Fallbrook Regional HEALTH DISTRICT

138 S. Brandon St. • Fallbrook CA 92028 • 760-731-9187

BOARD OF DIRECTORS

REGULAR BOARD MEETING

WEDNESDAY
JANUARY 10, 2018

6:00 PM

AT

FPUD
FALLBROOK PUBLIC UTILITY DISTRICT
990 EAST MISSION ROAD
FALLBROOK, CA 92028

AGENDA
FALLBROOK REGIONAL HEALTH DISTRICT
REGULAR BOARD MEETING
Wednesday, January 10, 2018, 6:00 p.m.
Fallbrook Public Utilities District, 990 E. Mission Rd., Fallbrook

A. CALL MEETING TO ORDER – PLEDGE OF ALLEGIANCE

B. ADDITIONS TO AGENDA

Pursuant to the Brown Act, additions to the Agenda as posted are exceptional, and expressly limited to three specific situations, as set forth in Government Code 54954.2(b): (1) an "emergency" as determined by majority vote of the board; (2) a 2/3 vote of the board finding that an item requires immediate action – and the need for this action arose in time after the agenda was posted or (3) the item was continued from an earlier meeting (no more than 5 days earlier), at which time the item was validly posted on the agenda of the earlier meeting.

C. BOARD MEMBER AND PUBLIC COMMENTS

Opportunity for board members and citizens to speak on items of interest within subject matter jurisdiction of the District. For the record, please state your name. "Request to speak" cards should be filled out in advance and presented to the Board President or the recording secretary. The Board has a policy limiting any speaker to not more than five minutes.

D. CONSENT ITEMS

D1. Approval of November 2017 Financial Statements
D2. Minutes of December 6, 2017 Finance Committee Meeting
D3. Minutes of December 13, 2017 Regular Board Meeting
D4. Minutes of December 19, 2017 Special Board Meeting

E. REPORTS

E1. Finance Committee – Committee of the Whole, Chair: Director Mroz
E2. Gov't/Public Relation/Community Relations Committee – Directors Salmon and Tinker
E3. Facilities/Strategic Planning Committee – Directors Abbott and Salmon
E4. Executive Director – Bobbi Palmer
E5. General Counsel – Blaise Jackson

F. ITEMS FOR SUBSEQUENT MEETINGS

F1. Other Director/Staff discussion items
  F1a. Item(s) for future board agendas
  F1b. Announcements of upcoming events
    - Board of Directors Workshop, January 27, 8:00am, Fallbrook Regional Health District Board Room, 138 S. Brandon Rd.
    - Woman of Wellness – Thursday, February 1, 6:00pm – Fallbrook Library
    - NCCCHI meeting – 1st Wednesday, February 7, 2:00-3:00pm

- Finance Committee meeting – 1st Wednesday, February 7, 5:00pm, Fallbrook Regional Health District Board Room, 138 S. Brandon Rd.
- Tour, Lunch and Presentation – Tri-City Wellness Center, February 20, 9am – 2:30pm, 6250 El Camino Real, Carlsbad, CA 92009,
  - Tour of facility from 9 am- noon
  - Lunch
  - Presentation to San Diego County Aging & Independence Services and Fall Prevention Task Force, North County Chapter by Rachel Mason, Kevin Mahr and Bobbi Palmer, 1-2:30pm

F2. Next Regular Board meeting – Wednesday, February 14, 6:00pm, Fallbrook Public Utility District Board Room

G. CLOSED SESSION

G1. Conference with Real Estate Negotiator Concerning Real Property Purchase Negotiations per Govt. Code 54956.8
District Negotiator: Roy Moosa of Sun Realty
APN # 105-092-22-01, 1636 E. Mission Rd.

G2. Conference with Legal Counsel Concerning Potential Litigation Pursuant to Gov't Code 54956.9(d)(2) – one case.

G3. Conference with Real Estate Negotiator Concerning Real Property Sale Negotiations per Govt. Code 54956.8
167 E. Alvarado St.
District Negotiator: Roy Moosa of Sun Realty

G4. Personnel Matters Pursuant to Government Code Section 54957 – Evaluation of Executive Director

H. RETURN TO OPEN SESSION

H1. Consideration of Employment Agreement for Chief Executive Officer

I. ADJOURNMENT

NOTE: This agenda posted at the Fallbrook Regional Health District Administration Office on Friday, January 5, 2018. The American with Disabilities Act provides that no qualified individual with a disability shall be excluded from participation in, or denied the benefits of District business. If you need assistance to participate in this meeting, please contact the District office 24 hours prior to the meeting at 760-731-9187.

Linda Bannerman

Board Secretary/Clerk

CONSENT ITEMS

FALLBROOK REGIONAL HEALTH DISTRICT
BALANCE SHEET COMPARISON
Comparison of November 2017 to October 2017

	Nov 30, 17	Oct 31, 17	$ Change
ASSETS			
Current Assets			
Checking/Savings			
102.9 · Cal Trust Investment Account	8,517,636.05	4,259,953.17	4,257,682.88
102.2 · Cash in Bank - Operating	407,763.13	4,934,330.21	(4,526,567.08)
102.6 · Cash in Bank -LAIF	1,455,752.59	1,455,752.59	0.00
Total Checking/Savings	10,381,151.77	10,650,035.97	(268,884.20)
Other Current Assets			
104 · Prepaid Insurance	8,792.24	31,416.76	(22,624.52)
107 · Tax apportion receivable	605,700.68	0.00	605,700.68
Total Other Current Assets	614,492.92	31,416.76	583,076.16
Total Current Assets	10,995,644.69	10,681,452.73	314,191.96
Fixed Assets			
120.01 · ALVARADO BLDG	291,240.00	291,240.00	0.00
121 · Equipment	21,394.96	21,394.96	0.00
121.2 · Equipment Depreciation	(19,985.49)	(19,933.45)	(52.04)
122.0 · ASSETS HELD FOR RESALE			
122.02 · WELLNESS CENTER	291,240.00	291,240.00	0.00
Total 122.0 · ASSETS HELD FOR RESALE	291,240.00	291,240.00	0.00
Total Fixed Assets	583,889.47	583,941.51	(52.04)
TOTAL ASSETS	11,579,534.16	11,265,394.24	314,139.92
LIABILITIES & EQUITY			
Liabilities			
Current Liabilities			
Accounts Payable			
140 · Accounts Payable	16,423.14	25,044.03	(8,620.89)
Total Accounts Payable	16,423.14	25,044.03	(8,620.89)
Credit Cards			
150.1 · American Express 41007	1,235.86	982.51	253.35
Total Credit Cards	1,235.86	982.51	253.35
Other Current Liabilities			
204 · Accrued Vacation & Sick Leave	23,900.57	23,900.57	0.00
215 · Comm Healthcare Programs Pybl			
215.24 · District Sponsored Programs	24,020.81	24,120.13	(99.32)
Total 215 · Comm Healthcare Programs ...	24,020.81	24,120.13	(99.32)
Total Other Current Liabilities	47,921.38	48,020.70	(99.32)
Total Current Liabilities	65,580.38	74,047.24	(8,466.86)
Total Liabilities	65,580.38	74,047.24	(8,466.86)

FALLBROOK REGIONAL HEALTH DISTRICT
BALANCE SHEET COMPARISON
Comparison of November 2017 to October 2017

	Nov 30, 17	Oct 31, 17	$ Change
Equity			
300 · Unrestricted Operations Fund	1,904,473.14	1,904,473.14	0.00
302.2 · Community Investment Fund	9,837,855.82	9,837,855.82	0.00
Net Income	(228,375.18)	(550,981.96)	322,606.78
Total Equity	11,513,953.78	11,191,347.00	322,606.78
TOTAL LIABILITIES & EQUITY	11,579,534.16	11,265,394.24	314,139.92

FALLBROOK REGIONAL HEALTH DISTRICT
Income Statement
For the Month Ended November 31, 2017 & Fiscal Year to Date

	Nov 17	Jul - Nov ...
Ordinary Income/Expense		
Income		
400. · District		
402 · Property tax revenue	605,701	762,179
403 · Interest / Dividends	9,663	34,575
406 · Unearned Inc(Loss) - Cal Trust	(17,033)	(29,789)
Total 400. · District	598,331	766,966
450. · Properties		
460 · Lease Income		
460.01 · A+ Urgent Care	4,800	24,000
Total 460 · Lease Income	4,800	24,000
450.001 · Hospital Building Sale		4,500,000
450.02 · Costs of Hospital Property Sale	(3,383)	(240,334)
450.01 · Hospital Property Cost Basis		(4,427,825)
Total 450. · Properties	1,418	(144,159)
Total Income	599,749	622,807
Gross Profit	599,749	622,807
Expense		
500 · Administrative Expenses		
500.36 · Accrued Vacation & Sick Leave		(2,393)
500.10 · Salaries	17,870	89,350
500.12 · Payroll Taxes	1,512	7,470
500.14 · W/C Insurance	152	760
500.15 · Employee Health & Welfare	891	4,666
500.16 · Board Stipends	1,900	8,300
500.17 · Education & Conferences	413	5,397
500.18 · Dues & Subscriptions	5,562	13,779
500.19 · Insurance - General	1,071	16,055
500.20 · Independent Accounting Services	850	4,250
500.21 · Annual Independent Audit		8,834
500.23 · General Counsel	4,480	56,933
500.25 · Office Expense		
01 · Communications	126	1,434
02 · I.T. and Website services	253	2,074
03 · Refreshments	20	1,380
04 · Office Expenses	670	2,033
05 · Admin fees		1,009
06 · Independent Contract Services	4,082	17,141
Total 500.25 · Office Expense	5,151	25,071
500.27 · Depreciation	52	260
500.29 · Dist Promotions & Publications	3,903	23,798
500.32 · Consultant Fees	4,525	34,128
500.33 · Copier Lease	873	4,295
Total 500 · Administrative Expenses	49,205	300,952

FALLBROOK REGIONAL HEALTH DISTRICT
Income Statement
For the Month Ended November 31, 2017 & Fiscal Year to Date

	Nov 17	Jul - Nov ...
590 · Management & Maintenance		
590.02 · Gas & Electric	14	25,544
590.03 · Water	215	7,009
590.04 · Waste Management		421
590.05 · Security	4,450	9,570
590.06 · Landscape - Grounds Environment	600	7,000
590.07 · Custodial Services	330	1,530
590.08 · Elevator	182	901
590.10 · Maintenance Services & Repairs	412	2,135
590.11 · Medical Records Store & Service	2,331	11,718
590.12 · Fire Alarm System		495
Total 590 · Management & Maintenance	8,534	66,324
600 · Community Health Contracts		
600.02 · Fbk Citizens Crime Prevention	2,500	5,000
600.59 · Palomar Health Foundation		(5,000)
600.58 · Michelle's Place	6,000	12,000
600.54 · Healthy Adventures Foundation	2,250	4,500
600.53 · Jeremiah's Ranch	3,688	7,375
600.04 · Boys & Girls Club	10,000	30,000
600.07 · Fbk Senior Citizens Srvc Club	18,750	50,100
600.08 · Fallbrook Smiles Project	17,875	35,750
600.11 · Palomar Family Counseling Srvc	19,750	39,500
600.14 · Fbk Family Health Center	25,000	50,000
600.17 · Foundation for Senior Care	52,278	104,557
600.18 · Fallbrook Food Pantry	18,000	36,000
600.19 · Live Oak Park Coalition	10,000	20,000
600.33 · REINS Therapeutic Prgm	16,250	32,500
600.37 · Trauma Intervention Prgm of SD	2,250	4,500
600.46 · Mental Health Systems, Inc.	2,312	4,625
600.48 · UCSD Eye Mobile for Children	2,500	2,500
Total 600 · Community Health Contracts	209,403	433,907
800 · District Direct Care Services		
800.02 · A+ Urgent Care	10,000	50,000
Total 800 · District Direct Care Services	10,000	50,000
Total Expense	277,142	851,182
Net Ordinary Income	322,607	(228,375)
Net Income	322,607	(228,375)

FALLBROOK REGIONAL HEALTH DISTRICT
Profit & Loss Actual vs Budget
July through November 2017

