDATES, AND LICENSING AND CERTIFICATION ESTIMATE

#### PANELISTS

- **Jean Iacino**, Deputy Director, Center for Health Care Quality, DPH
- **Scott Vivona**, Acting Deputy Director, Center For Health Care Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Health Care Quality, DPH
- **Benjamin Menzies**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

#### *Public Comment*

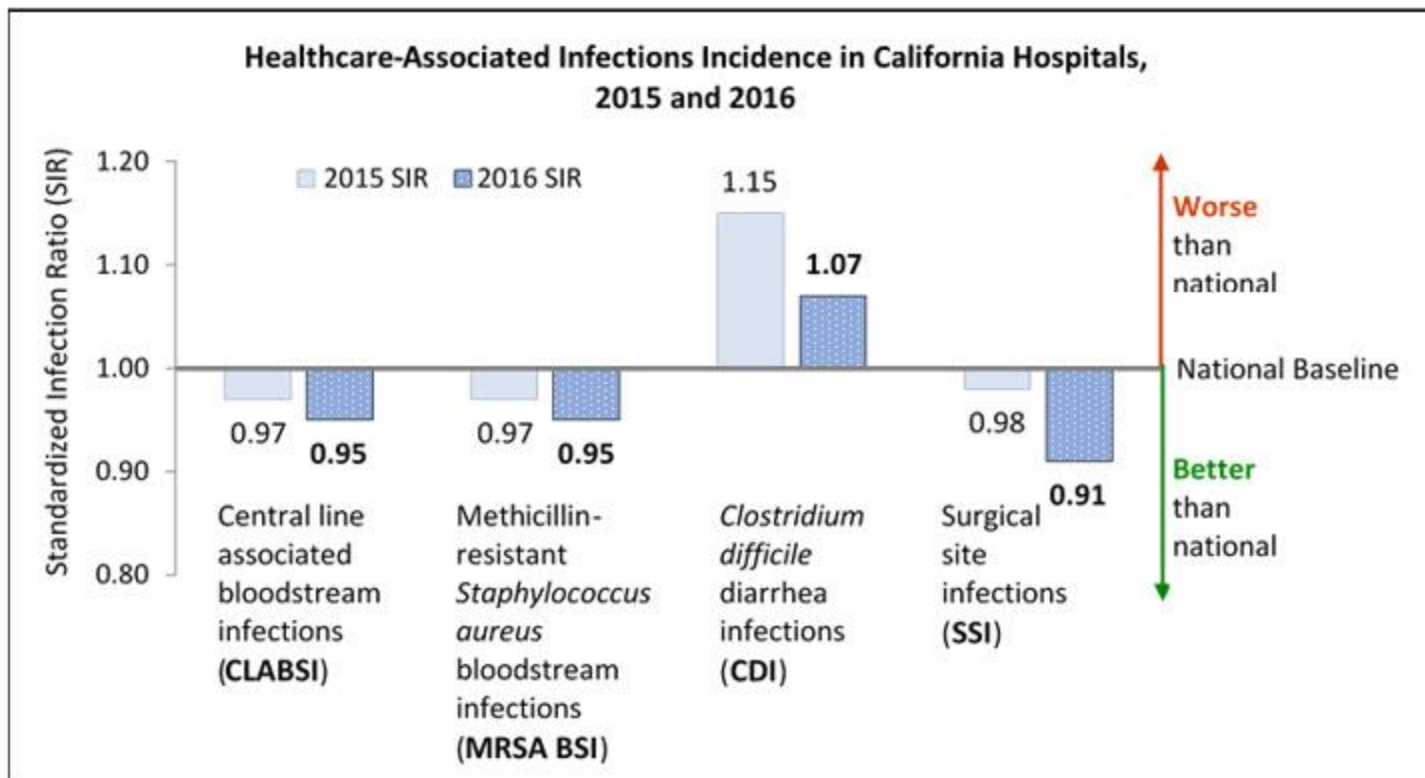
#### OVERVIEWS

##### ***Hospital Acquired Infections***

The Healthcare-Associated Infections (HAI) Program is one of two programs in the [Center for Health Care Quality](#). The Program was created by mandate to oversee the prevention, surveillance, and reporting of HAI in California's general acute care hospitals. HAI are the most common complication of hospital care. The Centers for Disease Control and Prevention (CDC) estimates that 722,000 HAI occur each year in the U.S., resulting in approximately 75,000 deaths, and 1 in 25 hospital patients contract an HAI during the course of their hospital care. Since 2010, the HAI Program has produced annual public reports of hospital HAI data to inform choices of healthcare consumers and prompt providers to take actions to prevent infections. DPH also actively engages in HAI prevention by performing site visits to hospitals with high infection rates, convening regional HAI prevention collaboratives, and providing infection prevention education to providers. The HAI Program also consults with local public health agencies to assist with investigations of unusual infection occurrences or outbreaks that occur in healthcare facilities.

