Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Senator Jeff Stone

Thursday, February 28, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

PUBLIC COMMENT

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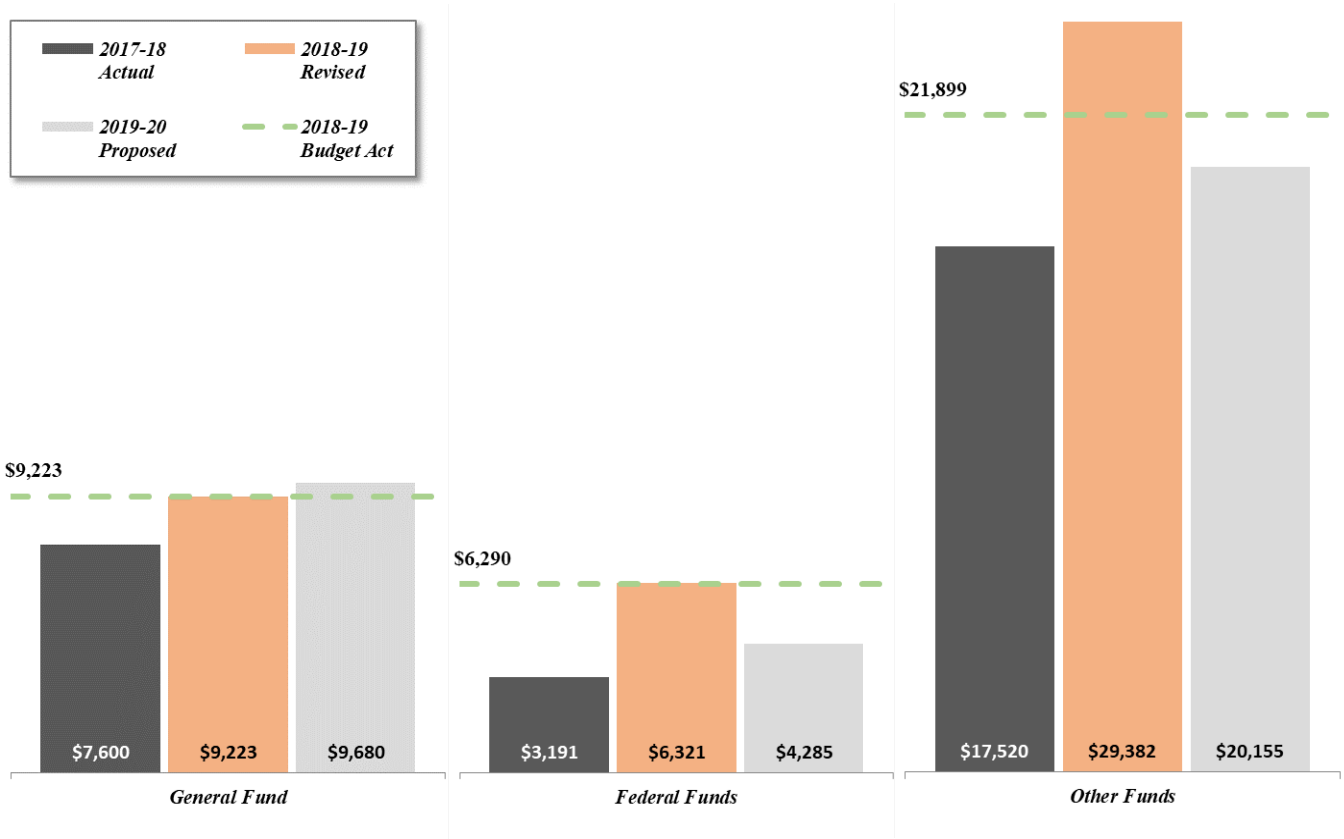
4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview

Emergency Medical Services Authority – *Three-Year Funding Summary*



(dollars in thousands)

Emergency Medical Services Authority – *Department Funding Changes Since Budget Act*			
Fund Source	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund (0001)	$9,223,000	$9,223,000	$9,680,000
Federal Funds (0890)	$6,290,000	$6,321,000	$4,285,000
Other Funds (*detail below*)	$21,899,000	$29,382,000	$20,155,000
Total Department Funding:	**$37,412,000**	**$44,926,000**	**$34,120,000**
Total Authorized Positions:	**69.9**	**70.0**	**76.0**
Other Funds Detail:			
EMS Training Prog. Approval Fund (0194)	*$217,000*	*$218,000*	*$218,000*
EMS Personnel Fund (0312)	*$2,608,000*	*$2,630,000*	*$2,682,000*
Reimbursements (0995)	*$17,520,000*	*$24,970,000*	*$15,560,000*
EMT Certification Fund (3137)	*$1,554,000*	*$1,564,000*	*$1,695,000*

Background. The Emergency Medical Services Authority (EMSA), authorized by the Emergency Medical Services System and Prehospital Emergency Care Act, administers a statewide system of coordinated emergency medical care, injury preventions, and disaster medical response that integrates public health, public safety and health care services. Prior to the establishment of EMSA in 1980, California did not have a central state agency responsible for ensuring the development and coordination of emergency medical services (EMS) programs statewide. For example, many jurisdictions maintained their own certification requirements for paramedics, emergency medical technicians (EMTs), and other emergency personnel, requiring individuals certified to provide emergency services in one county to re-test and re-certify to new standards to provide emergency services in a different county. EMSA is organized into three program divisions: the Disaster Medical Services Division, the EMS Personnel Division, and the EMS Systems Division.

Disaster Medical Services Division. The Disaster Medical Services Division coordinates California's medical response to major disasters by carrying out EMSA's mandate to provide medical resources to local governments in support of their disaster response efforts. The division coordinates with the Governor's Office of Emergency Services, the Office of Homeland Security, the California National Guard, the Department of Public Health, and other local, state, and federal agencies, private sector hospitals, ambulance companies, and medical supply vendors, to promote and improve disaster preparedness and emergency medical response in California.

EMS Personnel Division. The EMS Personnel Division is responsible for the certification, licensing, and discipline of all active paramedics throughout the state. The division develops and implements regulations that set training standards and the scope of practice for various levels of personnel; sets standards for and approves training programs in pediatric first aid, cardiopulmonary resuscitation (CPR), and preventive health practices for child day care providers and school bus drivers; and develops standards for emergency medical dispatcher training, pre-arrival emergency care instructions, and epinephrine auto-injector training.

EMS Systems Division. The EMS Systems Division is in charge of developing and implementing EMS systems throughout California, including supporting local Health Information Exchange projects that will allow the state to collect more meaningful data so emergency medical services providers can deliver better patient care. The division oversees system development and implementation by the local EMS agencies, the statewide trauma system, and emergency medical dispatcher and communication standards. It establishes regulations and guidelines for local agencies, reviews and approves local plans to ensure they meet minimum state standards, coordinates injury and illness prevention activities with the Department of Public Health and the Office of Traffic Safety, manages the state's EMS data and quality improvement processes, conducts Ambulance Exclusive Operating Area evaluations, and oversees the operation of California's Poison Control System and EMS for Children programs.

Subcommittee Staff Comment. This is an informational item.

Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of EMSA's mission and programs.

Issue 2: Conversion of Blanket Positions to Permanent

Budget Issue. EMSA requests establishment of four positions funded by existing appropriation authority. If approved, these positions would address ongoing Emergency Medical Services Division workload.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**4.0**	**4.0**

* Positions are ongoing after 2020-21.

Background. The EMS Systems Division is in charge of developing and implementing EMS systems throughout California, including supporting local Health Information Exchange projects that will allow the state to collect more meaningful data so emergency medical services providers can deliver better patient care. The division oversees system development and implementation by the local EMS agencies, the statewide trauma system, and emergency medical dispatcher and communication standards. It establishes regulations and guidelines for local agencies, reviews and approves local plans to ensure they meet minimum state standards, coordinates injury and illness prevention activities with the Department of Public Health and the Office of Traffic Safety, manages the state's EMS data and quality improvement processes, conducts Ambulance Exclusive Operating Area evaluations, and oversees the operation of California's Poison Control System and EMS for Children programs.

Federal Preventive Health and Health Services Block Grant. In 2014-15, EMSA received notification that its federal Preventive Health and Health Services Block Grant funding allocation had increased by $1.4 million for a total $2.6 million grant award. These federal grant funds support oversight and administration of the California EMS Information System (CEMSIS), coordination and leadership of local Trauma Care Systems, and other administrative duties in the EMS Systems Division. This workload is currently managed by four temporary help positions supported by the federal grant.

Establish Permanent Positions to Replace Temporary Help. EMSA is requesting establishment of four positions funded by its existing federal fund appropriation authority. If approved, these positions would address ongoing Emergency Medical Services Division workload currently managed by temporary help staff established in response to the increased federal grant award. According to EMSA, the requested positions include:

One Staff Services Manager I – Provides management and oversight of the administration of CEMSIS, grant coordination, and quality improvement programs within the EMS Systems Division.

One Research Program Specialist – Responsible for a wide range of research and analytical duties regarding CEMSIS statistical data, including analysis, for use in the resolution of multiple program-related issues.

One Health Program Specialist II – Functions as the Trauma Care Program Coordinator providing statewide coordination and leadership for the planning, development, and implementation of local

Trauma Care Systems, including technical assistance to the 33 local EMS agencies, and review and approval of local trauma care system plans.

One Office Technician – Performs various clerical duties to support EMS Division activities.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Continued Appropriation for Paramedic Discipline Case Workload

Budget Issue. EMSA requests expenditure authority from the Emergency Medical Services Personnel Fund of $309,000 annually. If approved, these resources would provide permanent funding for two positions authorized in the 2017 Budget Act to address the workload associated with prosecution of Emergency Medical Technician-Paramedic (EMT-P) license violations.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0312 – Emergency Medical Services Personnel Fund	$309,000	$309,000
Total Funding Request:	**$309,000**	**$309,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources are ongoing after 2020-21.

Background. Under its regulatory authority over paramedic licensing, EMSA may deny, revoke, suspend, or place on probation a paramedic's license if there is evidence of a threat to public health and safety. EMSA's legal counsel is responsible for disciplinary actions under this authority. Previously, EMSA's legal unit consisted of one full-time attorney, two retired annuitant attorneys, one retired annuitant staff services analyst, and one student assistant. The full-time attorney provided all legal services to EMSA, including: legal advice to the director, review of contracts, legal support for all EMSA divisions, review of local EMS agency solicitations and ambulance exclusive operating areas, public records act request review, subpoena and litigation response, employee discipline, and paramedic enforcement case supervision. The two retired annuitant attorneys prepared paramedic enforcement cases, negotiate settlements, and represent EMSA at administrative hearings at various locations throughout the state. The remaining staff provide administrative support to all three attorneys.

In response to an increase in litigation related to local EMS plan appeals and local EMS agency Exclusive Operating Area solicitation reviews, the 2017 Budget Act included the establishment of one Attorney I and one Staff Services Analyst, and expenditure authority from the Emergency Medical Services Personnel Fund of $314,000 in 2017-18 and 2018-19 to manage the increased workload related to paramedic licensing enforcement. According to EMSA, the workload related to plan appeals has persisted at the projected level since approval of the 2017 Budget Act request. As a result, EMSA is requesting permanent authority for the resources that support the previously authorized positions.

EMSA requests permanent expenditure authority from the Emergency Medical Services Personnel Fund of $309,000 to continue managing the increased workload related to paramedic licensing enforcement. These resources would continue to support the Attorney I and Staff Services Analyst included in the 2017 Budget Act.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: EMT Certification Denial Reporting (AB 2293)

Budget Issue. EMSA requests one position and General Fund expenditure authority of $159,000 in 2019-20 and $152,000 annually thereafter. If approved, these resources would allow EMSA to receive and compile data from local EMS agencies regarding approval or denial of EMT applicants and report on the extent to which prior criminal history may be an obstacle to EMT certification, pursuant to the requirements of AB 2293 (Reyes), Chapter 342, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$159,000	$152,000
Total Funding Request:	**$159,000**	**$152,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources are ongoing after 2020-21.

Background. The EMS System and the Prehospital Emergency Medical Care Personnel Act requires EMSA to establish training, scope of practice, and continuing education standards for EMTs. Local EMS agencies certify EMT-Is and EMT-IIs, while the statewide EMSA is authorized to license paramedics. Local EMS agencies and EMSA can deny, suspend, revoke, or place on probation EMT or paramedic certification for conduct that violates the Health and Safety Code. These violations include, but or not limited to, acts of theft, violence, negligence, incompetence, abuse of drugs and alcohol, serious felony convictions, certain sexually related offenses, patient mistreatment, and failing to maintain the confidentiality of patient medical information. Since 2008, California law requires that all applicants for EMT or paramedic certification receive a criminal background check prior to approval.

Employment Options for Ex-Offender Firefighters May Be Limited. The California Department of Corrections and Rehabilitation (CDCR) operates the Conservation Camp Program, which provides CDCR inmates with the opportunity to work on meaningful projects throughout the state. 43 conservation camps in 29 counties, many operated jointly with the California Department of Forestry and Fire Protection (CalFIRE), house up to 4,522 adult inmates and 80 juveniles that comprise approximately 219 fire-fighting crews. These crews provide approximately three million person-hours responding to fires and other emergencies and seven million person-hours in community service projects in an average year. All inmates earn the right to work in a conservation camp by their non-violent behavior and conformance to rules while incarcerated. All volunteers are screened and medically cleared prior to acceptance and are ineligible if convicted of sexual offenses, arson, or any history of escape with force or violence. Inmates considered potential fire crew members are evaluated for their physical fitness by CDCR and are trained in fire-fighting techniques by CalFIRE, which includes a week of classroom instruction and a second week of field exercises.

Although firefighters are not required by statute to obtain EMT certification, it is often required by municipal fire departments that provide EMS services. Because applicants seeking EMT certification receive a criminal background check prior to approval, many ex-offender firefighters trained in the Conservation Camp Program may be discouraged from applying for certification, or may be denied certification by local agencies.

AB 2293 Reporting Requirements. In response to concerns that ex-offender firefighters may have limited employment options as firefighters upon release, AB 2293 requires local EMS agencies to report to EMSA data on the approval or denial of EMT-I or EMT-II candidates including:

- The total number of applicants who applied for initial certification;
- The total number of applicants with a prior criminal conviction who applied for initial certification;
- The number of applicants who were denied, the number of applicants who were approved, and the number of applicants who were approved with restrictions;
- The number of applicants with a prior criminal conviction who were denied, the number of applicants with a prior criminal conviction who were approved, and the number of applicants with a prior criminal conviction who were approved with restrictions;
- The reason or reasons stated for denying an applicant with a prior criminal conviction, or the reason or reasons stated for approving with restrictions an applicant with a prior criminal conviction;
- The restrictions imposed on approved applicants with a prior criminal conviction, and the duration of those imposed restrictions; and,
- Race, ethnicity, gender, and age demographic data for all applicants who were denied, approved, or approved with restrictions.

AB 2293 also requires EMSA to report to the EMS Commission and to the Legislature on the extent to which prior criminal history may be an obstacle to certification as an EMT-I or EMT-II.

EMSA is requesting **one Associate Governmental Program Analyst** to manage the process for data collection from local EMS agencies regarding denial for EMT certification. Specifically, this position would convene experts and stakeholders to identify the appropriate data collection fields, update EMSA's Central Registry to allow data collection, establish policies and procedures for local agency data submission, and provide ongoing technical assistance. In addition, this position would analyze the collected data to produce the annual report to the Commission and the Legislature required by AB 2293.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: Ambulance Patient Offload Time Reporting (AB 2961)

Budget Issue. EMSA requests one position and General Fund expenditure authority of $189,000 in 2019-20 and $141,000 annually thereafter. If approved, these resources would allow EMSA to analyze ambulance patient offload time data reported by local EMS agencies and report to the Legislature and the EMS Commission, pursuant to the requirements of AB 2961 (O'Donnell), Chapter 656, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$189,000	$141,000
Total Funding Request:	**$189,000**	**$141,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources are ongoing after 2020-21.

Background. In March 2013, EMSA and the California Hospital Association created the Ambulance Patient Offload Delay Collaborative to analyze and develop solutions to the problem of ambulance patient offload delays. Ambulance patient offload time is defined as the interval between the arrival of an ambulance at an emergency department and the time the patient is transferred to an emergency department gurney, bed, chair or other acceptable location and the emergency department assumes responsibility for the care of the patient. According to the Collaborative, delays in ambulance patient offload time have been a concern in the health care community due to potential impacts on patient safety and quality of care. A national study of 200 cities found the average wait time for offloading ambulance patients doubled between 2006 and 2014 from 20 minutes to over 45 minutes, resulting in a loss of nearly five million hours of EMS system productivity. The Collaborative also reported on survey research that suggested the problem of extended ambulance patient offload times is not uniform or consistently reported, with some hospitals reporting insignificant delays and others disproportionately affected. As of 2015, EMSA reported that 13 of the state's local EMS agencies serving 70 percent of the state's population identified ambulance patient offload time as an issue. According to the Collaborative, many factors have been identified as contributing to decreased patient throughput, including: 1) decreased inpatient capacity, 2) nurse patient ratios, 3) hospital regulations limiting areas of care, and 4) inability to rapidly turn over hospital beds.