	Jul - Nov ...	Budget	$ Over B...
Ordinary Income/Expense			
Income			
400. · District			
402 · Property tax revenue	762,179	129,733	632,446
403 · Interest / Dividends	34,575	25,000	9,575
406 · Unearned Inc(Loss) - Cal Trust	(29,789)	0	(29,789)
Total 400. · District	766,966	154,733	612,233
450. · Properties			
460 · Lease Income			
460.01 · A+ Urgent Care	24,000	24,000	0
Total 460 · Lease Income	24,000	24,000	0
450.001 · Hospital Building Sale	4,500,000		
450.02 · Costs of Hospital Property Sale	(240,334)		
450.01 · Hospital Property Cost Basis	(4,427,825)		
Total 450. · Properties	(144,159)	24,000	(168,159)
Total Income	622,807	178,733	444,074
Gross Profit	622,807	178,733	444,074
Expense			
500 · Administrative Expenses			
500.36 · Accrued Vacation & Sick Leave	(2,393)	0	(2,393)
500.10 · Salaries	89,350	104,446	(15,096)
500.12 · Payroll Taxes	7,470	7,682	(212)
500.14 · W/C Insurance	760	760	(0)
500.15 · Employee Health & Welfare	4,666	5,208	(543)
500.16 · Board Stipends	8,300	7,500	800
500.17 · Education & Conferences	5,397	7,292	(1,894)
500.18 · Dues & Subscriptions	13,779	14,410	(631)
500.19 · Insurance - General	16,055	16,055	0
500.20 · Independent Accounting Servi...	4,250	4,250	0
500.21 · Annual Independent Audit	8,834	8,600	234
500.23 · General Counsel	56,933	37,500	19,433
500.25 · Office Expense			
01 · Communications	1,434	1,667	(232)
02 · I.T. and Website services	2,074	2,500	(426)
03 · Refreshments	1,380	2,708	(1,329)
04 · Office Expenses	2,033	5,417	(3,383)
05 · Admin fees	1,009	0	1,009
06 · Independent Contract Services	17,141	25,000	(7,859)
Total 500.25 · Office Expense	25,071	37,292	(12,221)
500.27 · Depreciation	260	500	(240)
500.29 · Dist Promotions & Publications	23,798	9,167	14,631
500.32 · Consultant Fees	34,128	55,313	(21,185)
500.33 · Copier Lease	4,295	4,167	128
500.45 · Community Garden	0	3,000	(3,000)
Total 500 · Administrative Expenses	300,952	323,141	(22,189)

FALLBROOK REGIONAL HEALTH DISTRICT
Profit & Loss Actual vs Budget
July through November 2017

	Jul - Nov ...	Budget	$ Over B...
590 · Management & Maintenance			
590.02 · Gas & Electric	25,544	3,125	22,419
590.03 · Water	7,009	2,500	4,509
590.04 · Waste Management	421	213	208
590.05 · Security	9,570	7,088	2,482
590.06 · Landscape - Grounds Environ...	7,000	5,000	2,000
590.07 · Custodial Services	1,530	2,919	(1,389)
590.08 · Elevator	901	838	63
590.09 · Vehicle Expenses	0	125	(125)
590.10 · Maintenance Services & Repairs	2,135	1,500	635
590.11 · Medical Records Store & Servi...	11,718	17,083	(5,366)
590.12 · Fire Alarm System	495	917	(422)
590.13 · Renovations / Improvements	0	25,000	(25,000)
Total 590 · Management & Maintenance	66,324	66,308	16
600 · Community Health Contracts			
600.02 · Fbk Citizens Crime Prevention	5,000	5,000	0
600.59 · Palomar Health Foundation	(5,000)	0	(5,000)
600.58 · Michelle's Place	12,000	12,000	0
600.54 · Healthy Adventures Foundation	4,500	4,500	0
600.53 · Jeremiah's Ranch	7,375	7,375	0
600.04 · Boys & Girls Club	30,000	30,000	0
600.07 · Fbk Senior Citizens Srvc Club	50,100	50,100	0
600.08 · Fallbrook Smiles Project	35,750	35,750	0
600.11 · Palomar Family Counseling Srvc	39,500	39,500	0
600.14 · Fbk Family Health Center	50,000	50,000	0
600.17 · Foundation for Senior Care	104,557	104,557	0
600.18 · Fallbrook Food Pantry	36,000	36,000	0
600.19 · Live Oak Park Coalition	20,000	20,000	0
600.33 · REINS Therapeutic Prgm	32,500	32,500	0
600.37 · Trauma Intervention Prgm of SD	4,500	4,500	0
600.46 · Mental Health Systems, Inc.	4,625	4,625	0
600.48 · UCSD Eye Mobile for Children	2,500	2,500	0
Total 600 · Community Health Contracts	433,907	438,907	(5,000)
800 · District Direct Care Services			
800.02 · A+ Urgent Care	50,000	0	50,000
Total 800 · District Direct Care Services	50,000	0	50,000
Total Expense	851,182	828,356	22,826
Net Ordinary Income	(228,375)	(649,623)	421,248
Net Income	(228,375)	(649,623)	421,248

FALLBROOK REGIONAL HEALTH DISTRICT
Profit & Loss Budget Overview 2017 - 2018
July 2017 through June 2018

	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	TOTAL Jul '17 - Jun 18
Ordinary Income/Expense													
Income													
400. · District													
402 · Property tax revenue	15,065	29,617	9,576	25,343	50,132	600,620	297,496	63,789	458,124	214,331	14,470	21,437	1,800,000
403 · Interest / Dividends	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	60,000
Total 400. · District	20,065	34,617	14,576	30,343	55,132	605,620	302,496	68,789	463,124	219,331	19,470	26,437	1,860,000
450. · Properties													
460 · Lease Income													
460.01 · A+ Urgent Care	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	57,600
Total 460 · Lease Income	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	57,600
Total 450. · Properties	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	4,800	57,600
Total Income	24,865	39,417	19,376	35,143	59,932	610,420	307,296	73,589	467,924	224,131	24,270	31,237	1,917,600
Gross Profit	24,865	39,417	19,376	35,143	59,932	610,420	307,296	73,589	467,924	224,131	24,270	31,237	1,917,600
Expense													
500 · Administrative Expenses													
500.36 · Accrued Vacation & Sick Leave	0	0	0	0	0	0	0	0	0	0	0	20,700	20,700
500.10 · Salaries	19,408	20,665	19,928	22,222	22,222	22,222	22,222	22,222	22,222	22,222	22,222	22,222	260,000
500.12 · Payroll Taxes	1,327	1,455	1,381	1,760	1,760	1,760	1,760	1,760	1,760	1,760	1,760	1,760	20,000
500.14 · W/C Insurance	152	152	152	152	152	152	152	152	152	152	152	152	1,825
500.15 · Employee Health & Welfare	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	1,042	12,500
500.16 · Board Stipends	1,300	1,700	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	1,500	18,000
500.17 · Education & Conferences	1,458	1,458	1,458	1,458	1,458	1,458	1,458	1,458	1,458	1,458	1,458	1,458	17,500
500.18 · Dues & Subscriptions	8,471	667	0	0	5,272	110	880	0	0	100	0	0	15,500
500.19 · Insurance - General	3,746	3,746	3,746	3,746	1,071	1,071	1,071	1,071	1,071	1,071	1,071	1,071	23,550
500.20 · Independent Accounting Services	850	850	850	850	850	850	850	850	850	850	850	850	10,200
500.21 · Annual Independent Audit	0	8,600	0	0	0	0							8,600
500.23 · General Counsel	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	7,500	90,000
500.25 · Office Expense													
01 · Communications	333	333	333	333	333	333	333	333	333	333	333	333	4,000
02 · I.T. and Website services	500	500	500	500	500	500	500	500	500	500	500	500	6,000
03 · Refreshments	542	542	542	542	542	542	542	542	542	542	542	542	6,500
04 · Office Expenses	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	1,083	13,000
06 · Independent Contract Services	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	5,000	60,000
Total 500.25 · Office Expense	7,458	7,458	7,458	7,458	7,458	7,458	7,458	7,458	7,458	7,458	7,458	7,458	89,500
500.27 · Depreciation	100	100	100	100	100	100	100	100	100	100	100	100	1,200
500.29 · Dist Promotions & Publications	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	1,833	22,000
500.32 · Consultant Fees	11,063	11,063	11,063	11,063	11,063	11,063	11,063	11,063	11,063	11,063	11,063	11,063	132,750
500.33 · Copier Lease	833	833	833	833	833	833	833	833	833	833	833	833	10,000
500.45 · Community Garden	0	0	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	10,000
Total 500 · Administrative Expenses	66,542	69,123	59,845	62,517	65,114	59,952	60,722	59,842	59,842	59,942	59,842	80,542	763,825
590 · Management & Maintenance													
590.02 · Gas & Electric	625	625	625	625	625	625	625	625	625	625	625	625	7,500
590.03 · Water	500	500	500	500	500	500	500	500	500	500	500	500	6,000
590.04 · Waste Management	71	0	71	0	71	0	71	0	72	0	70	0	425
590.05 · Security	1,424	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416	1,416	17,000
590.06 · Landscape - Grounds Environment	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	1,000	12,000
590.07 · Custodial Services	587	583	583	583	583	583	583	583	583	583	583	583	7,000
590.08 · Elevator	174	166	166	166	166	166	166	166	166	166	166	166	2,000
590.09 · Vehicle Expenses	25	25	25	25	25	25	25	25	25	25	25	25	300
590.10 · Maintenance Services & Repairs	300	300	300	300	300	300	300	300	300	300	300	300	3,600
590.11 · Medical Records Store & Service	3,417	3,417	3,417	3,417	3,417	3,417	3,417	3,417	3,417	3,417	3,417	3,417	41,000
590.12 · Fire Alarm System	183	183	183	183	183	183	183	183	183	183	183	183	2,200
590.13 · Renovations / Improvements	0	0	0	12,500	12,500	12,500	12,500	0	0	0	0	0	50,000
Total 590 · Management & Maintenance	8,306	8,215	8,286	20,715	20,786	20,715	20,786	8,215	8,286	8,215	8,284	8,215	149,025

FALLBROOK REGIONAL HEALTH DISTRICT
Profit & Loss Budget Overview 2017 - 2018
July 2017 through June 2018

	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	TOTAL Jul '17 - Jun 18
600 · Community Health Contracts													
600.02 · Fbk Citizens Crime Prevention	2,500	0	0	0	2,500	0	0	2,500	0	0	2,500	0	10,000
600.58 · Michelle's Place	6,000	0	0	0	6,000	0	0	6,000	0	0	6,000	0	24,000
600.54 · Healthy Adventures Foundation	2,250	0	0	0	2,250	0	0	2,250	0	0	2,250	0	9,000
600.53 · Jeremiah's Ranch	3,688	0	0	0	3,688	0	0	3,688	0	0	3,688	0	14,750
600.04 · Boys & Girls Club	20,000	0	0	0	10,000	0	0	10,000	0	0	10,000	0	50,000
600.07 · Fbk Senior Citizens Srvc Club	31,350	0	0	0	18,750	0	0	18,750	0	0	18,750	0	87,600
600.08 · Fallbrook Smiles Project	17,875	0	0	0	17,875	0	0	17,875	0	0	17,875	0	71,500
600.11 · Palomar Family Counseling Srvc	19,750	0	0	0	19,750	0	0	19,750	0	0	19,750	0	79,000
600.14 · Fbk Family Health Center	25,000	0	0	0	25,000	0	0	25,000	0	0	25,000	0	100,000
600.17 · Foundation for Senior Care	52,279	0	0	0	52,278	0	0	52,278	0	0	52,278	0	209,113
600.18 · Fallbrook Food Pantry	18,000	0	0	0	18,000	0	0	18,000	0	0	18,000	0	72,000
600.19 · Live Oak Park Coalition	10,000	0	0	0	10,000	0	0	10,000	0	0	10,000	0	40,000
600.33 · REINS Therapeutic Prgm	16,250	0	0	0	16,250	0	0	16,250	0	0	16,250	0	65,000
600.37 · Trauma Intervention Prgm of SD	2,250	0	0	0	2,250	0	0	2,250	0	0	2,250	0	9,000
600.46 · Mental Health Systems, Inc.	2,312	0	0	0	2,312	0	0	2,312	0	0	2,312	0	9,249
600.48 · UCSD Eye Mobile for Children	0	0	0	0	2,500	0	0	3,000	0	0	3,000	0	8,500
Total 600 · Community Health Contracts	229,504	0	0	0	209,403	0	0	209,903	0	0	209,903	0	858,712
Total Expense	304,352	77,338	68,131	83,232	295,303	80,667	81,508	277,960	68,128	68,157	278,029	88,757	1,771,562
Net Ordinary Income	(279,488)	(37,921)	(48,755)	(48,089)	(235,370)	529,753	225,788	(204,371)	399,796	155,974	(253,759)	(57,520)	146,038
Net Income	**(279,488)**	**(37,921)**	**(48,755)**	**(48,089)**	**(235,370)**	**529,753**	**225,788**	**(204,371)**	**399,796**	**155,974**	**(253,759)**	**(57,520)**	**146,038**