California hospitals report specific types of healthcare-associated infections (HAI) to DPH (per Health and Safety Code section 1288.55). DPH publishes hospital HAI data to provide consumers and healthcare purchasers information to evaluate the quality of care among California hospitals. DPH intends for this annual report to prompt hospitals to act by accelerating HAI prevention efforts. Most HAIs can be prevented if health care personnel strictly follow existing infection prevention practices for all care encounters and communicate infection information when transferring patients.

In 2016, 400 general acute care hospitals reported 18,924 HAIs to DPH. Overall, DPH finds that California hospitals are better than national standard populations (baselines) for three types of infections and worse than the national baseline for one infection type (figure).



The lowest statewide HAI incidence is among deep and organ/space surgical site infections, which occur as a result of contamination during surgery (ratio of reported and predicted infections, 0.91). The highest statewide HAI incidence (ratio 1.07) is for a type of diarrhea that occurs when a patient is treated with antibiotics and inadvertently ingests the organism, *C. difficile*, a common pathogen in health care facilities. For more details, the full report can be accessed at the following link:

<https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/AnnualHAIRports.aspx>

**Licensing & Certification (L&C) Program Estimate**

The Governor's budget proposes a 5.2 percent increase for L&C funding for 2018-19 as shown in the chart below:

<b>L&amp;C Program Funding &amp; Positions (Dollars in Thousands)</b>			
<b>Funding Source</b>	<b>2017-18 2017 Budget Act</b>	<b>2018-19 Proposed</b>	<b>Budget Act to Budget Year Change</b>
General Fund Transfer	\$3,700	\$3,700	\$0 (0%)
Federal Funds	\$97,570	\$102,056	\$4,486 (4.6%)
Internal Department Quality Improvement Account	\$2,389	\$2,304	-\$85 (-3.6%)
State Health Facilities Citation Penalty Account	\$2,144	\$2,144	\$0 (0%)
Federal Health Facilities Citation Penalty Account	\$398	\$398	\$0 (0%)
Reimbursements	\$9,706	\$10,436	\$730 (7.5%)
L&C Program Fund	\$147,626	\$156,110	\$8,484 (5.6%)
<b>Total Funds</b>	<b>\$263,533</b>	<b>\$277,148</b>	<b>\$13,615 (5.2%)</b>
Field Positions – Health Facilities Evaluator Nurses	600.2	600.2	0
Field Positions – Other	453.1	453.1	0
Headquarters Positions	251.0	251.0	0
<b>Total L&amp;C Positions</b>	<b>1,304.3</b>	<b>1,304.3</b>	<b>0</b>

The Governor's budget includes the following estimates for key L&C accounts:

<b>L&amp;C Accounts Fund Conditions 2018-19</b>			
	<b>State Health Facilities Citation Penalties Account</b>	<b>Federal Health Facilities Citations Penalties Account</b>	<b>Internal Department Quality Improvement Account</b>
Beginning Balance	\$5,989,000	\$14,387,000	\$17,966,000
Revenues	\$2,685,000	\$3,350,000	\$2,662,000
Total Resources	\$8,674,000	\$17,737,000	20,628,000
Expenditures	\$4,340,000	\$973,000	\$2,304,000
<b>Fund Balance</b>	<b>\$4,334,000</b>	<b>\$16,764,000</b>	<b>\$18,324,000</b>

*State Health Facilities Citation Penalties Account* - Used primarily to pay for temporary managers and/or receivers for skilled nursing facilities (SNFs). Funds from this account also have been used to support the Department of Aging's Long Term Care Ombudsman programs.

*Federal Health Facilities Citations Penalties Account* - Used to fund innovative facility grants to improve the quality of care and quality of life for residents of SNFs or to fund innovative efforts to increase employee recruitment or retention subject to federal approval.

*Internal Departmental Quality Improvement Account* - Used to fund internal L&C program improvement efforts. Funded by administrative penalties on hospitals.

### **Health Facility Licensing Fees**

Existing statute requires the L&C Program to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

Licensing fee rates are structured on a per “facility” or “bed” classification and are collected on an initial license application, an annual license renewal, and change of ownership. The fees are placed into a special fund—the Licensing and Certification Special Fund.

The fee rates are calculated as follows:

- Combining information on projected workload hours for various mandated activities by specific facility type (such as skilled nursing home, community-based clinic, or hospital).
- Calculating the state workload rate percentage of each facility type in relation to the total state workload.
- Allocating the baseline budget costs by facility type based on the state workload percentages.
- Determining the total proposed special fund budget cost comprised of baseline, incremental cost adjustments, and credits.
- Dividing the proposed special fund cost per facility type by the total number of facilities within the facility type or by the total number of beds to determine a per facility or per bed licensing fee.

