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CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 2424

Introduced by Assembly Member Gomez

February 19, 2016

An act to add Part 8 (commencing with Section 106050) to Division 103 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 2424, as amended, Gomez. Community-based Health Improvement and Innovation Fund.

Existing law establishes the State Department of Public Health, within the California Health and Human Services Agency, vested with certain duties, powers, functions, jurisdiction, and responsibilities over specified public health programs.

This bill, among other things, would create the Community-based Health Improvement and Innovation Fund in the State Treasury, and the moneys in the fund would be available, upon appropriation by the Legislature, for certain purposes, including, but not limited to, reducing health inequity and disparities in the rates and outcomes of priority chronic health conditions, as defined, preventing the onset of priority chronic health conditions using community-based strategies in communities statewide and with particular focus on health equity priority populations, as defined, and strengthening local, regional, and state

level collaborations between public health jurisdictions and health care providers, and across government agencies and community partners to create healthier communities, using a health-in-all-policies approach. The department would be required to use a specified percentage of moneys from the fund for certain public health and administrative activities and would be required to award a specified percentage of moneys from the fund to local health jurisdictions and as competitive grants to eligible applicants to be used to improve health and health equity, as provided.

This bill would create the 13-member Community-based Health Improvement and Innovation Fund Advisory Committee to, among other things, advise the department with respect to policy development, integration, and evaluation of community-based chronic disease and injury prevention activities funded under these provisions, and for development of a master plan of recommendations and proposed strategies for the future implementation of those activities. The bill would require the advisory committee, based on the results of programs supported by these provisions, to produce a comprehensive set of recommendations and proposed strategies for advancing chronic disease and injury prevention throughout the state, to include implementation strategies in the recommendations for each priority chronic health condition throughout the state and identification of areas where innovative solutions are especially needed, and to submit the recommendations and proposed strategies to the Legislature triennially.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Part 8 (commencing with Section 106050) is added to Division 103 of the Health and Safety Code, to read:

PART 8. COMMUNITY-BASED HEALTH IMPROVEMENT AND INNOVATION FUND

106050. The Legislature finds and declares all of the following:

(a) Over the past century, chronic diseases have emerged as a predominant challenge to public health. Chronic disease and injury account for eight of every 10 deaths and ~~affects~~ *affect* the quality of life of 14 million Californians.

(b) Obesity and diabetes in particular have grown rapidly, posing a grave threat to health. Today over one-half of California adults are estimated to have either diabetes or prediabetes. Thirteen million adults in California, 46 percent of the adult population, are estimated to have prediabetes or undiagnosed diabetes, while another 2.5 million adults, 9 percent of the adult population, have already been diagnosed with diabetes.

(c) The health inequities in this state are stark:

(1) Ethnic minorities and individuals who have low incomes have higher rates of diabetes. Nearly ~~one-in-five~~ *1 in 5* African Americans and Latinos in California have diabetes, more than double the rate of Whites.

(2) Nearly 12 years of life separate the life expectancy at the top and at the bottom of neighborhood clusters in California, from a life expectancy of 87 years in parts of northwest Santa Clara County to 75.3 years in the City of Twentynine Palms and the City of Barstow in the County of San Bernardino.

(3) Economically disadvantaged children are far less likely to complete the fitness requirements of the physical fitness test offered to students in grade school.

(4) Adolescents covered by Medi-Cal reported significantly higher rates of drinking sugar-sweetened beverages and less daily consumption of vegetables than the general California adolescent population and were significantly more likely to be obese.

(d) The following short list of risk factors is responsible for much of the burden of chronic disease: tobacco use, physical inactivity, unhealthful diet, excessive consumption of alcohol, hyperlipidemia, and uncontrolled high blood pressure. These risk factors and chronic conditions are largely preventable, inequitably distributed, and significantly influenced by the social determinants of health.

(e) The State Department of Public Health estimates that as much as 80 percent of heart disease, stroke, and type II diabetes and more than 30 percent of cancers can be prevented by eliminating the underlying risk factors.