Toolkit to Reduce Ambulance Patient Offload Delays. In 2014, the Collaborative published the "Toolkit to Reduce Ambulance Patient Offload Delays in Emergency Department." The toolkit included definitions, process guidelines, and strategies to be considered to evaluate current practices and develop process improvements at the local level. The toolkit identified three key factors employed by hospital emergency departments that reported no or insignificant offload delays: 1) optimization of the intake process, 2) successful hospital process improvement strategies, and 3) hospital and local EMS agency collaboration and ongoing process improvement strategies.

Previous Legislation Sought to Collect Voluntary Data on Offload Times. In response to concerns about a lack of data regarding ambulance patient offload delays, AB 1223 (O'Donnell), Chapter 379, Statutes of 2015, required EMSA to adopt a statewide standardized methodology for calculating and voluntary reporting of ambulance patient offload times by local EMS agencies. EMSA also developed guidance for implementation and reporting of offload times, recommending an average time of 20

minutes. In addition, AB 1129 (Burke), Chapter 377, Statutes of 2015, required EMS providers to use an electronic health record system compliant with EMSA's California EMS Information System (CEMSIS) and ensure their system is integrated with the local EMS agency's system so provider data may be collected.

Despite the system established by AB 1223, EMSA reports statewide statistics for ambulance patient offload times are not currently available due to limited data. As of September 2018, 17 of the 33 local EMS agencies have provided at least one quarter of information for 2017, while 16 have provided at least one quarter of information for 2018.

AB 2961 Requires Local EMS Agencies to Report on Ambulance Patient Offload Times. In response to a lack of statewide data, AB 2961 requires, on or before July 1, 2019, local EMS agencies to transmit ambulance patient offload time data to EMS, calculating average offload times for each agency's total jurisdiction and each facility within the jurisdiction. AB 2961 also requires EMSA to analyze the data collected from the local EMS agencies on ambulance patient offload times and submit a biannual report to the EMS Commission. The bill also requires a one-time report to the Legislature, including recommendations to reduce or eliminate offload delays, on or before December 1, 2020.

EMSA requests one position and General Fund expenditure authority of $189,000 in 2019-20 and $141,000 annually thereafter to implement the workload associated with AB 2961, including **one Research Program Specialist I** to: 1) develop a statewide program to collect, consolidate, analyze and report submitted offload time data from all 33 local EMS agencies; 2) identify an appropriate automation system for data entry and analysis; 3) provide technical assistance and establish relationships with local EMS data staff to facilitate compliance with and consistency in data collection; 4) prepare the one-time report for the Legislature; and 5) prepare biannual reports to the EMS Commission.

Included in this request is a one-time $30,000 General Fund expenditure in 2019-20 for a consultant to assist in setting up the database, program reports, and to train EMSA staff on a statistical software suite to develop reports.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: Child Care Provider Lead Poisoning Training (AB 2370)

Budget Issue. EMSA requests General Fund expenditure authority of $177,000 in 2019-20. If approved, these resources would allow EMSA to add the topic of lead poisoning prevention to the preventive health practices course for child care providers, pursuant to AB 2370 (Holden), Chapter 676, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$177,000	$-
Total Funding Request:	**$177,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. Existing state law requires some child care providers who work in licensed child care centers and all child care providers who work in child care homes to have 16 hours of training in first aid, cardiopulmonary resuscitation, and preventive health and safety practices. State law also requires EMSA to establish minimum standards for the review and approval of child care provider training programs. The training curricula are developed and submitted to EMSA by private industry health and safety trainers.

EMSA operates the Child Care Training Approval Program within the EMS Personnel Division, which reviews and approves the curricula for 52 first aid, cardiopulmonary resuscitation, and preventative health and safety training programs. Of these 52 training programs, 24 provide preventive health and safety practices training. These programs train approximately 80,000 child care providers annually.

The Child Care Training Approval Program is supported through fees charged on child care provider training programs that are deposited in the EMS Training Program Approval Fund. Training programs pay the EMS Authority a fee of $240 for the bi-annual review of their program curriculum and 40 course completion stickers that they affix to their students' course completion cards. Training programs may receive additional course completion stickers at a cost of $3 per sticker. The majority of EMS Training Program Approval Fund revenues are attributable to course completion sticker fees.

AB 2370 Addresses Potential Lead Contamination in Child Care Facilities. In response to concerns about potential lead exposure for young children, AB 2370 expanded lead testing in drinking water at child care facilities regulated by the Department of Social Services' Community Care Licensing Division. While California previously required school sites to be tested for lead, as of December 2017 only six states required licensed child care centers to test their drinking water for lead.

In addition to expanded lead testing for drinking water at child care centers, AB 2370 also requires instruction in the prevention of lead exposure to be included in training requirements for child care facility staff. This added instruction is required to be consistent with the most recent child care lead poisoning prevention training curriculum from the Department of Public Health (DPH) and will be required for child care facility licenses issued on or after July 1, 2020. According to EMSA, the DPH training curriculum can be completed within 30 minutes to one hour.

EMSA requests General Fund expenditure authority of $177,000 in 2019-20 to allow EMSA to add the topic of lead poisoning prevention to the preventive health practices course for child care providers. These resources will support the equivalent of two positions to update regulations, provide technical assistance to private industry training programs, provide technical assistance to covered child care providers, and review and recertify training programs with the new curriculum. EMSA staff will review the updated training curriculum to verify the existing required topics are covered adequately in addition to the new lead poisoning prevention curriculum within the eight hour training timeframe. According to EMSA, due to the timing of recertification of the existing 24 private industry training programs, 12 to 15 would need to be recertified early for all 24 to meet the deadline of July 1, 2020, imposed by AB 2370.

EMSA also reports it is requesting General Fund expenditure authority because the EMS Training Program Approval Fund cannot absorb the one-time costs. The fund has a structural imbalance, with annual revenues approximately $18,000 lower than expenditures in 2018-19, and projected to be $20,000 lower than expenditures in 2019-20.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 7: Individual Tax ID Number for EMT Certification (SB 695)

Budget Issue. EMSA requests General Fund expenditure authority of $100,000 in 2019-20. If approved, these resources would allow EMSA to conduct outreach and assistance to local EMS agencies to implement acceptance of Individual Taxpayer Identification Numbers and prohibit requiring disclosure of citizenship or immigration status for the purpose of EMT certification, pursuant to the requirements of SB 695 (Lara), Chapter 838, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$100,000	$-
Total Funding Request:	**$100,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. In California, all licensing entities established under the Business and Professions Code are required to accept either an individual taxpayer identification number (ITIN) or a Social Security Number (SSN) for purposes of complying with state and federal requirements. An ITIN is a tax processing identification number issued by the U.S. Internal Revenue Service (IRS) for taxpayers and their dependents that are not eligible to obtain a SSN. The IRS issues ITINs because all wage earners, regardless of their immigration status, are required to pay federal taxes. ITINs allow people who are ineligible for a SSN to comply with tax laws, and are issued regardless of immigration status.

SB 695 (Lara), Chapter 838, Statutes of 2018, expands the requirement to accept ITIN in addition to SSN for licensing or credentialing applications to professions governed by the Department of Public Health (e.g. certified hemodialysis technicians, certified nurse assistants, certified home health aides, and radiologic technicians), the Commission on Teacher Credentialing (e.g. teacher credentialing and renewals), and EMSA (e.g. EMT-Is, EMT-IIs, and paramedics). SB 695 also prohibits licensing entities from requiring disclosure of citizenship or immigration status, and prohibits denial of licensure to otherwise qualified and eligible individuals based solely on citizenship or immigration status.

EMSA requests one-time General Fund expenditure authority of $100,000 in 2019-20 to procure a consultant to conduct outreach and assistance to local EMS agencies to implement acceptance of ITINs and prohibit requiring disclosure of citizenship or immigration status for the purpose of EMT certification, pursuant to the requirements of SB 695. The consultant would evaluate the impact of accepting ITINs for certification, provide outreach to local certifying entities, collaborate with the Department of Justice on ITIN use on fingerprint forms, create training documents for local certifying entities, implement and facilitate statewide training for EMSA and local staff, and work with local certifying entities to include ITINs in local certification systems.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 8: Administrative Support Costs

Budget Issue. EMSA requests expenditure authority of $186,000 ($98,000 General Fund and $88,000 special funds) in 2019-20 and 2020-21, and $190,000 ($98,000 General Fund and $92,000 special funds) annually thereafter. If approved, these resources would allow EMSA to support increased costs associated with contracted fiscal and personnel services, facilities, and utilities.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$98,000	$98,000
0194 – EMS Training Program Approval Fund	$-	$-
0312 – EMS Personnel Fund	$57,000	$57,000
3137 – EMT Certification Fund	$31,000	$31,000
Total Funding Request:	**$186,000**	**$186,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional Resources in 2021-22: $4,000 EMS Training Program Approval Fund. Resources are ongoing after 2021-22.

Background. EMSA contracts with the Department of General Services (DGS) Contract Fiscal Services (CFS) for accounting and budgeting services and with the DGS Office of Human Resources (OHR) for personnel services. According to EMSA, because it is a relatively small state entity, it is more cost-effective to contract with DGS for these services to be provided on a contract basis than to hire staff within the authority to perform this workload. The costs for the contracts with CFS, which has increased from $113,000 to $278,000 between 2014-15 and 2017-18, and OHR, which has increased $166,000 to $236,000 during the same period, are allocated proportionally to all of the funding sources that support EMSA including the General Fund, the EMS Training Program Approval Fund, the EMS Personnel Fund, the EMT Certification Fund, federal funds, and reimbursements. In addition to increases in its DGS contract costs, EMSA also reports its facilities and utilities costs have increased from $830,000 in 2014-15 to $872,000 in 2017-18.

EMSA requests expenditure authority of $186,000 ($98,000 General Fund and $88,000 special funds) in 2019-20 and 2020-21, and $190,000 ($98,000 General Fund and $92,000 special funds) annually thereafter to allow EMSA to support the increased costs associated with the DGS contracted fiscal and personnel services, as well as increased costs of facilities and utilities. According to EMSA, these increased operating costs have been funded by salary savings from vacant positions in the EMT Registry Program, resulting in delays in issuance and renewal of EMT certifications, investigations of paramedic licensure violations, and technical assistance to local EMS agencies.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

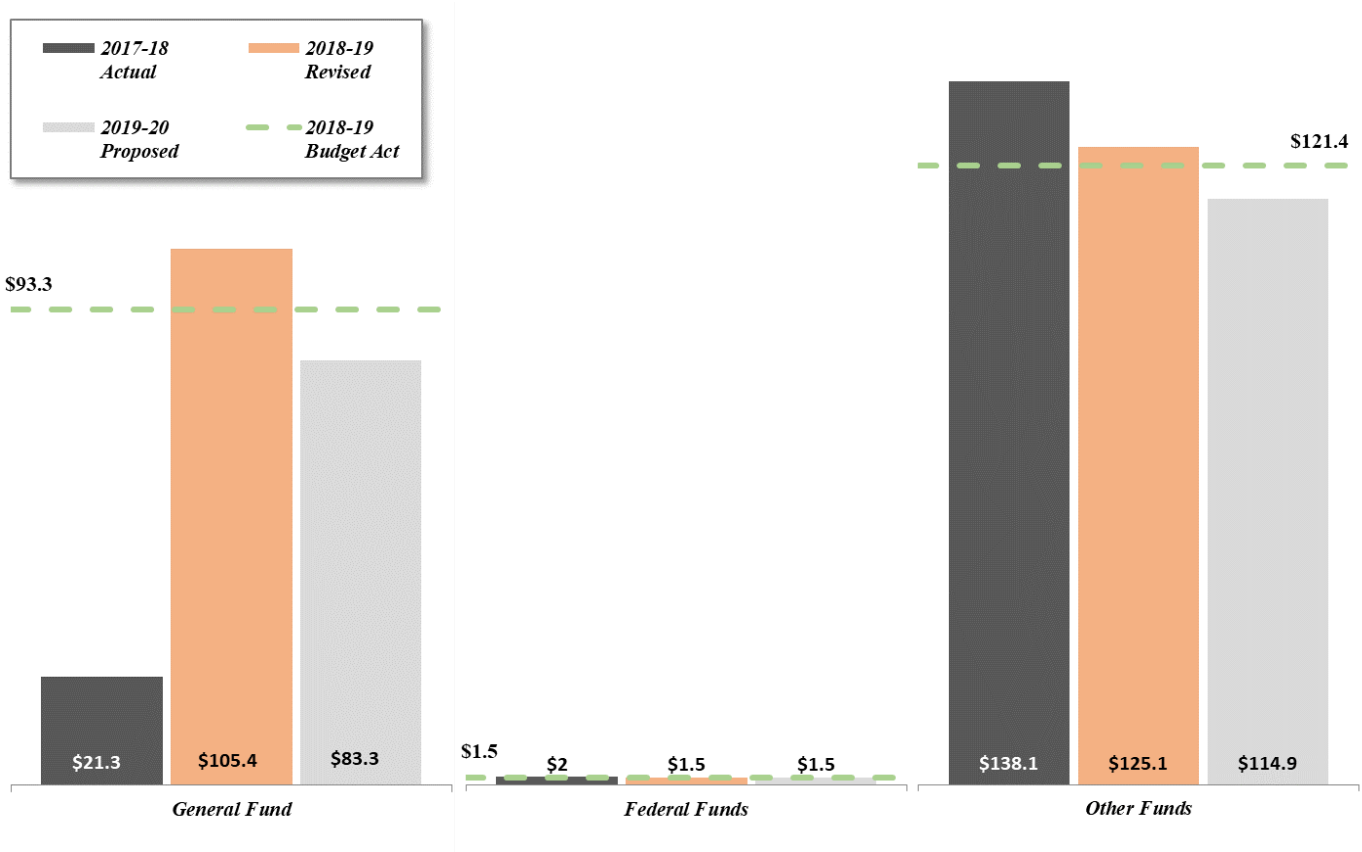
Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Overview

Office of Statewide Health Planning and Development – *Three-Year Funding Summary*
(dollars in millions)



Office of Statewide Health Planning and Development - *Department Funding Summary*			
Fund Source	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund (0001)	$93,333,000	$105,387,000	$83,333,000
Federal Funds (0890)	$1,464,000	$1,464,000	$1,463,000
Other Funds (*detail below*)	$121,404,000	$125,065,000	$114,918,000
Total Department Funding:	**$216,201,000**	**$231,916,000**	**$199,714,000**
Total Authorized Positions:	**430.5**	**430.5**	**434.5**
Other Funds Detail:			
Hospital Building Fund (0121)	*$63,521,000*	*$65,750,000*	*$65,762,000*
CA Health Data and Planning Fund (0143)	*$31,752,000*	*$32,670,000*	*$33,407,000*
Registered Nurse Education Fund (0181)	*$2,180,000*	*$2,192,000*	*$2,192,000*

Health Fac. Const. Loan Ins. Fund (0518)	*$4,943,000*	*$5,078,000*	*$5,079,000*
Health Professions Education Fund (0829)	*$1,099,000*	*$1,111,000*	*$1,111,000*
Medically Underserved Account/Phys (8034)	*$2,399,000*	*$2,724,000*	*$2,402,000*
Reimbursements (0995)	*$868,000*	*$868,000*	*$868,000*
Mental Health Practitioner Ed. Fund (3064)	*$395,000*	*$396,000*	*$821,000*
Vocational Nurse Education Fund (3068)	*$224,000*	*$225,000*	*$225,000*
Mental Health Services Fund (3085)	*$14,023,000*	*$14,051,000*	*$3,051,000*

Background. The Office of Statewide Health Planning and Development (OSHPD) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Health Care Workforce Development Division. OSHPD administers programs designed to increase access to healthcare to underserved populations and provide a culturally competent healthcare workforce. Specifically, OSHPD encourages demographically underrepresented groups to pursue healthcare careers, incentivizes primary care and mental health professionals to work in underserved communities, evaluates new and expanded roles for health professionals and new health delivery alternatives, designates health professional shortage areas, and serves as the state's central repository of health education and workforce data.