Local Agency Investment Fund
P.O. Box 942809
Sacramento, CA 94209-0001
(916) 653-3001

www.treasurer.ca.gov/pmia-laif/laif.asp
December 14, 2017

FALLBROOK HEALTHCARE DISTRICT

ADMINISTRATOR
P.O. BOX 2587
FALLBROOK, CA 92088

PMIA Average Monthly Yields

Account Number:

Tran Type Definitions

November 2017 Statement

Account Summary

Total Deposit:	0.00	Beginning Balance:	1,455,752.59
Total Withdrawal:	0.00	Ending Balance:	1,455,752.59

CalTRUST
c/o Gemini Fund Services LLC
PO Box 541150
Omaha, NE 68154-9150
www.caltrust.org
Email: CalTRUSTSupport@thegeminicompanies.com
Fax: 402-963-9094
Phone: 833-CALTRUST (225-8787)

Investment Account Summary

11/01/2017 through 11/30/2017

SUMMARY OF INVESTMENTS

Fund	Account Number	Total Shares Owned	Net Asset Value per Share on Nov 30 ($)	Value on Nov 30 ($)	Average Cost Amount ($)	Cumulative Unrealized Gain/(Loss) ($)
FALLBROOK REGIONAL HEALTH DISTRICT						
CalTRUST Medium Term Fund	[illegible]	852,616.221	9.99	8,517,636.05	8,552,485.14	(34,849.09)
	Portfolios Total value as of 11/30/2017			**8,517,636.05**		

DETAIL OF TRANSACTION ACTIVITY

Activity Description	Activity Date	Amount ($)	Amount in Shares	Balance in Shares	Price per Share ($)	Balance ($)	Average Cost Amt ($)	Realized Gain/(Loss) ($)
CalTRUST Medium Term Fund			**FALLBROOK REGIONAL HEALTH DISTRICT**			**Account Number:**		
Beginning Balance	11/01/2017			425,569.747	10.01	4,259,953.17		
Purchase	11/02/2017	4,265,052.50	426,079.171	851,648.918	10.01	8,525,005.67	0.00	0.00
Accrual Income Div Reinvestment	11/30/2017	9,663.36	967.303	852,616.221	9.99	8,517,636.05	0.00	0.00
Closing Balance as of	**Nov 30**			**852,616.221**	**9.99**	**8,517,636.05**		

Please note that this information should not be construed as tax advice and it is recommended that you consult with a tax professional regarding your account.

FALLBROOK REGIONAL HEALTH DISTRICT
Property Tax Revenue - Fiscal Year to Date
July 2017 through June 2018

Type	Date	Name	Amount	Balance
400. · District				
402 · Property tax revenue				
General Jou...	07/31/17	County of SD-pro...	29,432.21	29,432.21
General Jou...	08/31/17	County of SD-pro...	14,327.35	43,759.56
General Jou...	09/30/17	County of SD-pro...	22,989.72	66,749.28
General Jou...	10/31/17	County of SD-pro...	89,729.00	156,478.28
General Jou...	11/30/17	County of SD-pro...	605,700.68	762,178.96
Total 402 · Property tax revenue			762,178.96	762,178.96
Total 400. · District			762,178.96	762,178.96
TOTAL			**762,178.96**	**762,178.96**

FALLBROOK REGIONAL HEALTH DISTRICT
Check Detail Report - November 2017

Type	Date	Num	Name	Memo	Amount
102.2 · Cash in Bank - Operating					
Check	11/01/17	9393	A+ Urgent Care, Inc.	November 2017 subsidy payment	-10,000.00
Bill P...	11/01/17	9394	L & M Enterprises, Inc.	October bookkeeping services	-3,100.00
Bill P...	11/01/17	9395	Palomar Mountain Premiu...	45919	-513.92
Bill P...	11/01/17	9396	SDG&E FHD - 6994	40605976994	-1,574.57
Bill P...	11/01/17	9397	Village News	1641	-259.00
Check	11/06/17	9398	William Leach	Mileage reimbursements: ACHD, ...	-413.40
Bill P...	11/06/17	9399	Citrus Plaza Self Storage	Storage Unit #322 rental fee 11/1-1...	-203.00
Bill P...	11/06/17	9400	FPUD - Hospital 1 007720...	007720	-205.25
Bill P...	11/06/17	9401	Galvanized strategies form...	Retainer - Community engagement...	-4,000.00
Bill P...	11/06/17	9402	Glennie's Office Products, ...	Inv. 1721733-0 and 1722865-0	-180.80
Bill P...	11/06/17	9403	Iron Mountain SX-302	SX302/Fallbrook Hosp.	-970.46
Bill P...	11/06/17	9404	Jim's Sign Shop	Banner for Community Garden 48" ...	-301.70
Bill P...	11/06/17	9405	Laboratory Corp of Americ...	Annual Prostate Screening; Acct. 0...	-1,078.00
Bill P...	11/06/17	9406	SDG&E- Hospital - 8171 / ...	Billing period ending 10/19/17 - Ac...	-1,965.69
Check	11/08/17	9407	Boys & Girls Club - Triple ...	CHC NO. 298 - TRIPLE PLAY - P...	-10,000.00
Check	11/08/17	9408	Fallbrook Family Health C...	CHC NO. 300 - HEALTH PROMO...	-25,000.00
Check	11/08/17	9409	Fallbrook Food Pantry	CHC NO. 301 - NUTRITIOUS FOO...	-18,000.00
Check	11/08/17	9410	Fallbrook Senior Citizens ...	CHC NO. 303 - SENIOR NUTRITI...	-18,750.00
Check	11/08/17	9411	Fallbrook Smiles Project	CHC NO. 304 - CELEBRATE HEA...	-17,875.00
Check	11/08/17	9412	Foundation for Senior Care	CHC NO. 308 - RESPITE SUPPO...	-7,395.75
Check	11/08/17	9413	Foundation for Senior Care	CHC NO. 306 - CARE VAN/EXPA...	-17,193.25
Check	11/08/17	9414	Foundation for Senior Care	CHC NO. 307 - DOOR THRU DO...	-12,729.50
Check	11/08/17	9415	Foundation for Senior Care	CHC NO. 305 - CARE ADVOCATE...	-14,959.50
Check	11/08/17	9416	Healthy Adventures Found...	CHC NO. 309 - COMMUNITY CEN...	-2,250.00
Check	11/08/17	9417	Jeremiah's Ranch	CHC NO. 310 - JEREMIAH'S RAN...	-3,687.50
Check	11/08/17	9418	Live Oak Park Coalition	CHC NO. 311- HEALTH IMPROVE...	-10,000.00
Check	11/08/17	9419	Mental Health Systems-NI...	CHC NO. 312 - FALLBROOK YOU...	-2,312.25
Check	11/08/17	9420	Michelle's Place	CHC NO. 313 - BREAST HEALTH ...	-6,000.00
Check	11/08/17	9421	Palomar Family Counselin...	CHC NO. 314 - HEALTHY BODIE...	-19,750.00
Check	11/08/17	9422	Reins	CHC NO. 315 - BEHAVIORAL HE...	-16,250.00
Check	11/08/17	9423	Trauma Intervention Progr...	CHC NO. 316 - TRAUMA INTERV...	-2,250.00
Check	11/08/17	9424	UCSD Eyemobile for Child...	CHC 317 - UCSD EYEMOBILE FO...	-2,500.00
Bill P...	11/08/17	9425	American Express - Credit ...	0-41007	-1,769.54
Bill P...	11/08/17	9426	AT&T U-Verse - computer	146524365	-70.00
Bill P...	11/08/17	9427	Iron Mountain-153	Inv. PHZ6766	-1,181.29
Bill P...	11/08/17	9428	Jim's Sign Shop	Removal of old graphics and new l...	-300.00
Bill P...	11/08/17	9429	Purchase Power (Pitney B...	8000909009769550	-244.79
Bill P...	11/08/17	9430	Termin-8 Pest Control	Inv. 110769 and 110770	-250.00
Bill P...	11/08/17	9431	TJ Technologies	Est. 5859; balance of Aiphone inter...	-3,658.82
Check	11/08/17	9432	Fallbrook Citizens - FCCPC	CHC NO. 299 - GANAS MENTORI...	-2,500.00
Check	11/15/17	9230	UCSD Eyemobile for Child...	VOID: CHC NO. 317 - UCSD EYE...	0.00
Bill P...	11/15/17	9433	Apple One Staffing	00102494-0000	-1,558.23
Bill P...	11/15/17	9434	Aztec Cleaning & Maintena...	Office cleaning - Inv. 033711	-150.00
Bill P...	11/15/17	9435	Fallbrook Rooter & Drain S...	A+ Urgent Care leak repair	-161.74
Bill P...	11/15/17	9436	Jim's Sign Shop	3' x 12' banner for Christmas parad...	-263.99
Bill P...	11/15/17	9437	Palomar Mountain Premiu...	45919	-725.41
Bill P...	11/15/17	9438	Ramirez Landscaping & Tr...	Landscape maintenance October 2...	-1,600.00
Bill P...	11/15/17	9439	Scott & Jackson Esq.	Professional services 2017 October	-6,624.00
Bill P...	11/15/17	9440	Sun Realty	Property strategies/facilities meetin...	-525.00
Bill P...	11/17/17	9441	Ascent Elevator Services, I...	Elevator Service - Inv. 29479	-182.00
Bill P...	11/17/17	9442	Jim's Sign Shop		-399.76
Bill P...	11/17/17	9443	Kathleen Bogle		-1,450.00
Bill P...	11/17/17	9444	Streamline	Website monthly fee November 20...	-200.00
Check	11/22/17	9445	Pamela Knox	Reimburse - Medicare	-110.00
Bill P...	11/22/17	9446	CalPERS	1559595490	-781.02

Type	Date	Num	Name	Memo	Amount
Bill P...	11/22/17	9447	CSDA-State	1589	-5,587.00
Bill P...	11/22/17	9448	TJ Technologies	Est. 5865; Aiphone sub master, la...	-791.50
Bill P...	11/22/17	9449	Touchbase	344664	-56.38
Bill P...	11/22/17	9450	Aztec Cleaning & Maintena...	Office cleaning - Inv. 033714	-180.00
Bill P...	11/27/17	9451	Apple One Staffing	00102494-0000	-352.80
Bill P...	11/27/17	9452	Citrus Plaza Self Storage	Storage Unit #322 rental fee 11/1-1...	-203.00
Bill P...	11/27/17	9453	Fitness Moves	2 workshops on meditation 12/5 an...	-200.00
Bill P...	11/27/17	9454	FPUD - FHD 2 007720-001	007720-001	-130.95
Bill P...	11/27/17	9455	FPUD - Hospital 1 007720...	007720	-690.42
Bill P...	11/27/17	9456	Konica Minolta Leasing - qds	061-0116888-000	-878.78
Bill P...	11/27/17	9457	SDG&E- Hospital - 8171 / ...	Billing period ending 11/19/17 - Ac...	-13.95
Bill P...	11/27/17	9458	Village News	1641	-975.00
Total 102.2 · Cash in Bank - Operating					-266,433.91
TOTAL					-266,433.91

Fallbrook Regional HEALTH DISTRICT

FINANCE COMMITTEE

Wednesday, December 6, 2017 at 5:00 P.M.
Board Conference Room, 138 S. Brandon Rd., Fallbrook CA 92028

MINUTES

Committee Members Present: Directors Mroz, Leach, Salmon
Others Present: Executive Director Bobbi Palmer; Bookkeeper Wendy Lyon and Accountant Kathy Bogle.

1. Call to Order/Roll Call
   The meeting was called to order at 5:15 p.m. by Chair Barbara Mroz

2. Public Comments
   None

3. RFPs for Urgent Care Services

   a. Interview(s) based on proposals received on November 30, 2017.
   Director Salmon reported that representatives from the companies responding to the RFP for Urgent Care Services had been interviewed and the information will be shared with the entire board at an upcoming workshop and considered for action at a future board meeting.