(f) The economic burden of chronic disease in California weighs heavily on families, employers, and all levels of government. Approximately $98 billion, or 42 percent of all health care expenditures in the state, was spent on treating just six common

chronic health conditions (arthritis, asthma, cardiovascular disease, diabetes, cancer, and depression) in 2010.

(g) The indirect costs associated with chronic disease in California are also high. According to the Economic Burden of Chronic Disease (EBCD) Index, the projected impact of lower productivity and lost workdays for individuals with chronic conditions and their caregiving family members in California was estimated to be $51 billion in 2010.

(h) The cost of health care continues to surpass the rate of inflation, causing increasing strain on the budgets of families, employers, and the government. Yet the ability of ~~healthcare~~ *health care* alone to solve health problems that arise in the community is limited.

(i) Despite the fact that chronic disease results in decreased quality of life, premature death, and exorbitant medical costs, investments in measures that prevent chronic disease have been minimal.

(j) The United States spends only 2.6 percent of health care dollars on all public health, yet 75 percent of health care costs are attributable to preventable health conditions.

(k) Paying for prevention works and upstream strategies have a remarkable history of success, measured in both cost avoidance and health improvement. In the County of Los Angeles, smoking ~~amongst~~ *among* high school students fell from 27 percent to 7 percent between 1997 and 2013, thanks to investment in policy and environmental changes as well as education.

(*l*) Childhood obesity ~~amongst~~ *among* Los Angeles Unified School District 5th graders decreased by 10.6 percent (from 31.2 percent to 27.9 percent) between 2010 and 2013, and leveled off among 7th and 9th graders, after nine years of steady increases, reflecting investments to reduce the consumption of sugar-sweetened beverages, promote healthier eating, and increase physical activity.

(m) The California Health and Human Services Agency, in partnership with the State Department of Public Health, has defined ambitious health improvement goals for the state through the "Let's Get Healthy California" initiative, including making California the healthiest state in the nation by 2022, reducing health disparities, and achieving better health at lower cost. These goals cannot be met by improvements in health care or on an individual

basis alone. Meeting these goals requires urgent and substantial investment in community-based prevention of chronic disease and injuries.

(n) The Health in All Policies Task Force was established by Executive Order No. S-04-10 on February 23, 2010, under the auspices of the Strategic Growth Council (SGC), in order to foster ~~multi-agency~~ *multiagency* collaboration to identify priority programs, policies, and strategies to improve the health of Californians while advancing the SGC's goals of improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the state's climate change goals.

(o) Senate Concurrent Resolution No. 47 (Resolution Chapter 56 of the Statutes of 2012) affirms the work of the Health in All Policies Task Force by encouraging public officials in all sectors and levels of government to recognize that health is influenced by policies related to air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, sustainable communities, and climate change, and to consider health when formulating policy, and by encouraging interdepartmental collaboration with an emphasis on the complex environmental factors that contribute to poor health and inequities when developing policies in a wide variety of areas, including, but not limited to, housing, transportation, education, air quality, parks, criminal justice, and employment.

(p) The Office of Health Equity was established in Section 131019.5 of the Health and Safety Code in order to achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, and it directs the Office of Health Equity to work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.

(q) The existing limited resources of funding for chronic disease prevention are threatened, declining from past levels, and subject to significant restrictions.

(r) Strategic investment in upstream prevention will protect, not deplete, the coffers of government. Investment in prevention has a strong evidence base of positive return on investment through reducing health care costs on a long-term basis.

106051. For purposes of this part, the following terms have the following definitions:

(a) "Community food projects" means those established in the federal Food and Nutrition Act of 2008 (7 U.S.C. Sec. 2011 et seq.) and the federal Food, Conservation, and Energy Act of 2008 (7 U.S.C. Sec. 8701 et seq.) that are designed to increase food security, including access to a healthy diet in communities. They may bring representatives from the community, food, and public health systems together to assess strengths, establish linkages, and create projects, ~~non-profit~~ *nonprofit* enterprises, or both, that improve access and self-reliance of community members over their food needs. These may also include urban or peri-urban farms and gardens that dedicate production to low-income communities, food hubs, farm stands, farmers markets, mobile vendors, and community-supported agriculture projects that provide distribution systems, and community-owned and managed enterprises that make healthy food more accessible to low-income families.