The following table shows the most up-to-date fees, as reflected in the 2018 Fee Report, including proposed supplemental fees for Los Angeles County facilities:

**Table 1: Health Care Facility License Fee Table**

Facility Type	Fee Per Bed or Facility	Number of Licensed Facilities/Beds		License Fees (see Note Below)			
		2017-18	2018-19	2017-18	2018-19		
					Total Combined Fees	Statewide	Los Angeles County Supplemental Fee**
Acute Psychiatric Hospitals	Bed	8,233	8,238	\$ 515.04	\$ 591.32	\$ 540.79	\$ 50.53
Adult Day Health Centers	Facility	266	267	\$ 6,241.53	\$ 6,241.53	\$ 6,241.53	\$ -
Alternative Birthing Centers	Facility	11	13	\$ 2,737.22	\$ 2,737.22	\$ 2,737.22	\$ -
Chemical Dependency Recovery Hospitals	Bed	496	496	\$ 321.33	\$ 321.33	\$ 321.33	\$ -
Chronic Dialysis Clinics	Facility	555	575	\$ 3,407.02	\$ 4,426.98	\$ 3,407.02	\$ 1,019.96
Community Clinics	Facility	1,373	1,408	\$ 1,387.87	\$ 1,529.46	\$ 1,457.26	\$ 72.20
Congregate Living Health Facilities	Bed	909	1,174	\$ 602.78	\$ 778.86	\$ 632.92	\$ 145.94
Correctional Treatment Centers	Bed	2,493	2,493	\$ 1,108.39	\$ 1,163.81	\$ 1,163.81	\$ -
General Acute Care Hospitals	Bed	74,517	75,260	\$ 515.04	\$ 591.32	\$ 540.79	\$ 50.53
Home Health Agencies	Facility	1,603	1,617	\$ 2,761.90	\$ 3,601.96	\$ 2,761.90	\$ 840.06
Hospices (2-Year License Total)	Facility	1,007	1,150	\$ 2,970.86	\$ 3,788.92	\$ 2,970.86	\$ 818.06
Hospice Facilities	Bed	88	88	\$ 524.16	\$ 524.16	\$ 524.16	\$ -
Intermediate Care Facilities (ICF)	Bed	5,330	5,294	\$ 602.78	\$ 778.86	\$ 632.92	\$ 145.94
ICF/Developmentally Disabled (DD)	Bed	10,338	12,475	\$ 1,121.33	\$ 1,459.18	\$ 1,177.40	\$ 281.78
ICF/DD - Habilitative	Bed			\$ 1,121.33	\$ 1,459.18	\$ 1,177.40	\$ 281.78
ICF/DD - Nursing	Bed			\$ 1,121.33	\$ 1,459.18	\$ 1,177.40	\$ 281.78
Pediatric Day Health and Respite Care Facility	Bed	318	318	\$ 290.59	\$ 305.12	\$ 305.12	\$ -
Psychology Clinics	Facility	21	21	\$ 2,852.91	\$ 2,852.91	\$ 2,852.91	\$ -
Referral Agencies	Facility	2	2	\$ 3,728.78	\$ 3,728.78	\$ 3,728.78	\$ -
Rehab Clinics	Facility	12	12	\$ 501.07	\$ 636.13	\$ 526.12	\$ 110.01
Skilled Nursing Facilities *	Bed	120,140	120,047	\$ 606.17	\$ 782.25	\$ 636.31	\$ 145.94
Surgical Clinics	Facility	36	34	\$ 4,804.88	\$ 6,115.16	\$ 5,045.13	\$ 1,070.03

Data Source: 2018-19 Licensing Fees Chart

Note: Beginning in 2018-19, under the proposed trailer bill aimed at reconciling the differential cost associated between LA County contract cost and the Department licensing and certification program cost, a separate assessment fee would be imposed for all of LA County district facilities.

\* SNF fee includes: \$632.92 statewide basic license fee, \$145.94 LA County supplemental license fee, and \$3.39 Department of Aging's SNF Long Term Care Ombudsman Program fee.