4. Review of Financial Statements for October 2017

   1) Balance Sheet Comparison of October – September

   2) Income Statement for October 2017 and fiscal year to date

   3) Profit & Loss Actual vs Budget – October

   4) Profit & Loss Budget Overview July 2016 – June 2017
   The above financial statements were reviewed and discussed. The balance sheet still reflected more than $4 million from the sale of the old hospital building as the transfer of the funds to the Cal-Trust account took place two days after the close of the month. Legal costs continued to be higher than normal due to the sale of the old hospital building.

   5) LAIF Report
   The balance in the LAIF account was $1,451,823

   6) CalTrust
   The balance is the Cal-Trust account was $4,259,953.

7) Property Tax Revenue – fiscal year to date
The balance was $156,478, with additional funding anticipated in January.

8) Check Detail as of October 2017
This report is provided as information to the committee.

9) Adjournment
There being no further business, the meeting was adjourned at 5:29 p.m.

_____
Barbara Mroz, Chairperson

REGULAR BOARD MEETING
Wednesday, December 13, 2017, 6:00 p.m.
Fallbrook Public Utilities District, 990 E. Mission Rd., Fallbrook

MINUTES

A. CALL MEETING TO ORDER – PLEDGE OF ALLEGIANCE

President Gordon Tinker called the meeting to order at 6:01 p.m. and led the Pledge of Allegiance.

Present: Stephen Abbott, William Leach, Barbara Mroz, Howard Salmon and Gordon Tinker.
Also present: Executive Director Bobbi Palmer and Legal Counsel Blaise Jackson.

A1. Annual Organizational Meeting: Election of Officers of the Board
Legal Counsel Blaise Jackson said the election of new officers typically is scheduled for the regular meeting of the board in December. He said officers include the following: President, Vice-President, Secretary and Treasurer. He then called for nominations for the office of President.
Action: It was moved by Director Salmon, seconded by Director Abbott to nominate Gordon Tinker for President for the ensuing year. There were no other nominations.
Roll call vote:
Director Leach: Aye
Director Salmon: Aye
Director Abbott: Aye
Director Mroz: Aye
Director Tinker: Aye
Motion carried. 5-0.

Action: It was moved by Director Tinker, seconded by Director Salmon that all other officers of the board continue in their current role for the ensuing year. These include the following: Vice President - Howard Salmon; Secretary - Stephen Abbott and Treasurer - Barbara Mroz.
Roll Call Vote:
Director Leach: Aye
Director Salmon: Aye
Director Abbott: Aye
Director Mroz: Aye
Director Tinker: Aye

A2. Commencement of Regular Monthly Meeting – Newly Elected President

B. ADDITIONS TO AGENDA

None

C. BOARD MEMBER AND PUBLIC COMMENTS

None

D. CONSENT ITEMS

D1. Approval of October 2017 Financial Statements
D2. Minutes of November 1, 2017 Finance Committee Meeting
D3. Minutes of November 8, 2017 Regular Board Meeting
President Tinker asked if any member of the board wanted to pull any Consent Item for further discussion. There was no further discussion.
Action: Director Abbott moved and Barbara Mroz seconded to approve the Consent Items as presented.
Motion carried. 5-0

E. REPORTS

E1. Finance Committee – Committee of the Whole, Chair: Director Mroz
Chairperson Barbara Mroz provided the report for the December 6th Finance Committee meeting. She said the financial statements were reviewed and discussed. All variances were accounted for. The balance in the LAIF account was $1,451,823 and the balance is the Cal-Trust account was $4,259,953. Property tax revenue to date for the fiscal year was $156,478, with additional funding anticipated in January.

E2. Gov't/Public Relation/Community Relations Committee – Directors Salmon and Tinker
No Report

E3. Facilities/Strategic Planning Committee – Directors Abbott and Salmon
This report will be confined to Closed Session.

E4. Executive Director – Bobbi Palmer
Executive Director Bobbi Palmer reported that the California Special Districts Association's magazine publishing in January 2018 will include information about Fallbrook Regional Health District regarding our community outreach efforts. FRHD again participated in the Fallbrook Christmas Parade. She said the District will be establishing a Wellness Committee in 2018.

E5. General Counsel – Blaise Jackson
Legal Counsel reported that his comments would be confined to Closed Session and Discussion/Action Items

F. DISCUSSION/ACTION ITEMS

F1. Retention Items – Authorization to Destroy Outdated Records (Gov. Code 34090, Per Board Resolution 393)
Legal Counsel said a list of old records was sent to the Board for authorization to destroy outdated records that are not permanent. He said he reviewed the list and with the exception of the Lease Agreement with CHS to operate the hospital, which is historical, and the Accounts Payable records to be destroyed only up to 2011, he recommended approval of the destruction of outdated records.
Action: It was moved by Director Abbott, seconded by Director Leach to authorize the destruction of outdated records.
Motion carried. 5-0

F2. CHS – Requested Acknowledgement and Release of Unnecessary Repairs
Legal Counsel explained that CHS had requested the District's signature on a document verifying that the former OSHPD recommendation that was part of the settlement agreement between CHS and Fallbrook Healthcare District, for repairs to the roof of the old hospital building was no longer necessary. Crestwood

Behavioral Health agreed as does Fallbrook Regional Health District (formerly Fallbrook Healthcare District).
Action: It was moved by Director Salmon, seconded by Director Abbott, to empower the Executive Director to sign the Acknowledgement and Release of Unnecessary Repairs as requested by CHS.
Motion carried. 5-0

F3. Urgent Care Services Proposals Received
President Tinker said he, Director Salmon and Bobbi Palmer had interviewed all three responders to the RFP for Urgent Care Services. He asked Director Salmon to provide a report.
Director Salmon said proposals had been received from A+ Urgent Care, CHS, Inc. CA and Dr. Timothy Coen. Director Salmon said representatives from all three were asked specific questions. Criteria included that they demonstrate a record of success providing medical/urgent care services to the community; the qualifications and experience of staff; and the entity's willingness to commit to providing service on an indefinite time basis beyond the defined period of temporary support by the District. Discussion ensued. It was noted that A+ Urgent Care has the most support services, e.g. x-ray and a physician on-call at all times, of the three entities submitting proposals. Based on the submissions and the interviews, the recommendation to the full board is to continue with A+ Urgent Care, whose contract terminates in March of 2018. During the interview process, Dr. Kimes (owner of A+ Urgent Care) was asked to provide specific information regarding exactly what services would be supported by a subsidy from the District. Further discussion ensued.
Action: It was moved by Director Salmon, seconded by Director Leach to table this agenda item to the January board meeting for possible action at that time with the caveat that A+ Urgent Care provides the requested information a week to 10 days prior to the meeting.
Motion carried. 5-0

G. ITEMS FOR SUBSEQUENT MEETINGS

G1. Other Director/Staff discussion items
G1a. Item(s) for future board agendas
G1b. Announcements of upcoming events
- NCCCHI meeting – 1st Wednesday, January 3, 2018, 2:00-3:00pm
- Finance Committee meeting – 1st Wednesday, January 3, 2018, 5:00pm, Fallbrook Regional Health District Board Room, 138 S. Brandon Rd.
- Woman of Wellness – Thursday, January 4, 2018, 6pm – Fallbrook Library
- Community Collaborative for Health & Wellness Committee (CCH&W) meeting Monday, January 15, 2018, 9:00-10:30am, Fallbrook Public Utility District Board Room

G2. Next Regular Board meeting – Wednesday, January 10, 2018, Fallbrook Public Utility District Board Room

H. CLOSED SESSION

H1. Personnel Matters Pursuant to Government Code Section 54957 – Evaluation of Executive Director

The Board adjourned to Closed Session at 6:34 p.m.

I. RETURN TO OPEN SESSION

The Board returned to Open Session at 6:50 p.m. having completed the appraisal process.

J. ADJOURNMENT

There being no further business, the meeting was adjourned at 6:51 p.m.

_____
Gordon Tinker, President

_____
Stephen Abbott, Secretary

Fallbrook Regional HEALTH DISTRICT

SPECIAL BOARD MEETING

Tuesday, December 19, 2017, 3:00 p.m.
Fallbrook Regional Health District, Board Room, 138 S. Brandon Rd., Fallbrook

MINUTES

A. CALL MEETING TO ORDER / ROLL CALL / PLEDGE OF ALLEGIANCE

The meeting was called to order by President Gordon Tinker at 3:07 p.m.

Present: Directors Gordon Tinker, Howard Salmon, Barbara Mroz and Bill Leach.
Absent: Director Stephen Abbott.
Also present: Executive Director Bobbi Palmer; Legal Counsel Blaise Jackson, who joined the meeting via conference call and District Negotiator Roy Moosa.

B. BOARD MEMBER AND PUBLIC COMMENTS

None

C. CLOSED SESSION

C1. Conference with Real Estate Negotiator Concerning Real Property Purchase Negotiations per Govt. Code 54956.8
District Negotiator: Roy Moosa of Sun Realty
APN # 105-092-22-01, 1636 E. Mission Rd.

D. RETURN TO OPEN SESSION

The meeting returned to Open Session at 3:46 p.m. and the District Negotiator was directed to take appropriate action regarding the real property.

E. ADJOURNMENT

There being no further business, the meeting was adjourned at 3:47 p.m.

_____
Gordon Tinker, President

_____
Howard Salmon, Vice-President

REPORTS

REPORTS

Executive Director – Bobbi Palmer

Fallbrook Regional HEALTH DISTRICT

To: Board of Directors
Fallbrook Regional Health District
From: Bobbi Palmer, MBA, MSW
Executive Director
Re: Monthly Report
Date: January 5, 2018

Community Health

1. Women of Wellness Featured Presentation: "Meditation Techniques for Relaxation and Rejuvenation" by Sandra Buckingham
2. Influenza Watch for San Diego County and data trend with implications for Urgent Care Services. See attached documents

Community Engagement

- Community Engagement and Sample of Community Action Plan for "Exercise is Medicine" concept in partnership with American Fitness Index ACSM, See attached documents.

Legislative Reports

1. This Week in Sacramento: Worth Noting: Legislature Expected to Focus on Sexual Harassment in Capitol Culture. Consequently, mandatory training AB 1825 required for all elected officials.
2. California Special Districts Association (CSDA); LAFCOs administer and approve the formation, dissolution, and boundaries of local agencies, including cities and special districts. See Document attached.

Woman Of Wellness
WOW

Thursday, January 4, 2018
Fallbrook Library
124 S. Mission Rd.
6:00 p.m. – Social & Refreshments

Sponsored by

Fallbrook Regional
HEALTH DISTRICT

Featured Presentation:

"Meditation Techniques for Relaxation and Rejuvenation"

Learn simple techniques that can help bring about a sense of calm and focus, lift your spirits and relax your mind and body.

Presenter:

Sandra Buckingham, E-RYT200, RYT500, YACEP
Experienced Registered Yoga Teacher, Yoga Alliance

Free Event including Refreshments • Door Prizes

Please Note: No need for Reservations at this time
Please plan to attend and bring a friend!

Questions? Contact Pam Knox at pknox@fallbrookhealth.org
Or call 760-731-9187

Please bring non-perishable food items for Fallbrook Food Pantry

County of San Diego

January 3, 2017
Volume 17, Issue 13

INFLUENZA WATCH

Week 52
Ending 12/30/2017

The purpose of the weekly ***Influenza Watch*** is to summarize current influenza surveillance in San Diego County. ***Please note that reported weekly data are preliminary and may change due to delayed submissions and additional laboratory results.***

Report Contents

Current Week

Current Week 52 (ending 12/30/2017)

- 3,334 new influenza detections reported: *Elevated level*
- 13% influenza-like-illness (ILI) among emergency department visits: *Elevated level*
- 33 new influenza-related deaths reported this week
- 61 new ICU cases reported this week
- 8% of deaths registered with pneumonia and/or influenza: *Expected level*

Current Season Summary

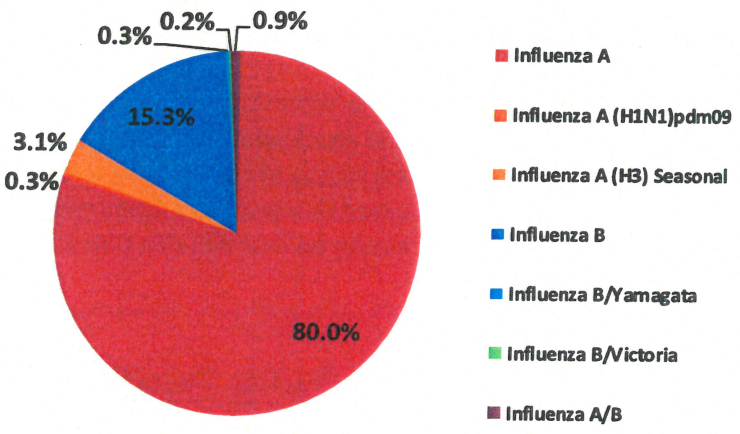
7,314 Total Cases

98 ICU Cases

44 Deaths

55 Outbreaks*

Virus Characteristics



* At least one case of laboratory-confirmed influenza in a setting experiencing ≥2 cases of influenza like illness (ILI) within a 72-hour period.