(b) "Department" means the State Department of Public Health.

(c) "Fund" means the Community-based Health Improvement and Innovation Fund.

(d) "Health equity" means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

(e) "Health equity priority population" means, for each condition, populations that exhibit significant disparities with respect to prevalence of a priority chronic health condition or injury or worse ~~outcomes~~ *outcomes*, such as higher hospitalization or death rates. Priority populations may be defined based on race, ethnicity, geography, socioeconomic status, including income or education, other factors as defined by the department, or current findings and recommendations of research, including assessments of innovations funded by the fund.

(f) "Local health jurisdiction" means a county health department or a combined health department in the case of counties acting jointly or a city health department within the meaning of Section 101185.

(g) "Priority chronic health conditions" means asthma, type II diabetes, cardiovascular and cerebrovascular disease, cancer, dental disease, obesity, and other chronic conditions and injuries that are prevalent, largely preventable, and associated with high health care costs, as defined by the department. High-burden conditions whose prevention is not adequately supported by other funding streams shall be prioritized.

106052. (a) (1) There is hereby created in the State Treasury the Community-based Health Improvement and Innovation Fund. The fund shall consist of any revenues deposited therein, including any fine or penalty revenue allocated to the fund, any revenue from appropriations specifically designated to be credited to the fund, any funds from public or private gifts, grants, or donations, any interest earned on that revenue, and any funds provided from any other source.

(2) A target level of annual statewide investment from the fund shall be established as a set dollar amount per capita, to be allocated for the purposes described in subdivision (b) and as described in Section 106053.

(b) (1) Moneys in the fund shall be available, upon appropriation by the Legislature, for any of the following purposes:

(A) Reducing health inequity and disparities in the rates and outcomes of priority chronic health conditions and injuries.

(B) Preventing the onset of priority chronic health conditions using community-based strategies in communities statewide and with particular focus on health equity priority populations.

(C) Strengthening local, regional, and state level collaborations between public health jurisdictions and health care providers, and across government agencies and community partners to create healthier communities, using a health-in-all-policies approach.

(D) Supporting collaboration between public health entities and nonhealth organizations and agencies in fields such as, but not limited to, housing, transportation, land use planning, natural resources, parks, food access, education, economic development, community development, and employment, to promote community environments that support healthy communities and families, and that reduce inequities in disease and injury using a health-in-all-policies approach.

(E) Contributing to a stronger evidence base of effective community-based prevention strategies for priority chronic health conditions.

(F) Evaluating the effectiveness and cost-effectiveness of innovative community-based prevention strategies for priority chronic health conditions, as a basis for future decisions about investment in those strategies in order to reduce the costs of providing health care services and to improve population health status.

(2) Moneys in the fund shall be used to address social, environmental, and behavioral determinants of chronic disease and injury at any phase of the life cycle, including, but not limited to, all of the following:

(A) Promotion of healthy diets, improved access to healthy foods, and healthy food environments.

(B) Promotion of physical activity and of a safe, physical activity-promoting environment.

(C) Prevention of unintentional and intentional injury.

(D) Building partnerships to address social determinants of chronic disease.

(3) In expending moneys from the fund, policy, systems, and environmental change approaches are to be emphasized, although funds can support implementation of community-based programs.

(4) Moneys in the fund shall not be used for clinical services.

(5) Revenues deposited in the fund that are unexpended at the end of a fiscal year shall remain in the fund and not revert to the General Fund.

(6) The award of contracts, grants, or funding allocations provided through this part shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

106053. (a) The department shall be allocated an amount not greater than 20 percent of the annual appropriation from the fund for all of the following activities:

(1) Mandatory activities for which the funds shall be used are as follows:

(A) Statewide media and communications campaigns, which shall be allocated 9 percent of total funds.

