Advancing Prevention in the 21st Century: Our Commitment to Action (P21) 2.0 Conference Proceedings

May 16 – 17, 2017

Sacramento, CA

Summary

The California Wellness Plan provides a roadmap to eliminate preventable chronic disease deaths, reduce the number of Californians living with chronic disease, improve the quality of life of those with chronic disease, lower the cost of care, and achieve health equity. The California Department of Public Health (CDPH), in partnership with a broad group of representatives from health departments, advocacy groups and injury prevention organizations, worked to plan and host the Advancing Prevention in the 21st Century: Commitment to Action (P21) 2.0 conference on May 16-17, 2017 in order to share progress, inspire continued collaboration and achieve a broad, coordinated chronic disease prevention movement. Throughout the meeting, attendees provided “Commitments to Action” to support California Wellness Plan implementation.

Contents

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Introduction

The California Wellness Plan is California's chronic disease prevention and health promotion plan. The California Wellness Plan provides a roadmap to eliminate preventable chronic disease deaths, reduce the number of Californians living with chronic disease, improve the quality of life of those with chronic disease, lower the cost of care, and achieve health equity. The plan was published in February 2014, and includes objectives with baseline, benchmark and target outcomes. Numerous partners are working together to implement the plan. The first *Advancing Prevention in the 21st Century (P21)* conference was held in February 2014, and goal area teams worked together to identify strategies and activities for each California Wellness Plan goal for 2014-2016. Partner organizations identified their commitments, and an update on implementation was shared in 2015. In 2017, a California Wellness Plan progress report was drafted, and this conference, P21 2.0, reconvened partners from the first conference, as well as additional partners, to share progress and inspire continued collaboration.

Conference Description

Overview

The California Department of Public Health (CDPH), in partnership with a broad group of representatives from health departments, advocacy groups and chronic disease and injury prevention organizations, worked to plan and host the *Advancing Prevention in the 21st Century: Commitment to Action (P21) 2.0* conference on May 16-17, 2017. Approximately 230 leaders from local public health departments, local, regional and state non-profit community partners, health providers, government agencies, academic institutions, voluntary, advocacy and policy organizations and foundations convened to share progress, inspire continued collaboration and achieve a broad, coordinated chronic disease prevention movement. For a full breakdown of audience constituents, see Appendix I.

Conference Objectives

1. Share California Wellness Plan Progress Report and how chronic disease prevention efforts associated with Let's Get Healthy California have contributed to improvement in public health
2. Highlight successes and best practices to create synergies and build collective impact
3. Showcase Public Health 2035 Initiative by featuring inspiring innovators and visionaries to describe the optimal public health system

Materials

Videos of keynote speaker presentations are available on the CDPH YouTube channel at https://www.youtube.com/user/CAPublicHealth.

Commitments to Action by California Wellness Plan Goal Area

Throughout the meeting and as part of the meeting evaluation, attendees provided "Commitments to Action" to support the California Wellness Plan implementation (https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/Pages/CaliforniaWellnessPlanImplementation.aspx).

Overarching Goal: Equity in Health and Well-being

Local Health Departments

- Work with epidemiologists to map health outcomes with income/poverty level data (San Mateo)
- Collaborate with American Cancer Society, American Lung Association, and America Heart Association for health equity and planning work (Napa County)
- Bring awareness to other county partners regarding Health in All Policies (Tehama County)
- Share information learned from the P21 2.0 conference with staff (Calaveras County)
- Increase resident engagement in leadership for chronic disease prevention (Solano County)
- Use Sonoma County's approach for forming a wellness fund (Napa County)
- Strengthen and expand utilization of equity lens in policy decision-making; revise policies as needed to increase equity (Long Beach)

Health providers/health plans

- Educate physician colleagues about social determinants as an area they can/should be involved in (OHE Advisory Committee member)
- Launch three additional health equity projects for Health Net members, providers, and community
- Outreach to safety net clinicians for advocacy (California Primary Care Association - CPCA)
- Develop CPCA academy to develop pipeline of health care team

Non-profit/community partner/advocacy and policy organizations/academic institutions

- Evaluate new NEOP (Nutrition Education and Obesity Prevention) work with equity lens (Community Actions Partnership OC)
- Review and revise, as necessary, current and future program intervention plans to make sure health equity strategies are front and center (California Health Collaborative)
- Identify ways to engage more Black and Latino Californians in state health policy using new technology (Public Health Advocates)
- Make at least one new non-traditional partner to engage in the conversation of social determinants of health and health equity (Breathe California Sacramento and the SOL Project)

- Develop new law and policy resources related to the social determinants of health (Change Lab Solutions)
- Frame regional work around wellness plan when applicable (Center for Healthy Communities)
- Hold focus groups in Humboldt and Tehama Counties regarding equity in the county (Health and Social Policy Institute)
- Reach out to professional organizations to encourage members to address equity in their private practices and general advocacy efforts (UCSF Program)
- Increase current commitment to integrate health equity in projects' scope of work (UCSF Program)
- Be part of HIP - move forward community engagement (Community Actions Partnership OC)
- Increase care program/advocacy exposure (California Chronic Care Coalition)
- Continue to activate partners across CA for social justice and health equity with an emphasis on grassroots, authentic engagement and power building (CA4Health)
- New Health Equity Plan implementation (American Heart Association)

GOAL 1: Healthy Communities

Create healthy, safe, built environments that promote active transport, regular daily physical activity, healthy eating and other healthy behaviors, such as by adoption of health considerations into General Plans.