Table 1. Influenza Surveillance Indicators

Indicator	FY 2017-18*			FY 2016-17		Prior 3-Year Average**	
	Week 52	Week 51	FYTD#	Week 52	FYTD#	Week 52	FYTD#
All influenza detections reported (rapid or PCR)	3,334	2,338	7,314	284	883	182	588
Percent of emergency department visits for ILI	13%	9%		4%		5%	
Percent of deaths registered with pneumonia and/or influenza	8%	6%		7%		6%	
Number of influenza-related deaths reported^	33	6	44	1	5	1	3

FYTD=Fiscal Year To Date (FY is July 1- June 30, Weeks 27-26). Total deaths reported in prior years: 87 in 2016-17, 68 in 2015-16, and 97 in 2014-15.
* Previous weeks case counts or percentages may change due to delayed processing or reporting.
** Includes FYs 2014-15, 2015-16, and 2016-17.
^ Current FY deaths are shown by week of report; by week of death for prior FYs.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY PUBLIC HEALTH SERVICES

Epidemiology and Immunization Services Branch
(619) 692-8499 EpiDiv.HHSA@sdcounty.ca.gov

LIVE WELL SAN DIEGO

San Diego Influenza Cases Spike

A record number of influenza reports were received last week in San Diego, reflecting better testing and surveillance systems in the region and an influenza season that is more severe than in recent years. The County of San Diego Health and Human Services Agency is closely monitoring the impact of influenza on local healthcare capacity and utilization. Local healthcare systems are currently effectively managing the increased workload.

Three important actions to reduce the local impact of influenza are:

- Vaccinate everyone over six months of age who has not yet received the annual influenza shot. It's not too late to be vaccinated!
- Practice everyday preventive steps to stop the spread of influenza. Avoid close contact with anyone who is ill and remain at home when sick for at least 24 hours after fever is gone. See everyday preventive actions and non-pharmaceutical interventions for more information about actions individuals and communities can take to stop the spread of influenza.
- Use antiviral medications for influenza using the Centers for Disease Control and Prevention guidelines. Patients should check with local pharmacies about the availability of influenza antiviral medications. Although the supply of these medications are adequate overall, individual pharmacies may not have supply due to increased demand. Providers who have supply issues should inform the County Epidemiology Program during normal working hours at 619-692-8499.

Table 2. Influenza Detections Reported, FY 2017-18*

Positive Test Type/Subtype	Week 52	Total FY-To-Date
Influenza A†	2,810	5,852
Influenza A(H1N1) Pandemic 2009	7	21
Influenza A (H3) Seasonal	13	227
Influenza B†	481	1,120
Influenza B/Victoria	0	12
Influenza B/Yamagata	0	19
Influenza A/B†	23	63
Total	3,334	7,314

* FY is July 1- June 30.

† No further characterization performed, or results were not yet available at time of publication.

Note: Totals may change due to further laboratory findings.

Figure 1. Percent of Emergency Department Visits for Influenza-like Illness by Week and FY

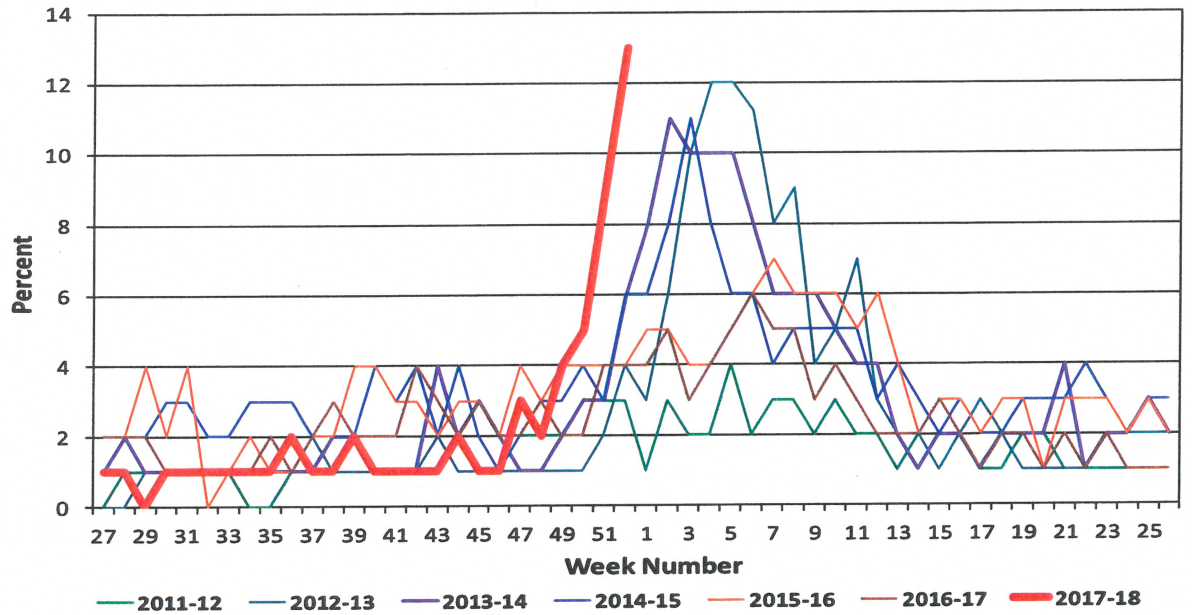


Figure 2. San Diego County Influenza Detections by Type and Week of Report, 2017-18 FYTD (N=7,314)

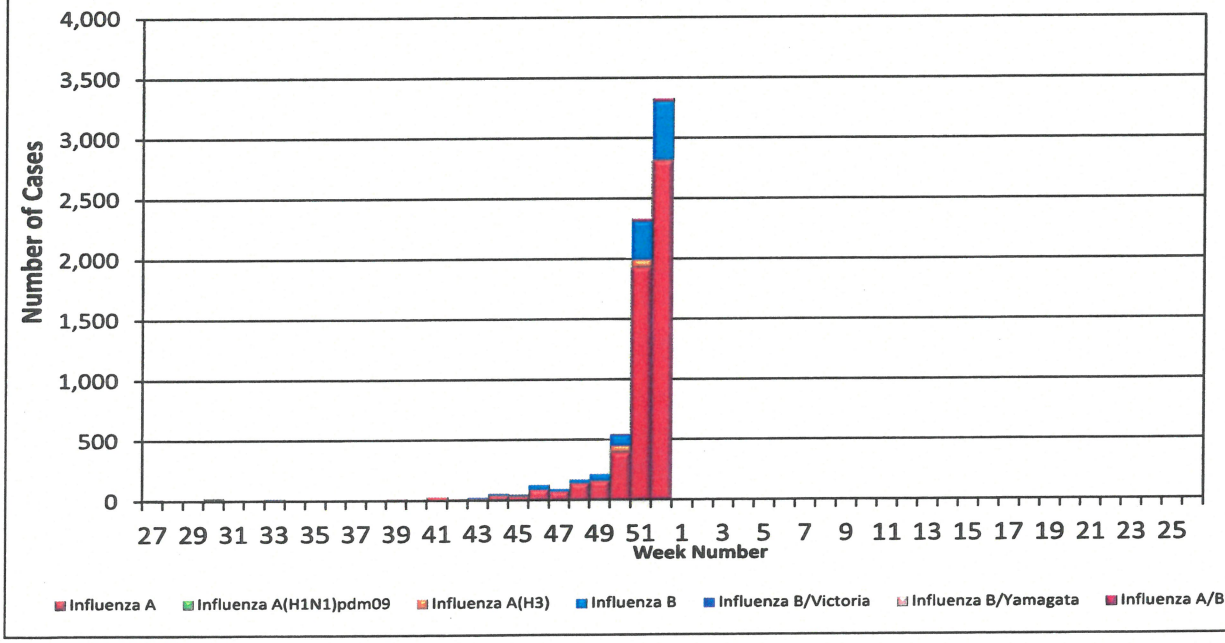


Figure 3. Percent of Reported Influenza Cases by Age Group and Season, 2011-12 to 2017-18 FYTD