(B) Evaluation of all program activities supported through the fund, including the creation of a robust evaluation framework,

which shall be allocated at least 5 percent of those funds. This evaluation framework shall include all of the following:

(i) Regular monitoring of local health jurisdiction awards to ensure activities are conducted pursuant to approved plans and consistent with all requirements of this part.

(ii) Measures to ensure funding provided pursuant to this part supplements and does not supplant existing funding or efforts.

(iii) Data collection and reporting requirements for grant awardees sufficient to assess impact and monitor compliance with this part.

(iv) A plan to analyze the impact of this part on process measures relevant to community health promotion and, if practicable, on outcome measures.

(C) Other activities, which shall be allocated no more than 6 percent of total funds, as follows:

(i) Overall program implementation and oversight, including review and approval of local health improvement plans, and granting of and monitoring the implementation of local health jurisdiction awards and competitive grant awards.

(ii) The definition of criteria for evidence-based and innovative approaches to improving health and health equity, with evaluation criteria appropriate to each type of approach. Criteria for evidence-based projects shall include cost-effectiveness or projections of return on investment to the state.

(iii) The definition of priority chronic health conditions and health equity priority populations based on public health data.

(iv) The definition of criteria for participation of community partners in local health jurisdiction funding.

(v) The development of tools that can be used by the state and by grantees to monitor progress towards improving health and health equity, including establishment of a health equity index and progress towards “Let’s Get Healthy California” goals.

(2) Discretionary activities, as may be appropriate to support community-based prevention of priority chronic health conditions throughout the state, for which the funds may be used, include, but are not limited to, any of the following:

(A) Research, development, and dissemination of best practices, including training and technical assistance for grantees.

(B) Development of infrastructure, including, but not limited to, data resources or information technology resources to be shared statewide.

(C) Coordination of local efforts.

(D) Development and promotion of statewide initiatives.

(E) Grants or contracts to nonprofit organizations at the state level to provide technical assistance, resource development, or other support to the department, local health jurisdictions, and other grantees directly serving communities.

(3) The department, in consultation with the advisory committee established pursuant to Section 106054, may define state priorities and require activities supported by the fund to align with those priorities in a manner that is consistent with the intent of this part. The department may narrow the list of priority chronic health conditions, if necessary, to ensure an effective program.

(4) The department shall require activities pursuant to this part to be conducted in a manner consistent with principles of effectiveness, cost efficiency, relevance to community needs, maximal impact to improve community health, and sustainability of impact over time.

(b) The department shall award at least 80 percent of total moneys made available in the annual appropriation from the fund to eligible applicants to be used consistent with the purposes described in subdivision (b) of Section 106052. Moneys from the fund shall be distributed and awarded according to the following criteria:

(1) (A) At least 47 percent of total funds shall be awarded to local health jurisdictions and shall be allocated on a formula basis to local health jurisdictions, or their nonprofit designee, with approved applications for three-year funding cycles.

(B) Each local health jurisdiction shall submit an application for a three-year funding cycle, to be reviewed and approved by the department, that includes all of the following information:

(i) A detailed assessment of community health needs and factors contributing to those conditions within the local health jurisdiction with respect to priority chronic health conditions and health equity priority populations.

(ii) A health improvement and evaluation plan that includes initiatives focused on health equity priority populations.

(iii) The level of local funds, including in-kind resources, for community-based prevention activities that was provided in the most recently completed fiscal year.

(iv) Documentation of the existence and activities of a community health partnership pursuant to subparagraph (D) of paragraph (1) of subdivision (b) of Section 106052, which includes leading health care providers, local health jurisdictions, community partners, including those serving health equity priority populations, businesses, and other relevant local government agencies and community leaders and their commitments to support the efforts.

(v) How funds will be used in a manner consistent with principles of effectiveness, cost efficiency, relevance to community needs, maximal impact to improve community ~~health, sustainability of impact over time, and projections of return on investment to the state.~~ *health, and sustainability of impact over time.*

(C) Each local health jurisdiction with an approved application shall receive a base award of two hundred fifty thousand dollars ($250,000) for a three-year funding cycle. The balance of the funds shall be awarded to local health jurisdictions proportional to the number of residents living below the federal poverty level.