Local Health Departments

- Map funding opportunities for comprehensive and coordinated chronic disease prevention program in a San Mateo County
- Build clinical to community connections for asthma (Long Beach)
- Identify funding streams to support healthy retail opportunities (Long Beach)
- Advocate for more walkable/bikeable areas in Tehama County
- Partner with other sections in county health dept., citywide institutional partners and community leaders to create healthy communities (San Francisco)
- Help create our own population health dashboard (Nevada County)
- Support obesity prevention plan at workplace through promotion of healthy choices and activities while at work (Calaveras County)
- Explore banning sale of menthol and flavored tobacco at city level; explore tobacco density laws (Long Beach)
- Improve focus on neighborhoods with highest burden of chronic disease (Solano County)

Other government

- Continue the GO Human campaign; develop tools to help cities integrate into general plans (SCAG)

Health providers/health plans

- Continue to promote education, especially preschool and First 5 approach, as critical to preventive chronic disease in the next generation (OHE Advisory Member; Health Provider)
- Incorporate into program efforts: member and community efforts around daily activity, healthy eating and behaviors (Health Net)
- Best practices discovered in CA FQHC's re S.D.O.H. activities (CPCA)

Non-profit/community partner/advocacy and policy organizations/academic institutions

- Support Garden Grove's effort to include master bike/ped plan into general plan
- Identify and/or create opportunities to coordinate with local/regional planning entities to incorporate health related outcomes (California Health Collaborative)
- Advocate for state policy for water infrastructure (potable safe drinking water) parks, and environments which promote healthy behaviors (e.g. less sugar) (Public Health Advocates)
- (Leverage) resources coming from food systems joint use of school kitchens, transportation zero…and affordable housing, and MORE (Change Lab Solutions)
- Continue to identify and advance policy measures that will improve justice elements related to healthy communities (CA4Health)
- Introduce data mapping for our 15 county region as a strategy for rural far North capacity building (Center for Healthy Communities)
- Work to pass additional soda taxes in state to fund prevention; support development of best practice model regulations, clear local retail licensing and taxation of marijuana (Public Health Institute)
- Connect with Prevention Institute on how their services can complement our current project goals (UCSF program)
- Support home meal delivery businesses for new mothers that includes a checklist of support for healthy infants (UCSF program)
- Collaborate with Prevention Institute with initial goal of reaching "non-traditional" partners to promote tobacco control policies by increasing community education and engagement (UCSF program)

GOAL 2: Optimal Health Systems Linked with Community Prevention Commitments to Action

Build on strategic opportunities, current investments and innovations in the Patient Protection and Affordable Care Act, prevention, and explained managed care, to create a systems approach to improving patient and community health.

Local Health Departments

- Look into how to participate in the WPC project to advocate for upstream strategies (San Mateo)
- Disseminate information to local clinicians on colon cancer screening (Nevada County)
- Bring information learned today back to program managers (Calaveras County)
- Continue to engage and work to drive data sharing across systems for improved referral opportunities (Long Beach)
- CMSP Pilot Project - in collaboration with community partners (Tehama County)
- Utilize Syndromic Surveillance Summary to start data conversation, data sharing with hospitals (Long Beach)

Health providers/health plans

- All part of the model used for health equity projects; continue efforts with three new projects (Health Net)
- Improve value-based care models (CPCA)

Non-profit/community partner/advocacy and policy organizations

- Research OC Whole Person Care Program; Reengage Covered OC (Community Actions Partnership OC)
- Advocate for the expansion of the diabetes prevention program & the menu labeling provision of ACA in CA (Public Health Advocates)
- Continuing educating public hard to advocate for health care (California Chronic Care Coalition)

GOAL 3: Accessible and Usable Health Information

Expand access to comprehensive statewide data with flexible reporting capacity to meet state and local needs.

Local Health Departments

- Look into the CHPN for data opportunities (San Mateo)
- Expand data linkages with at least two new health care systems (Los Angeles)
- Share data information with Health Education program and accreditation team (Calaveras)
- Contact Dr. Hogarth querying pSCANNER and integration with other miscellaneous data in CA such as from CURS 2.0 (Solano)
- Continue to collaborate with partners to fund a new [illegible] provider (Napa)

- Create a better local opioid dashboard (Nevada)
- Continue to encourage faster rapport w/ hoop systems FQHCs Epi

Health providers/health plans

- Explore options to share data from health equity projects (Health Net)
- Develop unified population health data platform (CPCA)
- Improve workflow for data collection & retrieval (CPCA)

Non-profit/community partner/advocacy and policy organizations

- Provide (publish) new layered data on trauma, incarceration, and chronic disease by CA legislative district (Public Health Advocates)
- Gave all consultants new smokers helpline information and cards (Health & Social Policy Institute)
- Start to develop measurements for Buena Park - La Habra (Community Actions Partnership OC)
- Opportunities to integrate or link data systems. (American Heart Association)
- Support HIP-dashboard-share data, measure change (Community Actions Partnership OC)
- Continue to add to data collection (California Chronic Care Coalition)
- Gain a better understanding of usable data surveillance and how we can incorporate into our community programs (CA Chronic Care Coalition)

GOAL 4: Prevention Sustainability and Capacity

Collaborate with health care systems, providers and payers to show the value of greater investment in community-based prevention approaches that address underlying determinants of poor health and chronic disease; Create new, dedicated funding streams for community-based prevention, and; Align newly secured and existing public health and cross-sectoral funding sources to support broad community-based prevention.

Local Health Departments

- Promote encourage staff to think outside the box to blend funding & [illegible] in other nontraditional partners
- Share prevention and innovation funding ideas with management (Calaveras)
- Investigate Soda & Sugary Beverage tax at city level (Long Beach)
- Work toward getting new partners to see health as part of their job and funding (Solano)
- Demonstrate through chronic disease data on impacts of housing homeless individuals & comorbidities (Napa)
- Increase data & storytelling capacities to engage possible funders; engage in learning collaborative re: wellness funds for support (Long Beach)
- Consider sustainable funding streams in the context & program changes (Tehama County)

- Explore recently-passed local Long Beach marijuana tax funding

Health providers/health plans

- Develop community health worker training (CPCA)
- Continue to work with community partners and support efforts around our health equity work (Health Net)

Non-profit/community partner/advocacy and policy organizations/academic institutions

- Advocate for the expansion of the diabetes prevention program & the menu labeling provision of ACA in CA (Public Health Advocates)
- Not sure yet, but we are looking closely (Change Lab Solutions)
- Find new sources, strategies for "prevention"; Link AHOC and OCFAC - start a discussion about merger (Community Actions Partnership OC)
- Continue working on policies, teaching patient advocacy (California Chronic Care Coalition)
- Expand and strengthen the efforts to strengthen prevention funding through California Alliance for funding of prevention (Public Health Institute)
- Continue to have discussions with my colleagues working on environmental changes to consider including a focus (or at least acknowledgment) on tobacco control policies and recognizing that de-normalizing tobacco adds to an enhanced community and decreases disparities (UCSF program)
- Continue to assess & pursue alternative approaches to funding for our collaborative (CA4Health)

Agenda

Advancing Prevention in the 21st Century: Commitment to Action (P21) 2.0 Conference
Detailed Agenda

Doubletree, 2001 Point West Way, Sacramento, CA 95815

California Wellness Plan's Overarching Goal: Equity in Health and Wellbeing

Chronic disease prevention and health promotion

MEETING OBJECTIVES

- Illustrate how progress in achieving California Wellness Plan goals, and how chronic disease prevention efforts associated with Let's Get Healthy California have contributed to improvement in public health.
- Specify successes and best practices to create synergies and build collective impact to prevent chronic disease.
- Visualize the optimal public health system through inspiring innovators and visionaries that showcase Public Health 2035.