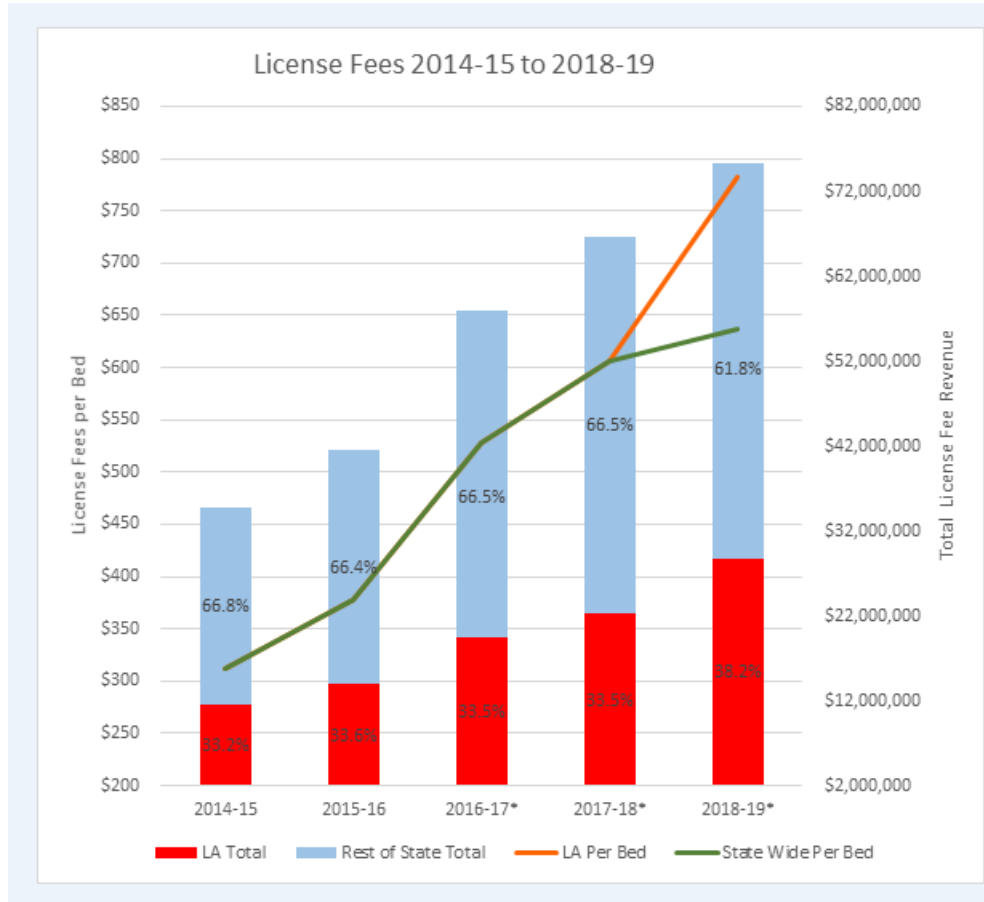
\*\* CDPH does not assess a supplemental fee on facilities that Los Angeles County Department of Public Health does not regulate.

### Stakeholder Response

Generally, stakeholders (i.e., skilled nursing facilities and hospitals) have significant concerns with the amount of increases to the fees over the past several years and as reflected in this new fee schedule, both statewide and in reference to the new supplemental fees being proposed for LA County facilities. These stakeholders have expressed to Subcommittee staff that they do not oppose the fee increases outright, however their concerns reflect the fact that they do not see increased performance and service from either the State DPH or LA County DPH, which should accompany steady fee increases. For example, stakeholders point out that LA County may be improving on its performance in completing new complaint investigations, yet they are doing no work on the "legacy backlog." However, LA County explains that their contract with the state is very specific about what work is funded and not funded, and the backlog work is not

funded. They agree that this is a significant problem, and state that the state should either do the work or fund LA County to do the work.

The California Association of Health Facilities provided the following chart to show the steady increase in licensing fees over the past four years:



**BACKGROUND**

The DPH Licensing and Certification Program (L&C) is responsible for regulatory oversight of licensed health facilities and health care professionals to ensure safe, effective, and quality health care for Californians. L&C fulfills this role by conducting periodic inspections and compliant investigations of health facilities to ensure that they comply with federal and state laws and regulations. L&C licenses and certifies over 7,500 health care facilities and agencies in California, such as hospitals and nursing homes, in 30 different licensure and certification categories.



The federal Centers for Medicare and Medicaid Services (CMS) contracts with L&C to evaluate facilities accepting Medicare and Medicaid (Medi-Cal in California) payments to certify that they meet federal requirements. L&C evaluates health care facilities for compliance with state and federal laws and regulations, and it contracts with Los Angeles County to license and certify health care facilities located in Los Angeles County. L&C's field operations are implemented through district offices, including over 1,000 positions, throughout the state, and through a contract with Los Angeles County. In addition, L&C oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

### ***Long-Standing Deficiencies Within L&C***

There have been long-standing concerns about the L&C program. Multiple recent legislative oversight hearings, an audit released by the California State Auditor in October 2014, and media reports have highlighted significant gaps in state oversight of health facilities and certain professionals that work in these facilities.

### ***CMS Concerns***

On June 20, 2012, CMS sent a letter to DPH expressing its concern with the ability of DPH to meet many of its current Medicaid survey and certification responsibilities. In this letter, CMS states that its analysis of data and ongoing discussions with DPH officials reveal the crucial need for California to take effective leadership, management, and oversight of DPH's regulatory organizational structure, systems, and functions to make sure DPH is able to meet all of its survey and certification responsibilities.

The letter further states that "failure to address the listed concerns and meet CMS' expectations will require CMS to initiate one or more actions that would have a negative effect on DPH's ability to avail itself of federal funds." In this letter, CMS acknowledges that the state's fiscal situation in the last few years, and the resulting hiring freezes and furloughs, has impaired DPH's ability to meet survey and certification responsibilities.