(D) Health improvement and evaluation plans shall emphasize sustainable policy, systems, and environmental change approaches to creating healthier communities.

(E) Local health jurisdictions may come together if they so desire to submit combined regional applications.

(F) No single recipient may receive more than 30 percent of the funding allocated to local health jurisdictions on a formula basis.

(G) Recipients of funds pursuant to this paragraph shall maintain the level of local funds, including in-kind resources, for community-based prevention activities that were provided in the most recently completed fiscal year prior to July 2016. Funds provided pursuant to this paragraph shall supplement and not supplant existing funding for community-based prevention activities of priority chronic health conditions.

(H) Local health jurisdiction investments shall prioritize communities in the third and fourth quartiles of the California Health Disadvantage Index or other criteria of health equity priority populations subsequently adopted by the department.

(I) The initial year of funding may be used for needs assessment, planning, and development.

(2) At least 33 percent of total funds shall be allocated for competitive grants as follows:

(A) (i) Competitive grants shall be awarded to local or regional level entities or statewide nonprofit organizations. Funds provided pursuant to this paragraph shall supplement and not supplant existing funding for community-based prevention activities of priority chronic health conditions.

(ii) Local, regional, and state level entities, including nonprofit and community-based organizations in partnership with other entities, including, but not limited to, other nonprofit and community-based organizations, other local public agencies, schools, religious organizations, businesses, labor unions, health care plans, hospitals, clinics, other health care providers, or other community-based entities.

(iii) Each participating health care plan or hospital shall identify monetary, in-kind, or both, contributions to projects.

(iv) Local or regional projects shall prioritize investments that serve communities in the third and fourth quartiles of the California Health Disadvantage Index or other criteria of health equity priority populations subsequently adopted by the department.

(v) At least 10 percent of the total funds shall be used for statewide nonprofit organizations to support activities conducted regionally or at the state level.

(vi) At least 5 percent of total funds shall be used for a competitive grant program administered by the department to support healthy food incentives for low-income Californians, support community food projects, as defined under Section 106051, and aid community food producers or socially disadvantaged, beginning, military veteran, or ~~limited resource~~ *limited-resource* specialty crop producers that improve the health and resilience of their communities by increasing access to any variety of fresh, canned, dried, or frozen whole or cut fruits and vegetables without added sugars, fats or oils, and salt. The department shall coordinate, as necessary, with the Department of Food and Agriculture to implement this clause.

(vii) Organizations receiving competitive grants shall coordinate efforts with the department and any local health jurisdictions where they are carrying out activities.

(B) (i) Competitive grant applicants shall identify projects as either an evidence-based or an innovative project.

(ii) Applications for evidence-based projects shall demonstrate how funds will be used in a manner consistent with principles of effectiveness, cost efficiency, relevance to community needs, maximal impact to improve community health, and sustainability of impact over time.

(iii) At least 10 percent of the funding for competitive grants shall be set aside for innovative projects that test previously untested strategies in order to improve the evidence base of effective community-based prevention strategies for priority chronic health conditions and injuries.

(iv) Applications for innovative projects shall provide a rationale for the defined approach and any evidence that suggests the innovative project will be effective, as well as a plan and resource allocation for the evaluation.

(v) Competitive grants may be used by organizations for policy systems or environmental change efforts, direct program delivery, or for technical assistance to other grantees.

106054. (a) There is hereby created the Community-based Health Improvement and Innovation Fund Advisory Committee in state government that shall advise the department with respect to policy development, integration, and evaluation of community-based chronic disease and injury prevention activities funded under this part, and for development of a master plan of recommendations and proposed strategies for the future implementation of those activities.

(b) The advisory committee shall include, at a minimum, experts on priority chronic health conditions, effective nonclinical prevention strategies, policy strategies for chronic disease prevention, and the unique needs of health equity priority populations.

(c) The advisory committee shall be composed of 13 members to be appointed as follows:

(1) One member representing voluntary health organizations dedicated to the reduction of chronic disease, injuries, or health inequities appointed by the Speaker of the Assembly.