Tuesday, May 16, 2017	
6:00 pm to 8:00 pm	Check-In and Reception Welcome Remarks Karen L. Smith, MD, MPH, Director and State Public Health Officer, California Department of Public Health (CDPH) Liz Helms, President/CEO, California Chronic Care Coalition Senator Bill Monning, 17th Senate District (D-Carmel) (invited)

Wednesday, May 17, 2017	
7:00 am to 8:00 am	Light Breakfast and Check-In/ Networking [Grand Ballroom]
8:00 am to 8:45 am	Welcome [Grand Ballroom] Claudia Crist, RN, FACHE, Chief Deputy Directory, Policy & Programs, CDPH Karen L. Smith, MD, MPH, CDPH Director & State Public Health Officer Opening Remarks: Diana S. Dooley, Secretary California Health & Human Services Agency
8:45 am to 9:45 am	KEYNOTE PANEL: Advancing Prevention in the 21st Century: National Perspective Moderator: Wm. Jahmal Miller, MHA, Deputy Director – Office of Health Equity, CDPH Keynote Panel: • John Auerbach, MBA, President and CEO, Trust for America's Health • Alonzo L. Plough, PhD, MPH, Vice President, Research-Evaluation-Learning, Chief Science Officer, Robert Wood Johnson Foundation Learning Objectives: After keynote, participants will be able to: 1. Describe collaborations with health care systems in which providers and payers demonstrate the value of community-based prevention investment to address underlying social determinants of poor health and chronic disease. 2. Summarize impacts of proposed Affordable Care Act repeal on prevention.

Wednesday, May 17, 2017	
	3. Specify dedicated funding models for community-based prevention.
9:45 am to 10:00 am	Break
10:00 am to 12:00 pm	Goal Presentations: Future vision and innovations in California's chronic disease prevention and health promotion effort [Grand Ballroom] Moderator – Karen L. Smith, MD, MPH, CDPH Director & State Public Health Officer Goal 1: Healthy Communities: Creating Healthier Community Environments Larry Cohen, MSW, Founder & Executive Director Prevention Institute Learning Objectives: After presentation, participants will be able to: 1. Describe a vision for healthy communities' work that weaves together promising and evidence-informed strategies to create healthier community environments with equity as a priority outcome. 2. Describe three California successes that advance healthy communities. 3. Illustrate evidence-informed strategies that support healthcare in advancing a population approach to their work to help achieve healthy communities. 4. Detect strategies that advance equity in healthy communities. Goal 2: Optimal Health Systems: Medi-Cal Whole Person Care Pilot Brian Hansen, Health Program Specialist II Program Monitoring & Medical Policy Branch CA Department of Health Care Services Learning Objective: After presentation, participants will be able to: 1. Demonstrate how the overarching goal of the Whole Person Care (WPC) Pilots through the coordination of health, behavioral health, and social services, in a patient-centered manner, increases integration among county agencies, health plans, providers, and other entities within the participating county or counties.

Wednesday, May 17, 2017	
	Goal 3: Useable Data: Querying Clinical Data to Address Public Health Needs Michael Hogarth, MD, FACP, FACMI, Professor, Department of Pathology and Laboratory Medicine & Department of Internal Medicine, University of California, Davis (UCD) Health System Learning Objective: After presentation, participants will be able to: 1. Describe the benefits/uses of a clinical data network for public health surveillance. 2. Summarize the challenges. 3. Specify the role of providers/benefits to providers in submitting/using data.
	Goal 4: Sustainability: Disseminate understanding and advance models for sustainable funding for prevention and its key supports *Sonoma County Health Action* - Jen Lewis, MEM, MA, Special Projects Director, Sonoma County Department of Health Services Learning Objective: After presentation, participants will be able to: 1. Describe how prevention and health equity strategies can be funded and sustained. 2. Describe models of innovative funding to support prevention based on valuing outcomes for benefit and savings. 3. Describe braided funding for prevention and population health. 4. Describe capacity needed for engaging in these approaches. 5. Describe challenges encountered when pursuing innovative funding streams.
12:00 pm to 1:00 pm	Lunch [Box Lunches] / Resource Tables / Poster Session / Networking
1:00 pm to 2:15 pm	Breakout Presentations (Participants will choose one of eight sessions to attend) 1: G1 (Healthy Communities): Moving upstream: Addressing community conditions and determinants of health Moderator: Melissa Jones, MPA, Executive Director, Bay Area Regional Health Inequities Initiative

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Community Development
Speaker #1: Anita Kumar, PhD, Collaborative Manager, East Bay Asian Local Development Corporation
Education
Speaker #2: D'Artagnan Scorza, PhD, Executive Director and Founder, Social Justice Learning Institute
Access to Healthy Food
Speaker #3: Keith Bergthold, Executive Director, Fresno Metro Ministry
Learning Objectives: At breakout completion, participants will be able to:

1. Specify three key social determinants of health.
2. Illustrate examples of how different sectors can work together to address social determinants that can improve health.
3. Summarize challenges in addressing social determinants of health.

2: G1 (Healthy Communities): Land use, planning, and health equity

Moderator: Rachel Bennett, MPH, MURP, Associate Program Manager, Prevention Institute
Metropolitan Planning Organization (MPO)
Speaker #1: Greg Chew, Senior Planner, Sacramento Area Council of Governments
Local Government
Speaker #2: Tyler Summersett, MPA, Senior Transportation and Trails Planner, Tuolumne County Transportation Council
Advocacy/Research
Speaker #3: Mojgan Sami, PhD, Project Scientist, The Sustainability Initiative, UC Irvine

Learning Objectives: At breakout completion, participants will be able to:

1. Illustrate the role of planning, specifically, in supporting equitable health and safety outcomes.
2. Review best practices and innovative partnerships in supporting equitable health and safety outcomes.
3. Demonstrate the importance of including safety and environmental justice in general plans and sustainable community strategies.