As a result of these concerns, CMS set benchmarks that DPH must attain and is requiring quarterly updates from DPH on its work plans and progress on meeting these benchmarks. The state was in jeopardy of losing \$1 million in federal funds if certain benchmarks were not met. (Ultimately, \$138,123 in federal funding was withheld.)

### ***State Auditor Concerns***

In October 2014, the State Auditor released a report regarding the L&C program. The findings from this report include:

- DPH's oversight of complaints processing is inadequate and has contributed to the large number of open complaints and entity reported incidents. For example, the Auditor found more than 11,000 complaints and entity-reported incidents open for an average of nearly a year.

- DPH does not have accurate data about the status of investigations into complaints against individuals.
- DPH has not established formal policies and procedures for ensuring prompt completion of investigations of complaints related to facilities or to the individuals it certifies.
- DPH did not consistently meet certain time frames for initiating complaints and ERIs.

### ***Hospital Complaint Investigations & Staffing Ratios***

While the focus of audits, reports and media coverage has been on nursing homes, DPH acknowledged that they also faced a backlog of complaint investigations that are hospital-based. Moreover, DPH explains that DPH only investigates a hospital's compliance with statutorily-required staffing ratios when they receive a complaint about the hospital. DPH stated in 2015 that the staffing/resources provided in 2015 would address the full spectrum of workload and backlogs within L&C, including complaint investigations for both nursing homes and hospitals. DPH also stated that these resources will enable L&C to do licensing surveys of hospitals every three years, as is statutorily-required.

### ***Budgets Address Problems***

The 2014-15 and 2015-16 budgets took actions to address these concerns.

**2014-15 Budget.** The Legislature adopted trailer bill language that required L&C to:

- Report metrics, beginning October 2014 and on a quarterly basis, on: (1) investigations of complaints related to paraprofessionals certified by DPH; (2) long-term care health facility complaints, investigations, state relicensing, and federal recertification surveys; and (3) vacancy rates and hiring within L&C.
- Report by October 2016 the above information for all facility types.
- Assess the possibilities of using professional position classifications other than health facility evaluator nurses to perform licensing and certification survey or complaint workload by December 1, 2014.
- Hold semiannual meetings, beginning August 2014, for all interested stakeholders to provide feedback on improving the L&C program to ensure that Californians receive the highest quality of medical care in health facilities.

**2015-16 Budget.** The 2015-16 budget included:

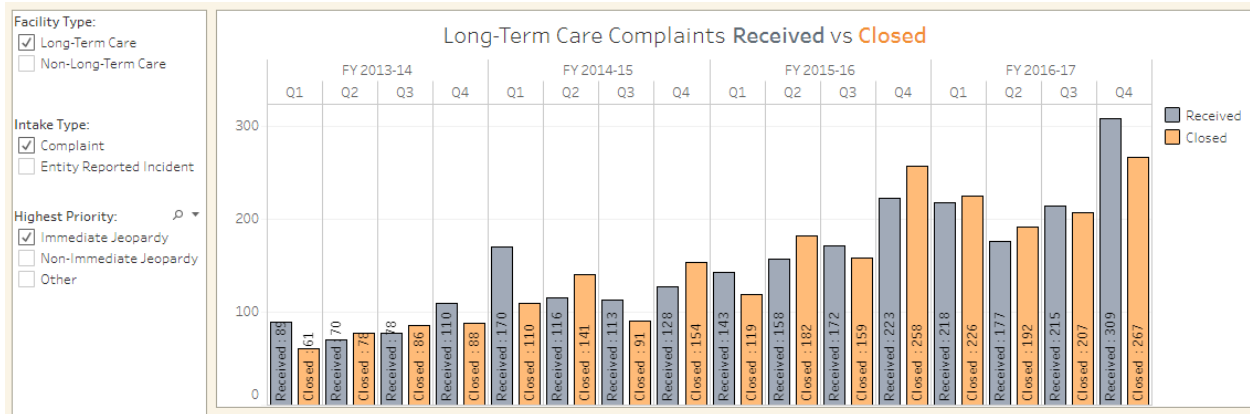
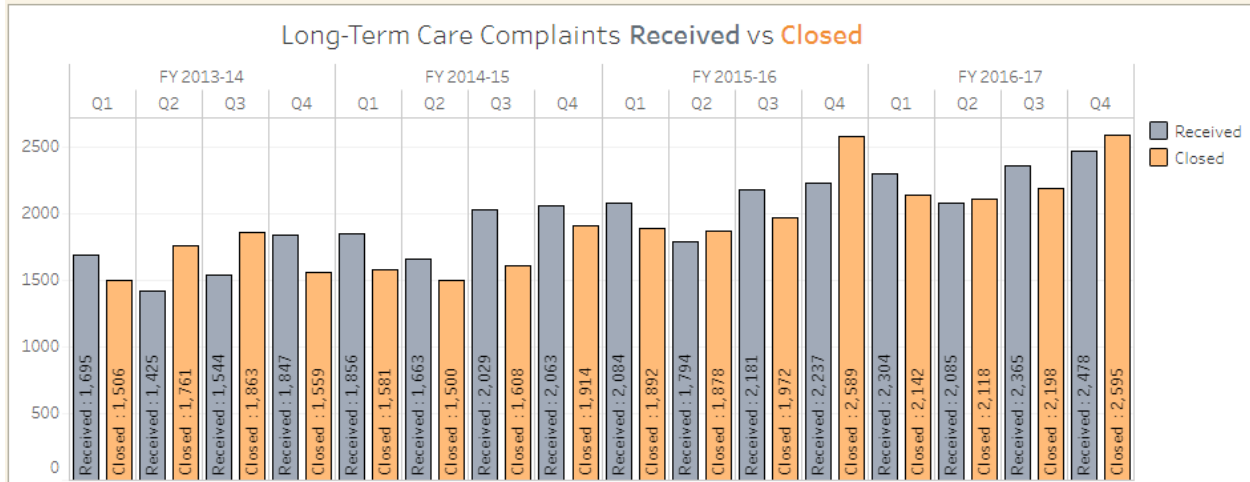
- **Workload.** An increase of \$19.8 million in 2015-16 for 237 positions (123 positions to become effective July 1, 2015 and 114 positions on April 1, 2016), and an increase in expenditure authority of \$30.4 million in 2016-17 from the L&C Special Fund to address the licensing and certification workload.
- **Quality Improvement Projects.** An increase of \$2 million in 2015-16 from the Internal Departmental Quality Improvement Account to implement quality improvement projects.
- **Los Angeles County Contract.** An increase in expenditure authority of \$14.8 million from the L&C Special Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County.
- **Los Angeles County Contract Monitoring.** An increase of \$378,000 from the L&C Special Fund and three positions, to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities.
- **Complaint Investigation Timelines.** The Legislature adopted trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities. This language requires the department to do the following:
  - For complaints that involve a threat of imminent danger or death or serious bodily harm that are received on or after July 1, 2016, the department must complete the investigation within 90 days of receipt. This time period may be extended up to an additional 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
  - For all other categories of complaints received on or after July 1, 2017, the department must complete the investigation within 90 days of receipt. This time period may be extended up to an additional 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a

