AGENDA

ASSEMBLY BUDGET SUBCOMMITTEE NO. 1

ON HEALTH AND HUMAN SERVICES

ASSEMBLYMEMBER DR. JOAQUIN ARAMBULA, CHAIR

MONDAY, MARCH 6, 2017

2:30 P.M. - STATE CAPITOL ROOM 127

ITEMS TO BE HEARD

LIST OF PANELISTS IN ORDER OF PRESENTATION

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: OVERVIEW OF DEPARTMENT AND BUDGET

- **Karen Smith**, MD, MPH, Director and State Public Health Officer, Department Of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 2: OVERVIEW AND PROGRAM UPDATES FOR CENTER FOR CHRONIC DISEASE

- **Mark Starr**, Acting Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Greg Oliva**, Assistant Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 3: TOBACCO TAX (PROPOSITIONS 99 AND 56) FUNDING

- **Greg Oliva**, Assistant Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 4: CHILDHOOD LEAD POISONING BUDGET CHANGE PROPOSAL

- **Mark Starr**, Acting Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance

- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 5: LICENSING AND CERTIFICATION ESTIMATE

- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 6: LOS ANGELES COUNTY CONTRACT BUDGET CHANGE PROPOSAL

- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Cynthia Harding, MPH,** Chief Deputy Director, Los Angeles County Department of Public Health

Public Comment

ISSUE 7: PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT BUDGET CHANGE PROPOSAL

- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 8: HEALTHCARE-ASSOCIATED INFECTIONS BUDGET CHANGE PROPOSAL

- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 9: CALQUALITYCARE.ORG – STAKEHOLDER PROPOSAL

- **Leslie Ross**, PhD, CalQualityCare.org, PI/Project Director, University of California San Francisco
- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 10: OVERVIEW AND PROGRAM UPDATES FOR CENTER FOR FAMILY HEALTH

- **Connie Mitchell**, Deputy Director, Center For Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 11: WOMEN INFANTS & CHILDREN (WIC) PROGRAM ESTIMATE

- **Connie Mitchell**, Deputy Director, Center For Family Health, DPH
- **Christine Nelson**, Chief, Women Infants & Children Division, Center For Family Health, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 12: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

- **Connie Mitchell**, Deputy Director, Center For Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, DPH
- **Richard Olney**, MD, MPH, Chief, Genetic Disease Screening Program, Center For Family Health, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ISSUE 13: NEWBORN SCREENING BUDGET CHANGE PROPOSAL

- **Connie Mitchell**, Deputy Director, Center For Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, DPH
- **Richard Olney**, MD, MPH, Chief, Genetic Disease Screening Program, Center For Family Health, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

ITEMS TO BE HEARD

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: OVERVIEW OF DEPARTMENT AND BUDGET

PANELISTS

- **Karen Smith**, MD, MPH, Director and State Public Health Officer, Department Of Public Health
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **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. The DPH's goals are to achieve health equities and eliminate health disparities; eliminate preventable disease, disability, injury, and premature death; promote social and physical environments that support good health for all; prepare for, respond to, and recover from emerging public health threats and emergencies; improve the quality of the workforce and workplace; and promote and maintain an efficient and effective organization.

DPH Budget

The Governor's proposed 2017-18 budget provides DPH approximately $3.3 billion overall, representing a $289.3 million (total funds), or 8.8 percent, increase from the current year DPH budget, primarily reflecting the infusion of Proposition 56 (2016 tobacco tax) funding. General Fund dollars of $132.2 million make up just 4 percent of the department's total budget while federal funds make up approximately 52 percent of the total department budget.

DEPARTMENT OF PUBLIC HEALTH
(Dollars In Thousands)

Fund Source	2015-16 Actual	2016-17 Projected	2017-18 Proposed	CY to BY $ Change	CY to BY % Change
General Fund	**$128,330**	**$148,211**	**$132,221**	**-$15,990**	**-10.8%**
Federal Funds	1,592,872	1,696,107	1,727,858	31,751	1.9%
Special Funds & Reimbursements	362,445	428,462	675,763	247,301	57.7%
Licensing & Certification	114,827	142,287	146,536	4,249	3.0%
Genetic Disease Testing Fund	114,944	132,311	136,624	4,313	3.3%
WIC Manufacturer Rebate Fund	217,652	223,377	216,412	-6,965	-3.1%
AIDS Drug Assistance Program Rebate Fund	181,009	242,813	267,413	24,600	10.1%
Total Expenditures	**$2,712,079**	**$3,013,568**	**$3,302,827**	**$289,259**	**9.6%**
Positions	3,352.0	3,468.2	3,632.0	163.8	4.7%

The following table shows the proposed expenditures by program area:

DPH Program Expenditures
(In Thousands)

Program	2015-16 Actual	2016-17 Estimate	2017-18 Proposed	CY to BY $ Change	CY to BY % Change
Emergency Preparedness	$88,968	$87,866	$102,526	$14,660	16.7%
Chronic Disease Prevention & Health Promotion	$262,524	$317,844	$554,579	$236,735	74.5%
Infectious Disease	$512,102	$588,729	$597,796	$9,067	1.5%
Family Health	$1,491,332	$1,613,446	$1,631,106	$17,660	1.1%
Health Statistics & Informatics	$26,856	$27,370	$27,518	$148	0.5%
County Health Services	$7,197	$4,103	$4,087	-$16	-0.4%
Environmental Health	$91,316	$97,702	$108,468	$10,766	11.0%
Health Facilities	$218,858	$263,293	$262,765	-$528	-0.2%
Laboratory Field Services	$12,926	$13,135	$13,982	$847	6.4%
Total Expenditures	**$2,712,079**	**$3,013,568**	**$3,302,827**	**$289,259**	**9.6%**

BACKGROUND

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 to respond to the following:

1. What are DPH's highest priorities at this time?

2. Please explain the $16 million reduction in General Fund.

3. What is the average State General Fund contribution to public health across all fifty states?

4. Should California be spending more or less of its own General Fund on public health? Which DPH programs are underfunded?

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

CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

ISSUE 2: OVERVIEW AND PROGRAM UPDATES FOR THE CENTER FOR CHRONIC DISEASE

PANELISTS

- **Mark Starr**, Acting Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Greg Oliva**, Assistant Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **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 the 2016 budget, including: Biomonitoring and Alzheimers Prevention.

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 $554,579,000 for this Center, approximately 17 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. 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. Our staff 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.

Background on Diabetes
Diabetes - a chronic disease affecting one in ten adults in California - is a growing epidemic that affects the health and economic wellbeing of families, employers, and communities. Diabetes is a serious health condition in which the body has a shortage of insulin, a decreased ability to use insulin, or both. It is a major risk factor for heart disease and stroke. Uncontrolled diabetes can also lead to significant disability, including blindness, amputations, and kidney failure. The number of adults in California with diabetes has risen dramatically since 1990, and continues to increase.

The UCLA Center for Health Policy Research reports, in their March 2016 policy brief, *Prediabetes in California: Nearly Half of California Adults on Path to Diabetes*:

"In California, more than 13 million adults (46 percent of all adults in the state) are estimated to have prediabetes or undiagnosed diabetes. An additional 2.5 million adults have diagnosed diabetes. Altogether, 15.5 million adults (55 percent of all California adults) have prediabetes or diabetes. Although rates of prediabetes increase with age, rates are also high among young adults, with one-third of those ages 18-39 having prediabetes. In addition, rates of prediabetes are disproportionately high among young

adults of color, with more than one-third of Latino, Pacific Islander, American Indian, African-American, and multiracial Californians ages 18-39 estimated to have prediabetes. Policy efforts should focus on reducing the burden of prediabetes and diabetes through support for prevention and treatment."

Public Health Advocates provides the following statistics that should set off alarms for the State of California, particularly from a budgetary perspective:

- 125 amputations per week are done in California;
- 55% of California adults have been *diagnosed* with either diabetes or pre-diabetes (some additional percentage remain undiagnosed);
- 1/3 of all children born in the year 2000 will become diabetic;
- ½ of all children of color born in the year 2000 will become diabetic;
- $15 billion is the annual health care costs of diabetes in California.

Although $15 billion is the amount of all healthcare costs, not just Medi-Cal, it is important to note that diabetes rates are highest in low-income populations, and therefore it can be assumed that over half of all Californians with diabetes are enrolled in Medi-Cal and therefore the Medi-Cal program likely bears more than half of the cost.

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 prevention.

2. Please provide an update on DPH's participation in the National Violent Death Reporting System (VDRS) and on California's VDRS.

3. Which water quality test would the EHLB recommend as the most cost-effective screen of water quality and safety in this state?