OSHPD awards scholarships and loan repayments to aspiring health professionals and graduate students who agree to provide direct patient care in medically underserved areas for one to four years. OSHPD serves as California's Primary Care Office supporting the state's healthcare workforce through pipeline development, training and placement, financial incentives, systems redesign, and research and policy with a focus on underserved and diverse communities.

Song-Brown Program. The Song-Brown Health Care Workforce Training Act (Song-Brown Program) was established in 1973 to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, as well as family nurse practitioner, physician assistant, and registered nurse education programs throughout California. The Song-Brown program is aided by the California Healthcare Workforce Policy Commission (CHWPC), a 15-member citizen advisory board that provides expert guidance and statewide perspectives on health professional education issues, reviews applications, and recommends contract awards.

The Song-Brown program was funded exclusively with state General Fund until the 2004-05 fiscal year. Between 2004-05 and 2008-09, the program received a combination of General Fund and funding from the California Health Data and Planning Fund (Data Fund), which receives fee revenue from licensed health facilities in California. Beginning in 2008-09, the program received no General Fund resources until 2017-18. During that period, the program relied on resources from the Data Fund and a $21 million grant from the California Endowment for family medicine and family nurse practitioner/physician assistant training.

The 2017 Budget Act authorized $100 million over three years for augmentation of health care workforce initiatives at OSHPD. The $33.3 million annual allocation provides up to $18.7 million for existing primary care residency slots, up to $3.3 million for new primary care residency slots at existing residency programs, up to $5.7 million for primary care residency slots at teaching health centers, up to $3.3 million for newly accredited primary care residency programs, up to $333,000 for the State Loan Repayment Program, and up to $2 million for OSHPD state operations costs. Unspent funds in each of these categories from prior years are available for expenditure for the subsequent five fiscal years. For example unspent funds from 2017-18 are available until June 30, 2023, and unspent funds from 2018-19 are available until June 30, 2024. According to OSHPD, the Song-Brown program awarded the following in 2018-19:

1) *Existing Primary Care Residency Slots* – $20.6 million to support over 160 existing residency slots at 62 existing programs
2) *Newly Accredited Primary Care Residency Programs* - $5.6 million ($3.3 million General Fund, $3.1 million Data Fund, and $273,000 California Endowment Funds) to support seven new programs.
3) *Teaching Health Centers (THC)* - $5.1 million to support residency slots at six existing THCs
4) *New Primary Care Residency Slots at Existing Programs* - $2.1 million to support three new residency slots in existing programs

Song-Brown: Existing Primary Care Residency Slots Awards – August 2018

Residency Program Name	Award	Residency Program Name	Award
Adventist Health Glendale	$625,000	San Joaquin General Hospital (FM)	$500,000
Alameda Health System - Highland Hospital	$185,000	Santa Rosa	$185,000
Charles R. Drew University	$185,000	Scripps Memorial, Chula Vista	$625,000
Citrus Valley Health Partners	$500,000	Shasta Community Health Center	$310,000
Contra Costa FM Residency Program	$625,000	St. Joseph Medical Center - Stockton	$310,000
Dignity Health California Hospital Medical Center	$625,000	Stanford Health Care - O'Connor Hospital	$310,000
Family Health Centers of San Diego	$500,000	UCSD Combined FM and Psychiatry Residency	$125,000
Harbor-UCLA (Pediatrics)	$125,000	UCSF Benioff Children's Hospital Oakland	$310,000
Harbor-UCLA (OB/GYN)	$125,000	UCSF Fresno (FM)	$625,000
Harbor-UCLA (FM)	$625,000	UCSF Fresno (Pediatrics)	$185,000
John Muir	$125,000	UCSF Fresno (IM)	$310,000
Kaiser Permanente Fontana	$185,000	UCSF Fresno (OB/GYN)	$125,000
Kaiser Permanente Los Angeles (Pediatrics)	$125,000	UCSF-SFGH Family and Community Medicine	$625,000
Kaiser Permanente Los Angeles (FM)	$250,000	University of California, Davis (IM)	$185,000
Kaiser Permanente Orange County	$310,000	University of California, Davis (FM)	$125,000
Kaiser Permanente San Diego	$500,000	University of California, Irvine	$500,000
Kaiser Permanente Santa Rosa	$125,000	University of California, Los Angeles (FM)	$625,000

Kaiser Permanente Woodland Hills	$185,000	University of California, Los Angeles (Pediatrics)	$185,000
Loma Linda-Inland Empire Consortium	$125,000	University of California, Riverside (IM)	$500,000
Loma Linda University - Primary Care Track	$185,000	University of California, Riverside (OB/GYN)	$310,000
Long Beach Memorial	$250,000	University of California, Riverside (FM)	$500,000
Marian Regional Medical Center (FM)	$125,000	University of California, San Francisco (IM)	$310,000
Marian Regional Medical Center (OB/GYN)	$185,000	University of California, San Francisco (OB/GYN)	$310,000
Mercy Medical Center Merced	$500,000	Valley Children's Hospital Madera	$125,000
Mercy Medical Redding	$125,000	Valley FM Residency of Modesto	$185,000
Natividad Medical Center	$310,000	Valley Health Team	$500,000
Pomona Valley Hospital	$500,000	Ventura County Medical Center	$310,000
Rio Bravo	$625,000	White Memorial Medical Center (FM)	$625,000
Riverside Community Hospital/UCR (FM)	$500,000	White Memorial Medical Center (OB/GYN)	$125,000
Riverside Community Hospital/UCR (IM)	$185,000	White Memorial Medical Center (IM)	$310,000
Riverside University Health System/UCR	$625,000	**TOTAL - $20,565,000**	
San Joaquin General Hospital (IM)	$125,000		

* FM = Family Medicine, IM = Internal Medicine, OB/GYN = Obstetrics/Gynecology

Song-Brown: New Primary Care Residency Slots Awards – August 2018

Residency Program Name	Award	Residency Program Name	Award
Adventist Health Ukiah Valley	$800,000	North East Medical Services	$800,000
Borrego Community Health	$800,000	St Joseph Med Center-Stockton (IM)	$800,000
Centro de Salud de la Comunidad de San Ysidro	$800,000	St Joseph Med Center-Stockton (OB/GYN)	$800,000
Lifelong Medical Care	$800,000	**TOTAL - $5,600,000**	

* FM = Family Medicine, IM = Internal Medicine, OB/GYN = Obstetrics/Gynecology

Song-Brown: Teaching Health Center Awards – August 2018

Residency Program Name	Award	Residency Program Name	Award
Clinica Sierra Vista – Rio Bravo	$1,020,000	Valley Family Medicine Residency-Modesto	$1,190,000
Family Health Centers of San Diego	$1,020,000	Valley Health Team	$680,000
Loma Linda-Inland Empire Consortium	$680,000	**TOTAL - $5,100,000**	
Shasta Community Health Center	$510,000		

Song-Brown: Primary Care Residency Expansion Awards – August 2018

Residency Program Name	Award	Residency Program Name	Award
Loma Linda-Inland Empire Consortium	$300,000	UCSF-Fresno (IM)	$900,000
UCSF Fresno (FM)	$900,000	**TOTAL - $2,100,000**	

* FM = Family Medicine, IM = Internal Medicine, OB/GYN = Obstetrics/Gynecology

Budget Proposes Ongoing Extension of Song-Brown Funding. The Governor's January budget summary proposes to permanently extend the $33.3 million annual General Fund expenditure authority for the Song-Brown program. The 2019-20 fiscal year will be the final year of the three-year, $100 million General Fund allocation for the program approved in the 2017 Budget Act. The Governor's proposed extension would allocate ongoing funding beginning in 2020-21 and annually thereafter. According to OSHPD, the extended funding would continue to adhere to the current allocations for existing primary care residency slots ($18.7 million), new primary care residency slots at existing programs ($3.3 million), primary care residency slots at teaching health centers ($5.7 million), newly accredited primary care residency programs ($3.3 million), the State Loan Repayment Program ($333,000), and state operations costs ($2 million).

Stakeholder Proposal to Expand Song-Brown Funding for Pediatrics. The California Children's Hospital Association (CCHA) requests an additional $2 million General Fund allocation to the Song-Brown program for pediatric residency programs. According to CCHA, Song-Brown currently allocates between $1 million and $1.3 million for pediatric residencies. This request would augment OSHPD's General Fund expenditure authority by an additional $2 million and designate a total of $3 million of Song-Brown funding for pediatric residency programs.

Stakeholder Proposal to Expand Primary Care and Behavioral Health Workforce Development. California Health+ Advocates requests General Fund expenditure authority of $50 million for grants to eligible safety net organizations, including primary care clinics and public hospitals, to help close existing primary care and behavioral health vacancy gaps by resourcing recruitment strategies. This proposal would allocate $49.5 million to these strategies, including: 1) recruitment/signing incentives, 2) salary/benefit subsidies, or 3) housing or relocation grants. Included in the request would be $300,000 for OSHPD grant administration and technical assistance, and $200,000 for program monitoring and evaluation. According to California Health+ Advocates, without additional tools to recruit this critical healthcare workforce, safety net health care organizations, including community health centers, will be unable to provide high-quality care for the nearly 6.9 million low-income, uninsured and underserved Californians who depend on community health centers each year for their care.

Workforce Education and Training (WET) Program. In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directs the majority of revenues to county mental health programs for community services and supports, prevention and early intervention, innovative programs, WET, and capital facilities and technological needs. For WET programs, Proposition 63 allocated $210 million to counties and $234.5 million to the state over a ten-year period beginning in 2008. The state's WET programs were originally administered by the Department of Mental Health (DMH), which developed the first five-year plan for the program. After dissolution of DMH in 2012, program responsibility was transferred to OSHPD, which developed the second five-year plan for 2014-2019 in coordination with the California Mental Health Planning Council.

WET Program Five-Year Plan 2020-2025. In February 2019, OSHPD released the third five year WET plan covering the period from 2020-2025. After engaging with stakeholders, the report is meant to

guide efforts to improve and expand the public mental health system (PMHS) workforce throughout California. Unlike the previous two plans, there is no funding associated with this plan, which OSHPD designed to be programmatically flexible based on the level of funding provided. The plan sets out the following goals and objectives:

Goals

1. Increase the number of diverse, competent licensed and non-licensed professionals in the PMHS to address the needs of persons with serious mental illness.
2. Expand the capacity of California's current public mental health workforce to meet California's diverse and dynamic needs.
3. Facilitate a robust statewide, regional, and local infrastructure to develop the public mental health workforce.
4. Offer greater access to care at a lower level of intensity that enables consumers to maintain and maximize their overall well-being.
5. Support delivery of PMHS services for consumers within an integrated health system that encompasses physical health and substance use services.

Objectives

1. Expand awareness and outreach efforts to effectively recruit racially, ethnically, and culturally diverse individuals into the PMHS workforce.
2. Identify and enhance curricula to train students at all levels in competencies that align with the full spectrum of California's diverse and dynamic PMHS needs.
3. Develop career pathways for individuals entering and advancing across new and existing PMHS professions.
4. Expand the capacity of postsecondary education to meet the identified PMHS workforce needs.
5. Expand financial incentive programs for the PMHS workforce to equitably meet identified PMHS needs in underrepresented, underserved, unserved, and inappropriately served communities.
6. Expand education and training programs for the current PMHS workforce in competencies that align with the full spectrum of PMHS needs.
7. Increase the retention of PMHS workforce identified as high priority.
8. Evaluate methods to expand and enhance the quality of existing PMHS delivery systems to meet California's PMHS needs.
9. Develop and sustain new and existing collaborations and partnerships to strengthen recruitment, training, education, and retention of the PMHS workforce.
10. Explore stakeholder-identified policies that aim to further California's efforts to meet its PMHS needs.
11. Provide flexibility to allow local jurisdictions to meet their unique needs.
12. Standardize PMHS workforce education and training programs across the state.
13. Promote care that reduces demand for high-intensity PMHS services and workforce.

Stakeholder Proposal to Establish WET Trust Fund to Finance Five-Year Plan. The California Council of Community Behavioral Health Agencies (CBHA) requests General Fund expenditure authority of $70 million over two years for the WET Trust Fund to be administered by OSHPD. The fund would support the workforce efforts outlined in the recently released WET Five-Year Plan 2020-2025. These efforts would include funding for loan repayment programs and stipends for behavioral health clinicians, increasing capacity at universities to train and supervise behavioral health professionals, and regional partnerships where counties can pursue specific strategies to address their communities' needs. CHBA estimates each year of the Five-Year Plan would cost $35 million and this request would fund the first two years of the plan.

State Loan Repayment Program. The State Loan Repayment Program (SLRP) is a federally funded, state-run program that provides student loan repayment funding to healthcare professionals who commit to practicing in Health Professional Shortage Areas (HPSAs) in California. Professionals eligible for awards under SLRP include physicians (M.D. and D.O.), psychiatric nurse specialists, dentists, mental health counselors, registered dental hygienists, health service psychologists, nurse practitioners (primary care), licensed clinical social workers, physician assistants (primary care), licensed professional counselors, certified nurse midwives, marriage and family therapists, and pharmacists. Recipients must also, among other requirements, commit to a two-year (four-year, if half-time) initial service obligation at a SLRP Certified Eligible Site (CES) in one of the areas designated as an HPSA. According to OSHPD, the SLRP made 98 awards totaling $1.3 million in 2018-19.

Health Professions Education Foundation. OSHPD administers the Health Professions Education Foundation (HPEF), a 501(c)(3) non-profit public benefit corporation established in 1987 through legislation. The HPEF offers scholarships and loan repayments for students and graduates willing to practice in underserved areas. The HPEF manages the following six scholarship and seven loan repayment programs:

Program(s)	Eligible Professions
Allied Healthcare Scholarship (AHSP) Allied Healthcare Loan Repayment (AHLRP)	Community Health Worker, Medical Assistant, Medical Imaging, Occupational Therapy Assistant, Pharmacy Technician, Physical Therapy Assistant, Radiation Therapy Technician, Radiologic Technician
Vocational Nurse Scholarship (VNSP) Licensed Vocational Nurse Loan Repayment (LVNLRP)	Vocational Nurses
LVN to Associate Degree Nursing Scholarship (LVN to ADN)	Licensed Vocational Nurses
Associate Degree Nursing Scholarship (ADNSP)	Nursing (Associate Degree students)
Bachelor of Science in Nursing Scholarship (BSNSP) Bachelor of Science in Nursing Loan Repayment (BSNLRP)	Nursing (Bachelor's Degree students)
Advanced Practice Healthcare Scholarship (APHSP) Advanced Practice Healthcare Loan Repayment (APHLRP)	Certified Nurse Midwives, Clinical Nurse Specialists, Dentists, Nurse Practitioners, Occupational Therapists, Pharmacists, Physical Therapists, Physician Assistants, Speech Language

	Pathologists
Licensed Mental Health Services Provider Education (LMHSPEP)	Psychologists, Postdoctoral Psych. Assistants, Postdoctoral Psych. Trainees, Marriage and Family Therapists, Clinical Social Workers, Professional Clinical Counselors
Mental Health Loan Assumption (MHLAP)	Determined by counties
Steven M. Thompson Physician Corp Loan Repayment (STLRP)	Primary care physicians (65 percent), geriatric physicians (15 percent), specialty physicians (up to 20 percent)

In 2017-18, the HPEF awarded 1,664 scholarships and loan repayments in its 13 programs for a total award amount of $17.1 million. These programs are funded by a combination of foundation grant funding and licensing fees collected by professional licensing boards for the professions benefitting from HPEF training programs. Foundations providing funding include the California Endowment, the California Medical Services Program, the California Wellness Foundation, and Kaiser Permanente California Community Benefit Foundation.

Facilities Development Division – Hospital Seismic Safety. In 1971, the Sylmar earthquake struck the northeast San Fernando Valley, killing 64 people and causing significant damage to structures. In particular, the San Fernando Veterans Administration Hospital in Sylmar, constructed in 1926 with unreinforced concrete, collapsed, resulting in the deaths of 44 individuals trapped inside the building. In addition, a more recently constructed psychiatric ward at Sylmar's Olive View Community Hospital collapsed during the quake, resulting in three deaths and the evacuation of more than 1,000 patients. In response to these tragic events, the Legislature approved the Alfred E. Alquist Hospital Facilities Seismic Safety Act (Alquist Act), which required hospitals to meet stringent construction standards to ensure they are reasonably capable of providing services to the public after a disaster. In 1983, the act was amended to transfer all hospital construction plan review responsibility from local governments to OSHPD, creating the state's largest building department, the Facilities Development Division.