3: G2: (Optimal Health Systems) Community Clinical Partnership for Prevention

Moderator: Michael Hochman, MD, MPH, Director, USC Gehr Center for Implementation Science

Wednesday, May 17, 2017	
	The Power of Diabetes Self-Management Programs: Keys to Sustaining and Scaling Programs that Work Speaker #1: Neal Kaufman, MD, MPH, Founder and Chief Medical Officer, Canary Health Comprehensive Medication Management – How this works Speaker #2: Steven Chen, PharmD, FASHP, FCSHP, FNAP, Associate Professor and Chair, Titus Family Department of Clinical Pharmacy, William A. Heeres and Josephine A. Heeres Endowed Chair in Community Pharmacy, University of Southern California Learning Objectives: At breakout completion, participants will be able to: 1. Specify the Value Proposition/clinical and financial alignment between diabetes self-management programs and health systems priorities. 2. Summarize key strategies, resources and best practices to assist with program implementation, expansion, and sustainment. 3. Specify the Value Proposition/clinical and financial alignment between Comprehensive Medication Management and health systems priorities. 4. Summarize key strategies, resources and best practices to assist with program implementation, expansion, and sustainment.
4: G2: (Optimal Health Systems) Prevention Strategies & Models that Work	Moderator: Shauntay L. Davis, MPH, Program Director Comprehensive Cancer Control Program, CDPH Colorectal Cancer Screening Utilizing the Fecal Immunochemical Test (FIT) to Increase Colorectal Cancer Screening Speaker #1: Daniel “Stony” Anderson, MD, FACP, President, Board of Directors, California Colorectal Cancer Coalition Tobacco Status Identification and Counseling The Impact of this Strategy on Cessation Speaker #2: Elisa K. Tong, MD, MA, Department of Internal Medicine, UC Davis Health System Learning Objectives: At breakout completion, participants will be able to: 1. Specify the Value Proposition/clinical and financial alignment between Colorectal Cancer Screening with FIT and health systems priorities.

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2. Summarize key strategies, resources and best practices to assist with program implementation, expansion, and sustainment.
3. Specify the Value Proposition/clinical and financial alignment between Tobacco Status Identification and Counseling and health systems priorities.
4. Summarize key strategies, resources and best practices to assist with program implementation, expansion, and sustainment.

5: G3 (Useable Data): Using Technology to Facilitate Data Collection and Surveillance

Moderator: April Roeseler, BSN, MSPH, Chief, California Tobacco Control Branch, CDPH

Using Handheld Devices to Collect Observational Data and Public Intercept Surveys

Speaker #1: Diana Cassady, DrPH, Professor, Department of Public Health Sciences, University of California, Davis

Enhancing Emerging Tobacco Product Surveillance with Novel Data Streams

Speaker #2: Jon-Patrick Allem, Ph.D., M.A., Postdoctoral Scholar Research Associate, Preventive Medicine, Center for Health Equity in the Americas, USC Institute for Global Health, USC Department of Preventive Medicine, and Institute for Prevention Research

Using Online Data Collection for Fast, Economical Surveillance and Media Tracking

Speaker #3: Xueying Zhang, MD, MPH, MS, Chief, Evaluation Unit, California Tobacco Control Program (IPR), California Department of Public Health

Learning Objectives: At breakout completion, participants will be able to:

1. Illustrate three ways in which they could use technology to facilitate data collection and surveillance (e.g., use of handheld devices, social media monitoring, online surveys).
2. Select at least two new partners that they could collaborate with on data collection, surveillance or program evaluation efforts.
3. Specify at least two new tools for training non-professional data collectors (e.g., online training quiz, Kahoot).

6: G3 (Useable Data): Creating New Partners in Data Collection, Surveillance and Program Evaluation

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Moderator: David J. Reynen, DrPH, MA, MPPA, MPH, CPH, Research Scientist III, California Stroke Registry / California Coverdell Program, CDPH

Silo-busting: Partnering to Collect Tobacco, Food, Alcohol and Condom Data to Create Healthier Retail Environments that Support Healthy Communities

Speaker #1: Elizabeth Andersen-Rodgers, MA, MSPH, Research Scientist, California Tobacco Control Program, California Department of Public Health

Health Information Exchange: Experiences from Solano County, California

Speaker #2: Bela T. Matyas, MD, MPH, Health Officer and Deputy Director, Solano County

California Cancer Registry Modernization

Speaker #3: Jeremy Pine, Technology and Operations Section Chief, California Cancer Registry, CDPH

Learning Objectives: At breakout completion, participants will be able to:

1. Select at least two new partners that they could collaborate with on data collection, surveillance or program evaluation efforts.
2. Specify at least two new tools for training non-professional data collectors (e.g., online training quiz, Kahoot).

7: G4 (Sustainability): Mobilizing and Braiding Sustainable Funding for Prevention in Cities and Counties

Moderator: Paul Simon, MD, MPH, Chief Science Officer & Director, Division of Assessment, Planning, and Quality, Los Angeles County Department of Public Health

Local Braided Funding

Speaker #1: *Live Well San Diego* - Wilma J. Wooten, MD, MPH, Public Health Officer, County of San Diego, Health and Human Services Agency, Public Health Services

Berkeley Soda Tax Model

Speaker #2: Vicki Alexander, MD, MPH, President, Board of Directors, Healthy Black Families, Inc.

Learning Objectives: At breakout completion, participants will be able to:

1. Review approaches counties and cities are taking to mobilize and structure sustainable funding for prevention at the local level.