(2) One member representing an organization that represents health care employees appointed by the Senate Rules Committee.

(3) One member representing a statewide nonprofit health organization dedicated to the improvement of public health appointed by the Governor.

(4) One member representing a community-based organization with a demonstrated track record implementing community prevention programs appointed by the Governor.

(5) One representative of a university with expertise in programs intended to reduce chronic disease appointed by the Governor.

(6) Two representatives of a population group with priority health conditions appointed by the Governor.

(7) One representative of the Health and Human Services Agency appointed by the Governor.

(8) One representative of the Department of Food and Agriculture appointed by the Governor.

(9) One representative of the Health in All Policies Task Force appointed by the Strategic Growth Council.

(10) One member representing the interests of the general public appointed by the Governor.

(11) One representative of the California Conference of Local Health Officers.

(12) One representative from the California Health Benefit Exchange appointed by the executive board of the exchange.

(d) Members of the advisory committee shall serve for a term of two years, renewable at the option of the appointing authority. The initial appointments of members shall be for two or three years, to be drawn by random lot at the first meeting. The committee shall be staffed by the department's coordinator of the program as described in paragraph (3) of subdivision (a) of Section 106053.

(e) The committee shall meet as often as it deems necessary, but shall meet not less than four times per year.

(f) The members of the committee shall serve without compensation, but shall be reimbursed for necessary travel expenses incurred in the performance of the duties of the committee.

(g) The committee shall be advisory to the department, the Department of Food and Agriculture, and the Health and Human Services Agency, for all of the following purposes:

(1) Evaluation of research on community-based policies, practices, and programs funded under this part as necessary in order to assess the overall effectiveness of efforts made by the programs to reduce the occurrence of preventable chronic disease and injuries.

(2) Facilitation of programs directed at reducing and eliminating preventable chronic disease and injury that are operated jointly by more than one agency or entity. The committee shall propose strategies for the coordination of proposed programs administered by the department, the Department of Food and Agriculture, the Health and Human Services Agency in general, and the efforts of the other members, such as the Health in All Policies Task Force, in order to maximize the public benefit of the programs.

(3) Making recommendations to the department, the Department of Food and Agriculture, and the Health and Human Services Agency regarding the most appropriate criteria for the selection of, standards of operation of, and types of activities to be funded under this part.

(4) Reporting to the Legislature on or before January 1 of each year on the number and amount of chronic disease and injury prevention activities funded by the Community-based Health Improvement and Innovation Fund, the amount of money in the fund, any moneys previously appropriated to the department, but unspent by the department, a description and assessment of all programs funded under this part, and recommendations for any necessary policy changes or improvements.

(5) Ensuring that the most current research findings regarding chronic disease and injury prevention are applied in designing the Community-based Health Improvement and Innovation Fund activities administered by the department. The department shall apply the most current findings and recommendations of research, including assessments of innovations funded by the fund.

(h) (1) Based on the results of programs supported by this part and any other proven methodologies available to the advisory committee, the advisory committee shall produce a comprehensive set of recommendations and proposed strategies for advancing chronic disease and injury prevention throughout the state.

(2) The recommendations shall include implementation strategies for each priority chronic health condition throughout the state and identification of areas where innovative solutions are especially needed.

(3) The advisory committee shall submit the recommendations and proposed strategies to the Legislature triennially.

(4) The advisory committee recommendations shall include specific goals for reduction of the burden of preventable chronic

conditions and injuries by 2030, administrative arrangements, funding priorities, integration and coordination of approaches by the department, the Department of Food and Agriculture, local health jurisdictions, ~~non-profit~~ *nonprofit* and community-based organizations, the University of California, the Health in All Policies Task Force, and their support systems, and progress reports relating to each health equity priority population.

(i) A report submitted pursuant to section shall be submitted in compliance with Section 9795 of the Government Code.

106055. Implementation of this part shall be contingent on an appropriation provided for this purpose in the annual Budget Act or other measure.

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