In 1994, the Northridge earthquake struck the San Fernando Valley again, resulting in major structural damage to many hospitals constructed prior to the Alquist Act, many of which were evacuated. In contrast, hospitals constructed in compliance with Alquist Act standards resisted the Northridge earthquake, suffering very little structural damage. In response, the Legislature approved SB 1953 (Alquist), Chapter 740, Statutes of 1994, which amended the Alquist Act to require hospitals to evaluate and rate all general acute care hospital buildings for seismic resistance according to standards developed by OSHPD to measure a building's ability to withstand a major earthquake. SB 1953 and subsequent OSHPD regulations also require hospitals to submit plans to either retrofit or relocate acute care operations according to specific timeframes. According to OSHPD, there are 476 general acute care and acute psychiatric hospitals comprised of 3,066 hospital buildings and 88,126 licensed beds covered by the seismic safety provisions of SB 1953. In addition to oversight of seismic safety compliance for acute care hospitals, OSHPD is responsible for ensuring seismic and building safety compliance for skilled nursing facilities and intermediate care facilities. According to OSHPD, SB 1953 covers 1,162 skilled nursing facilities with 1,200 buildings and 114,333 licensed beds. The Facilities Development Division receives funding from fees paid by hospitals and skilled nursing facilities for plan review and building permits of construction projects, as follows:

1) 1.95 percent of construction costs for collaborative phased plan review
2) 1.64 percent of construction costs for hospitals
3) 1.5 percent of construction costs for skilled nursing facilities

Cal-Mortgage Loan Insurance Division. OSHPD's Cal-Mortgage Loan Insurance Division administers the California Health Facility Construction Loan Insurance Program. Cal-Mortgage provides credit enhancement for eligible health care facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of California, which permits borrowers to obtain lower interest rates. Eligible health facilities must be owned and operated by private, nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage include hospitals, skilled nursing facilities, intermediate care facilities, public health centers, clinics, outpatient facilities, multi-level facilities, laboratories, community mental health centers, facilities for the treatment of chemical dependency, child day care facilities (in conjunction with a health facility), adult day health centers, group homes, facilities for individuals with developmental disabilities, and office or central service facilities (in conjunction with a health facility). As of November 30, 2018, Cal-Mortgage insures 82 loans with a total value of approximately $1.7 billion.

Information Services Division. The Information Services Division (ISD) collects and disseminates timely and accurate healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products.

Information Technology Services and Support. The division supports operations, data collection, and reporting functions through maintenance of technical infrastructure and enterprise systems, including IT customer support, project portfolio management, and enterprise architecture.

Data Collection and Management. The division collects and publicly discloses facility level data from more than 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. In addition, approximately 450 hospitals report demographic and utilization data on approximately 16 million inpatient, emergency department, ambulatory surgery patients, and by physician, about heart surgery patients.

Healthcare Data Analytics. The division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality and outcome ratings for heart surgery and other procedures are also published. The division conducts a wide range of special studies on such topics as preventable hospital admissions and readmission, trends in care, and racial or ethnic disparities. The division also provides information to the public on non-profit hospital and community benefits, and hospital prices and discount policies.

Engagement and Technical Assistance. The division provides assistance to the members of the public seeking to use OSHPD data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of OSHPD's mission and programs.

Issue 2: Increased Expenditure Authority for Mental Health Practitioner Education Fund

Budget Issue. OSHPD requests additional expenditure authority from the Mental Health Practitioner Education Fund of $425,000. If approved, these resources would allow OSHPD to increase the grant awards provided through the Licensed Mental Health Service Provider Education Program. These resources would be funded from increased licensure fee revenue approved pursuant to AB 1188 (Nazarian), Chapter 557, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3064 – Mental Health Practitioner Education Fund	$425,000	$425,000
Total Funding Request:	**$425,000**	**$425,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2020-21.

Background. AB 1188 increased the biennial license renewal fee for certain licensed mental health providers from $10 to $20, effective July 1, 2018. These fees are collected by the Board of Psychology and the Board of Behavioral Sciences and are deposited in the Mental Health Practitioner Education Fund, which supports the Licensed Mental Health Service Provider Education Program administered by OSHPD's Health Professions Education Foundation. The Licensed Mental Health Provider Education Program is a loan repayment program that reimburses eligible mental health providers for their education loans, up to $15,000, in exchange for a required service obligation in a mental health shortage area or in a publicly funded mental health facility. The program is intended to increase access to mental health services throughout the state.

The additional revenue collected in 2018-19 from the fee increase is estimated to be $425,000 and will be awarded through the program in 2019-20. The current revenue and expenditure authority for the Mental Health Practitioner Education Fund is $395,000. OSHPD requests additional expenditure authority from the fund of $425,000 for a total of $820,000 to reflect the expected increased revenue and expenditures for the program in 2019-20.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: SNFs: Disclosure of Interest in Businesses Providing Services (AB 1953)

Budget Issue. OSHPD requests one position and expenditure authority from the California Health Data and Planning Fund of $369,000 in 2019-20 and $119,000 annually thereafter. If approved, these positions and resources would allow OSHPD to collect data and report on disclosures by skilled nursing facilities regarding ownership interests in related parties that provide services to the facility, pursuant to the requirements of AB 1953 (Wood), Chapter 383, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0143 – CA Health Data and Planning Fund	$369,000	$119,000
Total Funding Request:	**$369,000**	**$119,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources ongoing after 2020-21.

Background. In May 2018, the California State Auditor released an audit of skilled nursing facilities titled "Absent Effective State Oversight, Substandard Quality of Care Has Continued". The audit reviewed three large private operators of skilled nursing facilities in California finding that, while revenues for the industry as a whole declined, these three operators increased their net income by tens of millions of dollars. The audit found these gains were made, in part, by the ability of these operators to receive revenue from the sale of goods or services provided to their facilities by entities owned or controlled by themselves or family members. These related party transactions are legal, though federal programs like Medicare and Medicaid attempt to limit the possibility these programs are paying for profits from these transactions. The Auditor recommended that OSHPD consolidate facility related party transactions, currently reported in two different areas of facility cost reporting, and expand the detail of the transactions.

In response to these concerns, AB 1953 requires each organization that operates, conducts, owns, or maintains a skilled nursing facility to file with OSHPD whether the management of the facility has an ownership or control interest greater than five percent in a related party that provides services to the facility. The disclosure must include all services provided to the facility, the number of individuals who provide that service at the facility, and any other information requested by the office. AB 1953 also requires the disclosure to include the related party's profit and loss statement and the facility's payroll-based journal, if goods and services were worth more than $10,000.

OSHPD requests one position and expenditure authority from the California Health Data and Planning Fund of $369,000 in 2019-20 and $119,000 annually thereafter. These resources would allow OSHPD to procure contract services for $250,000 to update its data collection forms, accounting systems, and program regulations. Included in the contract request is $75,000 for project management and business analysis and $175,000 for system software development and engineering. These activities would include conducting business analysis, developing system requirements, and designing changes to collect the new data elements, all of which would be subject to the Project Approval Lifecycle at the California Department of Technology.

OSHPD also requests **one Health Program Auditor II** to assist in the development of regulations and accounting system changes, and review submitted data to ensure consistency with OSHPD's accounting and reporting system standards.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Mental Health Workforce Development

Budget Issue. OSHPD requests General Fund expenditure authority of $50 million, available for expenditure until June 30, 2025. If approved, these resources would allow OSHPD to support mental health workforce development through existing loan repayment and scholarship programs that support mental health professions.

Program Funding Request Summary		
Fund Source	**2019-20***	**2020-21**
0001 – General Fund	$50,000,000	$-
Total Funding Request:	**$50,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* One-time funding available for expenditure until June 30, 2025.

Background. According to OSHPD, a 2018 study by the Healthforce Center at the University of California San Francisco for the California Health Care Foundation showed that the projected demand for behavioral health services outpaces projected supply. If current trends continue, between 2016 and 2028, the supply of behavioral health professionals will not be sufficient to meet demand. In addition, the mental health workforce is maldistributed across the state and does not adequately represent the diversity of California's population.

OSHPD requests General Fund expenditure authority of $50 million, available for expenditure until June 30, 2025, to allow OSHPD to support mental health workforce development through existing loan repayment and scholarship programs that support mental health professions. OSHPD's scholarship and loan forgiveness mental health programs serve to increase access to and the retention of providers in mental health professions, especially in underserved areas. According to OSHPD, the funding requested in this proposal would allow for additional loan repayment and scholarship awards for eligible practitioners to increase the number of mental health providers throughout the state. For each of the five years, OSHPD expects 4,212 loan repayment applications with 880 loan repayments awarded, as well as 130 scholarship applications with 50 scholarships awarded.

According to OSHPD, the existing programs funded by the $50 million request, allocated dependent on the number of eligible applications received, are as follows:

Loan Repayment Scholarship Programs	Mental Health Professions	Application Opens	Awards Made	Max Award Amount	Service Obligation Period
Allied Healthcare Loan Repayment Program	Community Health Worker/Promotores Medical Assistant Social Worker	August 2019	May 2020	$8,000	One Year
Licensed Mental Health Services Provider Education Program	Licensed Clinical Social Worker Licensed Marriage and Family Therapist Licensed Professional Counselor Licensed Psychologist Postdoctoral Psychological Assistant Postdoctoral Psychological Trainee	August 2019	May 2020	$15,000	Two Years
Advanced Practice Healthcare Loan Repayment Program	Clinical Nurse Specialist Nurse Practitioner Physician Assistant	August 2019	May 2020	$25,000	Two Years
State Loan Repayment Program	Health Service Psychologist Licensed Clinical Social Worker Licensed Professional Counselor Licensed Marriage and Family Therapist Psychiatric Mental Health Nurse Practitioner Psychiatric Nurse Specialist Psychiatrist	August 2019	December 2019	$50,000	Two Years
Steven M. Thompson Physician Corps Loan Repayment Program	Psychiatrist	December 2019	June 2020	$105,000	Three Years
Allied Healthcare Scholarship Program	Community Health Worker/Promotoras Medical Assistant Social Worker	January 2020	June 2020	$8,000	One Year

Advanced Practice Healthcare Scholarship Program	Clinical Nurse Specialist Nurse Practitioner Physician Assistant	January 2020	June 2020	$25,000	One Year
Mental Health Loan Assumption Program	Consumer or Peer Counselor Licensed Marriage and Family Therapist Licensed Clinical Social Worker Licensed Professional Counselor Licensed Psychologist Mental Health Admin or Support Staff Psychiatric Mental Health Nurse Practitioner Psychiatrist Rehabilitation Counselor	January 2020	June 2020	$10,000	One Year

Stakeholder Proposal to Fund Loan Repayments for Former Foster Youth. Journey House requests an allocation of $750,000 General Fund to the Mental Health Practitioner Education Fund for loan repayment grants for mental health providers who were formerly in the California child welfare system. AB 2608 (Stone), Chapter 585, Statutes of 2018, established an account within the Mental Health Practitioner Education Fund that was earmarked for mental health workforce development for former foster youth. However, no funding was provided for the account. According to the proponents, these grants would target former foster youth who are now mental health providers in public facilities or provider shortage areas to repay educational loans. Outreach to ensure that former foster youth are aware of the availability of loan repayment grants would be performed along with existing outreach efforts for the Licensed Mental Health Service Provider Education Program. This investment would fund loan repayment grants for at least 50 former foster youth, incentivizing former foster youth on their path to a master's degree and expanding the ability of the California child welfare system to recruit dedicated, qualified, and culturally competent service providers. This proposal is consistent with the Governor's proposed allocation of $50 million for mental health workforce development, as a portion of the loan repayment funding could be designated through the administration of current mental health workforce programs for professionals who are former foster youth.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

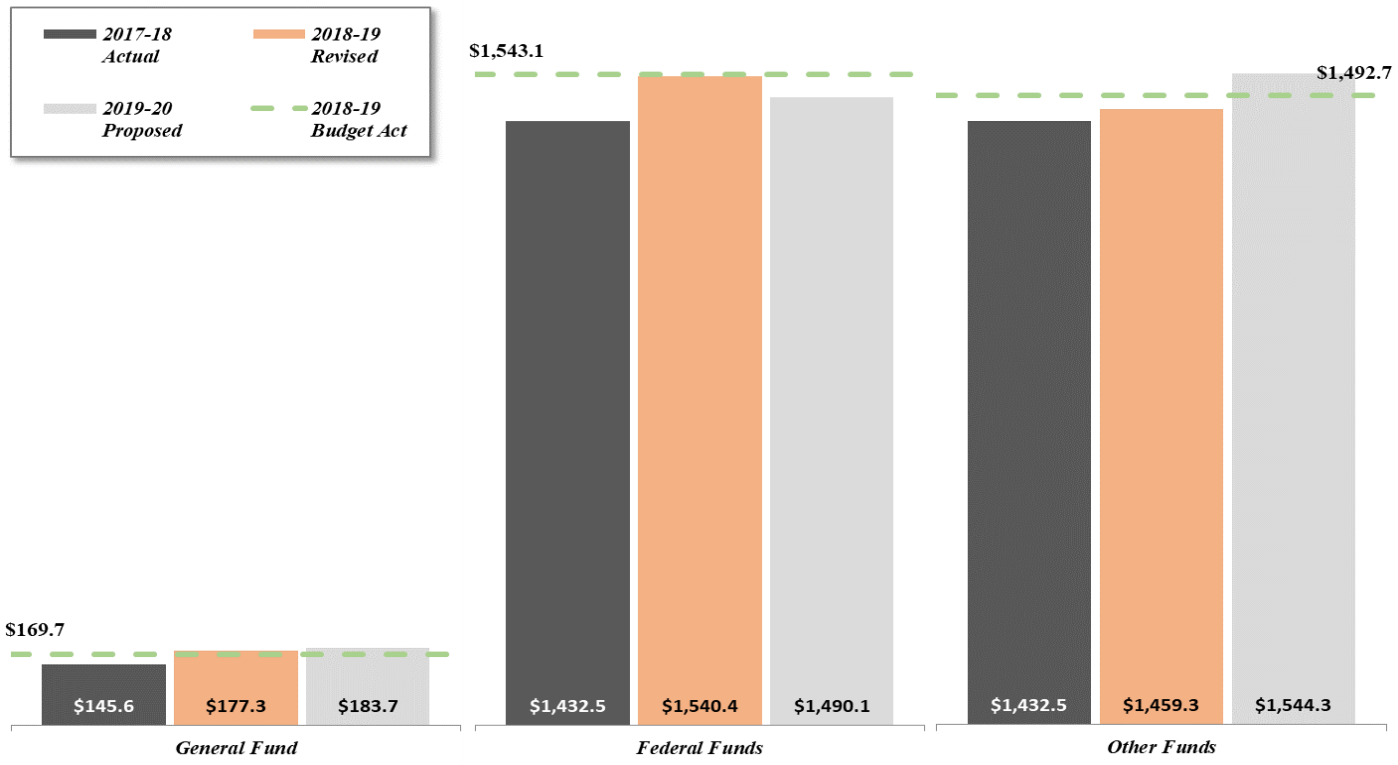
Questions. The subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview

Department of Public Health – *Three-Year Funding Summary*
(dollars in millions)



Department of Public Health - *Department Funding Summary*			
Fund Source	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund	$169,723,000	$177,280,000	$183,686,000
Federal Funds	$1,543,068,000	$1,540,352,000	$1,490,075,000
Other Funds (*detail below)*	$1,492,661,000	$1,459,329,000	$1,544,261,000
Total Department Funding:	**$3,205,452,000**	**$3,176,961,000**	**$3,218,022,000**
Total Authorized Positions:	**3658.7**	**3660.7**	**3773.0**
Other Funds Detail:			
Breast Cancer Research Account (0007)	*$2,104,000*	*$2,104,000*	*$1,179,000*
Nuclear Planning Assessment Acct (0029)	*$984,000*	*$984,000*	*$984,000*
Motor Vehicle Acct, Trans. Fund (0044)	*$1,493,000*	*$1,552,000*	*$1,550,000*
Sale of Tobacco to Minors Ctrl Acct (0066)	*$1,104,000*	*$544,000*	*$1,098,000*