Diabetes Prevention

4. Please discuss the Department's approach to the diabetes epidemic.

5. What does DPH recommend the state do to prevent diabetes?

6. What is the value of the Diabetes Prevention Program and how can the state benefit most from it?

7. Is the state aggressively working to prevent diabetes in kids? In Latino kids? In the Central Valley?

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

ISSUE 3: TOBACCO TAX (PROPOSITIONS 99 AND 56) FUNDING

PANELISTS

- **Greg Oliva**, Assistant Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSALS

DPH proposes $178.5 million in Proposition 56 funding and 26 permanent positions to reinforce and increase its existing tobacco control programs and efforts, currently funded with Proposition 99 (tobacco tax) funds. 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

Beginning April 1, 2017, the 2016 Tobacco Tax Act increases the excise tax on cigarettes by $2.00 per pack (based on a pack of 20 cigarettes) and imposes an equivalent excise tax on other tobacco products. A portion of the 2016 Tobacco Tax Act revenues will be 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 Public Health to provide enforcement related activities and $30 million annually for Public Health'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 the Department of Public Health and the Department of Education for tobacco prevention, and 5 percent to the University of California for medical research.

CDPH 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. CDPH TCB administers funds to local health departments and competitively selected community-based organizations, runs a statewide media campaign, and completes comprehensive evaluation efforts.

DPH reports that, since California's Tobacco Control Program began in 1989, cigarette consumption per capita declined by 71 percent and adult smoking declined by 51 percent. Smoking prevalence among high school students declined by 51 percent since 2000. However, many groups still smoke at higher rates than the statewide average of 11.6 percent. For example, 17.3 percent of Medi-Cal beneficiaries smoke. Tobacco-related diseases result in approximately 40,000 adult deaths in California each year. The economic burden of smoking in California is $18.1 billion. Real dollar per capita expenditures for tobacco control in California declined by approximately 80 percent from 1989 to 2013.

This proposal is for $178.5 million annually, subject to revenue levels, to CDPH TCB tobacco use prevention and reduction efforts including media, competitive grants, local lead agencies, evaluation, and program administration.

CDPH TCB will track process and tobacco use outcome measures to monitor the program's impact and provide accountability. Major tobacco use outcome measures to be tracked are described in California Tobacco Facts and Figures 2016. These include: smoking prevalence, tobacco consumption, secondhand smoke and aerosol exposure, cancer incidence and mortality rates, tobacco retail marketing, tobacco sales to minors, and smoking cessation. A Tobacco-Related Health Equity Report Card will be developed and used to track progress made towards reducing tobacco use among vulnerable population groups most impacted by tobacco use.

Proposition 99 Adjustments

Proposition 99 (Tobacco Tax) Revenues
2017-18
(Dollars in Thousands)

	Health Education Account 20%	Hospital Services Account 35%	Physicians' Services Account 10%	Research Account 5%	Public Resources Account 5%	Unallocated Account 25%	TOTALS
Beginning Balance	$7,933	$38,383	$19,849	$1,611	$1,499	$28,264	**$97,540**
Total Revenues	$55,136	$79,591	$22,733	$13,788	$6,261	$51,163	**$228,673**
Totals Available	**$63,069**	**$117,975**	**$42,582**	**$15,400**	**$7,761**	**$79,427**	**$326,213**

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

Proposition 99 Health Education Account (*Dollars in Thousands*)					
	2015-16 Actuals	**2016-17 Estimate**	**2017-18 Proposed**	**CY to BY $ Change**	**CY to BY % Change**
Beginning Balance	$14,379	$17,882	$7,933	-$9,949	-55.6%
Total Revenues	$64,847	$60,389	$55,136	-$5,253	-8.7%
Totals Available	**$79,226**	**$78,272**	**$63,069**	**-$15,203**	**-19.4%**

The LAO provided the following chart in their recent 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[a]	Amount	Purpose
Step 1: Replace Lost Revenues		
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.
Step 2: Pay for Tax Administration		
State Board of Equalization (BOE)—administration	5 percent of remaining funds	For costs to administer the tax.
Step 3: Allocate Specific Amounts for Various State Entities[b]		
Various state entities—enforcement[c]	$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.
Step 4: Distribute Remaining Funds for State Health Programs		
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.

[a]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.

[b]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.

[c]Funds distributed to Department of Justice ($36 million), DPH ($6 million), and BOE ($6 million).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the portion of this Budget Change Proposal that is proposed to be used to fund the Tobacco Control Program within the Center for Chronic Disease.

The Subcommittee also requests the administration to provide an overview of Proposition 99 funding, including the estimates included in the January 2017 budget, describing trends and any changes to program funding being proposed in the budget.

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

ISSUE 4: PROTECTING CHILDREN FROM LEAD EXPOSURE BUDGET CHANGE PROPOSAL

PANELISTS

- **Mark Starr**, Acting Deputy Director, Center For Chronic Disease Prevention and Health Promotion, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH, Division of Environmental and Occupational Disease Control, Childhood Lead Poisoning Prevention Branch (CLPPB) requests expenditure authority from the Childhood Lead Poisoning Prevention Fund (Fund 0080) of $480,000 in Fiscal Year (FY) 2017-18, $158,000 in FY 2018-19, and annually thereafter, and 1 permanent position to allow CLPPB to conduct a Project Approval Life Cycle (PAL) for a new Surveillance, Health, Intervention, and Environmental Lead Database (SHIELD) to support electronic laboratory reporting of blood lead tests, management of lead-exposed children, and assessment of sources of lead exposure, and to replace the existing Response and Surveillance System for Childhood Lead Exposures (RASSCLE 2).

BACKGROUND

The California CLPP Program works to prevent the damaging effects of lead. Young children considered at increased risk for lead exposure are primarily those receiving services from a publicly funded program for low-income children, such as California Medicaid (Medi-Cal), Child Health and Disability Prevention, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and those living in deteriorated or recently renovated older housing (which may be associated with lead-based paint and lead-contaminated dust and soil). These children are targeted by CLPP activities (described immediately below) and are required to be blood lead tested (California Code of Regulations (CCR), Title 17, Division 1, Chapter 9, §37000 et seq.). Children of any background and age may be blood lead tested, if circumstances have put them at risk for lead exposure, and children identified with high blood lead levels are eligible for CLPP services regardless of documentation status or income.

Direct services to children are provided by 43 local CLPP programs in 40 counties and 3 cities, which contract with the CDPH CLPPB for funding (the contracted CLPP programs

are in the cities of Berkeley, Long Beach, and Pasadena and most of the counties in California, with the exception of 18 counties). Services include: outreach to populations at increased risk of lead exposure; specific educational and other defined services for children identified with increased blood lead levels; full public health nursing and environmental services (including home visits and inspections) to children who are identified with the highest blood lead levels and who are considered cases of lead poisoning; and, follow-up to ensure that sources of lead exposure are removed.

The CDPH CLPPB is responsible for direct public health nurse and environmental investigations and for providing services in 18 non-contracted jurisdictions, which may collaborate with CLPPB on some CLPP activities, but do not choose to formally contract. CLPPB also provides: information on laboratory reported lead tests to the local CLPP programs; and statewide surveillance, data analysis, oversight, outreach, and technical assistance for all counties.

To perform these activities, CDPH CLPPB relies on an electronic information system, RASSCLE 2, which receives reports on laboratory tests and supports management and monitoring of lead-exposed children. Any laboratory performing blood lead analyses is required to report the lead test results electronically to CLPPB (Health and Safety Code Section 124130). In addition to providing a portal for laboratories to report approximately 700,000 test results each year, the data system aggregates and compares repeat tests done on individual children, evaluates each test to determine whether medical and public health intervention is required, and serves as a health record system to support management of children with lead exposure. Alerts are issued to local jurisdictions about children needing acute services, and local programs can view their jurisdiction's information online. Without this system, CLPP programs would not be able to provide services to children, oversight to clinicians caring for lead-exposed children, or to identify and evaluate sources of lead exposure.

Design of the current system (RASSCLE 2) began in 2001, and the system was activated in 2006. The CLPPB has taken steps to provide necessary upgrades to maintain functionality and ensure maximum lifespan of the system. Measures also have been, and continue to be, taken to add new functions such as Geographic Information System (GIS) mapping services. This approach is aimed at keeping the system functioning over the next six years during the development of SHIELD. The Budget Act of 2016 included additional funding of $500,000 annually from the Childhood Lead Poisoning Prevention Fund through FY 2019-20, for short-term system changes. Additionally, $180,000 was provided in FY 2016-17 and $320,000 in FY 2017-18 for GIS mapping functions to support assessment of suspected environmental sources of lead exposure. However, the current system is approaching its capacity and is becoming at risk for future system failure.

STAFF COMMENTS/QUESTIONS

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

1. What are the most common sources of lead exposure for children in California?
2. Are schools tested for lead in paint, drinking water, or elsewhere?