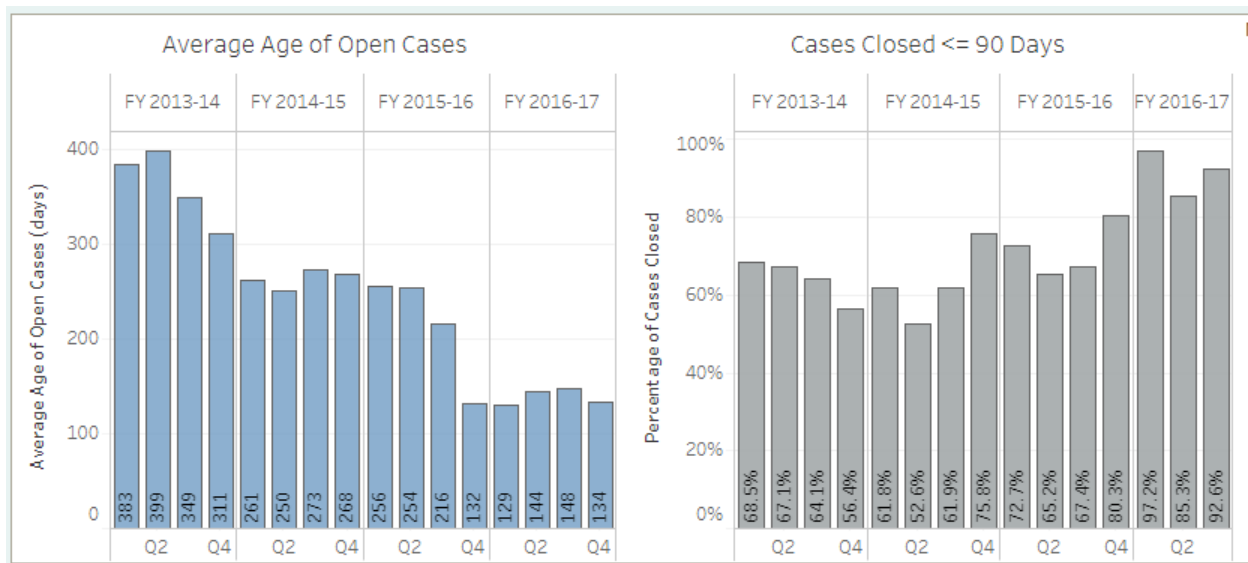
result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.