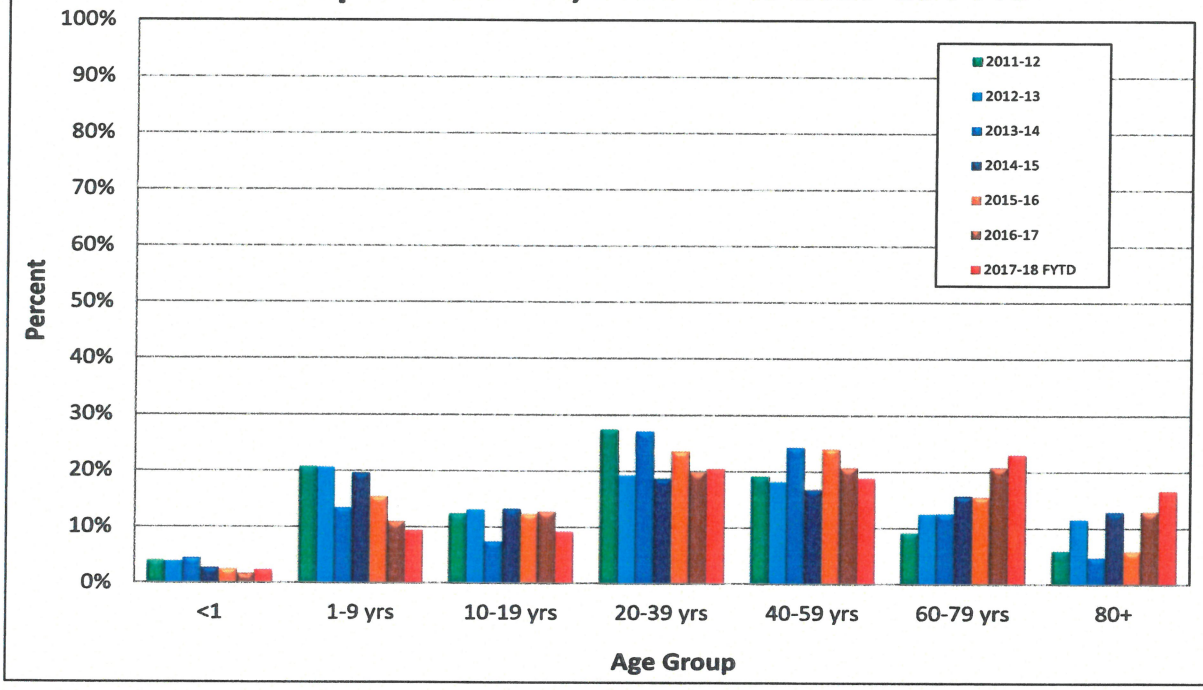


Figure 4. Cumulative Influenza Case Reports by Episode Week & Season

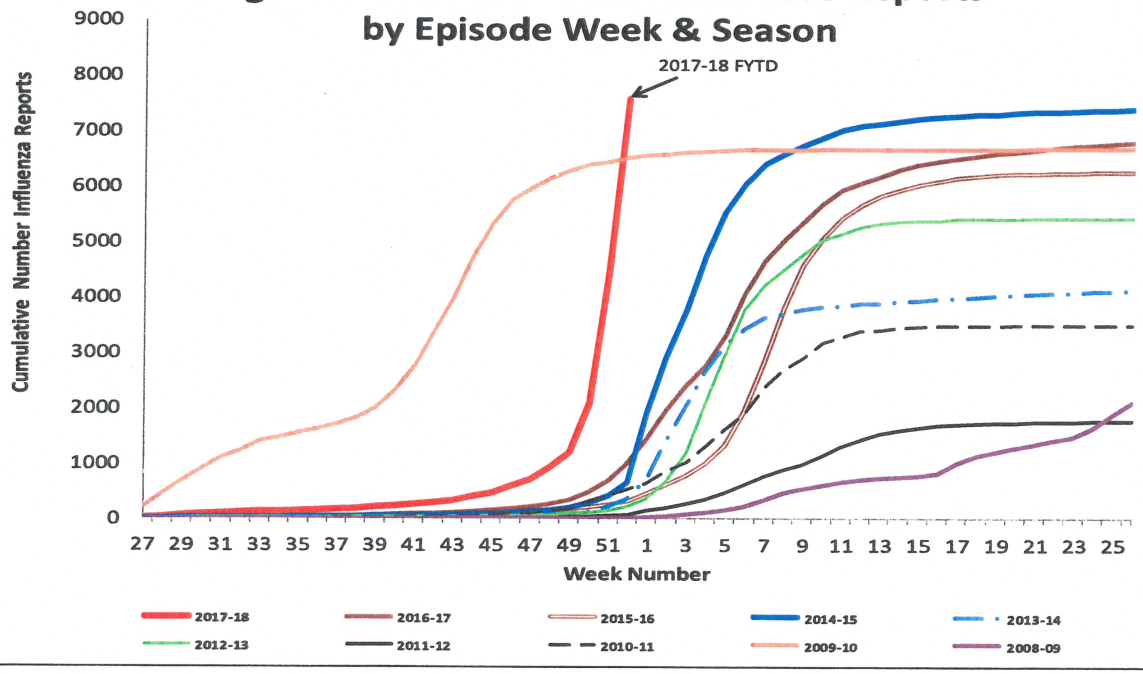


Figure 5. Percent of San Diego County Emergency Department Visits for Influenza-like Illness by Week and FY Compared to 5-Year Baseline & Upper 95% Threshold Values (Serfling Method)

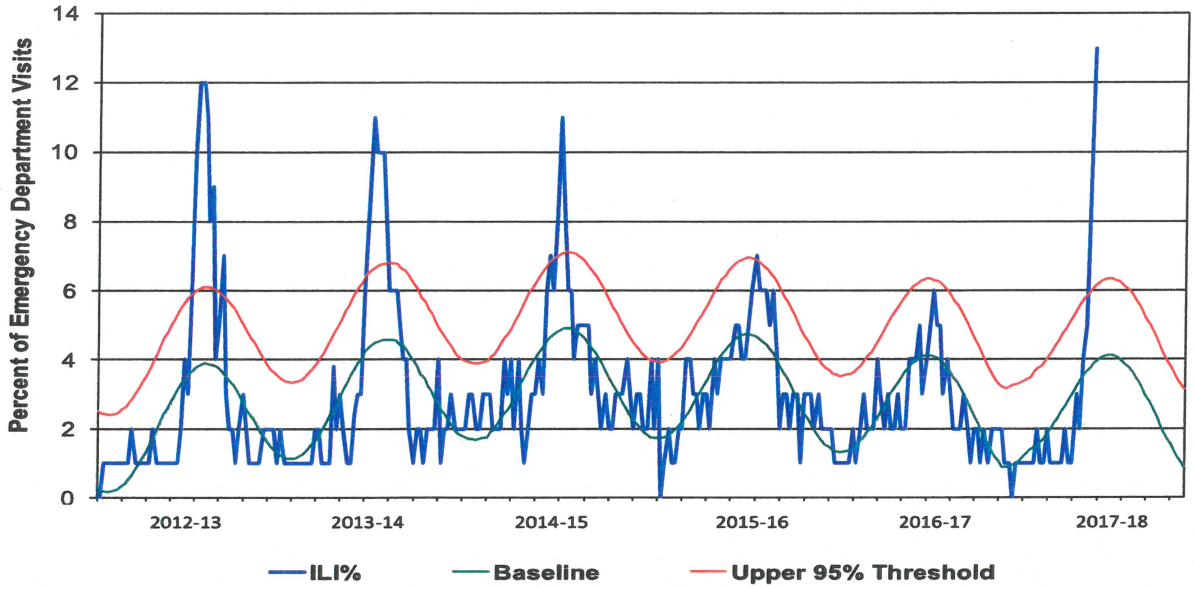


Figure 6. Percent of San Diego County Deaths Registered with Pneumonia and/or Influenza by Week and FY Compared to Prior 5-Year Baseline & Upper 95% Threshold Values (Serfling Method)