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

CENTER FOR HEALTHCARE QUALITY

ISSUE 5: LICENSING AND CERTIFICATION PROGRAM ESTIMATE

PANELISTS

- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

Licensing & Certification (L&C) Program Estimate

The Governor's budget proposes a 0.2 percent decrease to L&C funding for 2017-18, representing a decrease in federal funds which will no longer be passed through DPH to the Department of Health Care Services, as shown in the chart below:

L&C Program Funding & Positions (Dollars in Thousands)			
Funding Source	**2016-17 2016 Budget Act**	**2017-18 Proposed**	**Budget Act to Budget Year Change**
Federal Funds	$95,386	$97,296	$1,910
Internal Departmental Quality Improvement Account	$2,304	$2,389	$85
State Health Facilities Citation Penalty Account	$2,144	$2,144	$0
Federal Health Facilities Citation Penalty Account	$973	$973	$0
Reimbursements	$16,444	$9,672	-$6,772
L&C Program Fund	$145,987	$150,236	$4,249
Total Funds	**$263,238**	**$262,710**	**-$528 (-0.20%)**
Field Positions – Health Facilities Evaluator Nurses	600.2	679.2	79.0 (%)
Field Positions – Other	415.1	476.7	61.6 (%)
Headquarters Positions	245.0	251.0	6.0 (%)
Total L&C Positions	**1,260.3**	**1,406.9**	**146.6 (11.6%)**

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

L&C Accounts Fund Conditions 2017-18			
	State Health Facilities Citation Penalties Account	**Federal Health Facilities Citations Penalties Account**	**Internal Departmental Quality Improvement Account**
Beginning Balance	$7,125,000	$11,041,000	$16,960,000
Revenues	$2,145,000	$2,986,000	$3,188,000
Total Resources	$9,270,000	$14,027,000	20,148,000
Expenditures	$4,340,000	$973,000	$2,389,000
Fund Balance	**$4,930,000**	**$13,054,000**	**$17,759,000**

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 License 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 fee data reflects the 2016 Licensing Fee report as DPH has not yet released the 2017 report:

License Fees by Facility Type			
	Fee Per Bed or Facility	FY 2015-16 Fee Amounts	FY 2016-17 Proposed Fee Amounts
Acute Psychiatric Hospitals	Bed	$319.90	447.86
Adult Day Health Centers	Facility	$4,997.90	6,241.53
Alternative Birthing Centers	Facility	$2,380.19	2380.19
Chemical Dependency Recovery Hospitals	Bed	$229.52	321.33
Chronic Dialysis Clinics	Facility	$2,862.63	3,407.02
Community Clinics	Facility	$862.03	1,206.84
Congregate Living Health Facilities	Bed	$374.40	524.16
Correctional Treatment Centers	Bed	$688.44	963.82
District Hospitals Less Than 100 Beds	Bed	$319.90	447.86
General Acute Care Hospitals	Bed	$319.90	447.86
Home Health Agencies	Facility	$2,761.90	2761.90
Hospices (2-Year License Total)	Facility	$2,970.86	2970.86
Hospice Facilities	Bed	$374.40	524.16
Intermediate Care Facilities (ICF)	Bed	$374.40	524.16
ICF - Developmentally Disabled (DD)	Bed	$696.48	975.07
ICF - DD Habilitative	Bed	$696.48	975.07
ICF - DD Nursing	Bed	$696.48	975.07
Pediatric Day Health/Respite Care	Bed	$180.49	252.69
Psychology Clinics	Facility	$1,771.99	2,480.79
Referral Agencies	Facility	$2,795.53	3,728.78
Rehab Clinics	Facility	$311.22	435.71
Skilled Nursing Facilities	Bed	$377.77	527.51
Surgical Clinics	Facility	$2,984.40	4,178.16
Special Hospitals	Bed	$319.90	447.86

Data Source: FY 16-17 Licensing Fees Chart

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 Problems with 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.

- See the following website for the publication of this data: http://www.DPH.ca.gov/programs/Pages/CHCQPerformanceMetrics.aspx

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.

Report on the Use of Non-Registered Nurses in L&C Regulatory Activities. As noted above, SB 857 required DPH to provide a report to the Legislature assessing the possibilities of using professional position classifications other than registered nurses (RNs) to perform licensing and certification survey or complaint investigation workload in order to help evaluate if using different position classifications would help the program recruit and retain staff and address concerns with L&C. This report was received on February 22, 2016. According to the report, DPH found the following:

> **Importance of Using RNs as Surveyors**. The department believes RNs possess the technical, professional, and clinical expertise needed to appropriately evaluate patient care and safety, assess health facility operations in a highly regulated environment, interpret regulations, interact with patients and facility staff, and apply the clinical judgment needed to perform licensing and certification surveys and complaint investigations. This includes serious patient care events that occur in health care settings, and the potential for those events to lead to situations that cause or are likely to cause serious injury or death (immediate jeopardy).
>
> In the department, RNs normally investigate a complaint or ERI. Most complaint and ERI investigations involve clinical or clinically-related questions and issues. The investigations are multifaceted and include medical record reviews, interviews, and observations related to the allegations in the complaint or ERI. These activities include interviews with facility clinicians and patients whose physical and mental condition may be clinically compromised.
>
> Using RNs allows the survey staff to respond to shifting circumstances that may occur during the course of an investigation. During a survey or an investigation, a surveyor may identify a patient safety issue that requires them to stop what they are doing to investigate, or an investigation may require more clinical judgment than was initially anticipated. Because RNs are competent to perform any survey task, they have the ability to fulfill any role on the survey team at any time. This allows the department to address shifting and immediate workload demands. Further, the increasing level of acuity of residents in general acute care hospitals and skilled nursing facilities requires a higher level of clinical skill among surveyors. Filling most surveyor positions with RNs reflects the nature of the department's workload, and the requisite background required to perform capably as a surveyor in all relevant situations.

Potential for Using Licensed Vocational Nurses (LVNs) to Perform Surveys or Complaint Investigations. In the past, the department has hired LVNs in the health facilitator evaluator (HFE) I classification to perform survey and investigation work. This is the only classification in the HFE series performing survey and investigation work for which an LVN could meet the minimum qualifications. The current minimum qualifications for the HFET and the HFE I is a four-year degree in specified medical fields. Each two years of LVN experience can substitute for one year of education. Thus, an LVN would require eight years of experience to meet the minimum qualifications. When the pending HFE reclassification proposal becomes effective, the HFET and HFE I classifications will be eliminated.

Using information from the Department of Consumer Affairs, the department determined that approximately 130,339 LVNs are licensed in California, compared with over 500,000 RNs licensed in California. Given the education or experience requirements needed in addition to an LVN license, the lack of an appropriate civil service classification, and the small number of LVNs compared with RNs, the department determined that limiting the applicant pool to LVNs would likely not yield enough viable candidates to result in a notable impact on workload.

Potential for Using Other Classifications to Perform Medical Information Breach Investigations. The department had approximately 5,100 medical information breach cases pending investigation as of June 30, 2015. Medical breach investigations represent about 10 percent of the total annual complaints/ERIs received.

Currently, the department uses HFENs as the primary investigators of medical information breaches. However, this type of investigation does not require the clinical expertise of an RN. Since July 1, 2014, the department has had a small staff of non-RNs investigating medical information breaches. Expanding this investigative staff with Associate Governmental Program Analysts (AGPAs) or Special Investigators may be an effective way to relieve some workload from HFENs, enabling them to focus their clinical expertise on survey and other complaint/ERI investigation work. The applicant pool for AGPAs and SIs is substantial. The AGPA classification is the journey-level analyst civil service classification used by departments statewide and the SI classification is also used statewide.

In December 2015, using existing position authority, the department initiated a pilot program that will use 13 AGPAs or SIs spread across the six regions of the state to investigate medical information breaches. These AGPAs or SIs will address medical breach investigation workload in each of the 14 district offices and Los Angeles County but will not be physically located in every district office.

The department proposes a three-year pilot to allow time to recruit and train the AGPAs or SIs and collect sufficient data to assess this model's effectiveness, as well as feasibility of expanding the program. The department will periodically provide updates in its November estimates on the pilot's progress.

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

Field Operations

Long-Term Care Health Facility Complaints

Data as of June 30, 2016 (Cumulative through Quarter 4, SFY 2015-16)

TIMELINESS

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Reporting Period	Complaints Received During Reporting Period	Complaints Completed During Reporting Period (Regardless of Receipt Date)	Immediate Jeopardy (IJ) (24 hours)*		Non-Immediate Jeopardy (Non-IJ) (10 working days)*		Number of Complaints Completed During Reporting Period by Working Days from Receipt to Completion				Complaints Completed by Working Days from Receipt to Completion, as a Percentage of Total Completed			
			Number Received	Percent Initiated Timely	Number Received	Percent Initiated Timely	≤90	91-180	181-365	>365	≤90	91-180	181-365	>365
Current State Fiscal Year														
2015-2016, Cumulative through Quarter 4	8,286	8,323	701	97%	7,289	97%	5,787	1,139	640	757	70%	14%	8%	9%
Previous State Fiscal Years														
2014-2015	7,609	6,601	527	96%	6,757	96%	4,670	795	561	575	71%	12%	8%	9%
2013-2014	6,511	6,689	347	95%	5,800	97%	4,019	848	696	1,126	61%	13%	11%	17%
2012-2013	6,412	6,737	226	99%	5,670	98%	4,030	1,023	789	895	61%	15%	12%	14%
2011-2012	6,161	5,986	236	97%	5,478	97%	3,400	1,030	646	910	52%	16%	10%	14%

This table identifies how long it takes Licensing and Certification Program's Field Operations to initiate and complete complaint cases related to Skilled Nursing Facilities, Intermediate Care Facilities (including all those serving Developmentally Disabled), Congregate Living Health Facilities, and Pediatric Day Health and Respite Care Facilities. Licensing and Certification Program's Field Operations considers a case complete when it has fully completed the investigation and documented the case as completed in its database.