- For all complaints received on or after July 1, 2018, the department must complete the investigation within 60 days of receipt. This time period may be extended up to an additional 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
- Report on an annual basis (in the Licensing and Certification Fee report) data on the department's compliance with these new timelines.
- Beginning with the 2018-19 Licensing and Certification November Program budget estimate, the department must evaluate the feasibility of reducing investigation timelines based on experience implementing the timeframes described above.
- States the intent of the Legislature that the department continues to seek to reduce long-term care complaint investigation timelines to less than 60 days with a goal of meeting a 45-day timeline.
- **Notification for Hospital Complaints.** The Legislature adopted trailer bill language to require the department to notify hospitals and complainants if there are extenuating circumstances impacting the department's ability to meet complaint investigation timelines. This notification would include the basis for the extenuating circumstances and the anticipated completion date.
- **Long-Term Care (LTC) Ombudsman Program.** The Legislature directed \$1 million (one-time) from the State Health Facilities Citation Penalties Account to the LTC Ombudsman Program at the Department of Aging in 2015-16 and adopted trailer bill language to increase the L&C fee for skilled nursing facilities to generate \$400,000 to support the LTC Ombudsman Program on an ongoing-basis. This increase in funds would be used to support skilled nursing facility complaint investigations and quarterly visits. The 2016-17 and 2017-18 budgets also included increased resources for the Ombudsman Program, specifically with a one-time \$1 million funding shift from the State Health Facilities Citation Account and budget bill language that provides for this shift annually mid-year, starting in 2018-19, if certain conditions for the Account balance are met.

**Quarterly Data Reporting**

The following charts are components of the CHCQ's most recent quarterly quality metrics reporting on their website, for the fourth quarter of 2016-17 (ending June 30, 2017):





### Skilled Nursing Facilities 2017 Increased Staffing Ratios Implementation Update

The 2017 budget package includes trailer bill that increases the required staffing ratios in skilled nursing facilities to 3.5 hours per patient day, including 2.4 hours per patient day specifically for certified nurse assistants (CNAs), effective July 1, 2018. The language also provides for two different types of waivers from these new requirements for which facilities can apply, as follows:

1. Workforce Waiver - an exemption for facilities that can demonstrate that the workforce is not sufficient for them to hire the required number of nurses.
2. Acuity Waiver - an exemption for facilities that already meet the 3.5 ratio with registered nurses, but not the 2.4 ratio with CNAs, and can demonstrate that a higher level of patient acuity justifies an exemption.

DPH is tasked with developing and adopting regulations for the enforcement of staffing ratios and implementation of these waivers from the new higher staffing ratios. According to stakeholders, DPH issued draft guidelines that, in their view, would automatically disqualify hundreds of facilities from even applying for these waivers. They state that the guidelines make facilities ineligible if the facility has ever received a citation, regardless of how long ago and whether or not the citation was safety-related. They point out that these facilities may have changed ownership since the citation was issued, and now they meet the new 3.5 staffing ratio.

Stakeholders request a delayed, phased-in implementation beyond July 1, 2018, in order to: 1) give facilities more time to prepare; 2) settle the issues associated with DPH

implementation of the waivers; and 3) allow the funding to catch up with the required workforce increases.

<b>STAFF COMMENTS/QUESTIONS</b>
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The Subcommittee requests DPH to present an overview of the L&C program and estimate, and respond to the following:

- 1) Please summarize L&C's status in regard to meeting the new facility complaint timeframe requirements that became effective July 1, 2016, 2017, and 2018.
- 2) Please provide an update on state program vacancies and turnover, and how the state is attempting to address these vacancies and high turnover.
- 3) Are there regional differences for the cost of doing business for the state in more difficult-to-access/rural communities or high cost-of-living/doing-business regions? If so, how are those differences addressed within the state fees?
- 4) Please describe the implementation of the new higher nurse staffing ratios and waivers, and the status of the progress of the skilled nursing facilities in being able to meet the new standards by July 1, 2018.

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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**ISSUE 14: LOS ANGELES COUNTY CONTRACT BUDGET CHANGE PROPOSAL AND TRAILER BILL****PANELISTS**

- **Jean Iacino**, Deputy Director, Center for Health Care Quality, DPH
- **Scott Vivona**, Acting Deputy Director, Center For Health Care Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Health Care Quality, DPH
- **Angelo Bellomo**, Deputy Director for Health Promotion, Los Angeles County Department of Public Health
- **Benjamin Menzies**, Finance Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

**Public Comment****PROPOSAL**

DPH requests an increase in expenditure authority of \$1.9 million from the Licensing and Certification Program Fund (Fund 3098). The increase will augment the Los Angeles (LA) County contract to fund a one-year extension of the existing contract for FY 2018-19, accounting for updates to: the indirect cost rate, the employee benefits rate, personnel costs, and lease costs. Additionally, DPH is requesting trailer bill language to assess a supplemental license fee on facilities located in LA County to offset additional costs necessary to regulate these entities in LA County.