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	2. Distinguish the value of prevention funding on improving community health outcomes. 3. Examine challenges that counties and cities may encounter. 4. Recommend steps at the local, state, or federal level that can help accelerate progress locally. 8: G4 (Sustainability): State Level Innovation for Mobilizing Sustainable Funding for Prevention Moderator: Dan Peddycord, RN, MPA, Director of Public Health, Contra Costa Health Services <u>1115 Waiver</u> Speaker #1: Stephen Williams, Director of Health and Human Services, Houston, Texas <u>Endowment Trust Model</u> Speaker #2: Tracey Strader, Executive Director Emeritus, Oklahoma Tobacco Settlement Endowment Trust <u>Sugar Sweetened Beverage Tax</u> Speaker #3: Lynn Silver, MD, MPH, Lynn Silver, MD, MPH, Senior Advisor, Public Health Institute and Co-Chair, California Alliance for Funding Prevention Learning Objectives: At breakout completion, participants will be able to: 1. Specify three alternative or innovative models for sustainable state level funding for prevention and how that may complement local work. 2. Detect opportunities and feasibility for engaging in these approaches. 3. Examine challenges encountered when creating statewide funding streams.
2:15 pm to 2:30 pm	Break
2:30 pm to 3:15 pm	Closing Keynote Panel: Health Access: What would be the impact of Patient Protection and Affordable Care Act (ACA) repeal/replace? Moderator: Marice Ashe, JD, MPH, Founder and CEO, ChangeLab Solutions • Emalie Huriaux, MPH, Director of Federal & State Affairs, Project Inform and Chair, California Hepatitis Alliance • Anthony Wright, Executive Director, Health Access California

Wednesday, May 17, 2017	
	Learning Objectives: After keynote panel, participants will be able to: 1. Demonstrate how proposed changes to the ACA will affect Californians. 2. Specify action steps to take to ensure prevention stays at the forefront of California's commitment to health and health equity.
3:30 pm	Adjourn

After Meeting Discussions	
3:45 pm to 4:45 pm	The Patient-Centered SCAlable National Network for Effectiveness Research (pSCANNER) meeting (California Salon 1)
3:45 pm to 4:45 pm	Oral Health Stakeholder Meeting (California Salon 2)
3:45 pm to 4:45 pm	California Alliance on Funding for Prevention Reception (California Salon 3)
3:45 pm to 5:00 pm	Office of Health Equity Advisory Committee Meet and Greet (California Salon 4)

Next Steps

Future plans for CDPH include finalizing the California Wellness Plan progress report, conducting strategic planning for CDPH's chronic disease and health promotion efforts, and continuing to implement the Plan and share progress with partners.

Appendix I: Audience Constituents

Audience	Percent
Local public health department	30%
State government agency	30%
Non-profit (n=26); Foundation (n=3); Community member (n=1)	13%
Advocacy and policy organization	12%
Academic institution	7%
Other local government (n=6); Private sector (n=2); Tribal (n=2)	4%
Health plan (n=4); Health provider (n=4)	3%

Appendix II: Overview of Presentations

Advancing Prevention in the 21st Century: State Perspective

Karen L. Smith, MD, MPH, Director and State Public Health Officer CDPH
Dr. Smith served as the "emcee" for the meeting. She presented:

- An overview of the California Wellness Plan (CWP) progress and the Public Health 2035 Initiative.
- Survey results from attendees throughout the day, and on how their work aligns with CWP.
- Highlighted areas of success and coordination.

Diana S. Dooley, Secretary, California Health and Human Services Agency
Co-chair of the Let's Get Healthy California Task Force, Ms. Dooley presented:

- California's efforts to prioritize prevention, including essential health benefits and incentivizing wellness.
- Need to continue integrating social determinants of health and prevention into the healthcare delivery system.

Advancing Prevention in the 21st Century: National Perspective

Moderator Wm. Jahmal Miller, MHA, Deputy Director, Office of Health Equity (OHE), CDPH presented:

- Purpose and goals of OHE; and overview of OHE's framework that links disease management to a system of prevention that addresses the social determinants of health.
- How access to care and coverage is not enough. People also need access to healthy communities to maintain health, reduce health care costs and reduce disparities.

John Auerbach, MBA, President and CEO, Trust for America's Health (TFAH)
Mr. Auerbach shared TFAH's current priorities, and outlined four strategies for a prevention-oriented health care system:

1. **Insurance coverage**: Make the case to insurers that preventive coverage in clinical settings and community settings will save money in five years or less. The Center for Medicare & Medicaid Services (CMS) is embracing the idea of social determinants of health as part of insurance coverage.
2. **Government funding**: Federal, State, and local funding is declining. Current federal budget draft proposals include significant funding cuts for agencies that affect the social determinants of health—transportation, education, and environmental protection.
3. **Innovative funding**: Identify and secure funding from public health trusts and funds, taxes, and community benefits.
4. **Policies**: Implement interventions that reach whole populations. Focus on preventative care with evidence-based, community-wide interventions. Create and support regulatory and similar policy approaches that "make the healthy choice the easy choice."

Alonzo L. Plough, PhD, MPH, Vice President, Research-Evaluation-Learning
Chief Science Officer of the Robert Wood Johnson Foundation (RWJF), Dr. Plough shared RWJF's vision and health framework:

1) Highlighted RWJF's goals that align with CWP goals and strategies.
2) Emphasized our collective efforts are helping the movement to address the social determinants of health to improve health equity
3) Action areas for RWJF include the 500 Cities project to provide local, actionable data that engages people; a new walkability measure developed with Rand Corporation to addresses issues like residential segregation, projects that increase social connectedness and reduce incarceration rates; and a ten-year sentinel community study that includes the California cities of Stockton and San Diego. See culture of health (https://www.cultureofhealth.org/) website for more information.

Discussion

During the Advancing Prevention in the 21st Century: National Perspective panel discussion, panelists discussed:

- How the use of technology accelerates improvements in health.
- RWJF's Pioneering Ideas Program invests in high-tech applications to improve health for marginalized populations.
- Air Louisville is coupling technology with political will to address health impacts from living near transit corridors.
- Phone apps that provide support for mental health conditions, including chronic illnesses.
- Apply technologies to everyone, not only those with high quality insurance coverage; and to not only screen for the social determinants of health, but also work to improve them.

Future Vision and Innovations in Chronic Disease Prevention and Health Promotion Efforts

Plenary presenters highlighted progress in each of the California Wellness Plan's four goal areas:

Goal 1: Healthy Communities

Creating Healthier Community Environments

Larry Cohen, MSW, Founder and Executive Director, Prevention Institute shared:

- Strategies to build systems of prevention, including involving communities as key partners.
- Need for connecting physical, mental and behavioral health systems.
- Emphasize the return on investment from prevention.
- Importance of continuing the work to change norms that gain size and momentum.