Other Funds Detail (continued):			
Occup. Lead Poisoning Prev Acct (0070)	*$3,653,000*	*$3,755,000*	*$3,585,000*
Medical Waste Management Fund (0074)	*$2,767,000*	*$2,903,000*	*$2,786,000*
Radiation Control Fund (0075)	*$25,704,000*	*$26,923,000*	*$27,319,000*
Tissue Bank License Fund (0076)	*$630,000*	*$659,000*	*$638,000*
Childhood Lead Poisoning Prev Fund (0080)	*$31,588,000*	*$31,992,000*	*$41,402,000*
Export Document Program Fund (0082)	*$758,000*	*$804,000*	*$801,000*
Clinical Lab. Improvement Fund (0098)	*$12,096,000*	*$12,532,000*	*$12,818,000*
Health Statistics Special Fund (0099)	*$27,380,000*	*$28,165,000*	*$29,115,000*
Dept. of Pesticide Regulation Fund (0106)	*$321,000*	*$328,000*	*$328,000*
Air Pollution Control Fund	*$297,000*	*$303,000*	*$303,000*
CA Health Data and Planning Fund (0143)	*$240,000*	*$240,000*	*$240,000*
Food Safety Fund (0177)	*$10,777,000*	*$10,967,000*	*$11,371,000*
Genetic Disease Testing Fund (0203)	*$132,952,000*	*$134,094,000*	*$141,176,000*
Health Education Account, Prop 99 (0231)	*$37,673,000*	*$37,828,000*	*$51,060,000*
Research Account, Prop 99 (0234)	*$5,813,000*	*$5,824,000*	*$6,938,000*
Unallocated Account, Prop 99 (0236)	*$3,311,000*	*$3,337,000*	*$4,415,000*
Infant Botulism Treatment/Prev Fund (0272)	*$6,302,000*	*$10,806,000*	*$14,202,000*
Child Health and Safety Fund (0279)	*$551,000*	*$551,000*	*$551,000*
Registered Enviro. Health Spec Fund (0335)	*$427,000*	*$446,000*	*$446,000*
Indian Gaming Spec Dist Fund (0367)	*$8,238,000*	*$8,270,000*	*$8,270,000*
Vectorborne Disease Account (0478)	*$194,000*	*$204,000*	*$204,000*
Toxic Substances Control Acct (0557)	*$439,000*	*$470,000*	*$468,000*
Domestic Violence Training/Ed Fund (0642)	*$605,000*	*$611,000*	*$617,000*
CA Alzheimers Research Fund (0823)	*$871,000*	*$871,000*	*$657,000*
Special Deposit Fund (0942)	*$5,717,000*	*$6,910,000*	*$6,945,000*
Reimbursements (0995)	*$208,824,000*	*$211,611,000*	*$205,812,000*
Drug and Device Safety Fund (3018)	*$7,135,000*	*$7,322,000*	*$7,212,000*
Tobacco Settlement Fund (3020)	*$0*	*$0*	*$0*
WIC Manufacturer Rebate Fund (3023)	*$229,772,000*	*$229,080,000*	*$214,929,000*
Medical Marijuana Program Fund (3074)	*$191,000*	*$51,000*	*$174,000*
AIDS Drug Assistance Program Fund (3080)	*$311,688,000*	*$288,936,000*	*$323,747,000*
Cannery Inspection Fund (3081)	*$2,748,000*	*$2,889,000*	*$2,931,000*
Mental Health Services Fund (3085)	*$52,384,000*	*$23,845,000*	*$33,307,000*
Licensing and Certification Fund (3098)	*$159,226,000*	*$163,942,000*	*$189,248,000*
Gambling Addiction Program Fund (3110)	*$150,000*	*$150,000*	*$150,000*
Birth Defects Monitoring Prog Fund (3114)	*$2,408,000*	*$2,408,000*	*$2,353,000*
Lead-Related Construction Fund (3155)	*$734,000*	*$758,000*	*$775,000*

Other Funds Detail (continued):			
Cost/Impl Acct, Air Poll. Ctrl Fund (3237)	*$358,000*	*$358,000*	*$358,000*
Cannabis Control Fund (3288)	*$26,590,000*	*$27,304,000*	*$29,011,000*
State Dental Program Acct., Prop 56 (3307)	*$30,000,000*	*$30,048,000*	*$27,523,000*
Tobacco Law Enforc Acct., Prop 56 (3308)	*$0*	*$0*	*$0*
Tobacco Prev/Control Acct., Prop 56 (3309)	*$0*	*$0*	*$0*
DPH Tobacco Law Enforc, Prop 56 (3318)	*$6,000,000*	*$6,000,000*	*$5,237,000*
DPH, Tobacco Prev/Ctrl, Prop 56 (3322)	*$129,464,000*	*$129,650,000*	*$130,028,000*

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

According to DPH, their goals include the following:

- 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.

The department is composed of seven major program areas:

(1) Center for Healthy Communities – This center works to prevent and control chronic diseases, such as cancer, cardiovascular diseases, asthma, adverse pregnancy outcomes, and diabetes; to reduce the prevalence of obesity; to provide training programs for the public health workforce; to prevent and control injuries, violence, deaths, and diseases related to behavioral, environmental, and occupational factors; to promote and support safe and healthy environments in all communities and workplaces; and to prevent and treat problem gambling.

(2) Center for Environmental Health – This center works to protect and improve the health of all California residents by ensuring the safety of drinking water, food, drugs, and medical devices; conducting environmental management programs; and overseeing the use of radiation through investigation, inspection, laboratory testing, and regulatory activities.

(3) Center for Family Health – This center works to improve health outcomes and reduce disparities in access to health care for low-income families, including women of reproductive age, pregnant and breastfeeding women, and infants, children, and adolescents and their families.

(4) Center for Health Care Quality – This center regulates the quality of care in approximately 8,000 public and private health facilities, clinics, and agencies throughout the state; licenses nursing home administrators, and certifies nurse assistants, home health aides, hemodialysis technicians, and other direct care staff.

(5) Center for Infectious Disease – This center works to prevent and control infectious diseases, such as HIV/AIDS, viral hepatitis, influenza and other vaccine preventable illnesses, tuberculosis, emerging infections, and foodborne illnesses.

(6) Center for Health Statistics and Informatics – This center works to improve public health by developing data systems and facilitating the collection, validation, analysis, and dissemination of health information.

(7) Public Health Emergency Preparedness – This program coordinates preparedness and response activities for all public health emergencies, including natural disasters, acts of terrorism, and pandemic diseases. The program plans and supports surge capacity in the medical care and public health systems to meet needs during emergencies. The program also administers federal and state funds the support DPH emergency preparedness activities.

Supplemental Reporting Language – State of the State's Public Health. The 2018 Budget Act included the following supplemental reporting language requiring DPH to provide information on the State of the State's Public Health.

Item 4265-001-0001—Department of Public Health

1. ***State of the State's Public Health***. At its first budget subcommittee hearings of the 2019-20 budget process, the Department of Public Health shall report to the health and human services budget subcommittees of both houses of the Legislature a summary of key public health statistics in California. The briefing and related handout shall include excerpted information from the County Health Status Profiles report on key public health indicators, including available information about these indicators' trends, for issues that the department considers major existing or emerging public health issues. The briefing and related handout may, for example, provide statistics on issues such as opioid overdoses and naloxone treatments, the number of people infected with sexually transmitted diseases (STDs) and the geographic regions in which STD transmissions are highest, rates of diabetes and/or other chronic diseases among various subpopulations, or recent public health outbreaks.

Subcommittee Staff Comment and Recommendation. This is an informational item.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of DPH's programs and budget.

2. Please present the State of the State's Public Health report, pursuant to the supplemental reporting language included in the 2018 Budget Act.

Issue 2: Improving Vital Records Interoperability and Data Quality

Budget Issue. DPH requests three positions and expenditure authority from the Health Statistics Special Fund of $1.2 million in 2019-20 and 2020-21, $1.3 million in 2021-22 and 2022-23, $1.4 million in 2023-24, and $21,000 annually thereafter. If approved, these resources would allow DPH to renew and modify an agreement with the University of California, Davis for vital records system enhancements and operations, and to shift activities performed by the University of California, Santa Barbara to department staff.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0099 – Health Statistics Special Fund	$1,223,000	$1,161,000
Total Funding Request:	**$1,223,000**	**$1,161,000**
Total Requested Positions:	**3.0**	**3.0**

* Additional fiscal year resources requested: 2021-22: $1,327,000; 2022-23: $1,308,000; 2023-24: $1,415,000; 2024-25 and ongoing: $21,000.

Background. The department's Center for Health Statistics and Information (CHSI) is responsible for the registration of vital events, the issuance of legal vital records documents, and the collection and management of public health and vital statistics data. This responsibility falls under the duties of the director of DPH, designated by statute as the State Registrar, to register each live birth, fetal death, and marriage, and to report every judgment of dissolution of marriage, legal separation, or nullity decree. According to DPH, CHSI annually compiles vital statistics data from birth, death, and fetal death certificates for more than 750,000 Californians, which is used by federal, state, and local government agencies, policy makers, and researchers for measuring population health, for research on health outcomes, and for state and local public health reporting and surveillance.

According to DPH, registration of births, deaths, and fetal deaths are done through electronic web-based registration systems where data necessary for the legal registration of births, deaths, and fetal deaths are entered by hospitals, funeral homes, attending physicians, and medical-examiner/coroners. Demographic and medical information captured during the registration process provide the foundational health data used for measurement of population health, identification of disparities, and assessment of program effectiveness. These vital records registration and reporting systems are housed and managed through two Interagency Agreements, one with the University of California (UC) Davis, which expires December 31, 2019, and the other with UC Santa Barbara, which expires June 30, 2019.

UC Davis maintains the California Integrated Vital Records System (Cal-IVRS) platform, comprised of applications developed for use over the secure internet by funeral directors, coroners, medical examiners, local registration districts, hospitals, physicians, counties and DPH to facilitate the registration and reporting of vital events in California. Cal-IVRS includes the following systems, bringing birth, death, and fetal death registration systems together onto a single platform:

- The California Electronic Birth Registration System (EBRS)
- The California Electronic Death Registration System (EDRS)
- The California Fetal Death Registration System (FDRS)

- The Vital Records Business Intelligence System (VRBIS)

In the 1980s, UC Santa Barbara developed the Automated Vital Statistics System (AVSS), the department's legacy birth registration system, which is set to retire upon completion of the UC Santa Barbara agreement on June 30, 2019. AVSS only supports the birth registration process and produces a paper certificate for signature that must be routed first to the local registration district and then to the state. The paper certificates are scanned and imaged by DPH for issuance.

DPH requests three positions and expenditure authority from the Health Statistics Special Fund of $1.2 million in 2019-20 and 2020-21, $1.3 million in 2021-22 and 2022-23, $1.4 million in 2023-24, and $21,000 annually thereafter. The resources requested reflect a renewed and modified five-year agreement with UC Davis ($3.9 million in 2019-20 and 2020-21, $4 million in 2021-22 and 2022-23, and $4.1 million in 2023-24 from the Health Statistics Special Fund) offset by base funding for the existing agreement with UC Davis ($2.7 million Health Statistics Special Fund) set to expire December 31, 2019. The total requested funding to support the agreement with UC Davis is $1.2 million in 2019-20, $1.1 million in 2020-21, $1.3 million in 2021-22 and 2022-23, and $1.4 million in 2023-24.

The current five-year agreement with UC Davis is estimated to cost $11.9 million Health Statistics Special Fund, while the proposed renewed five-year agreement is estimated to cost $20 million Health Statistics Special Fund. According to DPH, the increased costs reflect the hiring of four new UC Davis positions to oversee vital records system modifications, and adjustments for higher salary and benefits rates, data storage, equipment, and facility costs. These resources would continue development of vital records operating systems to implement interoperability solutions to make data capture more efficient, continuing California's capability for electronic vital records registration and data reporting to federal, state, county partners and researchers, contractors and stakeholders. These partners include the Centers for Disease Control and Prevention, the Social Security Administration, the Department of Health Care Services, the California Secretary of State, the Department of Motor Vehicles, the Department of Social Services, the Department of Child Support Services, the Department of Finance, the California Highway Patrol, the Medical Board of California, the Department of Consumer Affairs, the Department of Industrial Relations, OSHPD, the Department of Developmental Services, the Department of Justice, local health departments, some school districts, and county clerk recorders.

The request also includes three positions and $427,000 annually for DPH to transition workload currently performed by UC Santa Barbara, including data file creation, vital record file distribution, and analyses of data quality issues, to department staff. This workload would be managed by **one Staff Services Manager I and two Research Data Specialist I** positions. The requested amount is offset by existing base funding for the agreement with UC Santa Barbara ($406,000 Health Statistics Special Fund ongoing), as the UC Santa Barbara agreement is set to expire June 30, 2019. The net requested funding to shift these activities is $21,000 Health Statistics Special Fund annually.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Gambling Disorder Training and Education Services

Budget Issue. DPH requests establishment of three positions funded by redirection of resources from the Indian Gaming Special Distribution Fund (IGSD) due to an expiring contract. If approved, these positions would allow DPH to conduct public outreach for gambling disorder prevention.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0367 – Indian Gaming Special Distribution Fund	[$451,000]	[$451,000]
Total Funding Request:	**[$451,000]**	**[$451,000]**
Total Requested Positions:	**3.0**	**3.0**

* Positions and Resources ongoing after 2020-21. (Note: funding is non-add and represents savings from expiring contract)

Background. The Office of Problem Gambling (OPG) is responsible for developing a statewide gambling disorder prevention program, which includes training of health care professionals, educators, and nonprofit organizations in the identification of problem gambling behavior and the knowledge of referral services for gambling disorder treatment programs. OPG is funded by an annual allocation of gaming revenue deposited in the Indian Gaming Special Distribution Fund. According to DPH, since 2003, OPG executed a training and technical assistance contract to fulfill its mandated responsibilities. The existing contract for 2014-15 through 2018-19 has an annual cost of $500,000 from the Indian Gaming Special Distribution Fund and expires June 30, 2019.

DPH requests establishment of three positions to conduct public outreach for gambling disorder prevention, funded by redirecting Indian Gaming Special Distribution Fund resources from the expiring training and technical assistance contract. **One Health Program Specialist II**, **one Health Program Specialist I**, and **one Associate Governmental Program Analyst** would be responsible for training and outreach to health care professionals, non-profit organizations, educators, and local health departments throughout the state. These positions would also provide onsite training and outreach within community agencies and at community events, and develop resources such as workbooks, videos, and online training opportunities to make training available to more individuals. The cost of these positions would be $451,000. According to DPH, the remaining $49,000 of savings from the expiring contract would be redirected to OPG's prevention efforts.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 4: Oral Health Program Update and Additional Positions Request

Budget Issue. DPH requests establishment of seven positions funded by Proposition 56 tobacco tax revenue allocated to the Oral Health Program. If approve, these positions would allow DPH to continue implementation of the California Oral Health Plan.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3307 – Proposition 56 – State Dental Program Account	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**7.0**	**7.0**

* Positions ongoing after 2020-21.

Background. The current Oral Health Program was established by the 2014 Budget Act, which included General Fund and reimbursement resources to establish a State Dental Director, hire an epidemiologist, and provide consulting services to re-establish a statewide oral health program. DPH proposed that this program would: 1) offer surveillance and evaluation capacity to determine the burden of dental disease; 2) evaluate dental health infrastructure capacity and assess the impact of interventions; 3) provide vision and leadership to engage partners in an advisory committee to guide program priorities; and 4) develop a state dental plan to identify strategies to reduce the burden of dental disease. While DPH initially proposed publication of an Oral Disease Burden Report and a State Oral Health Plan in 2015, difficulties in hiring a State Dental Director delayed development and publication of these reports. In August 2015, Dr. Jay Kumar was appointed as the State Dental Director.

The Oral Disease Burden Report was published in April 2017 and the California Oral Health Plan for 2018-2028 was published in January 2018. The Oral Disease Burden Report, among other findings, indicated: 1) nearly one-third of children have untreated tooth decay, 2) there are significant disparities in the prevalence of tooth decay and other dental disease by race and income levels, and 3) among the more than five million children receiving dental services through Medi-Cal, only 44 percent of beneficiaries enrolled for at least 90 continuous days received at least one dental service.

Based on the findings of the Oral Disease Burden Report, the Oral Health Plan identified five key goals for improving oral health and achieving oral health equity in California:

1. Goal 1: Improve the oral health of Californians by addressing determinants of health and promote healthy habits and population-based prevention interventions to attain healthier status in communities.
2. Goal 2: Align the dental health care delivery system, payment systems, and community programs to support and sustain community-clinical linkages for increasing utilization of dental services.
3. Goal 3: Collaborate with payers, public health programs, health care systems, foundations, professional organizations, and educational institutions to expand infrastructure, capacity, and payment systems for supporting prevention and early treatment services.
4. Goal 4: Develop and implement communication strategies to inform and educate the public, dental teams, and decision makers about oral health information, programs, and policies.

5. Goal 5: Develop and implement a surveillance system to measure key indicators of oral health and identify key performance measures for tracking progress.