Table Notes:

- Column A shows the number of new complaints Field Operations received during the respective reporting period.
- Column B shows the number of complaints Field Operations completed during the respective reporting period, regardless of the reporting period in which the complaint was received.
- Columns C and D show the number of Immediate Jeopardy (IJ) complaints received, and the percentage of those received that Field Operations initiated within 24 hours during the respective reporting period. This includes all complaints prioritized as level A by federal requirements upon intake.
- Columns E and F show the number of Non-IJ complaints received that require an investigation, and the percentage of those received that Field Operations initiated within 10 working days during the respective reporting period. This includes all complaints prioritized as levels B-E by federal requirements upon intake.
- Columns G - J show the range of days Field Operations took to complete open complaints during the reporting period (G+H+I+J=B).
- Columns K - N show the percentage of open complaints completed within specific intervals during the reporting period (K=G/B, L=H/B, M=I/B, N=J/B). Numbers may not add to 100 due to rounding.

*Health and Safety Code section 1420(a)(1) requires the onsite investigation of a LTC complaint that involves imminent danger of death or serious bodily harm ("IJ – Immediate Jeopardy) to be initiated within 24 hours of receipt; and requires investigation of a LTC complaint that does not involve a threat of immediate danger of death or serious bodily harm (non-IJ) to be initiated within 10 working days.

Field Operations

Long-Term Care Health Facility Entity Reported Incidents (ERIs)

Data as of June 30, 2016 (Cumulative through Quarter 4, SFY 2015-16)

TIMELINESS

	A	B	C	D	E	F	G	H	I	J	K	L
Reporting Period	ERIs Received During Reporting Period	ERIs Completed During Reporting Period (Regardless of Receipt Date)	Immediate Jeopardy (IJ) (24 hours)*		Number of ERIs Completed During Reporting Period by Working Days from Receipt to Completion				ERIs Completed by Working Days from Receipt to Completion, as a Percentage of Total Completed			
			Number Received	Percent Initiated Timely	≤90	91-180	181-365	>365	≤90	91-180	181-365	>365
Current State Fiscal Year												
2015-2016, Cumulative through Quarter 4	19,905	18,346	581	94%	14,465	2,009	1,099	773	79%	11%	6%	4%
Previous State Fiscal Years												
2014-2015	20,419	19,356	459	96%	14,708	1,966	1,893	789	76%	10%	10%	4%
2013-2014	19,759	20,896	302	96%	14,266	2,573	2,239	1,818	68%	12%	11%	9%
2012-2013	20,318	21,002	217	95%	14,143	2,930	2,199	1,730	67%	14%	10%	8%
2011-2012	20,519	21,782	240	99%	14,191	2,775	2,337	2,479	65%	13%	11%	11%

This table identifies how long it takes Licensing and Certification Program's Field Operations to initiate and complete ERI cases related to Skilled Nursing Facilities, Intermediate Care Facilities (including all those serving Developmentally Disabled), Congregate Living Health Facilities, and Pediatric Day Health and Respite Care Facilities. Licensing and Certification Program's Field Operations considers a case complete when it has fully completed the investigation and documented the case as completed in its database.

Table Notes:

- Column A shows the number of new ERIs Field Operations received during the respective reporting period.
- Column B shows the number of ERIs Field Operations completed during the respective reporting period, regardless of the reporting period in which the ERI was received.
- Columns C and D show the number of Immediate Jeopardy (IJ) ERIs received, and the percentage of those received that Field Operations initiated within 24 hours during the respective reporting period. This includes all ERIs prioritized as level A by federal requirements upon intake.
- Columns E - H show the range of days Field Operations took to complete open ERIs during the reporting period (E+F+G+H=B).
- Columns I - L show the percentage of open ERI cases completed within specific intervals during the reporting period (I=E/B, J=F/B, K=G/B, L=H/B). Numbers may not add to 100 due to rounding.

*IJ: Field Operations follows Health and Safety Code section 1420(a)(1), requiring the onsite investigation of a LTC complaint that involves imminent danger of death or serious bodily harm ("IJ – Immediate Jeopardy") to be initiated within 24 hours of receipt.

L&C's Oversight of the Los Angeles County Contract. As noted above, the 2015-16 budget contained funding and positions to improve the state's oversight of the Los Angeles County Contract. According to DPH, CHCQ has significantly increased its monitoring of Los Angeles County's (LAC's) work performance. Below are some of the actions CHCQ has undertaken:

- Developed specific workload tracking worksheets to ensure compliance with contracted work as established in the new three-year contract.

- Dedicated one Field Operations Branch Chief whose primary function is to oversee LAC performance.

- Hired a former L&C district manager as a retired annuitant to conduct ongoing oversight and monitoring of the Los Angeles County contract performance through onsite monitoring, statistical data analysis, and audit review of required federal and state survey workload, as well as, assessment of proper assignment of scope and severity, triaging, timeliness and completion of complaints and entity reported incident (ERI) investigations.

- Established the LA County Monitoring Unit (LACMU) and hired a HFE nurse supervisor with 2 HFEN nurse surveyors to conduct concurrent onsite quality review of the federal recertification survey process through a defined State

Observation Survey Analysis (SOSA) process. [A SOSA survey is where one of DPH's trained HFENs observes an entire recertification survey to ensure proper survey protocols are used. The SOSA surveyor relays observations to LAC supervisors on areas needing improvement.]

- As of January 2016, conducted 11 SOSA surveys at selected skilled nursing facilities within the four LA District Offices and identified problems with the survey process involving sample selection, general investigation, and deficiency determination. The results from the SOSA surveys were shared with the LA County Health Facilities Inspection Division (HFID) managers and supervisors. CHCQ identified a need for additional training and developed a corrective action plan. CDPH and the federal Centers for Medicare and Medicaid Services will conduct a joint training in April 2016 to improve process and quality review outcomes.

- Conducted quality review and evaluation of complaints and ERI investigations by implementing quality improvement (QI) studies to review prioritization of complaints, investigative process, and principles of documentation.

- Developed and implemented a review tool, "Supervisor Worksheet for Complaint/ERI investigation by Surveyors," to document LAC supervisors review and discussion with survey staff of deficiency findings and citations.

- Conducted quality assurance audits on compliance with the abbreviated survey process, allegation prioritization, and standard level of review for principles of documentation for; intermediate care facilities, end stage renal disease facilities, and home health agencies.

- Conducted bi-monthly calls with individual LAC program managers to discuss work performance and enforcement actions.

- Conducted bi-monthly calls with the Health Facilities Inspection Division (HFID) branch chief, assistant branch chief and program managers to discuss ongoing operational issues and monitoring activities.

- Documented non-compliance with Licensing and Certification's policies and procedures, and requested a corrective action plan to address the problem and ensure compliance.

- Required LA County HFID supervisors and managers to participate in monthly District Administrators and District Managers (DA/DM) conference calls and required LAC managers to attend in-person, quarterly DA/DM meetings.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present an overview of the L&C program and estimate, and respond to the following:

1) Please provide an update on L&C's efforts to hire and retain nurse surveyor staff.

2) Please provide an update on L&C's oversight of the Los Angeles County contract.

3) Please provide an update on L&C's status in regard to meeting the new complaint timeframe requirements that became effective July 1, 2016.

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

ISSUE 6: LOS ANGELES COUNTY CONTRACT BUDGET CHANGE PROPOSAL

PANELISTS

- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office
- **Cynthia Harding, MPH,** Chief Deputy Director, Los Angeles County Department of Public Health

Public Comment

PROPOSAL

CDPH, Center for Health Care Quality (CHCQ), requests an ongoing increase in expenditure authority of $1.1 million from the State Department of Public Health Licensing and Certification Program Fund. The increase will augment the Los Angeles County contract to account for the annual cost of a 3 percent salary increase effective October 2016, and two 2 percent salary increases effective in October 2017 and April 2018. Los Angeles (LA) County has its own request to increase this augmentation from $1.1 million to $2.6 million, as described in more detail below.

BACKGROUND

CDPH is responsible for regulatory oversight of licensed health care facilities and health care professionals to ensure safe, effective, and quality health care for Californians. CDPH 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. CDPH receives funds through a grant from the Centers for Medicare and Medicaid Services (CMS) and licensing fees paid by health care facilities.

CDPH licenses and certifies over 7,500 health care facilities and agencies in California in 30 different licensure and certification categories. For over 30 years, CDPH has contracted with LA County to perform federal certification and state licensing surveys and investigate complaints and entity-reported incidents for approximately 2,500 health care facilities in the LA County area. Roughly one third of licensed and certified health care facilities in California are located in LA County, and 18.7 percent of the long-term care complaints and entity-reported incidents received statewide each year are generated in LA County.

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

Due to the timing of LA County's approval of salary increases, these costs were unforeseen and not included in the current contract. 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 in a timely manner, greater backlogs of open complaints, and the potential loss of future CMS grant awards due to lack of compliance.