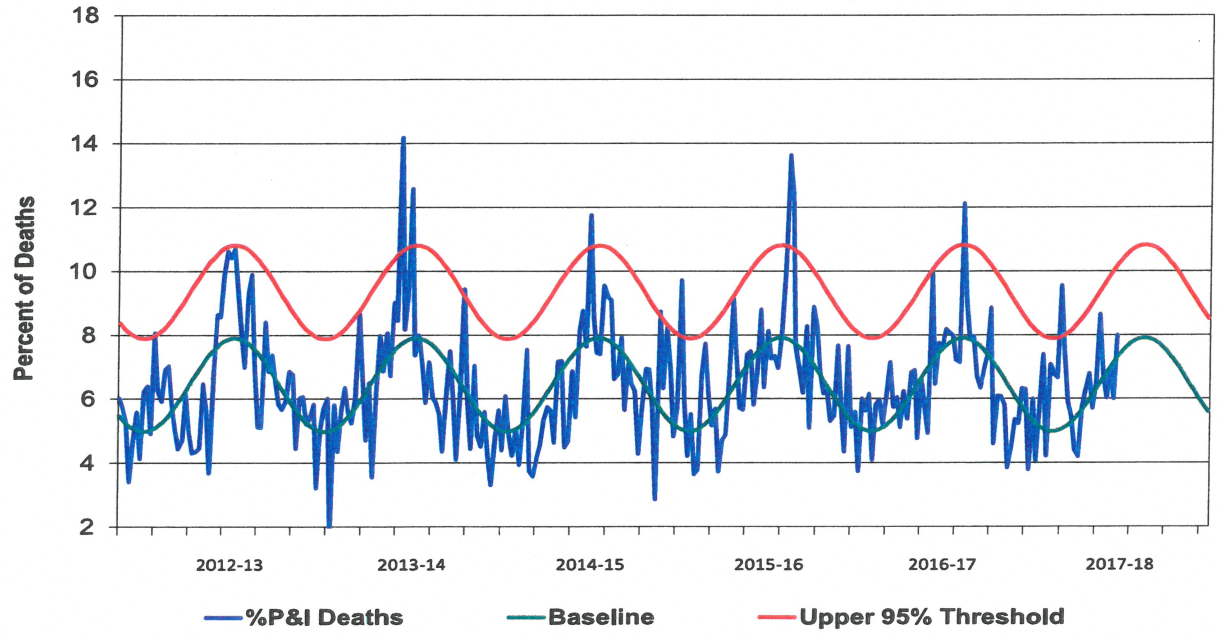


Figure 7. Influenza Deaths by Type and Season

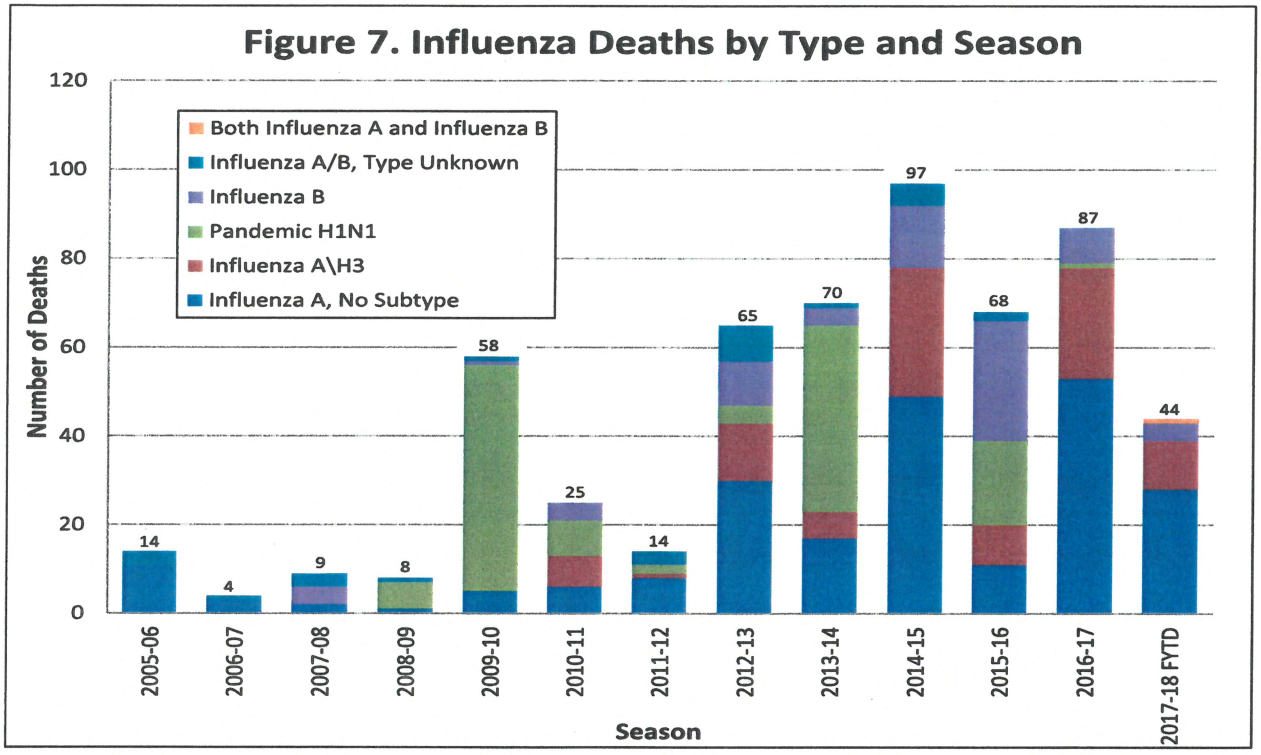


Figure 8. Influenza Deaths by Age and Season

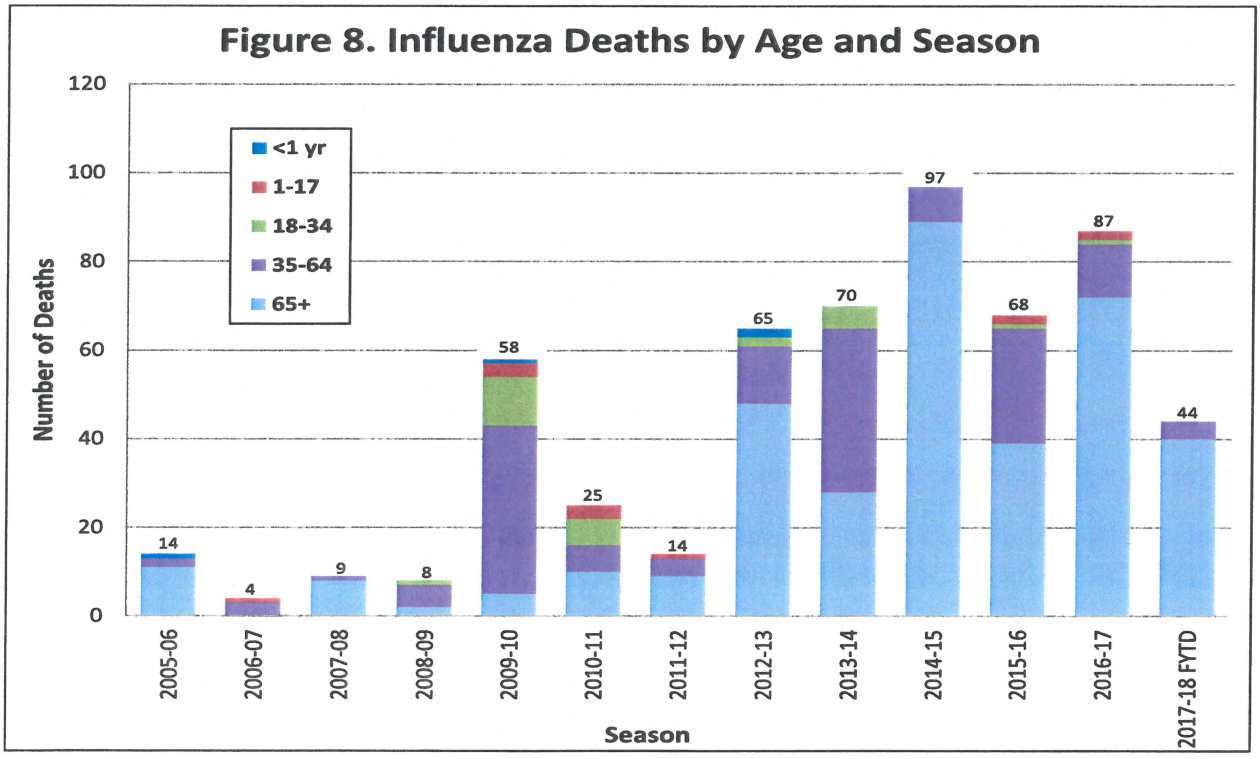
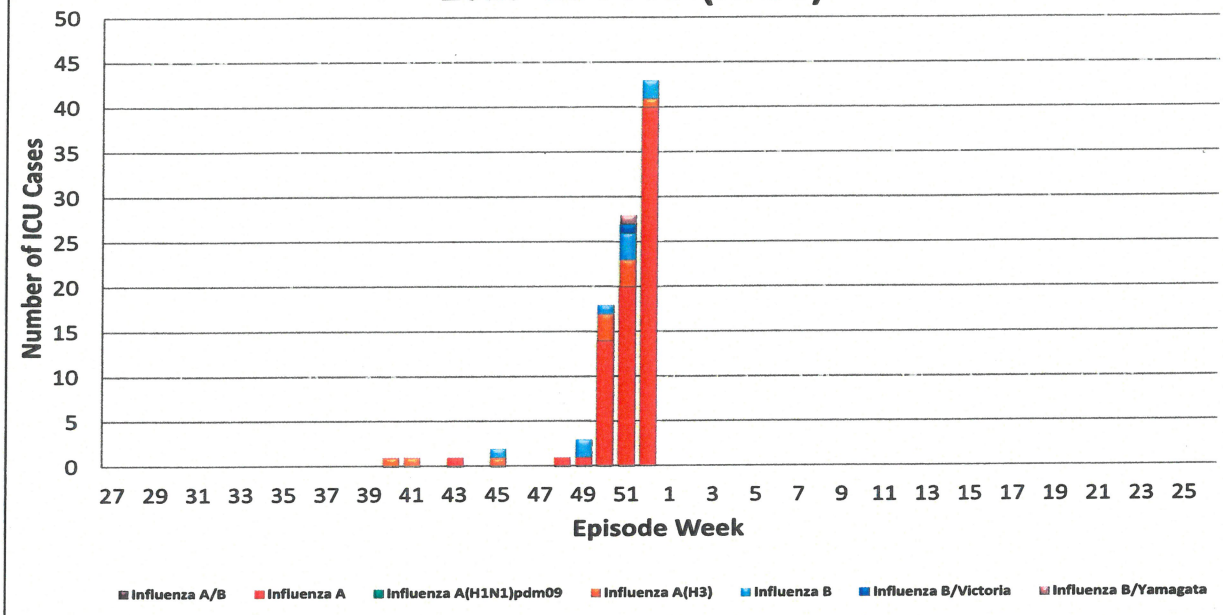


Figure 9. Number of Influenza Cases Requiring ICU Care by Episode Week and Type of Influenza, 2017-18 FYTD (N=98)



Episode week is the week of symptom onset, or earliest available date in which the case is identified.

Influenza Reporting in San Diego County

Local providers are encouraged to report laboratory positive influenza detections to the County Epidemiology Program by **FAX (858) 715-6458**. Please fax a Case Report Form and/or a printed laboratory result, and indicate if the patient was admitted to ICU or died, and/or is a resident of a congregate living facility.

For questions regarding sending specimens to Public Health Laboratory (PHL), call (619) 692-8500. Click here for the updated PHL PCR Test Request Form. Contact the Epidemiology Program with any questions at **(619) 692-8499** or by email to: EpiDiv.HHSA@sdcounty.ca.gov.

Resources

San Diego County Influenza Surveillance Weekly Slide Deck - presentation version of this report
County of San Diego Immunization Program www.sdiz.org
California Department of Public Health Influenza
Centers for Disease Control and Prevention Influenza Surveillance Weekly Report

Bobbi Palmer

From: Paul Hegyi <SDCMS@sdcms.org>
Sent: Thursday, January 04, 2018 3:25 PM
To: Bobbi Dupree
Subject: San Diego Flu Update

IMPORTANT INFLUENZA OUTBREAK ALERT

Wednesday, January 4, 2018

Bobbi Dupree,

As you are likely aware from your own patient experiences, the news, or the weekly Influenza Watch, San Diego County is experiencing a severe and earlier than usual influenza outbreak. In fact, it was reported yesterday that 13% of ED visits are for influenza-like illness (ILI). As a result, the prehospital and hospital system continues to be stressed and we are asking for help to alleviate the burden where possible.

Specifically, we are asking that you please consider adding extra walk-in slots for urgent care/sick visits so that ambulatory patients with influenza-like illness can seek attention in offices rather than local Emergency Rooms.

You might also find the most recent **Clinical Advisory** from the California Department of Public Health helpful. The County's influenza surveillance program is a collaborative effort between San Diego County Public Health Services' Epidemiology & Immunization Services Branch, our medical community and laboratory partners, and the San Diego Health Connect Health Information Exchange. To sign up for the weekly Influenza Watch, please contact the County at EpiDiv.HHSA@sdcounty.ca.gov or (619) 692-8499 with an y questions.

Keep checking www.SDCMS.org for additional information and updates within our San Diego Influenza Watch.

Sincerely,

Paul Hegyi, MBA
CEO, San Diego County Medical Society

Clinical Advisory (January 2, 2018)
Influenza

In California and throughout the United States (U.S.), influenza activity has increased significantly over recent weeks with influenza A(H3N2) viruses predominating so far this season. California Department of Public Health (CDPH) surveillance data sources for the 2017–2018 influenza season indicate influenza activity is widespread throughout California and is trending up earlier than in the 2016–2017 season. See the influenza disease page for more information.

A majority of influenza specimens have been typed as A(H3N2) in California this season. In the past, A(H3N2) virus-predominant influenza seasons have been associated with more hospitalizations and deaths in persons aged 65 years and older and young children compared to other age groups. In addition, influenza vaccine effectiveness in general has been lower against A(H3N2) viruses than against influenza A(H1N1) or influenza B viruses; however, all influenza viruses from California that have been antigenically characterized have matched the strains included in vaccine for this season. Vaccine effectiveness for the current season in the U.S. is not yet known; preliminary estimates are expected in February 2018.

CDPH is issuing this advisory to:

- Direct clinicians to national recommendations on testing and treatment of influenza included in a recent heath alert from the federal Centers for Disease Control and Prevention. In summary, all patients with suspected or confirmed influenza who are hospitalized or severely ill or at higher risk for complications should be treated as soon as possible with a neurominidase inhibitor antiviral agent, such as zanamivir and oseltamivir. While antiviral drugs work best when treatment is started within 2 days of illness onset, clinical benefit has been observed even when treatment is initiated later. Patients who are at higher risk for complications include:
  - children younger than 2 years (although all children younger than 5 years are considered at higher risk for complications from influenza, the highest risk is for those younger than 2 years)
  - adults aged 65 years and older
  - persons with chronic pulmonary, cardiovascular (except hypertension alone), renal, hepatic, hematological (including sickle cell disease), and metabolic disorders or neurologic and neurodevelopment conditions

  - people with immunosuppression, including those caused by medications or by HIV infection
  - women who are pregnant or postpartum (within 2 weeks after delivery)
  - people aged younger than 19 years who are receiving long-term aspirin therapy
  - American Indians/Alaska Natives
  - people with extreme obesity (i.e., body-mass index is equal to or greater than 40)
  - residents of nursing homes and other chronic-care facilities

- Offer influenza immunization. CDPH recommends immunization of all persons 6 months and older who have not yet received influenza vaccine this season. Even if vaccine effectiveness is limited, immunization can reduce illness, hospitalization and death due to influenza. As a reminder, children younger than 9 years of age who have never received influenza vaccine before require 2 doses at least 4 weeks apart during their first season. Supplies of influenza vaccine in California remain ample.

- Review CDPH guidelines, summarized below, on:
  - Laboratory testing
  - Reporting of influenza cases to public health
  - Infection control

Laboratory Testing

1) Collect both upper and lower respiratory tract specimens for influenza testing in hospitalized patients with suspected influenza. If the patient is ventilated, endotracheal aspirate specimens should be collected unless bronchoalveolar lavage (BAL) is done for other diagnostic reasons. Lower respiratory tract specimens can yield the diagnosis when influenza virus is no longer detectable in the upper respiratory tract; therefore, negative influenza testing results on an upper respiratory tract specimen in a critically ill patient with lower respiratory tract disease does not exclude influenza. Please refer to CDPH Viral and Rickettsial Disease Laboratory specimen collection guidelines.

2) For influenza testing, real-time reverse transcription polymerase chain reaction (rRT-PCR) is recommended. There are FDA-approved molecular assays commercially available, and testing can be done at public health laboratories and academic medical centers. Antigen detection tests such as rapid influenza diagnostic tests and immunofluorescence assays (DFA) are not recommended due to decreased testing sensitivity and the possibility of false negative results.

3) Patients receiving antiviral medications who do not respond to treatment might have an infection with an antiviral-resistant influenza virus. Oseltamivir resistance, sometimes within 1 week of treatment initiation, has been reported among immunocompromised patients receiving treatment. Oseltamivir resistance should be suspected in treated patients who are persistently positive with repeated PCR testing, particularly if they are immunocompromised. Specimens from these patients can be sent to the CDPH Viral and Rickettsial Disease Laboratory (VRDL) for antiviral resistance testing.

4) All specimens collected on critically ill or fatal cases with suspected or laboratory-confirmed influenza should be referred to a public health laboratory for further PCR confirmation and subtyping. The CDPH VRDL is also available for surge capacity testing as needed.

Reporting

Hospitals, clinicians, and nursing homes: Laboratory-confirmed fatal influenza-associated cases <65 years of age are reportable in California. In addition, laboratory-confirmed influenza cases requiring intensive care are voluntarily reportable, and some local health jurisdictions have asked that hospitals report these cases.

Local health departments are asked to promptly report to CDPH any laboratory-confirmed influenza in cases requiring intensive care and fatal cases age 0-64 years. Cases should be reported using CalREDIE or by faxing the "Severe Influenza Case History Form."

Infection Control

Infection prevention and control for influenza should include the following measures (excerpted from CDC's Prevention Strategies for Seasonal Flu in Healthcare Settings).
See also CDPH recommendations for the prevention and control of influenza in California long-term care facilities and All Facilities Letter (AFL).

1) Promote and administer seasonal influenza vaccine to health care providers and patients.

2) Take steps to minimize potential exposures.
   a. Before arrival to a healthcare setting
      - When scheduling appointments, instruct patients and persons who accompany them to inform healthcare personnel (HCP) upon arrival if they have symptoms of any respiratory infection and to take appropriate preventive actions (e.g., wear a facemask upon entry, follow triage procedure).
      - During periods of increased influenza activity, take steps to minimize elective visits by patients with suspected or confirmed influenza. For example, provide telephone consultation to patients with mild respiratory illness to determine if there is a medical need to visit the facility.
   b. Upon entry and during visit to a healthcare setting
      - Take steps to ensure all persons with symptoms of a respiratory infection adhere to respiratory hygiene, cough etiquette, hand hygiene, and triage procedures throughout the duration of the visit. Post visual alerts at the

entrance and in waiting areas, elevators, cafeterias, etc. to provide patients and HCP with instructions (in appropriate languages) about respiratory hygiene and cough etiquette. See CDC and CDPH signage.