In addition, the Oral Health Program is working on the following initiatives: 1) Community Water Fluoridation Implementation Project; 2) Oral Health Workforce Expansion Program; 3) Perinatal Infant Oral Health Quality Improvement Program; and 4) California Children's Dental Disease Prevention Program. These initiatives are currently funded by a combination of state and federal funds.

Proposition 56 allocates $30 million annually to the Oral Health Program. According to the text of the initiative, this allocation is "for the purpose and goal of educating about, preventing and treating dental disease, including dental disease caused by use of cigarettes and other tobacco products. This goal shall be achieved by the program providing this funding to activities that support the state dental plan based on demonstrated oral health needs, prioritizing serving underserved areas and populations. Funded program activities shall include, but not be limited to, the following: education, disease prevention, disease treatment, surveillance, and case management."

The ongoing allocation of resources from Proposition 56 is intended to create a comprehensive public health infrastructure to support oral health education, prevention, surveillance, and treatment of dental disease. The funding helps expand the capacity of the Oral Health Program, local health jurisdictions, and Denti-Cal to implement the goals, objectives, strategies, and activities of the Oral Health Plan, Healthy People 2020 Oral Health Objectives, Denti-Cal and Maternal and Child and Health Services Block Grant performance measures, and the California Wellness Plan. The impact of the expanded program activities will be evaluated through analysis of: 1) oral health surveys of kindergarten and 3rd grade children; 2) Denti-Cal utilization reported in the annual Denti-Cal performance report; 3) the Maternal and Infant Health Assessment; 4) the Behavioral Risk Factor Surveillance System; 5) the Youth Risk Behavior Surveillance System; 6) the California Health Interview Survey; 7) the National Survey of Children's Health; 8) the California Cancer Registry; and 9) surveys of dental practitioners.

The 2017 Budget Act authorized 11 positions and expenditure authority from the State Dental Program Account of the Proposition 56 Fund of $37.5 million in 2017-18 and $30 million annually thereafter for the Oral Health Program, including funding for: 1) local health department allocations; 2) community-focused competitive contract awards to non-profit organizations to promote oral health and tobacco prevention programs; 3) statewide-focused competitive grants, contracts, and interagency agreements for training and technical assistance; 4) a statewide-focused competitive grant, contract, or interagency agreement for an oral health literacy and media campaign; and 5) evaluation and surveillance contracts and interagency agreements.

Request for Additional Positions for Implementation of the Oral Health Plan. DPH requests seven positions to continue implementation of the state Oral Health Plan, including development of community water fluoridation, school-based and demonstration programs. The positions are as follows:

- **One Associate Health Program Adviser, two Associate Governmental Program Analysts, one Health Program Specialist I, and one Health Program Specialist I -** These positions would work with local health jurisdictions and contractors to evaluate applications, develop work plans, and negotiate, award, and monitor contracts. In addition, these positions would provide

guidance to local health jurisdictions as they assess their needs, conduct evaluation activities, and perform personnel liaison activities.

- **One Research Scientist Supervisor I (Epi/Bio) –** This position would provide leadership to the Surveillance and Evaluation Section, advise the State Dental Director regarding Oral Health Program activities, procure five demonstration projects, and help implement surveillance and evaluation activities.
- **One Health Education Consultant II** – This position would create a clearinghouse for education materials and develop trainings, work with national and statewide organizations, and identify age-appropriate materials for local jurisdictions, First 5 programs, and dental providers.

Local Health Jurisdiction Grant Funding. Proposition 56 funding for the Oral Health Program is intended, in part, to provide funding to local oral health programs in 61 local health jurisdictions in California. According to DPH, the goal of the program is to create and expand capacity at the local level to educate, prevent, and provide linkages to treatment programs, including dental disease caused by the use of cigarettes and other tobacco products. Local health jurisdictions are expected to establish or expand upon existing local oral health programs by providing education, disease prevention, linkage to treatment, case management and surveillance, with a priority on underserved areas and populations.

Budget Reduces Funding for Oral Health Program Due to Declining Proposition 56 Revenue. According to the text of Proposition 56, if the Franchise Tax Board determines there has been a reduction in revenues resulting from a reduction in the consumption of cigarettes and tobacco products due to the imposition of the additional taxes under the proposition, the amount of funds allocated to the University of California for graduate medical education ($40 million), DPH for the oral health program ($30 million), and DPH for tobacco enforcement ($48 million) shall be reduced proportionately. For the Oral Health Program, the budget includes a reduction of Proposition 56 authority to $28.8 million due to a finding of declining revenue. According to DPH, the Oral Health Program intends to fulfill its commitment to provide local health jurisdictions with $90 million over five years. However, after the five-year period, the program will be encouraging local health jurisdictions to develop their own long-term funding plans, including billing health care service plans or Medi-Cal for provided dental services. During the five-year period, DPH indicates it will scale back state activities to fulfill local commitments.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of the Oral Health Program, including regulatory responsibilities, organizational structure, and major programs.

2. Please summarize how the state is meeting the goals identified in the Oral Health Plan.

3. Please provide a brief overview of the request for additional positions.

4. Please describe the Oral Health Program's response to declining revenue from Proposition 56. What state-level activities will be prioritized with the remaining funding after fulfilling local funding commitments?

Issue 5: Alzheimer's Disease Program Grant Awards and Gov. Task Force on Brain Health

Budget Issue. DPH requests two positions and General Fund expenditure authority of $3 million annually. If approved, these positions and resources would allow DPH to expand research grants in the Alzheimer's Disease Program focused on the prevalence of the disease among women and communities of color. These resources would also support creation and implementation of the Governor's Task Force on Brain Health.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$3,000,000	$3,000,000
Total Funding Request:	**$3,000,000**	**$3,000,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

Background. The Alzheimer's Disease Program (ADP), established in 1984, seeks to reduce the human burden and economic costs associated with Alzheimer's Disease and related dementias. The program, currently funded by individual voluntary contributions by taxpayers on state tax returns, performs two primary functions:

1. *California Alzheimer's Disease Centers.* ADP established and administers a statewide network of ten California Alzheimer's Disease Centers (CADCs) at university medical centers. These Centers provide diagnostic and treatment services; professional training for medical residents, postdoctoral fellows, nurses, interns, and medical students; and community education such as caregiver training and support.
2. *Alzheimer's Disease and Related Disorders Research Fund Grants.* ADP established and administers the Alzheimer's Disease and Related Disorders Research Fund (ADRDF), which awards grants through a competitive process to scientists in California engaged in the study of Alzheimer's disease and related disorders.

California Alzheimer's Disease Centers. The ADP established ten CADCs across the state, which serve as Centers of Excellence for the diagnosis and treatment of Alzheimer's Disease and related disorders. Individuals with symptoms of memory loss, disorientation, or confusion are eligible to receive a comprehensive assessment at a CADC, which may include medical, neurological, psychological, and psychosocial evaluations, laboratory tests and imaging. Services are provided by a multidisciplinary clinical team which may include neurologists, psychiatrists, physician assistants, psychologists, nurse specialists, neuropsychologists and social workers. Most services are covered by Medicare, Medi-Cal or private insurance. The ten CADCs are:

- UC Davis (Sacramento)
- UC Davis (East Bay)
- UC San Francisco (San Francisco)
- UC San Francisco (Fresno)
- Stanford University
- UCLA

- Univ. of Southern California (Los Angeles)
- Univ. of Southern California (Rancho Los Amigos)
- UC Irvine
- UC San Diego

Alzheimer's Disease and Related Disorders Research Grants. Since its creation, ADP has provided more than $22 million of funding for 134 research projects to contribute to the better understanding, care, and support of patients and families affected by Alzheimer's Disease and related disorders. Past research grants have contributed to significant breakthroughs including: identifying a novel specific plasma biomarker for Alzheimer's Disease, improving differential diagnosis and training, and providing definitive evidence of how amyloids contribute to the basic pathophysiological abnormalities typical of Alzheimer's and other neurodegenerative diseases.

ADP has funded between five and seven research grants in recent years with its ADRDF allocations. The 2018 Budget Act included an additional $3.1 million General Fund allocation for Alzheimer's research. The 2018 research grant cycle included the following categories:

- *Caregiving*: strengthening caregivers' health and effectiveness
- *Prevention*: reducing risk for cognitive decline and dementia
- *Early Diagnosis and Detection*: expanding early detection and diagnosis
- *Long-Term Services and Support Systems/Health Services:* improving safety and quality of care for people living with dementia
- *Health Disparities:* understanding the prevalence, policies, environmental, and social determinants of health affecting California's diverse population.

Focus on Women and Communities of Color. According to DPH, Alzheimer's is the fifth most common cause of death for Americans ages 65 and older. Federal Centers for Disease Control and Prevention data indicates California had 15,570 deaths attributable to Alzheimer's disease in 2016, which made it the 4th leading cause of death in the state. Alzheimer's disease disproportionately impacts women, as nearly two-thirds of Americans with Alzheimer's disease or other dementias are women. While the prevailing view has been that the difference is due to the fact that women, on average, live longer than men and older age is the greatest risk factor for Alzheimer's, more research is needed to support the findings and understand the cause of this disproportionate outcome. Many researchers are questioning whether the risk of the disease is higher for women at any given age due to biological or genetic variations, or due to differences in life experiences.

Alzheimer's disease also disproportionately impacts some communities of color. African-Americans are about two times, and Hispanics are about one and one-half times, more likely than older whites to have Alzheimer's. Among people ages 65 and older, African Americans have the highest prevalence of Alzheimer's disease and related dementias (13.8 percent), followed by Hispanics (12.2 percent).

DPH requests General Fund expenditure authority of $2.7 million annually to focus on research to understand the greater prevalence of Alzheimer's among women and communities of color. In addition, DPH requests General Fund expenditure authority of $300,000 to fund the following positions and workload related to the implementation of the Governor's Task Force on Brain Health:

- **One Health Program Specialist I** would manage Healthy Brain Road Map strategies, convene stakeholders and create reports, provide technical assistance, develop guidelines on healthy brain initiatives, establish a surveillance and evaluation plan, and create a statewide health education campaign that targets women and communities of color.
- **One Associate Governmental Program Analyst** would organize, review, approve, and monitor the grant awards, as well as provide administrative and other support to the Governor's Task Force on Brain Health.

According to DPH, the Governor's Task Force on Brain Health, chaired by Maria Shriver, will be co-chaired by the Governor, will hold listening sessions in different parts of the state and develop guidelines on brain health that can be shared with partners in the public, private, and non-profit sectors. The task force will also look at the effects of Alzheimer's disease and policies that can point the way for brain-healthy families, workplaces, and communities.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe how DPH will evaluate requests for research proposals that target women and communities of color.

3. Please provide an update on the planned activities, composition status, and expected authority of the Governor's Task Force on Brain Health.

Issue 6: Childhood Lead Poisoning Prevention Program IT Project Implementation

Budget Issue. DPH requests eight positions and expenditure authority from the Childhood Lead Poisoning Prevention Fund of $8 million in 2019-20, $9.3 million in 2020-21, $5.9 million in 2021-22, and $3.4 million annually thereafter. If approved, these positions and resources would allow DPH to support the development and implementation of the Surveillance, Health, Intervention, and Environmental Lead Database (SHIELD) Information Technology Project.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0080 – Childhood Lead Poisoning Prevention Fund	$8,005,000	$9,285,000
Total Funding Request:	**$8,005,000**	**$9,285,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested: 2021-22: $5,948,000; 2022-23 and ongoing: $3,376,000.

Background. The Childhood Lead Poisoning Prevention (CLPP) program was established in 1986 to take steps necessary to reduce the incidence of childhood lead exposure in California. The program focuses on young children considered at increased risk for lead exposure, particularly those receiving publicly-funded services such as Medi-Cal and WIC, or those living in older housing stock with lead-based paint or lead-contaminated dust and soil. Children at high risk of exposure are required to be blood tested for lead and children with high blood lead levels are eligible for CLPP services.

There are 43 local CLPP programs in 40 counties and three cities that provide services to eligible children under a contract with DPH. The state CLPP program provides services to eligible children in the remaining 18 counties. These services include outreach to populations at high risk of lead exposure, educational and other services for children with high blood lead levels, full public health nursing and environmental services to children with lead poisoning, and follow-up to ensure sources of lead exposure are removed. The state CLPP program also provides information on laboratory reported lead tests to local CLPP programs; and statewide surveillance, data analysis, oversight, outreach and technical assistance for all counties.

The CLPP program's current electronic information system, RASSCLE 2, supports the receipt of laboratory lead testing results and the management and monitoring of lead-exposed children. According to DPH, RASSCLE 2, which was activated in 2006, suffers from several limitations that may not allow it to provide continued functionality to the CLPP program as testing caseload grows and program complexity increases. Some of these limitations include: 1) inability to handle the volume of testing information without reduced performance; 2) limitations in changing or adding data fields; 3) incompatibility with other electronic lab reporting formats; 4) reliance on data entry of paper records for family visit information; and 5) inadequate data security.

DPH is currently planning for the design of a new childhood lead data system, SHIELD, which will upgrade CLPP's testing, reporting, and security capabilities and address the limitations of RASSCLE 2. According to DPH, current measures to maintain and upgrade RASSCLE 2 are no longer sufficient to ensure long-term stability of the system and to meet program needs and public expectations for timely and accessible information.

Some of the proposed design components of SHIELD include:

1) Ability to handle the larger volume of reported blood lead tests, as well as the matching functions needed to track repeat blood tests for children receiving services.
2) Flexibility to add new data fields as program needs change
3) Compatibility with standardized laboratory reporting formats and the centralized Health Information Exchange (HIE) Gateway
4) Ability to link to other public program's databases to ensure all high-risk children are being screened for blood lead levels
5) Allow for initial electronic data entry, particularly from the field, which could reduce or eliminate the use of paper-based records
6) Automation of tracking, monitoring, and reporting functions

The 2017 Budget Act included one position and expenditure authority from the CLPP Fund of $480,000 in 2017-18 and $158,000 annually thereafter to conduct the initial Project Approval Lifecycle analyses to upgrade to the SHIELD system.

Resource Request to Complete Development and Implementation of SHIELD. DPH requests eight positions and expenditure authority from the CLPP Fund of $8 million in 2019-20, $9.3 million in 2020-21, $5.9 million in 2021-22, and $3.4 million annually thereafter. These positions and resources would allow DPH to complete the process of developing and implementing SHIELD, including the following workload:

- **Two Associate Governmental Program Analysts** would provide laboratory program function expertise to make the new data system incorporate all necessary requirements, and to provide expertise in validating the completion and accuracy of blood lead results received through the reporting system.
- **One Environmental Scientist** would assess local agency environmental investigation needs in the new system, and would train local environmental professionals on the functionalities and uses of the new system.
- **One Research Scientist Supervisor I** would serve as a program liaison to the system's vendor and program staff and to coordinate with county lead programs to help meet programmatic needs during requirements gathering, testing and feedback.
- **One Nurse Consultant III** would provide ongoing review and input of the clinical and case management aspects of the SHIELD system, monitoring that they are properly created and functional; gather and categorize local agency clinical and case management needs for a new SHIELD system; and after development is complete, train local nurses and case management staff on use and functionality of the SHIELD system.
- **One Information Technology Specialist I** would perform technical testing during design sessions of each functional roll-out, and provide support for research and evaluation of the new IT system.
- **Two Information Technology Specialist II positions** would install and configure database management software, perform database migrations to production and optimizes performance of SQL programming language services and databases.

In addition to these positions, DPH intends to redirect existing staff in its Information Technology Services Division to manage the SHIELD project. According to DPH, these staff are being redirected from workload related to the existing RASSCLE 2 system.

Included in this request is funding for consultant contracts, including:

- $110,000 in 2019-20, $147,000 in 2020-21, and $110,000 in 2021-22 for services provided by the California Department of Technology for project and planning oversight and statewide IT procurement.
- $5.6 million in 2019-20, $6.5 million in 2020-21, $3.2 million in 2021-22, and $950,000 annually thereafter for design, development and implementation and Tableau contractors. These costs also include Secure File Transfer Protocol for the automated electronic transfer of case files, identity management and health information exchange platforms, geographic information system services, and data cleanup and migration.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 7: Childhood Lead Poisoning Prevention Program Reporting (SB 1097 and SB 1041)

Budget Issue. DPH requests six positions and expenditure authority from the Childhood Lead Poisoning Prevention Fund of $769,000 annually. If approved, these positions and resources would allow DPH to carry out blood lead screening data collection, analysis, and reporting pursuant to the requirements of SB 1097 (Hueso), Chapter 691, Statutes of 2018, and SB 1041 (Leyva), Chapter 690, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0080 – Childhood Lead Poisoning Prevention Fund	$769,000	$769,000
Total Funding Request:	**$769,000**	**$769,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

Background. The Childhood Lead Poisoning Prevention (CLPP) program was established in 1986 to take steps necessary to reduce the incidence of childhood lead exposure in California. The program focuses on young children considered at increased risk for lead exposure, particularly those receiving publicly-funded services such as Medi-Cal and WIC, or those living in older housing stock with lead-based paint or lead-contaminated dust and soil. Children at high risk of exposure are required to be blood tested for lead and children with high blood lead levels are eligible for CLPP services.