The $1.1 million reflects the annual cost of the 3 percent salary increase effective October 2016; and the partial year costs for the 2 percent salary increase from October 2017 to June 2018 and the 2 percent increase from April 2018 to June 2018. This proposal funds the current contract positions at the county-approved LA County salary rates, which will increase the total annual budget of the contract to $45 million.

Los Angeles County Request and Justification

LA County requests the Legislature's support of this proposal for an increase of $1.1 million for this contract, and also requests an additional $1.5 million in funding for a total augmentation of $2.6 million. LA County reports that since negotiating a new contract with the state in 2014, the county program met and exceeded the terms and required quality metrics of the contract. The County hired 75 new staff in 2015-16, provided a year of training, and experienced a 100 percent passing rate for the new staff taking the state qualifications test. LA County reports that it has filled 91.5 percent of its budgeted positions and has a turnover rate of 5.9 percent and a vacancy rate of 8.5 percent. In comparison, the state's rates are approximately 19.6 percent for turnover and 16.5 percent vacancy. Moreover, LA County has experienced a significant increase in the number of facility complaints, a direct reaction to improved functioning of the program. LA County explains that the $1.1 million increase being proposed by the state was developed using outdated vacancy data and does not reflect direct costs, such as the need for increased office space, and therefore are asking for $2.6 million.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present their proposal, and requests LA County to present their proposal.

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

ISSUE 7: PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT BUDGET CHANGE PROPOSAL

PANELISTS

- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH, Center for Health Care Quality (CHCQ), requests expenditure authority of $2 million from the Internal Departmental Quality Improvement Account in each of the fiscal years 2017-18, 2018-19, and 2019-20 to execute quality improvement projects and contracts.

BACKGROUND

CHCQ provides regulatory oversight of health facilities, certified nurse assistants (CNAs), home health aides (HHAs), certified hemodialysis technicians (CHTs), and licensed nursing home administrators. Through the Center's Licensing and Certification (L&C) and Healthcare Associated Infections (HAI) programs, CHCQ protects patient safety by evaluating applicant health facilities, agencies, and CNA, HHA, CHT, and licensed nursing home administrator applicants for compliance with state laws and regulations. CHCQ also investigates complaints, certifies health facilities' and agencies' compliance with federal laws and regulations, and oversees the education, training, and criminal record clearance of nursing home administrators, CNAs, HHAs, and CHTs.

CHCQ is funded primarily by the federal Centers for Medicare and Medicaid Services (CMS) and licensing fees paid by health care facilities. CHCQ licenses and certifies more than 7,500 health care facilities and agencies in California in 30 different licensure and certification categories.

Health and Safety Code section 1280.15(f) establishes the Internal Departmental Quality Improvement Account and provides that "moneys in the account shall be expended for internal quality improvement activities in the Licensing and Certification Program." The account is funded by administrative penalties CDPH imposes against health facilities for violations that meet the definition of Immediate Jeopardy of death or

serious harm to a patient or administrative penalties associated with breaches of medical information.

In June 2012, CMS required CDPH to assess its survey and certification operations. CDPH contracted with Hubbert Systems Consulting to perform this assessment. In August 2014, Hubbert Systems Consulting issued a final report containing 21 recommendations. CHCQ continues to implement the recommendations to "allow for meaningful, measurable improvements in the Program's performance." The consultant's report and recommendations and CHCQ's implementation work plan and progress are documented on our stakeholder website at:
http://www.cdph.ca.gov/programs/Pages/CHCQStakeholderForum.aspx

In 2014-15, CHCQ received expenditure authority of $1.4 million from the Internal Departmental Quality Improvement Account and used these funds to hire consultants from The Results Group to conduct business process reengineering projects for its Centralized Applications Unit and Professional Certification Branch. As a result of these reports, the Professional Certification Branch, Investigation Section, continues to address complaint investigations in a more timely manner, and the Centralized Applications Unit is developing and implementing IT solutions to reduce the processing time for new licensure and change of ownership applications. CDPH also contracted with a project manager/change consultant to facilitate and coordinate the multi-year implementation of Hubbert Systems Consulting's recommendations.

In 2015-16, CDPH received expenditure authority of $2.2 million from the Internal Departmental Quality Improvement Account and used these funds to purchase hardware and software to develop internal and external performance dashboards, automate key business practices, and streamline data collection from regulated entities. Further, CDPH executed contracts to improve CHCQ's hiring, onboarding, and retention practices. CHCQ has also used the funds to continue to fund the project manager/change consultant.

In 2016-17, CDPH received expenditure authority of $2.2 million from the Internal Departmental Quality Improvement Account and is using these funds to redesign the Centralized Applications Unit's IT systems and the Health Facilities Consumer Information System and complete contracted services for project and change management, recruitment, and onboarding and retention.

CDPH projects the Internal Departmental Quality Improvement Account fund balance will be nearly $17 million by January 2017.

CHCQ has immediate and ongoing needs to contract for specialized quality improvement activities. Given the timelines sometimes required for contracting and the multi-year nature of some projects, in 2017-18 CDPH will need to use a portion of the

$2 million for contracts and purchases that CHCQ initiated in prior years. CDPH will also initiate new contracts that it does not anticipate completing in 2017-18, and anticipates starting and completing other projects in 2018-19 and 2019-20. Over the next three years, CHCQ plans to use the $2 million each year on the following contracts, projects, and purchases:

1. Information Technology Assessment: CDPH will contract with an IT contractor to assess the status and long-term viability of CHCQ's many IT systems. The contractor will develop an "IT road map" to identify, guide, and prioritize CHCQ's IT procurement needs. This assessment will cost approximately $250,000 in 2017-18. CHCQ anticipates this assessment will identify additional projects and expenditures, which will lead to an additional $250,000 per year in 2018-19 and 2019-20.

2. Performance Dashboards: CHCQ anticipates ongoing costs to create, publish, and maintain internal and external facing dashboards and other visual displays of data. Total expenditures for these efforts are approximately $250,000 in 2017-18, and an additional $50,000 per year in 2018-19 and 2019-20 for maintenance and minor modifications.

3. Improve Survey and Investigation Quality, Timeliness, and Consistency by Optimizing the Use of Tablets through Business Process Redesign: CDPH will contract with a consultant to identify strategies to optimize the use of surveyors' existing tablets. Due to extensive paper-based processes and/or lack of adequate training, most surveyors do not optimally use their tablets. CHCQ anticipates expenditures for this contract will total approximately $100,000 in 2017-18. CHCQ anticipates this contract will continue into 2018-19 and 2019-20, when an additional $100,000 and $25,000 will be needed, respectively.

4. Automate Certified Care-Giver Application Forms in the Professional Certification Branch: CDPH will execute a contract to further expand the use of automated form technology throughout CHCQ. This will automate a key business practice and provide better service to certified health care providers. CDPH anticipates expenditures for this will total approximately $125,000 in 2017-18. The process of automating forms in the branch will take several years; as such, CHCQ anticipates costs for this project will total $125,000 in 2018-19 and $50,000 in 2019-20.

5. Innovative Applications: In 2015-16, in collaboration with the California Health and Human Services Agency's Innovation Initiative, CHCQ began a pilot project to explore innovative ways to facilitate investigation of adverse events related to retained foreign objects. The goal of this pilot project is to develop strategies that CHCQ can adapt to other activities the Internal Departmental Quality Improvement Account can support. CHCQ anticipates these efforts will total

approximately $250,000 in 2017-18, and $500,000 per year in the two subsequent years.

6. Outcomes and Effectiveness Evaluation: CDPH will execute a contract to have a consultant annually evaluate the effectiveness of CHCQ's enforcement actions. Health and Safety Code section 1438 requires CDPH to produce an annual report to the Legislature to "review the effectiveness of the enforcement system in maintaining the quality of care provided by long-term health care facilities." CHCQ anticipates this contract will total $200,000 per year in 2017-18, 2018-19, and 2019-20.

7. Quality Improvement Facilitation: CHCQ will engage the services of a quality improvement facilitator who is trained in process mapping, performance measurement, and the "Plan-Do-Check-Act" (PDCA) quality improvement process that CDPH has adopted. In the past, CHCQ used California State University, Fresno, consultants to facilitate quality improvement projects pertaining to completing complaints more timely, and issuing citations. In 2017-18, CHCQ proposes to use quality improvement facilitators to address media responses more timely, and the scheduling of periodic surveys and unpredictable complaint activities. CHCQ anticipates the cost of these services will cost $200,000 per year in 2017-18, 2018-19, and 2019-20.

8. Staff Development, Leadership and Quality Improvement Training: CHCQ will provide training on leadership and quality improvement principles for all staff. CHCQ anticipates the cost of providing this training will total $400,000 in 2018-19, and $500,000 2019-20.

9. Onboarding, Retention, and Recruitment Contract: CDPH anticipates completing work on the onboarding and retention, and recruitment contracts that were initiated in 2015-16. CDPH anticipates expenditures for these two contracts will total approximately $125,000 in 2017-18.