Goal 2: Optimal Health Systems

Medi-Cal Whole Person Care Pilot

Brian Hansen, Health Program Specialist II, Health Care Delivery Systems, California Department of Health Care Services (DHCS) provided an overview of the Whole Person Care Pilot Program.

- Coordinates with health care providers and community partners to provide health improvements for high utilizers of the health care system that experience challenges with multiple social determinants of health.
- A waiver system in Medicaid is used to demonstrate that the Medi-Cal program saves the federal government money; and they reinvest the savings to support prevention strategies that reduce healthcare costs, such as housing assistance.
- There are 18 approved pilot programs in California counties who agreed to provide matching funds.
- The emphasis is on integrating different silos – jails, emergency rooms, public health departments and homeless services. Information (http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx) about the pilots are available, and submitted applications are available for review. Email (1115wholepersoncare@dhcs.ca.gov) questions and sign up for the listserv if interested in further information.

Goal 3: Useable Data Querying

Clinical Data to Address Public Health Needs

Michael Hogarth, MD, FACP, FACMI, Professor and Vice Chair of Informatics, Department of Pathology, and Professor, Department of Internal Medicine, University of California, Davis (UCD) Health System, described UCD's effort to bring health data together in a coordinated manner.

- UCD established a UC-Rx Federated Repository, and expanded it to a broader effort known as the California Health Data Network (originally the Patient-Centered SCAlable National Network for Effectiveness Research).
- There are 14 health systems with 30 million patient records, including data from the Veterans Administration and Medi-Cal.
- Established security protocols.
- Challenges with limitations in cleaning the data.
- Continue to explore how the data network can be useful for public health.

Goal 4: Sustainability

Disseminate Understanding and Advance Models for Sustainable Funding for Prevention and its Key Supports

Jen Lewis, MEM, MA, Special Projects Director, Sonoma County Department of Health Services, provided an overview of Sonoma's work to establish a sustainable funding stream to close the life expectancy gap in Sonoma.

- Sonoma formed a Sustainable Financing Catalyst Team.
- Conducted a needs assessment and identified the need for three funds.
- Conducted a feasibility analysis for showing documented, valued outcomes to potential investors.
- Tested the model with an accountable community for health initiative.
- **Discussion:** Following the presentations, Dr. Smith moderated a discussion amongst the panelists about how the CWP four goal areas can work together to impact health outcomes and reduce disparities.

Breakout Sessions

Breakout Session 1 for Goal 1: Healthy Communities

Moving upstream: Addressing Community Conditions and Determinants of Health

Melissa Jones, MPA, Executive Director, Bay Area Regional Health Inequities Initiative (BARHII) moderated the breakout session. Shared:

- BARHII framework
- Legislative policy platform
- Information on displacement brief and economic opportunity brief.

Keith Bergthold, MA, Executive Director, Fresno Metro Ministry, shared Fresno's work to increase access to healthy food:

- Mapping and a partnership with urban planners.
- Identified twelve food deserts in Fresno, and now working with communities and government institutions to increase healthy food options.

Anita Kumar, PhD, Collaborative Manager, East Bay Asian Local Development Corporation (EBALDC) discussed EBALDC's Healthy Neighborhoods Approach to community development.

- Developed an Asian Resource Center.
- Manage 30 affordable housing residences.
- Work on commercial real estate.
- Serve as a backbone convener to engage other partners to improve health and well-being in the neighborhoods where they have their development projects.

D'Artagnan Scorza, PhD, Executive Director and Founder, Social Justice Learning Institute, spoke to the role of understanding justice in the urban context in order to address the social determinants of health.

- Concentrated intergenerational disadvantages related to school systems, disinvestment, joblessness and poverty.
- Social Justice Learning Institute is collaborating with thirty stakeholders to implement healthy choices in Inglewood.

Discussion: Panelists discussed the value of collaborating with public health is to engage the community, and understanding how systems can work together to make an impact.

- Local health departments (LHDs) can be limited in how much data they share, and can do more to allow residents to lead planning processes.
- Pitting the economy against public health is not an effective strategy, so it is important to engage retailers, especially small business owners.

Breakout Session 2 for Goal 1 Healthy Communities

Land Use, Planning, and Health Equity

Moderator Rachel Bennett, MPH, MURP, Associate Program Manager, Prevention Institute, opened the session by defining health equity, and highlighting land use efforts that build health into community environments.

- A health equity lens is critical to land use work.
- Address health equity proactively, and with resident engagement.
- Changes at the federal level to environmental regulations, fair housing policies, investments in public transportation, etc. will all impact health equity

Gregory Chew, AICP, Senior Planner, Sacramento Area Council of Governments (SACOG), provided information on the Metropolitan Planning Organization's perspective on how transportation projects are identified and funded in the Sacramento region.

- Sacramento's population is doubling over 50 years, which will affect air quality.
- Funding will focus on projects to improve environments, with a separate program to address rural areas.

- Through SACOG's Blueprint for smart growth, they are limiting sprawl in the area.

Tyler Summersett, MPA, Senior Transportation Planner and Trails Coordinator, Tuolumne County Transportation Council, spoke to planning for health equity in a small, rural area.

- Tuolumne County has a population of 50,000, with most of the land federally owned.
- Working to increase active time outdoors through daily physical activities.
- Funding for a five-mile trail system that connects neighborhoods with the downtown area initially came from the Affordable Care Act through the public health department.

Mojgan Sami, PhD, Project Scientist and Lecturer, Department of Population Health and Disease Prevention, Program in Public Health, University of California, Irvine, examines public health problems from a social justice and equity standpoint (e.g., addressing the upstream drivers of homelessness).

- Equity is broader than resource redistribution. Some planning practices, such as zoning, are still rooted in colonial constructs meant to separate settler communities from indigenous communities.
- Public health research practices that inaccurately define race, such as observational research tools where researchers designate ethnicity by looking at people.
- Need to update tools, be open to multiple types of assessment (e.g., in-depth interviews and focus groups, especially for communities wary of government meetings – instead, take the meeting into the field), and for researchers to be connected to the community being observed.