There are 43 local CLPP programs in 40 counties and three cities that provide services to eligible children under a contract with DPH. The state CLPP program provides services to eligible children in the remaining 18 counties. These services include outreach to populations at high risk of lead exposure, educational and other services for children with high blood lead levels, full public health nursing and environmental services to children with lead poisoning, and follow-up to ensure sources of lead exposure are removed. The state CLPP program also provides information on laboratory reported lead tests to local CLPP programs; and statewide surveillance, data analysis, oversight, outreach and technical assistance for all counties.

SB 1097 and SB 1041 Require Additional Data Collection and Reporting. SB 1097, among its provisions, requires DPH to perform the following activities:

- Include the following data (identified by child's county and year of age) on its biennial lead poisoning case management report:
  - The total number of children tested for lead poisoning;
  - The results of blood lead testing by blood-lead-level range;
  - The number, by blood-lead-level range, who were referred for case management and environmental services and who received home visits, environmental investigations, family education and materials on lead, and nutrition assessment and education;
  - The identified sources of exposure for lead-exposed children and whether or not these lead hazards have been addressed by being removed, ameliorated, or abated.
- Post the biennial report on its website.

- Provide the data collected, along with the report, to the Healthy Communities Data and Indicators Project for its use in planning healthy communities and evaluating the impact of plans, projects, policies, and environmental changes on community health.

According to DPH, this data is not currently reported electronically to the CLPP and must be obtained in paper reports and other sources and manually entered into the program's system. For its requirements under SB 1097, DPH requests the following five positions:

- **Two Program Technician II** positions would perform data entry and extraction of information collected from environmental investigations and nursing case management information.
- **Two Associate Governmental Program Analysts** would detect, analyze, and validate information that accompanies the data that may be incomplete, wrong, or duplicative. These positions would also collaborate with local health jurisdictions to preserve the integrity of critical health data stored in the data systems.
- **One Research Scientist III** would determine the number of children referred for and receiving home visits and environmental investigations, analyze the sources of lead-exposed children, and present the findings to the Healthy Communities Data and Indicators Project.

SB 1041 requires DPH to collect and analyze data on blood lead level screening tests for children enrolled in Medi-Cal. The data will be used to monitor appropriate case management efforts, to advance lead testing of children enrolled in Medi-Cal, and for use in its biennial lead poisoning case management public reporting. While the CLPP data system, RASSCLE 2 contains information about lead screening, databases at the Department of Health Care Services (DHCS) contain the most complete information about Medi-Cal participation and billing of services. According to DPH, **one Research Scientist III** position would be needed to develop expertise in analyzing data from the DPH and DHCS system, and develop protocols for matching data in those systems for the purposes of the biennial reporting requirements of SB 1041.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Is DPH pursuing strategies to collect the required data electronically?

Issue 8: Women, Infants, and Children (WIC) Local Assistance Estimate

Budget Issue. The November 2018 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($892.1 million federal funds and $229.1 million WIC manufacturer rebate funds) in 2018-19 and $1.1 billion ($878.2 million federal funds and $214.9 million WIC manufacturer rebate funds) in 2019-20. The federal fund amounts include state operations costs of $63.7 million in 2018-19 and $62.3 million in 2019-20.

Women, Infants, and Children (WIC) Funding Summary			
	2018-19	**2019-20**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,684,000	$62,270,000	($1,114,000)
Local Assistance:	$828,388,000	$815,905,000	($12,483,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$229,080,000	$214,929,000	($14,151,000)
Total WIC Expenditures	**$1,121,152,000**	**$1,093,104,000**	**($28,048,000)**

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

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

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

- **Pregnant women** are eligible for the WIC program at any point in their pregnancy, and receive supplemental foods high in protein, calcium, iron, vitamin A, and vitamin C to support optimal fetal development.

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

According to the WIC program Estimate, food expenditures by participant category are as follows:

EXPENDITURE COMPARISON (all funds)								
Expenditure Category	2018 Budget Act	SFY 2018-19				SFY 2019-20		
		2018-19 Governor's Budget	November Estimate	Change from 2018 Budget Act		November Estimate	Change from 2018 Budget Act	
Pregnant	53,523,000	56,986,000	53,288,000	(235,000)	-0.44%	49,968,000	(3,555,000)	-6.64%
Breastfeeding	49,616,000	53,586,000	48,079,000	(1,537,000)	-3.10%	46,370,000	(3,246,000)	-6.54%
Non-Breastfeeding	26,252,000	27,618,000	26,375,000	123,000	0.47%	25,348,000	(904,000)	-3.44%
Infants	298,083,000	314,878,000	296,531,000	(1,552,000)	-0.52%	286,410,000	(11,673,000)	-3.92%
Children	322,094,000	342,190,000	305,377,000	(16,717,000)	-5.19%	294,416,000	(27,678,000)	-8.59%
Cash Value Voucher Increase	-	-	4,914,000	4,914,000	100.00%	6,194,000	6,194,000	100.00%
Reserve	22,487,000	23,858,000	22,037,000	(450,000)	-2.00%	21,261,000	(1,226,000)	-5.45%
Total Food Expenditures	**772,055,000**	**819,116,000**	**756,601,000**	**(15,454,000)**	**-2.00%**	**729,967,000**	**(42,088,000)**	**-5.45%**
Food Expenditures Paid from Rebate Funds	*229,772,000*	*230,852,000*	*229,080,000*	*(692,000)*	*-0.30%*	*214,929,000*	(14,843,000)	*-6.46%*
Food Expenditures Paid from Federal Funds	*542,283,000*	*588,264,000*	*527,521,000*	*(14,762,000)*	*-2.72%*	*515,038,000*	*(27,245,000)*	*-5.02%*
Other Local Assistance Expenditures (Federal NSA)	300,867,000	300,867,000	300,867,000	-	0.00%	300,867,000	-	0.00%
Total Federal Local Assistance Expenditures (Food + NSA)	**843,150,000**	**889,131,000**	**828,388,000**	**(14,762,000)**	**-1.75%**	**815,905,000**	**(27,245,000)**	**-3.23%**
State Operations (Federal NSA)	63,684,000	63,684,000	63,684,000	-	0.00%	62,270,000	(1,414,000)	-2.22%

The budget assumes 971,979 average monthly WIC participants in 2018-19, a decrease of 52,285 or 5.1 percent from the assumptions in the 2018 Budget Act. The budget assumes 917,057 average monthly WIC participants in 2019-20, a decrease of 54,922 or 5.7 percent from the revised 2018-19 caseload estimate.

Food Expenditures Estimate. The budget includes $756.6 million in 2018-19 for WIC program food expenditures, a decrease of $15.5 million or two percent, compared to the 2018 Budget Act. According to DPH, this decrease is due to lower than projected participation levels. However, the multi-year trend

of declining participation in the WIC program appears to be decelerating. Of these expenditures, federally funded food expenditures are $527.5 million, a decrease of $14.8 million from the 2018 Budget Act, and WIC Manufacturer Rebate Fund food costs are $229.1 million, a decrease of $692,000 from the 2018 Budget Act.

The budget includes $730 million in 2019-20 for WIC program food expenditures, a decrease of $26.6 million or 3.5 percent from the revised 2018-19 food expenditures estimate. According to DPH, this decrease is also due to the continued, though decelerating, downward trend of total participation in the program. Of these expenditures, federally funded food costs are $515 million, a decrease of $12.5 million from the revised 2018-19 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $214.9 million, a decrease of $14.2 million from the revised 2018-19 food expenditure estimate.

Nutrition Services and Administration (NSA) Estimate. The budget includes $300.9 million for other local assistance expenditures for the NSA budget in 2018-19 and 2019-20, which is unchanged from the level assumed in the 2018 Budget Act. The budget also includes $63.7 million for state operations expenditures in 2018-19, also unchanged from the level assumed in the 2018 Budget Act. The budget includes $62.3 million for state operations expenditures in 2019-20, a decrease of $1.4 million or 2.2 percent compared to the revised 2018-19 estimate.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.

2. Please provide an update on participation in the program as a percentage of eligible individuals in the state.

3. What is DPH doing to maximize participation in the WIC program to make full use of available federal WIC funding?

Issue 9: California Home Visiting Program Expansion

Budget Issue. DPH requests 13 positions and General Fund expenditure authority of $23 million annually. If approved, these resources would allow DPH to expand participation in current and new sites for the California Home Visiting Program (CHVP), and include new evidence-based home visiting models, with a focus on low-income, young mothers.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$23,000,000	$23,000,000
Total Funding Request:	**$23,000,000**	**$23,000,000**
Total Requested Positions:	**13.0**	**13.0**

* Positions and Resources ongoing after 2019-20.

Background. The California Home Visiting Program (CHVP), established in 2010 by authority contained in the federal Affordable Care Act, provides voluntary, evidence-based home visiting services to pregnant and newly parenting families who have one or more of the following risk factors: domestic violence, inadequate income, unstable housing, education less than 12 years, substance abuse, depression, or mental illness. Services are provided by a public health nurse or paraprofessional in the family's home and may begin prenatally or right after the birth of a baby up to age three.

Two Evidence-Based Models for Service Delivery. CHVP home visiting services are provided to eligible families by 23 local health jurisdictions (LHJ). Each uses one of the following evidence-based models, based on the specific needs of the local area:

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

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

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

    NFP Counties (16): Del Norte, Humboldt, Shasta, Sonoma, Solano, Sacramento, San Francisco, Contra Costa, Alameda, San Mateo, Stanislaus, Fresno, Kern, Riverside, San Diego, Los Angeles*

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

According to DPH, the CHVP is a high-yield investment that strengthens parent-child relationships, increases language and literacy skills, and reduces child abuse, neglect, poor health, academic failure and crime. According to a fact sheet developed by the Pacific Institute for Research and Evaluation[1], the Nurse-Family Partnership model resulted in the following outcomes in 2010:

Present Value of Benefits and Costs per Family Served by Nurse-Family Partnership, California, 2010 Benefits of NFP	**Per Case**
Reduced Smoking While Pregnant	$3
Reduced Preeclampsia	$670
Fewer Preterm First Births	$1,664
Fewer Subsequent Births	$435
Fewer Subsequent Preterm Births	$1,309
Fewer Infant Deaths	$24,324
Fewer Child Maltreatments:	
Substantiated Cases	$3,756
Indicated & Unreported Cases	$6,598
Fewer Nonfatal Child Injuries	$889
Fewer Remedial School Services	$90
Fewer Youth Crimes:	
Arrests	$1,440
Crimes	$9,892
Reduced Youth Substance Abuse	$29
More Immunizations:	
Savings Net of Immunization Cost	$105
Total Benefits	$51,204
Resource Cost Savings	$10,947
Intangible Savings (work, quality of life)	$40,257
Cost of NFP	$12,075
Net Cost Saving	**$39,129**
Resource Cost Savings Net of Program Costs	-$1,128
Benefit-Cost Ratio	4.2

According to DPH, as of December 2018, CHVP completed 185,422 home visits and served over 9,010 families at its 23 local sites.

Resource History and Status of Federal Funding. CHVP is fully supported by federal funds provided by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program grant. MIECHV was initially funded for its first five years, from 2010 through 2014, at $1.5 billion nationwide. The Protecting Access to Medicare Act of 2014 funded the program at $400 million nationwide in 2015, and separated the program from the balance of the Affordable Care Act. The Medicare and CHIP Reauthorization Act extended funding until September 30, 2017 at $372 million nationwide. The Bipartisan Budget Act of 2018, approved in February 2018, funded the program at $400 million nationwide for an additional five years, until September 30, 2022.

[1] Miller, T.R. 2017. Societal Return on Investment in Nurse-Family Partnership Services in California. Fact Sheet. Pacific Institute for Research and Evaluation, Beltsville, MD.

California's federal funding from MIECHV since 2010 has been as follows:

Federal Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017	2018
CA Funding Level (*millions*)	$8.2	$20.9	$20.9	$20.2	$20.6	$22.6	$22.2	$22.0	$22.0

After DPH was awarded funding from MIECHV Program grants in 2010-11 and 2011-12 to establish the CHVP, the 2010 and 2011 Budget Acts authorized a total of 36 five-year, limited-term positions to develop appropriate home visiting models, develop reporting and compliance procedures and manage the program. The 2015 Budget Act extended 27 of these positions for an additional three years. The 2018 Budget Act reauthorized the program's staff on a permanent basis. Based on the success of home visiting programs nationally and bipartisan federal support, DPH expects to continue to receive federal MIECHV Program grants for the CHVP.

Budget Proposes Expansion of CHVP to Additional Evidence-Based Models in New Counties. DPH requests 13 positions and General Fund expenditure authority of $23 million annually to expand participation in current and new sites for CHVP, and include new evidence-based home visiting models, with a focus on low-income, young mothers. This proposed General Fund allocation would more than double the funding for the program.

According to DPH, California selected its current two home visiting models to simplify implementation, data collection, monitoring practices, and overall costs. However, other models have been added to the federally approved list with different target populations and outcome goals. Currently, the following home visiting models meet the U.S. Department of Health and Human Services criteria for evidence of effectiveness according to the Home Visiting Evidence of Effectiveness project (HomVEE).

- Attachment and Biobehavioral Catch-Up (ABC)
- Child First
- Early Head Start Home-Based Option (EHS)
- Early Intervention Program for Adolescent Mothers
- Early Start (New Zealand) '
- Family Check-Up (ECU) -
- Family Connects
- Family Spirit
- Health Access Nurturing Development Services (HANDS)
- Healthy Beginnings
- Healthy Families America (HFA)
- HealthySteps
- Home Instruction for Parents of Preschool Youngsters (HIPPY)
- Maternal Early Childhood Sustained Home-Visiting (MECSH)
- Minding the Baby
- Nurse-Family Partnership (NFP)
- Oklahoma's Community-Based Family Resource and Support (CBFRS) Program
- Parents as Teachers (PAT)

- Play and Learning Strategies (PALS)
- SafeCare

DPH indicates it would examine and include new models as part of the CHVP to add greater flexibility to meet local needs. In order to allow for successful implementation, fidelity to the model, and accountability, DPH requests $21 million General Fund in local assistance to provide additional resources to local health jurisdictions and $2 million in state operations to fund 13 positions.

The local assistance resources would enable DPH to examine and implement new models outside of HFA and NFP, developing an approach to evaluate the various models including enhancing data collection and informatics for effective decision-making in choosing models. The planning process would occur in the first year while existing models at existing sites are expanded, expansion to new models would occur in the second year, and expansion to additional counties would occur in the third year.

The state operations resources would fund **one Health Program Manager II, two Health Program Specialist I** positions, **and two Health Program Specialist II** positions to develop and monitor a systems approach to program evaluation. The resources would also fund **one Research Scientist Supervisor I and three Research Scientist II** positions with a focus on informatics and epidemiology, and **three Associate Governmental Program Analysts** and **one Office Technician** to support the start-up of new home visiting models including new materials, trainings, data collection forms, and data system development.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe how DPH will evaluate adding additional models to CHVP.

3. What additional counties would receive funding from CHVP after expansion?

Issue 10: Black Infant Health Program Expansion

Budget Issue. DPH requests four positions and General Fund expenditure authority of $7.5 million annually. If approved, these resources would allow DPH to expand the Black Infant Health Program to improve African-American infant and maternal health.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$7,500,000	$7,500,000
Total Funding Request:	**$7,500,000**	**$7,500,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and Resources ongoing after 2019-20.

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

Black Infant Health Model. Originally, the Black Infant Health Program focused primarily on prenatal care and one-on-one case management to address infant mortality. However, a 2006 assessment by the Center on Social Disparities in Health at the University of California, San Francisco, indicated this approach was insufficient, prompting the state and the Center to work towards a new, evidence-based model. The new model, while still providing prenatal care and case management services, emphasizes social support, stress management, and empowerment. In particular, research demonstrated that women who participate in group sessions, rather than the previously standard one-on-one care settings, experience significantly reduced risk of pre-term births, better psychosocial outcomes, more prenatal care knowledge, and feel more prepared for labor and delivery.[2] Local Black Infant Health Programs provide 10 pre-natal and 10 post-partum group sessions exploring the following topics: 1) Cultural Heritage as a Source of Pride; 2) Healthy Pregnancy, Labor & Delivery; 3) Nurturing Ourselves & Our Babies; 4) Prenatal, Postnatal & Newborn Care; 5) Stress Management; 6) Healthy Relationships; and 7) Celebrating Our Families. Case management services link participants with needed community and health-related services, such as health insurance application assistance and family planning counseling.