**BACKGROUND**

DPH, CHCQ is responsible for regulatory oversight of licensed health care facilities and health care professionals to ensure safe, effective, and quality health care for all Californians. CHCQ fulfills this role by conducting periodic inspections and complaint investigations of health care facilities to ensure they comply with federal and state laws and regulations. DPH receives funds through a grant from the Centers for Medicare and Medicaid Services (CMS) and licensing fees paid by health care facilities. CHCQ licenses and certifies over 10,000 health care facilities and agencies in California in 30 different licensure and certification categories.

Approximately one third of licensed and certified health care facilities in California are located in LA County, and 20 percent of the long term care complaints and entity-reported incidents received statewide each year are generated in LA County.

For over 30 years, DPH has contracted with LA County to perform federal certification and state licensing surveys and investigate complaints and entity-reported incidents for approximately 2,900 health care facilities in the LA County area. The 2015 Budget Act



authorized an additional \$14.8 million in expenditure authority to 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. In July 2015, DPH 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. DPH augmented the contract by \$2.1 million in 2016-17 and again in 2017-18 by \$1.1 million.

DPH proposes to extend the current contract for an additional year (July 1, 2018 through June 30, 2019). For the contract beginning July 1, 2019, DPH and LA County are negotiating the terms of a revised contract that emphasizes pay for performance with defined quality, quantity, and service metrics.

DPH seeks to extend the term of the current contract by one year. DPH must augment the existing contract to continue contracting with LA County for the current level of workload. If this request is not approved, the LA County contract will not be fully funded and the County will not be able to pay for the staff necessary to complete the contracted workload. This will result in increased vacancies to offset the insufficient funding, fewer complaints being addressed timely, greater backlogs of open complaints, and the potential loss of future CMS grant awards due to lack of compliance.

This proposal includes \$1.9 million to fund changes to the LA County employee benefit rates, indirect cost rate, personnel costs, and lease costs, which will increase the total annual budget of the contract to \$47.7 million.

### ***Trailer Bill***

The requested trailer bill language will enable DPH to assess a supplemental license fee on facilities located in LA County to offset additional costs necessary to regulate these entities in LA County. The proposed supplemental fee will prevent the need to increase license fees on health care facilities statewide to absorb these increasing contract costs. The supplemental fee will allow health care facilities in LA County to receive services comparable to other health care facilities statewide and ensure that facilities pay license fees that are more commensurate with their regulatory costs.

### ***Los Angeles County Reaction***

Based on discussions with DPH, LA County was anticipating a \$4.6 million augmentation for the fourth year of their contract to be included in the January budget, as compared to the \$1.9 million that is actually proposed. LA County and DPH disagree on the appropriateness of the calculation that DPH used for indirect costs, which was a different calculation process than in prior years and resulted in lower costs. LA County states that they do not know why DPH changed the calculation, and that the new process is inconsistent with historical practices, and DPH states that they changed it at LA County's request. Furthermore, LA County believes that their costs should be based on a 100 percent staff non-vacancy rate, whereas DPH used a rate of 91 percent for year four of the contract, as compared to 97 percent for year three of the contract.

LA County and other stakeholders raise questions and concerns about the proposed fee increase:

- It is unclear if the fee increase is intended to cover any 2018-19 costs or only 2019-20 (and on-going) costs associated with a new, revised contract.
- DPH states that they do not intend to make the supplemental fees more than a 30 percent increase over what the fees would be otherwise, however this is not formally proposed for statute or regulation.
- It is unclear what new workload, and performance metrics, will be included in the new contract that justify the proposed supplemental fees.

#### **STAFF COMMENTS/QUESTIONS**

The Subcommittee requests DPH to present their proposal, and requests LA County to present their concerns, and respond to the following:

1. Is DPH of the belief that the Licensing and Certification program cost estimates are accurate throughout the State? Several years ago, DPH was before this committee explaining that the funding methodology needs to be reevaluated. We have not received an update on if the funding methodology has been revised.
2. Would any of the revenue generated from the proposed Los Angeles County Supplemental Fee be allocated to DPH? If so, for what purposes?
3. How were the fees calculated for those non-Long-Term Care facilities where DPH is doing the majority of the work and has assigned a minimal amount of the work to Los Angeles County? Is DPH planning to apply the supplemental fee across the board even to those non-LTC facilities where the County is not contracted for 100% of the work? If so, please explain the rationale for that.
4. Will DPH's Public Health Licensing & Certification Program Fund, Long-Term Care Quality Assurance Fund, and Health Facilities Citation Penalties Account be distributed to Los Angeles County licensing and certification activities as well?
5. Was DPH aware of Los Angeles County's original request to increase funding for FY 18-19 by \$4.6 million to offset increases in labor and operating costs? What are the reasons DPH chose to use a different methodology in calculating indirect costs?

6. For what reasons is DPH only funding positions at approximately 92% in FY 18-19?
7. Since Los Angeles County is only receiving \$1.9 million in FY 18-19, instead of the requested \$4.6 million, why is DPH proposing a supplemental fee increase for health care facilities in LA County that will result in additional \$8.6 million?

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**Staff Recommendation: Subcommittee staff recommends no action at this time.**

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