Breakout Session 3 FOR Goal 2: Optimal Health Systems

Community Clinical Partnership for Prevention

Improving Health Outcomes through Comprehensive Medication Management

Steven Chen, PharmD, FASHP, FCSHP, FNAP, Associate Dean for Clinical Affairs and the William A. Heeres and Josephine A. Heeres Chair in Community Pharmacy at the USC School of Pharmacy, discussed how medication management can bring value to health systems. Dr. Chen presented:

- Comprehensive Medication Management (CMM) patient-centered assessment tool.
- CMM has shown a positive return on investment for reducing hospital readmissions.
- Opportunities to incorporate into primary care.

The Power of Diabetes Self-Management Programs: Keys to Sustaining and Scaling Programs that Work

Neal Kaufman, MD, MPH, Founder and Chief Medical Officer, Canary Health, shared how:

- Onsite and online diabetes self-management is a key component to sustaining diabetes treatment.
- The Stanford Chronic Disease Self-Management Program and Diabetes Self-Management Education are proven systems to improve chronic disease, and reduce depression.

Moderator Michael Hochman, MD, MPH, Director, Gehr Center for Implementation Science, USC, moderated a discussion. Panelists discussed:

- Challenges with doctors' reluctance to refer patients to self-management.
- Need to provide best practice information to increase potential for providers to refer patients. The new Center for Medicare and Medicaid Services quality payment program focuses on value-based care, which should increase patient referrals to self-management programs.
- Health systems will need to give permission for doctors to direct patients to self-management programs.
- There is also a need for clinical coordination with community resources for high blood pressure.

Breakout Session 4 FOR Goal 2: Optimal Health Systems

Prevention Strategies & Models that Work

Shauntay L. Davis, MPH, Program Director, Comprehensive Cancer Control Program, CDPH, moderated the session.

Tobacco Status Identification and Counseling the Impact of this Strategy on Cessation

Elisa K. Tong, MD, MA, Associate Professor of Internal Medicine, UCD, discussed how public health, health plans and providers could collaborate for population-based tobacco cessation. Ms. Tong presented:

- Current smoking data; where disparities in sub-groups exist (Medi-Cal population, low socio-economic status, American Indians, Asian men, LGBT).
- Highlighted the DHCS' effort to increase Medi-Cal member referrals to the California Smokers' Helpline with offering a $20 gift card incentive or cessation-medication incentive. DHCS saw a 70 percent increase in calls to the helpline from 2012 - 2015; 12 percent of those referred asked for the $20 gift card incentive, and 73 percent the nicotine patch incentive.

- DHCS is working with health care on comprehensive tobacco treatment, including a two-way e-Referral to the Helpline.

Utilizing the Fecal Immunochemical Test (FIT) to Increase Colorectal Cancer Screening

Daniel "Stony" Anderson, MD, FACP, President, Board of Directors, California Colorectal Cancer Coalition, presented on how the FIT test is an effective colorectal cancer-screening tool to increase the percentage of people screened.

- FIT test is noninvasive.
- Preferred by patients over colonoscopies.
- Conducted at home without preparation.
- Opportunity to expand the offering of this test, especially in community clinics.

Breakout Session 5 FOR Goal 3: Useable Data

Using Technology to Facilitate Data Collection and Surveillance

April Roeseler, BSN, MSPH, Chief, California Tobacco Control Branch, CDPH moderated the session.

Using Handheld Devices to Collect Observational Data and Public Intercept Surveys

Diana Cassady, DrPH, Professor, Public Health Sciences Department, UCD, presented:

- UCD Tobacco Control Evaluation Center's work to collect healthy retail environment data at more than 10,000 stores across the state.
- Included a pilot test in 2012, and assessments in 2013 and 2016.
- Used a variety of device types and apps to conduct the surveys.

Enhancing Emerging Tobacco Product Surveillance with Novel Data Streams

Jon-Patrick Allem, PhD, MA, Postdoctoral Fellow, Keck School of Medicine of USC, presented his work in tracking e-cigarette and hookah usage on twitter, google search and Instagram.

- Tracking outcomes (analytics) offer timely insights into internet searches and social media activities related to e-cigarettes and hookah.
- Uses a (computer) program to differentiate social bot data.

Using Online Data Collection for Fast, Economical Surveillance and Media Tracking

Xueying Zhang, MD, MPH, MS, Chief, Evaluation Unit, California Tobacco Control Program, CDPH, presented:

- An overview of a longitudinal media tracking study from 2005-2012; online California Adult Tobacco Survey; and California Student Tobacco Survey.

- Shared costs and benefits of various data collection methods, including face-to-face, mail, telephone, and online, mobile and mixed-mode surveys.

Breakout Session 6 for Goal 3: Useable Data

Creating New Partners in Data Collection, Surveillance and Program Evaluation

Moderator David J. Reynen, DrPH, MA, MPPA, MPH, CPH, Research Scientist III, California Stroke Registry / California Coverdell Program, CDPH, moderated the session.

Silo-busting: Partnering to Collect Tobacco, Food, Alcohol and Condom Data to Create Healthier Retail Environments that Support Healthy Communities
Elizabeth Andersen-Rodgers, MA, MSPH, Research Scientist, California Tobacco Control Program, CDPH, discussed the Healthy Stores for Healthy Communities ten-year campaign initiated in 2013.
Campaign (http://healthystoreshealthycommunity.com/) is a partnership with CDPH's Tobacco Control Branch, Nutrition Education and Obesity Prevention Branch, Sexually Transmitted Disease Program, and DHCS' Alcohol and Substance Abuse Program.

- Examines nutrition, alcohol, and contraceptive and tobacco products in the retail environment. Partnership involves a statewide data collection effort and media campaign.
- Data collection included a Kahoot cellphone quiz.
- Nonprofessional data collectors trained with a "mock" store, and collectors had a 90% completion rate in the field.
- Shared key messages for the media based on the data results.

California Cancer Registry Modernization
Jeremy Pine, Information Technology Section Chief, California Cancer Registry, CDPH, described the California Cancer Registry (CCR) focus areas of quality improvement and data availability.

- One challenge is manual entry of data and a delay in analysis.
- If data analytics are enabled, data can be entered at diagnosis.
- Pathology data reporting can be a labor intensive and costly process.
- Assembly Bill 2325 requires electronic reporting to the CCR by pathologists and goes into effect in 2019.

Health Information Exchange: Experiences from Solano County, California
Bela T. Matyas, MD, MPH, Health Officer and Director of Public Health, Solano County Department of Health and Social Services, gave an overview of Solano's Public Health – Health Information Exchange (HIE).