10. Centralized Applications Unit and Health Facilities Consumer Information System redesign: The redesign of the Centralized Applications Unit information technology systems will replace substantially paper-based processes with information technology solutions that will allow recording and Analysis of Problem tracking of multi-level facility ownership structures, as well as online applications and reporting features. Established in 2008, the Health Facilities Consumer Information System provides consumers and patients access to information about CHCQ's licensed long-term care facilities and hospitals throughout the state. The website provides profile information for each facility, as well as performance history including complaints, facility self-reported incidents, state enforcement actions, and deficiencies identified by CHCQ staff. CHCQ anticipates completing work on the two projects proposed for 2016-17 in the first

half of 2017-18. CDPH has not executed either contract, but expects it to cost approximately $500,000 in 2017-18 to complete these two initiatives.

11. Emerging Quality Improvement Needs: CHCQ also has a need to respond to emerging and unforeseen quality improvement needs. These may arise from prior quality improvement projects or through CHCQ's focus on continuous quality improvement. CHCQ estimates $175,000 in 2018-19 and $225,000 in 2019-20 will be needed to allow for flexibility to respond to these emerging needs.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

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

ISSUE 8: HEALTHCARE-ASSOCIATED INFECTIONS BUDGET CHANGE PROPOSAL

PANELISTS

- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH, Center for Health Care Quality (CHCQ) requests ongoing expenditure authority of $991,000 from the State Department of Public Health Licensing and Certification Program Fund (Fund 3098) and six permanent, full-time positions for the Healthcare-Associated Infections (HAI) Program.

The six positions include four Nurse Consultant III (Specialists) to support the current federally-funded HAI Liaison Infection Preventionist Program; one Public Health Medical Administrator I to serve as the HAI program medical director and oversee program activities that require clinical expertise and experience with medical assessment and decision-making; and one Health Program Manager I to manage an increase in public education, track strategic performance measures, and support the HAI Advisory Committee.

BACKGROUND

All California licensed general acute care hospitals, regardless of size, are required to report HAI data to CDPH. In 2014, 392 licensed hospitals on 419 campuses reported HAI data to CDPH. CDPH cites for deficiencies hospitals that do not completely report all required HAI data. Eight hospitals failed to report complete HAI data in 2014. Based on the best estimates available, approximately 72,000-87,000 HAIs occur per year in California acute care hospitals. In 2014, California hospitals reported 19,200 HAIs to CDPH as required by State mandates. California hospitals are not required to report all HAI types to CDPH.

Preventing HAIs saves lives and reduces health care costs. Approximately 7,500 - 9,000 patients with HAIs die during their hospitalizations each year in California. According to the CDC, annual direct medical costs of HAIs in California hospitals are approximately $3.1 billion - $3.7 billion. Patients acquire antibiotic-resistant infections

and C. difficile diarrheal infections most often in hospitals. These infections are further transmitted when infected patients receive post-acute care in settings such as skilled nursing facilities. The CDC also suggests states need coordinated, strengthened public health efforts to continue to address HAIs by region (i.e., counties, or health care networks that share patients). The CDC described the regional variation of HAI in its 2013 "Antibiotic Resistance Threats in the United States" and provided evidence for regional strategies to prevent HAI in its 2015 "*Vital Signs: Estimated Effects of a Coordinated Approach for Action to Reduce Antibiotic-Resistant infections in Health Care Facilities*." Hospitals, nursing homes and other health care facilities routinely share and transfer patients. Preventing the emergence of and controlling transmission of C. difficile diarrheal infections and antibiotic-resistant infections require a coordinated regional approach led by CDPH. To minimize the likelihood of an individual acquiring an infection during the course of his/her medical care, health care providers at all levels (physicians, nurses, technicians) need to understand and consistently adhere to infection prevention and control practices. The public needs information about what they should expect when receiving safe, quality care.

CDPH requests ongoing funding and positions to continue vital HAI prevention work. Liaison infection preventionists work directly with hospitals and other care facilities to identify and improve problems that may cause HAIs. A medical director is needed to collaborate with local health department officials and provide guidance and clinical expertise necessary to address HAI on a regional bas is. A communications lead is needed to support the demands for public information for preventing HAI. The Center's HAI Program staff serves as subject matter experts to support health care providers, local public health officials, and the public by providing HAI prevention education, communication, consultation, and regionally based prevention projects.

Since the formation of CDPH's HAI Program and initiation of public reporting, the incidence of infections in California hospitals has declined, with the exception of C. difficile diarrheal infections (see table below).

California Hospital HAI Incidence in 2015 Compared to National Baselines	
C. difficile diarrheal infections	Increased 8% since 2011
Central-line associated bloodstream infections (BSI)	Decreased 39% since 2008
BSI due to methicillin-resistant S. aureus (MRSA)	Decreased 10% since 2011
Surgical site infections (from 29 reportable surgery types)	Decreased 34% since 2008

*National baselines are based on surveillance data reported by U.S. hospitals to the Centers for Disease Control and Prevention's National Healthcare Safety Network.

More public health clinical expertise is needed to address C. difficile diarrheal infection prevention, which requires a multi-factored approach of antimicrobial stewardship and adherence to infection control measures, including hand hygiene, prompt identification for proper management, thorough environmental cleaning, and facility-to-facility communication. This has become a serious public health issue requiring coordinated regional approaches for prevention.

To continue the significant progress California has made in reducing HAIs, the HAI Program needs to build more state-funded infrastructure to maintain the program as grant funds expire. This requires expanding prevention expertise to meet new emerging demands for detecting, controlling, and preventing antimicrobial resistant infections, and providing timely, up-to-date messaging about HAI prevention for the public and key stakeholders.

The HAI Program began in December 2009 using state program-funded civil service positions to meet the HAI data collection, reporting, and publishing requirements of Health and Safety Code sections 1288.45-1288.95.

Current state program funding supports 14 civil service positions:

- One Research Scientist Supervisor
- One Research Program Specialist I
- Three Research Scientist IIs (Epidemiology)
- Two Research Scientist Ills
- One Health Program Specialist I
- One Associate Health Program Advisor
- One Program Technician II
- One Office Technician (Typing)
- One Public Health Medical Officer III (Specialist)
- One Public Health Medical Officer III (Epidemiology)
- One Nurse Consultant III

These positions support the collection, analysis, interpretation, and publication of HAI data from 392 California hospitals, and develop the annual public reports as required by law. Further, they support external communications activities as required by law, including maintaining a public website to provide up-to-date HAI information, and support the HAI Advisory Committee. They also support the investigation of outbreaks and unusual occurrences of disease that occur in California health care facilities by providing clinical consultation and guidance, and provide subject matter expertise for developing HAI prevention education and content. The current state civil service staff cannot take on any of the additional critical work to advance HAI prevention, including assisting hospitals with high infection rates, providing HAI prevention education, and coordinating regional projects that tackle HAI problems that span across multiple health care facilities.

CDPH used a series of one-time or limited-term grant awards from various sources to expand the program's work and develop critical HAI prevention education and assistance programs to help California health care providers reduce HAI rates.

In 2009, CDPH augmented state funding with federal American Recovery and Reinvestment Act of 2009 (ARRA) funds from the Centers for Disease Control and Prevention (CDC) specifically for supporting HAI prevention activities. These funds allowed the HAI Program to create an HAI liaison infection preventionist program to conduct outreach and prevention activities and hire nine experienced, certified infection preventionists to provide regional support to hospitals for HAI surveillance, reporting, and prevention consultation and assistance.

ARRA funding ended in December 2011. From January 2012 to March 2014, CDPH used a series of CDC awards to support a smaller team of six liaison infection preventionists. In FY 2013-14, CDPH received authority to use the Internal Departmental Quality Improvement Account (IDQIA) fund to support two-year, limited-term contract positions. CDPH used IDQIA funds to establish a contract with UC Davis in March 2014 and in April 2014 to hire six contract liaison infection preventionists. The contract for IDQIA support for the liaison infection preventionists ended in December 2015.

In January 2016, CDPH transferred the contract liaison infection preventionists previously supported by the IDQIA funds to another contract supported by one-time CDC Epidemiology and Laboratory Capacity for Infectious Diseases Ebola Supplemental funds. CDC awarded the one-time funds to supplement activities aimed to control Ebola and other highly infectious new diseases and to build infection control capacity to prevent infections, which aligns with the prevention work of the HAI liaison infection preventionists. With this new funding, the HAI Program expanded HAI prevention outreach beyond hospitals to skilled nursing facilities, ambulatory surgery centers, and dialysis clinics.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present this proposal.

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

ISSUE 9: CALQUALITYCARE.ORG – STAKEHOLDER PROPOSAL

PANELISTS

- **Leslie Ross**, PhD, CalQualityCare.org, PI/Project Director, University of California San Francisco
- **Scott Vivona**, Acting Deputy Director, Center For Healthcare Quality, DPH
- **CJ Howard**, Chief, Policy and Planning, Center For Healthcare Quality, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

U.C. San Francisco requests $500,000 (State Citations Penalty Account) on-going to manage and maintain the CalQualityCare.org website.