Trends in African American Infant Mortality in California. According to data from the Centers for Disease Control (CDC), the infant mortality rate per 1,000 live births for African Americans in California declined from 13.29 to 8.87 between 1995 and 2015. While the state has made progress since 1995, this rate was still more than twice the rate in 2015 for white (4.24), Hispanic (4.40), and

[2] Ickovics J. Group prenatal care and perinatal outcomes. Obstetrics & Gynecology 2007;110(2 Pt 1): 330-339.

Asian/Pacific Islander (3.50)[3] Californians. In addition, there is some evidence that progress in reducing African American infant mortality has stalled in recent years.[4]

According to the CDC, the leading causes of black infant mortality include complications related to pre-term birth, low birth weight, congenital birth defects, Sudden Infant Death Syndrome (SIDS), and accidents. Complications related to pre-term birth and low birth weight are the most significant causes of black infant mortality, accounting for 60 to 75 percent of all deaths. In addition to being a significant cause of infant mortality, pre-term birth can lead to significant long-term intellectual and developmental disabilities including autism and behavioral problems, as well as chronic medical problems, such as asthma, diabetes, and cancer. Interventions that reduce pre-term birth rates would be likely to lead to reduced infant mortality, as well as significant reductions in neonatal intensive care stays and utilization of medical and mental health services for the treatment of developmental disabilities and other prematurity-associated chronic medical conditions.

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

In addition to these models, a pilot program in Sacramento County demonstrated significant reductions in pre-term birth and low birth weight among its participants compared to rates of these conditions in the county and nationally. The program, affiliated with a federally qualified health center, provided a team-based approach that included an extensive evaluation of each African American pregnant woman, personalized case management, an educational program, and wraparound care provided by home visitors and various medical personnel. The program identified 56 risk factors for pre-term birth and each patient was evaluated by a physician for these social and medical factors. Between June 2014 and April 2016, 454 African American women participated in the program. The combined medical plan and home visiting approach reduced the pre-term birth rate from 16.8 percent for African Americans in Sacramento County to 2.9 percent for participants in the program. The rate of low birth rates was similarly reduced from 13.8 percent in Sacramento County to 4.3 percent for program participants.

[3] United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/lbd-current.html on Mar 2, 2018.

[4] Corinne A. Riddell, PhD; Sam Harper, PhD., Jay S. Kaufman, PhD. Trends in Differences in US Mortality Rates Between Black and White Infants. JAMA Pediatr. 2017;171(9):911-913

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

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

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

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

According to DPH, the planning grants were allocated based on a combination of county population size and need. Need was defined based on the percentage of preterm births in the county and the county's infant mortality rate. The planning grant allocations were as follows:

County	Base Funding	Need-Adjusted Funding	Total Funding
Alameda	$350,000	$151,980	$501,980
Contra Costa	$350,000	$158,532	$508,532
Fresno	$350,000	$179,236	$529,236
Kern	$350,000	$159,747	$509,747
Los Angeles	$350,000	$904,107	$1,254,107
Riverside	$350,000	$116,440	$466,440
Sacramento	$350,000	$238,789	$588,789
San Bernardino	$350,000	$494,862	$844,862
San Diego	$350,000	$98,047	$448,047
San Francisco	$350,000	$52,768	$402,768
San Joaquin	$350,000	$128,119	$478,119
Santa Clara	$350,000	$7,617	$357,617
Solano	$350,000	$21,526	$371,526
Total	$4,550,000	$2,711,770	$7,261,770

Budget Includes Additional Augmentation for Existing Black Infant Health Program. DPH requests General Fund expenditure authority of $7.5 million annually to support expansion of the Black Infant Health Model, including adding strategies to support participant access and engagement and further expansion of sites and participants. According to DPH, $7 million of local assistance funding would provide additional support for the program, including:

- Completing an implementation evaluation to examine the contextual challenges to implementing the program in local health jurisdictions using existing reports and conducting key informant interviews; assess impact of quality improvement efforts.
- Improving data collection measures to capture key outcomes such as stress or baseline depression.

- Implementing technical upgrades to the BIH data system in order to analyze:
  - Additional data not previously reported (e.g., depression, food insecurity, experiences of racism)
  - Participant satisfaction data
  - Outcomes as a function of group size and dosage of intervention
  - Associations between participation and birth outcomes
  - Comparison of outcome with other strategies such as home visiting, preconception counseling, and fatherhood engagement
- Convening a state advisory group with representation of experts in health disparities and shared learning with other efforts, and with specific inclusion through authentic community engagement so that no decisions about black family health are done without inclusion of black families and community leaders.
- Assessing alternative direct service models such as those outlined in the California Perinatal Equity Initiative.

This request also includes $500,000 of state operations funding to support **two Associate Governmental Program Analysts** and **two Research Data Analyst II** positions. These positions will develop funding allocation processes, evaluate integration of additional interventions, research and standardize service interventions, provide technical assistance to local health jurisdictions, provide oversight and monitoring of local health jurisdictions, monitor data system access and training, draft evaluation and progress reports, and provide online and in-person training to state and local staff.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. How is DPH coordinating these additional resources with the existing allocations, as well as the 2018 Budget Act allocation for the California Perinatal Equity Initiative?

Issue 11: Maternal, Child, and Adolescent Health – Medi-Cal Oversight Activities

Budget Issue. DPH requests five positions and expenditure authority of $656,000 ($328,000 General Fund and $328,000 reimbursements) annually. If approved, these resources would allow DPH to comply with federal claiming and oversight requirements for federal Medicaid funds.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$328,000	$328,000
0995 – Reimbursements	$328,000	$328,000
Total Funding Request:	**$656,000**	**$656,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and Resources ongoing after 2019-20.

Background. DPH's Maternal, Child and Adolescent Health (MCAH) Division draws down federal Title XIX Medicaid reimbursements for Medi-Cal administrative activities workload on behalf of local health jurisdictions, which primarily assist individuals eligible for Medi-Cal with enrollment into programs or assist insured individuals with access to Medi-Cal providers, care, and services. Local health jurisdictions are required to submit a time study and other documentation on a quarterly basis to MCAH to draw down Medicaid reimbursements for activities that meet claiming requirements. Time studies are the primary documentation to determine the percent of personnel time eligible for Medicaid reimbursements, which must be spent performing Medi-Cal administrative activities.

According to DPH, local health jurisdictions are able to draw down and match more than $35 million of Medicaid reimbursements to supplement local costs to administer programs that link low-income Californians to Medi-Cal, including the Black Infant Health Program, the Adolescent Family Life Program, and MCAH Local Programs. According to DPH, in the past two years local health jurisdictions have been making a concerted effort to increase the amount of Medicaid reimbursements as a means to expand services to local clients in a more cost effective manner.

Medicaid reimbursement is implemented through an interagency agreement with the Department of Health Care Services (DHCS), California's single state Medicaid agency. According to DPH, Medicaid reimbursements were managed as pass-through funding to local health jurisdictions with minimal processing. However, a recent review by DHCS resulted in the identification of oversight requirements that previously had not been provided by DPH, but are important for federal auditing purposes. These oversight requirements include time-study and activity review, position reconciliation, secondary documentations, review of local health jurisdiction objectives, personnel duty statements, and scope of work activities to determine appropriate reimbursement claiming rates.

DPH request **five Associate Governmental Program Analysts** and expenditure authority of $656,000 ($328,000 General Fund and $328,000 reimbursements) to perform programmatic, analytical, technical, fiscal, and administrative tasks necessary to perform oversight responsibilities for the continued claiming of Title XIX Medicaid reimbursement for local health jurisdiction activities.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 12: Genetic Disease Screening Program (GDSP) Local Assistance Estimate

Budget Issue. The November 2018 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $134.1 million ($30.6 million state operations and $103.5 million local assistance) in 2018-19, and $141.2 million ($31.4 million state operations and $109.8 million local assistance) in 2019-20.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2018-19	**2019-20**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$30,593,000	$31,351,000	$758,000
Local Assistance:	$103,501,000	$109,825,000	$6,324,000
Total GDSP Expenditures	**$134,094,000**	**$141,176,000**	**$7,082,000**

Background. According to DPH, the Genetic Disease Screening Program (GDSP) performs the following tasks to support its mission:

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

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

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

2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to DPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2009, 14,989,863 babies were screened resulting in early identification of the following disorders:

Disorder	Cases
Phenylketonuria (PKU)	1,026
Primary Congenital Hypothyroidism	5802
Galactosemia	191
Sickle Cell Disease and other clinically significant Hemoglobinopathies	2,500
Hemoglobin H Disease	529
Biotinidase Deficiency (BD)	16
Cystic Fibrosis (CF)	242
Congenital Adrenal Hyperplasia (CAH)	114
Metabolic/Fatty Acid Oxidation Disorders	559
TOTAL	**10,979**

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be added to the NBS program screening panel within two years. In July, 2018, the U.S. Secretary of Health and Human Services added spinal muscular atrophy (SMA) to the RUSP. As a result, SMA must be added to the NBS program screening panel within two years. DPH is requesting positions and expenditure authority for this purpose. (For more information, see *Issue 13: Newborn Screening Program Implementation of Spinal Muscular Atrophy Screening*). The fee for screening in the NBS program is currently $142.25.

Caseload Estimate: The budget estimates NBS program caseload of 469,150 in 2018-19, a decrease of 9,171 or 1.9 percent, compared to the 2018 Budget Act. The budget estimates NBS program caseload of 468,693 in 2019-20, a decrease of 457 or 0.1 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in the number of live births. DPH assumes 100 percent of births will participate in the NBS program annually.

Prenatal Screening (PNS) Program. The Prenatal Screening (PNS) program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant women in California to detect birth defects during pregnancy. The program offers three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect:

- Sequential Integrated Screening – This screen combines first and second blood test results with nuchal translucency (NT) ultrasound results, which measure the back of a fetus' neck. This measurement helps screen for Down syndrome (trisomy 21).
- Serum Integrated Screening – This screen combines a first trimester blood test screening result with a second trimester blood test screening result.
- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy (second trimester test).

The PNS program provides pregnant women with a risk assessment for open neural tube defects (NTD), Down syndrome (trisomy 21), trisomy 18 and Smith-Lemli-Opitz Syndrome (SLOS) through one or two blood tests. The screening test indicates risk, but does not diagnose fetal birth defects.

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

Caseload Estimate: The budget estimates PNS program caseload of 334,430 in 2018-19, a decrease of 7,867 or 2.3 percent, compared to the 2018 Budget Act. The budget estimates PNS program caseload of 331,979 in 2019-20, a decrease of 2,451 or 0.7 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in the number of live births.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.

2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

Issue 13: Newborn Screening Program Implementation of Spinal Muscular Atrophy Screening

Budget Issue. DPH requests 5.8 positions and expenditure authority from the Genetic Disease Testing Fund (GDTF) of $4.3 million ($907,000 state operations and $3.4 million local assistance) in 2019-20, and eight positions and expenditure authority from the GDTF of $2.6 million ($1.2 million state operations and $1.4 million local assistance) annually thereafter. If approved, these resources would allow DPH to comply with expanded testing requirements for spinal muscular atrophy (SMA), pursuant to the requirements of SB 1095 (Pan), Chapter 363, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0203 – Genetic Disease Testing Fund		
State Operations:	$907,000	$1,232,000
Local Assistance**:	[$3,400,000]	[$1,400,000]
Total Funding Request:	**$907,000**	**$1,232,000**
Total Requested Positions:	**5.8**	**8.0**

* Positions and Resources ongoing after 2020-21.

** Local Assistance expenditures are non-add and are reflected in the GDSP Local Assistance Estimate.

Background. GDSP administers a statewide genetic disorder screening program for pregnant women and newborns that is fully supported by fees. When the Newborn Screening (NBS) program within GDSP began in 1980, each newborn was screened for only three disorders. Today, more than 500,000 newborns are screened for 80 disorders annually, resulting in more than 700 diagnoses. According to DPH, 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.

SB 1095 requires the 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). Mucopolysaccharidosis type I (MPS-I) and Pompe disease were added to the RUSP in 2016 and 2015, respectively, and were added to the panel for newborn screening in 2018. In July 2018, the U.S. Secretary of Health and Human Services added spinal muscular atrophy (SMA) to the RUSP. As a result, SB 1095 requires SMA be added to the NBS screening panel no later than July 2020.

DPH requests 5.8 positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million in 2019-20, and eight positions and expenditure authority from the Genetic Disease Testing Fund of $2.6 million annually thereafter. This request includes $3.4 million in local assistance funding in 2019-20 for laboratory supplies, equipment, and modifications to the program's Screening Information System (SIS). Local assistance costs will decrease to $1.4 million annually beginning in 2020-21, as screening will begin at the end of 2019-20. These costs are included in the Genetic Disease Screening Program Local Assistance Estimate and are not reflected separately in this request.

This request also includes $907,000 in state operations for the following positions and workload:

- **One Health Program Specialist I** in the NBS Section would monitor implementation of newborn screening for SMA, including all programmatic and SIS changes.
- **One Research Scientist Supervisor I** and **three Research Scientist II** positions would evaluate, validate, and verify a test method for SMA screenings, including laboratory quality control and quality assurance processes, as well as review and release of all newborn test results.
- **Three Research Scientist I** positions would assist with daily testing of approximately 2,000 new specimens beginning in 2020-21.

According to DPH, the increased expenditures for SMA screening will not result in a program fee increase in 2019-20. However, DPH indicates it may assess whether a fee increase may be needed to support the program after implementation of SMA screening in 2019-20.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 14: Proposals for Investment

Stakeholder Proposal for Managing Hypertension. The American Heart Association (AHA) requests General Fund expenditure authority of $10 million to create a 5-7 county pilot program for hypertension awareness, education, prevention, and control. The pilot program would be administered by DPH with funding provided to local health jurisdictions, and would be based on best practices as recommended by the AHA or the American Medical Association. According to AHA, the program would fund the following activities:

- Focus on the counties with the highest prevalence of hypertension, higher priority populations and geographic and population size diversity.
- Establish best practices, in participating health care systems, with a focus on federally qualified health centers and rural health centers.
- Increase utilization rates of blood pressure cuffs. Participating providers would prescribe blood pressure cuffs for self-measured home blood pressure monitoring. Formalizing this best practice would empower patients to fully engage in their own self-care through home monitoring. This includes patients recording their own blood pressure readings daily.
- Harness the power of community health workers (CHW) to expand the care team to provide more comprehensive health care. Participating clinics would hire a CHW to make home visits to high-risk patients to provide more education on blood pressure, ensure that patients are using the blood pressure cuffs properly, tracking their readings, and assist in lifestyle modification. The CHW would also do community outreach and provide screenings for priority populations.
- Upon completion of the Pilot Project, an evaluation would be conducted of the program.

Stakeholder Proposal to Implement Statewide Alzheimer's Infrastructure. The Alzheimer's Association requests one-time General Fund expenditure authority of $10 million to 1) build statewide public health infrastructure to support early detection and timely diagnosis ($3.7 million), and 2) initiate local public health efforts through community grants to eight pilot counties ($6 million – eight grants of $750,000 each). According to the Alzheimer's Association, more individuals with Alzheimer's live in California than in any other state, and California is home to the largest number of family caregivers in the nation. California is also on track to spend over $5 billion annually on Medi-Cal expenditures for this population, an increase of 36 percent between 2018 and 2025. California has a unique opportunity to be the first in the nation to adopt the Center for Disease Control's Healthy Brain Initiative.

Stakeholder Proposal for Lesbian, Bisexual, and Queer (LBQ) Women's Health. A broad coalition of LGBT organizations, health providers, governmental agencies, coalitions and advocates request General Fund expenditure authority of $17.5 million to 1) create an LBQ Women's Health Equity Fund at DPH to support a local comprehensive grant program to address LBQ women's health disparities ($15.5 million), and 2) fund research targeting LBQ women's health needs and inventory of existing programs ($2 million).

Stakeholder Proposal for Safe Cosmetics Program Augmentation. Breast Cancer Prevention Partners and a coalition of companies manufacturing safer cosmetics, public health and environmental health organizations request General Fund expenditure authority of up to $1.5 million to increase

staffing and for enforcement and program improvement activities. According to the coalition, increased funding would provide the following:

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

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested advocates to present these proposals and respond to questions from subcommittee members.