- Provider network includes clinics, large health care providers, the Veterans Administration, and commercial entities.

- All public health data in Solano flows to the HIE where data is transferred and mapped. There are two quality assurance checks.
- Interoperability is a challenge (e.g., race and ethnicity are defined differently by many systems). It is important to obtain raw data to address data quality and usability.
- Kaiser is a key partner who is interested in the social determinants of health; they would like a regional approach for a data exchange.
- Bay Area Health Officers are determining who else in the region would like to be involved.

Breakout Session 7 for Goal 4: Sustainability

Mobilizing and Braiding Sustainable Funding for Prevention in Cities and Counties.

Paul Simon, MD, MPH, Chief Science Officer, Los Angeles County Department of Public Health, moderated the session.

Live Well San Diego

Wilma J. Wooten, MD, MPH, Public Health Officer, County of San Diego, Health and Human Services Agency, Public Health Services, presented on the *Live Well San Diego* initiative to build better health for the entire San Diego region.

- The framework is an example of how to braid various sources of funding toward common goals. They use 10 indicators to measure five areas of influence.
- Examples of braided funding include CDC, USDA, First 5 and internal county funding to achieve the goals of the initiative in preventing chronic disease and improving safety.
- Example projects include worksite wellness, healthy retail (tobacco tax and nutrition education and obesity prevention funding), and resident engagement.
- Pharmacy rebates are an example of funds that can be leveraged to pay for items grants may not cover, like copying, translating, training, etc.
- Administering funding collaboratively, and in alignment with the local need and vision, maximizes the impacts of chronic disease prevention efforts in the region.

Berkeley Soda Tax Model: From Data and Talk to Policy and Action

Vicki Alexander, MD, MPH, President, Board of Directors, Healthy Black Families, Inc., presented on the evolution of the Berkeley Soda Tax.

- Unhealthy food and beverage ads target communities and children, particularly children of color.
- The Bigger Picture, a collaboration between Youth Speaks, and UC San Francisco Center for Vulnerable Populations, created “Perfect Soldiers” video by Gabriel Cortez. The video (https://www.youtube.com/watch?v=tgh8NxNnhoI) addresses type 2 diabetes and the devastating impact on a community and how advertising plays a role.

- Health department's role was to provide data and a health status report.
- Community became involved through a minister whose young adult son died of diabetes.
- Public influence led to the passage of the soda tax (with a 76% vote in favor), and directing of the funds to nutrition programs.
- Half of the funding goes to school district gardens, and the rest to community-based efforts to increase awareness and change norms.
- Important to make safe, affordable drinking water available in communities, so that the choice of drink is not an economic one.

Breakout Session 8 for Goal 4: Sustainability

State Level Innovation for Mobilizing Sustainable Funding for Prevention

Dan Peddycord, RN, MPA/HA, Director of Public Health, Contra Costa County Health Services moderated the session.

Utilizing 1115 Waiver to Support Public Health Programming

Stephen Williams, MEd, MPA, Director, City of Houston Health Department, described Houston's efforts to use Texas' 1115 Waiver to fund public health initiatives.

- State set aside 5% of the 1115 funding as part of the Delivery System Reform Incentive Program health to invest in public health issues like obesity, homelessness, HIV, TB and oral health, public health information technology infrastructure, and others.
- Payment is based on the value of projects, not the cost of implementing the projects, so savings could be used to support other public health activities.
- 15 approved projects, including two chronic disease projects focused on a Diabetes Awareness and Wellness Network and Colorectal Cancer Awareness and Screening.
- To sustain efforts, collaborating with the healthcare arena to advocate for a more substantial public health role, examining social impact bonds and managing the Essential Services Fund to extend funds beyond the project period.

Endowment Trust Model

Tracey Strader, MSW, Public Health Consultant, Executive Director Emeritus for the Oklahoma Tobacco Settlement Endowment Trust, spoke about how Oklahoma used 75 percent of their state's tobacco master settlement funding for an endowment trust.

- Established a Board of Investors to manage the fund, and a bipartisan Board of Directors to expend the earnings for programs to improve health.
- Activities funded include grants and health communications to prevent tobacco use and obesity, research and treatment in cancer and tobacco-related diseases, and emerging opportunities like physician recruitment through rural medical

residencies and medical loan repayment, and FitnessGram assessments in schools.

Sugar Sweetened Beverage Tax

Lynn Silver, MD, MPH, Senior Advisor, Public Health Institute and Co-Chair, California Alliance for Funding Prevention, gave an overview on taxes on sugary drinks.

- Provided data on the health impacts from consumption of sugary drinks, and documented the efforts across the world to tax sugary beverages to support obesity prevention.
- Philadelphia based a 3 cent per ounce tax as a measure to raise revenue for universal pre-K.
- Illustrated cost effectiveness modeling that a 1 cent per ounce sugar sweetened beverages (SSB) tax in the U.S. would yield a 55:1 return on investment over ten years.
- After the Berkeley soda tax was implemented, sales of SSBs feel by 10 percent in the first year, healthier drink purchases increased, overall beverage sales went up, and average grocery bills did not increase.
- The funding was used for community health programs.

Closing Keynote Panel

Health Access: What would be the Impact of Patient Protection and Affordable Care Act Repeal/Replace?

Moderator Marice Ashe, JD, MPH, Founder and CEO, ChangeLab Solutions, set the stage for the closing keynote discussion by describing the importance of Health in All Policies to address the determinants of health with a very limited budget.

Emalie Huriaux, MPH, Director of Federal & State Affairs, Project Inform and Chair, California Hepatitis Alliance, gave an overview of the chronic diseases Hepatitis B and C, and HIV.

- Hospitalizations from hepatitis and liver cancer are on the rise.
- Hepatitis is a preventable public health issue that disproportionately impacts certain communities.

Anthony Wright, Executive Director, Health Access California, spoke to the impacts of the Affordable Care Act on:

- Expanding coverage.
- Reforming the delivery system away from emergency care and toward prevention.
- California's new tobacco tax has an important impact on expanding dental care.

Discussion centered on the impacts of a potential repeal of the Affordable Care Act. One of the proposed bills would cut Medicaid and reduce the number of people who are

insured, which would increase premiums. California can play a leadership role in prevention, including with opioids. California's expanded coverage and investment in public health is important, and there is more to be done to create a health system that puts prevention first.