BACKGROUND

The www.calqualitycare.org website provides important, objective information to consumers about the quality of long term care facilities, including skilled nursing facilities, assisted living or hospice facilities. The website, which is administered by the University of California, San Francisco, has almost 400,000 hits annually, and gives consumers access to publicly available data to help them make placement decisions. Since 2002, the $500,000 annual cost of the website has been supported by the California Health Care Foundation (CHCF), but on-going funding has not be available since August 2016. The website's data elements include:

- Provider characteristics (e.g., location, size, ownership);
- Ratings – nursing facilities, home health, hospice, intermediate care facilities for the developmentally disabled;
- Staffing (number and type)
- Quality of Facility (deficiencies, complaints)
- Quality of Care (e.g., pressure ulcers, infections)
- Costs and Finances.

The CalQualCare.org website provides California consumers information on state citations and quality comparisons, staff salaries, finances, and costs – data not available on the federal website. The California website also includes information on an array of

other long-term care service and supports including, congregate living health facilities, hospice, assisted living, continuing care retirement communities, adult day care, adult day health care, and intermediate care for the developmentally disabled (ICF/DD).

STAFF COMMENTS/QUESTIONS

The Subcommittee requests U.C.S.F. to present this proposal.

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

CENTER FOR FAMILY HEALTH

ISSUE 10: CENTER FOR FAMILY HEALTH OVERVIEW AND PROGRAM UPDATES

PANELISTS

- **Connie Mitchell**, Deputy Director, Center For Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **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 Family Health; and 2) receive updates on Center for Family Health programs of interest to the Subcommittee.

BACKGROUND

The Center for Family Health is organized into three major program areas:

1. WIC Program – discussed in detail in issue 11 of this agenda;
2. Genetic Disease Screening Program – discussed in detail in issue 12 in this agenda; and
3. Maternal, Child and Adolescent Health (MCAH) Programs, described in more detail here (below):

The January budget proposes $1.6 billion for this Center, of which $1.3 billion is for the WIC program. MCAH includes the following programs:

1. Adolescent Family Life Program, AFLP
2. Adolescent Sexual Health Work Group, ASHWG
3. Black Infant Health Program, BIH
4. Breastfeeding Program, BFP
5. California Birth Defects Monitoring Program, CBDMP
6. California Diabetes and Pregnancy Program, CDAPP
7. California Early Childhood Comprehensive Systems, CA-ECCS
8. California Home Visiting Program (CHVP)
9. California Personal Responsibility Education Program (CA PREP)

10. Comprehensive Perinatal Services Program, CPSP
11. Fetal and Infant Mortality Review Program, FIMR
12. Human Stem Cell Research Program, HSCR
13. Infant Health
14. Information & Education (I&E) Program
15. Intimate Partner Violence, IPV
16. Local Health Jurisdiction Maternal, Child and Adolescent Health Program, Local MCAH
17. Maternal Health
18. Sudden Infant Death Syndrome Program, SIDS
19. Nutrition and Physical Activity Initiative, NUPA
20. Oral Health Program, OHP
21. Perinatal Substance Use Prevention, PSUP
22. Preconception Health
23. Regional Perinatal Programs of California, RPPC
24. Children and Youth with Special Health Care Needs (CYSHCN)
25. Text4baby Program

The Black Infant Health (BIH) and Adolescent Family Life (AFL) Programs have been of particular interest to the Legislature in recent years. Both programs received substantial funding reductions during the recent recession; funding has been restored to only the BIH.

BIH

The BIH seeks to improve African-American infant and maternal health, as well as decrease Black-White health inequities and social inequities for women and infants. The program serves African-American women who are 18 years or older and up to 26 weeks pregnant at the time of enrollment. Services are provided by Family Health Advocates, Group Facilitators, Public Health Nurses and Social Workers. Services are provided in communities where over 90% of African-American births occur, including:

Counties:

- Alameda
- Contra Costa
- Fresno
- Kern
- Los Angeles
- Riverside
- Sacramento
- San Bernardino
- San Diego
- San Francisco
- San Joaquin
- Santa Clara
- Solano

Cities:

- Long Beach
- Pasadena

In 2009, $3.9 million was cut from the BIH, and this funding was restored in 2014.

ALF

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

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

The AFLP was established in 1985 and since then has provided support services to over 150,000 teen parents and their children. In 2009, the budget eliminated the program's General Fund appropriation of $10.7 million, which resulted in the additional reduction of $5.4 million in federal matching funds. Since 2009, the program also experienced an additional $2.8 million reduction in federal funds, for a total loss of $18 million in funding. The AFLP had sufficient funding in 2008-09 to serve a high of 18,000 adolescent families and dropped to serving 3,956 teens in fiscal year 2014-15.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to provide an overview and updates on the Center for Family Health, with a particular focus on the BIH and ALFP, and respond to the following:

1. Is the state prepared to prevent the spread of the Zika virus?

2. What potential impacts do recent national proposals related to immigration have on the spread of the Zika virus and other public health issues and programs?

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

ISSUE 11: WOMEN INFANTS & CHILDREN (WIC) PROGRAM ESTIMATE

PANELISTS

- **Connie Mitchell**, Deputy Director, Center For Family Health, DPH
- **Christine Nelson**, Chief, Women Infants & Children Division, Center For Family Health, DPH
- **Benjamin Menzies,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

WIC BUDGET

As shown in the table below, the WIC estimate proposes total expenditures of $1.3 billion in 2017-18, a $17 million (1.3%) increase over the revised estimate for 2016-17.

WIC Expenditures					
	2016 Budget Act	**2016-17 Estimate**	**2017-18 Proposed**	**CYE to BY Change**	**% Change**
Local Assistance (FFP)	$1,075,817,000	$1,035,439,000	$1,057,618,000	$22,000,000	2.1%
Local Assistance (Rebate Funds)	$217,085,000	$223,377,000	$216,412,000	-$6,965,000	-3.1%
State Operations	$61,429,000	$61,429,000	$63,209,000	$1,780,000	2.90%
Total Expenditures	**$1,354,331,000**	**$1,320,245,000**	**$1,337,239,000**	**$16,994,000**	**1.3%**

The WIC program is funded almost entirely with federal funds, including a Food Grant from the United States Department of Agriculture (USDA) as well as Nutrition Services and Administration (NSA) grant. The state also contracts for rebates from infant formula providers, which amounts to approximately 15 percent of the program funding.

WIC Revenue					
	2016 Budget Act	2016-17 Estimate	2017-18 Proposed	CYE to BY Change	% Change
Food Grant	$833,503,000	$796,097,000	$796,794,000	$697,000	0.09%
Nutrition Services Admin (NSA) Grant	$373,875,000	$376,238,000	$376,824,000	$586,000	0.2%
Rebate Funds	$217,085,000	$223,377,000	$216,412,000	$6,965,000	3.1%
Total Revenue	**$1,424,463,000**	**$1,395,712,000**	**$1,390,030,000**	**-$5,682,000**	**-0.4%**

BACKGROUND

WIC provides supplemental food and nutrition for low-income families (185 percent of poverty or below) with pregnant women, breastfeeding and early postpartum mothers, infants, and children up to age five. WIC services include nutrition education, breastfeeding support, help finding health care and other community services, and checks for specific nutritious foods that are redeemable at retail food outlets throughout the state. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

DPH administers contracts with 84 local agencies (half local government and half private, non-profit community organizations) that provide 650 locations statewide. Approximately 3,000 local WIC staff assesses and document program eligibility based on residency, income, and health or nutrition risk, and issue 4.8 million food checks each month. Local WIC agencies issue WIC participants paper vouchers to purchase approved foods at authorized stores. Examples of WIC foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amounts and types of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

WIC Funding

DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the last 5 years. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

- **Food**. Food funds reimburse WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.

- **Nutrition Services and Administration.** Nutrition Services and Administration (NSA) Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition education, breastfeeding support, and referrals to health and social services, as well as support costs. States manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.

- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with infant formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down Federal WIC food funds.

Maximum Reimbursement Rate Methodology

The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, USDA directed CA WIC to remove 1-2 and 3-4 cash register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent higher than prices paid to other vendors. The WIC program submitted a plan to USDA to address price competitiveness, MADR methodology and cost containment, which was approved and implemented. The program has experienced lower overall food costs as a result.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the WIC estimate and describe significant changes to, and challenges and trends in, the program, and to respond to the following:

1. Please describe the WIC program's efforts to modernize its communications with WIC families and the public.

2. How many and which languages are utilized in WIC outreach and communications efforts?

3. Please describe any efforts underway to improve the WIC food package, and specifically ways to incentivize the purchasing of California-grown produce.

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

ISSUE 12: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

PANELISTS

- **Connie Mitchell**, Deputy Director, Center For Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, DPH
- **Richard Olney**, MD, MPH, Chief, Genetic Disease Screening Program, Center For Family Health, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

GDSP BUDGET

The total GDSP proposed 2017-18 budget is $136.6 million, a $3 million increase (2.2%) over the current year (2016-17) budget of $132.3 million. Of the proposed $136.6 million, $26.8 million is for state operations while $109.8 million is proposed for local assistance.

Genetic Disease Screening Program Budget

	2016 Budget Act	2016-17 Estimate	2017-18 Proposed	CY to BY Change
NBS Local Assistance	$42,770,000	43,423,000	$43,688,000	$918,000 (2.1%)
PNS Local Assistance	$36,002,000	35,349,000	$36,920,000	$918,000 (2.5%)
Operational Support	$26,999,000	26,999,000	$29,249,000	$2,250,000 (8.3%)
State Operations	$27,881,000	26,540,000	$26,767,000	-$1,114,000 (-4.0%)
TOTAL	**$133,652,000**	**$132,311,000**	**$136,624,000**	**$2,972,000 (2.2%)**

For 2017-18, DPH proposes one-time local assistance funding of $2.3 million to comply with SB 1095 (Pan, Chapter 363, Statutes of 2016) to expand statewide screening of newborns to include screening for any disease that is detectable in blood samples within two years of the disease being adopted by the federal Recommended Uniform Screening Panel (RUSP). In addition, the program proposes to transfer $330,000 one-time from Local assistance to State Operations and requests a one-time increase of $300,000 in State Operations spending authority for the purchase of equipment to perform second-tier testing of mass spectrometry.

BACKGROUND

The mission of the GDSP is "To serve the people of California by reducing the emotional and financial burden of disability and death caused by genetic and congenital disorders." California Health and Safety (H&S) Code sections 125000-125002, 125050-125119, and 124975-124996 require CDPH to administer a statewide genetic disorder screening program for pregnant women and newborn babies that is to be fully supported by fees.

The Genetic Disease Screening Program (GDSP) consists of two programs - the Prenatal Screening Program and the Newborn Screening Program. Both screening programs provide public education, and laboratory and diagnostic clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided to patients. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund - Genetic Disease Testing Fund.

Prenatal Screening Program (PNS). This program screens pregnant women who consent to screening for serious birth defects. Since July 1, 2016, the fee for this screening has been $221.60 (of which $211.60 is deposited into the Genetic Disease Testing Fund and $10 is deposited into the California Birth Defects Monitoring Program Fund). Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests for pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester. Women who are at high risk based on the screening test results are referred for follow-up services at state-approved “Prenatal Diagnosis Centers.” Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

Newborn Screening Program (NBS). This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee for this screening is $130.25 (and the program plans to increase it by $10 to implement SB 1095). Where applicable, this fee is paid by prepaid health plans and insurance companies. Medi-Cal also covers the fee for its enrollees. The NBS screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions, and referral information is provided where applicable.

When the NBS Program began in October 1980, each newborn was screened for only three disorders; today, with the advent of new scientific findings, the NBS Program screens for more than 75 disorders in over 500,000 newborns and diagnoses more than 700 babies each year. California leads the nation in the number of disorders screened and provides the most comprehensive program in terms of quality control, follow-up services, genetic counseling, confirmatory testing, and diagnostic services.

STAFF COMMENTS/QUESTIONS

The Subcommittee requests DPH to present the GDSP estimate.

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

ISSUE 13: NEWBORN SCREENING BUDGET CHANGE PROGRAM

PANELISTS

- **Connie Mitchell**, Deputy Director, Center For Family Health, DPH
- **Leslie Gaffney**, Assistant Deputy Director, Center For Family Health, DPH
- **Richard Olney**, MD, MPH, Chief, Genetic Disease Screening Program, Center For Family Health, DPH
- **Koffi Kouassi,** Finance Budget Analyst, Department of Finance
- **Phuong La**, Principal Program Budget Analyst, Department of Finance
- **Sonja Petek**, Fiscal and Policy Analyst, Legislative Analyst's Office

Public Comment

PROPOSAL

CDPH requests 1 permanent position and $2.69 million in expenditure authority from the Genetic Disease Testing Fund ($1.92 million in Local Assistance and $769,000 in State Operations) in FY 2017-18. This is composed of a one-time request of $2.25 million in Local Assistance and $139,000 in State Operations ($137,000 is ongoing) to comply with Senate Bill 1095 (Pan, Chapter 363, Statutes of 2016). The additional one-time request of $630,000 in State Operations (of which $330,000 is being shifted from Local Assistance) is to modernize the Genetic Disease Laboratory by adding second-tier testing for metabolic disorders. The program intends to increase the Newborn Screening fee of $130.25 by $10.

BACKGROUND

SB 1095 requires CDPH to expand the California Newborn Screening (NBS) Program to expand statewide screening of newborns to include screening for any disease that is detectable in blood samples within two years of the disease being adopted by the federal Recommended Uniform Screening Panel (RUSP).The bill mandates that CDPH begin screening for two disorders currently on the RUSP that are not on the California Newborn Screening panel. Traditionally, in addition to presence on the RUSP, CDPH has waited for legislative authority before adding new diseases to the NBS panel. Mucopolysaccharidosis type I (MPS-I) and Pompe disease were added to the RUSP in 2016 and 2015, respectively. As specified in the bill, CDPH is required to add these disorders to the California NBS panel within two years after the bill was enrolled (August 30, 2018).

CDPH continually strives to improve testing to prevent unnecessary stress and anxiety for parents while providing cost savings for the State of California. By coupling the

primary screening method with a second linked test that is more specific than the original method, CDPH can improve diagnostic specificity without reducing sensitivity. A second-tier test uses the same blood specimen that was sampled for the original test and measures additional metabolites that either strongly supports the presumption of a true positive case or shows that the patient does not have the disorder. Using second-tier testing to increase positive predictive values of screening assays is a common standard of practice in most newborn screening laboratories. The effectiveness of second-tier testing on decreasing overall costs for the NBS Program has been tested and validated and the results have been published by many researchers and other NBS Programs in the United States and around the world.

Newborn screening is a 50-year public health initiative supported by every state health department throughout the nation. Early detection and treatment of inborn genetic and metabolic disorders can prevent life-threatening complications, improve health and quality of life for many families, and reduce the high cost of care for these conditions.

Within two years, the CDPH Genetic Disease Screening Program (GDSP) will incorporate MPS-I and Pompe to the newborn panel. By incorporating these screenings into the newborn panel, California will meet the national standard of care as recommended by the federal Advisory Committee on Heritable Disorders in Newborns and Children and will bring the NBS Program into alignment with the most up-to-date research, technology, laboratory, public health standards and practices. In preparation for the addition of MPS-I and Pompe to the NBS panel, CDPH will implement a fee increase effective July 1, 2018 to fund the needed contracts, staffing and required Screening Information System (SIS) enhancements.

Based on an assessment of laboratory and processing costs, an increase of approximately $10.00 to the current NBS Program fee of $130.25 will be required. The NBS Program is fully fee-supported, as required by state statute, and a $10.00 fee increase will provide the revenues needed for the new testing to be fully implemented and provide sufficient resources on an ongoing basis. This funding will support expenditures associated with the ongoing workload of processing blood specimens at the CDPH Genetic Disease Laboratory, staff needed to perform the actual blood screen, testing chemicals, and equipment and supplies used to assay results. Funding will also be utilized to support follow-up costs for cases that screen positive, such as case management, diagnostic work-up, confirmatory processing, provider and family education, informative result mailers, and maintenance of equipment on an on-going basis.

Of the resources being requested, $2.25 million will fund one-time costs to incorporate MPS-I and Pompe and $139,000 will fund 1 Research Scientist II which will support testing activities. This includes such activities as: provide technical assistance and general support from staff evaluation on the addition of new biochemical markers to the

current screening program; plan, organize, and carry out program evaluation and research using data from the Genetic Disease Screening Program SIS to investigate lysosomal acid alpha-glucosidase enzymes, mutation panels, interpretation algorithms and other screening methods to optimize cost-effectiveness, sensitivity and specificity of the screening program for MPS-I and Pompe. This proposal represents startup costs. Any additional requests for future funding (approximately $4.3 million for on-going costs) will be requested in the Estimate process once additional information has been acquired and CDPH is ready to start screening.

In addition, CDPH is requesting a one-time increase of $300,000 in State Operations expenditure authority and a transfer of $330,000 in expenditure authority from Local Assistance to State Operations for the purchase of mass spectrometry equipment and support for second tier testing. This equipment would be purchased in early 2017-18 in order to perform the second-tier testing by early 2018. By performing second-tier testing, CDPH will save approximately $380,000 per year in Local Assistance beginning in Fiscal year 2018-19. Performing second-tier testing will also reduce overall expenditures and lead to less stress, anxiety, and concern for families. This process will bring the highest positive predictive values with the least number of false negatives and false positives, without the need to collect a second sample.

STAFF COMMENTS/QUESTIONS

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

1. Please describe how a disease or condition gets added to the RUSP.

2. How often are new conditions added to the RUSP?

3. Please explain the costs associated with adding conditions to California's Newborn Screening Program, as well as the cost-benefit analysis.

4. What are the approximate treatment costs for Mucopolysaccharidosis type I (MPS-I) and Pompe disease and what are the prevalence rates for these diseases in California?

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