- Provide facemasks to patients with signs and symptoms of respiratory infection.
- Provide supplies to perform hand hygiene to all patients upon arrival to facility and throughout the entire duration of the visit to the healthcare setting.
- Provide space and encourage persons with symptoms of respiratory infections to sit as far away from others as possible. If available, facilities may wish to place these patients in a separate area while waiting for care.
- During periods of increased community influenza activity, facilities should consider setting up triage stations that facilitate rapid screening of patients for symptoms of influenza and separation from other patients

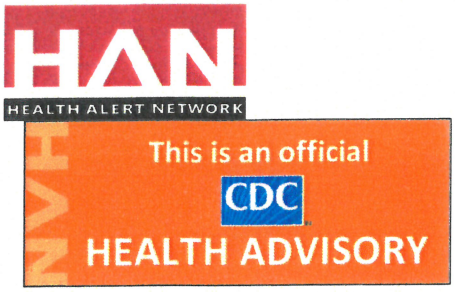
3) Monitor and manage ill healthcare personnel. Ill healthcare personnel should be excluded from work.

4) Adhere to standard and droplet precautions. Use caution when performing aerosol-generating procedures.
   - Influenza patients should be isolated in a single room or cohorted with other influenza patients if a single room is not available.
   - For aerosol-generating procedures, healthcare personnel should use an N95 respirator or higher level of respiratory protection.

5) Manage visitor access and movement within the facility. Visitors should be screened for illness. Visitors to patients in isolation for influenza should be limited to persons who are necessary for the patient's emotional well-being and care. Visitors who have been in contact with the patient before and during hospitalization are a possible source of influenza for other patients, visitors, and staff.

6) Monitor influenza activity. Healthcare settings should establish mechanisms and policies by which HCP are promptly alerted about increased influenza activity in the community or if an outbreak occurs within the facility and when collection of clinical specimens for viral culture may help to inform public health efforts.

Seasonal Influenza A(H3N2) Activity and Antiviral Treatment of Patients with Influenza



Distributed via the CDC Health Alert Network

December 27, 2017, 1030 ET (10:30 AM ET)

CDCHAN-00409

Summary

The Centers for Disease Control and Prevention (CDC) is providing: 1) a notice about increased influenza A(H3N2) activity and its clinical implications; 2) a summary of influenza antiviral drug treatment recommendations; 3) an update about approved treatment drugs and supply this season; and 4) background information for patients about influenza treatment.

Background

In the United States (U.S.), influenza activity has increased significantly over recent weeks with influenza A(H3N2) viruses predominating so far this season. In the past, A(H3N2) virus-predominant influenza seasons have been associated with more hospitalizations and deaths in persons aged 65 years and older and young children compared to other age groups. In addition, influenza vaccine effectiveness (VE) in general has been lower against A(H3N2) viruses than against influenza A(H1N1)pdm09 or influenza B viruses. Last season, VE against circulating influenza A(H3N2) viruses was estimated to be 32% in the U.S. CDC expects that VE could be similar this season, should the same A(H3N2) viruses continue to predominate. For this reason, in addition to influenza vaccination for prevention of influenza, the use of antiviral medications for treatment of influenza becomes even more important than usual. The neuraminidase inhibitor (NAI) antiviral medications are most effective in treating influenza and reducing complications when treatment is started early. Evidence from previous influenza seasons suggests that NAI antivirals are underutilized in outpatients and hospitalized patients with influenza who are recommended for treatment.

This CDC Health Advisory is being issued to—

1. Remind clinicians that influenza should be high on their list of possible diagnoses for ill patients because influenza activity is increasing nationwide, and
2. Advise clinicians that all hospitalized patients and all high-risk patients (either hospitalized or outpatient) with suspected influenza should be treated as soon as possible with a neuraminidase inhibitor antiviral. While antiviral drugs work best when treatment is started within 2 days of illness onset, clinical benefit has been observed even when treatment is initiated later.

Recommendations

1. CDC Antiviral Recommendations for the 2017–2018 Season

CDC recommends antiviral medications for treatment of influenza as an important adjunct to annual influenza vaccination. Treatment with neuraminidase inhibitors has been shown to have clinical and public health benefit in reducing illness and severe outcomes of influenza based on evidence from randomized controlled trials, meta-analyses of randomized controlled trials, and observational studies during past influenza seasons and during the 2009 H1N1 pandemic.[1,2,3,4,5,6]

2. All Hospitalized, Severely Ill, and High-Risk Patients with Suspected or Confirmed Influenza Should Be Treated with Antivirals

Any patient with suspected or confirmed influenza in the following categories should be treated as soon as possible with a neuraminidase inhibitor:
1) Any patient who is hospitalized—treatment is recommended for all hospitalized patients;
2) Any patient who has severe, complicated, or progressive illness—this may include outpatients with severe or prolonged progressive symptoms or who develop complications such as pneumonia but who are not hospitalized;
3) Any patient who is at higher risk for influenza complications but not hospitalized. Patients in this group include—

- children younger than 2 years (although all children younger than 5 years are considered at higher risk for complications from influenza, the highest risk is for those younger than 2 years)
- adults aged 65 years and older
- persons with chronic pulmonary (including asthma), cardiovascular (except hypertension alone), renal, hepatic, hematological (including sickle cell disease), and metabolic disorders (including diabetes mellitus), or neurologic and neurodevelopment conditions (including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual disability [mental retardation], moderate to severe developmental delay, muscular dystrophy, or spinal cord injury)

- people with immunosuppression, including that caused by medications or by HIV infection
- women who are pregnant or postpartum (within 2 weeks after delivery)
- people aged younger than 19 years who are receiving long-term aspirin therapy
- American Indians/Alaska Natives
- people with extreme obesity (i.e., body-mass index is equal to or greater than 40)
- residents of nursing homes and other chronic-care facilities

3. Timing of Treatment and Implications for Patient Evaluation, Treatment, and Testing

Clinical benefit is greatest when antiviral treatment is administered as early as possible after illness onset. Therefore, antiviral treatment should be started as soon as possible after illness onset and **should not be delayed** even for a few hours to wait for the results of testing. Ideally, treatment should be initiated within 48 hours of symptom onset. **However, antiviral treatment initiated later than 48 hours after illness onset can still be beneficial for some patients.**

A very large observational study of more than 29,000 hospitalized influenza patients reported that while the greatest clinical benefit was found when antiviral treatmen was initiated within 48 hours of illness onset, starting antiviral treatment more than 2 days after onset had survival benefit in adults versus no treatment. [6] Also, a randomized, placebo-controlled study suggested clinical benefit when oseltamivir was initiated 72 hours after illness onset among febrile children with uncomplicated influenza.[7] Clinical judgment, on the basis of the patient's disease severity and progression, age, underlying medical conditions, likelihood of influenza, and time since onset of symptoms, is important when making antiviral treatment decisions for outpatients, particularly those who are not at increased risk for influenza complications.

Because of the importance of early treatment, **decisions about starting antiviral treatment should not wait for laboratory confirmation of influenza**. Therefore, empiric antiviral treatment should generally be initiated as soon as possible when there is known influenza activity in the community. A history of current season influenza vaccination does not exclude a diagnosis of influenza in an ill child or adult. During influenza season especially, high-risk patients should be advised to call their provider promptly if they have symptoms of influenza. It may be useful for providers to implement phone triage lines to enable high-risk patients to discuss symptoms over the phone. To facilitate early initiation of treatment, when feasible, an antiviral prescription can be provided without testing and before an office visit.

4. Influenza Testing

Information to assist clinicians about influenza testing decisions is available at https://www.cdc.gov/flu/professionals/diagnosis/consider-influenza-testing.htm (https://www.cdc.gov/flu/professionals/diagnosis/consider-influenza-testing.htm). The most accurate influenza tests are molecular assays. Rapid molecular assays are available in clinical settings that can detect influenza virus nucleic acids in respiratory specimens in 15-30 minutes with high sensitivity and specificity. Other approved molecular assays can yield results in 60-80 minutes or in several hours with very high sensitivity and specificity.

For hospitalized patients with suspected influenza, molecular assays are recommended. Information on influenza molecular assays is available at https://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm (https://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm). Rapid influenza diagnostic tests (RIDTs) with an analyzer device can detect influenza A and B viral nucleoprotein antigens in respiratory specimens in 10-15 minutes with moderate sensitivity, and RIDTs without an analyzer device have low to moderate sensitivity compared with reverse transcription-polymerase chain reaction (RT-PCR).

Proper interpretation of influenza testing results is important to guide optimal management of influenza patients. An algorithm to assist clinicians in interpreting the results of influenza testing when influenza viruses ARE circulating in the community is available at https://www.cdc.gov/flu/professionals/diagnosis/algorithm-results-circulating.htm (https://www.cdc.gov/flu/professionals/diagnosis/algorithm-results-circulating.htm). **Clinicians should be aware that a negative RIDT result does not exclude a diagnosis of influenza in a patient with suspected influenza when there is influenza activity in the community.** Other factors such as the quality of the specimen, the source of the specimen in the respiratory tract, and the timing of specimen collection in relationship to illness onset, may also affect test results.

5. Antivirals in Non-High Risk Patients with Uncomplicated Influenza

Neuraminidase inhibitors can benefit other individuals with influenza. While current guidance focuses on antiviral treatment of those with severe illness or at high risk of complications from influenza, antiviral treatment may be prescribed on the basis of clinical judgment for any previously healthy (non-high risk) outpatient with suspected or confirmed influenza who presents within 2 days after illness onset. Neuraminidase inhibitors can reduce the duration of uncomplicated influenza illness by approximately 1 day when started within 2 days after illness onset in otherwise healthy persons. It is possible that antiviral treatment started after 48 hours may offer some benefit. [7]

6. Antiviral Medications

Three prescription neuraminidase inhibitor antiviral medications are approved by the U.S. Food and Drug Administration (FDA) and are recommended for use in the U.S. during the 2017–2018 influenza season: oseltamivir (available as a generic version or under the trade name Tamiflu®), zanamivir (Relenza®), and peramivir (Rapivab®).

- Oral oseltamivir is FDA-approved for treatment of uncomplicated influenza within 2 days of illness onset in persons aged 2 weeks and older, and for chemoprophylaxis to prevent influenza in people 1 year of age and older. Although not part of the FDA-approved indications, use of oral oseltamivir for treatment of influenza in infants younger than 14 days old, and for chemoprophylaxis in infants 3 months to 1 year of age, is recommended by CDC and the American Academy of Pediatrics. Due to limited data, use of oseltamivir for chemoprophylaxis is not recommended in children younger than 3 months unless the situation is judged critical. CDC recommends oseltamivir treatment as soon as possible for hospitalized patients with suspected or confirmed influenza, high-risk outpatients with suspected or confirmed influenza, and those with progressive disease.
- Inhaled zanamivir is FDA-approved for treatment of uncomplicated influenza within 2 days of illness onset in persons 7 years and older and for prevention of influenza in persons 5 years and older. Inhaled zanamivir is not recommended for treatment of influenza in hospitalized patients due to limited data.
- Intravenous peramivir is FDA-approved for the treatment of acute uncomplicated influenza within 2 days of illness onset in persons aged 2 years and older.

Adamantanes (rimantadine and amantadine) are not currently recommended for antiviral treatment or chemoprophylaxis of influenza A because of high levels of resistance among circulating influenza A viruses.

There are no current national shortages of neuraminidase inhibitors (i.e., oseltamivir, zanamivir and peramivir), and manufacturers report they expect to meet projected seasonal demands. If there is difficulty locating oseltamivir for oral suspension, as there has been in some previous seasons, oral suspension can be compounded by a pharmacy from oseltamivir capsules. However, this compounded suspension should not be used for convenience or when oseltamivir oral suspension is commercially available.

More information about compounding an oral suspension from oseltamivir 75 mg capsules can be found at https://www.gene.com/download/pdf/tamiflu_prescribing.pdf (https://www.gene.com/download/pdf/tamiflu_prescribing.pdf)

Additional Considerations for Clinicians

- **Bacterial Infections:** Antibiotics are not effective against influenza virus infection, and early diagnosis of influenza can reduce the inappropriate use of antibiotics if bacterial co-infection is not suspected. However, because certain bacterial infections can produce symptoms similar to influenza and bacterial infections can occur as a complication of influenza, bacterial infections should be considered and appropriately treated, if suspected. In addition, because pneumococcal infections are a serious complication of influenza infection, current pneumococcal vaccine recommendations for adults 65 years of age or older, as well as adults and children at increased risk for invasive pneumococcal disease due to chronic underlying medical conditions, should be followed (see http://www.cdc.gov/vaccines/vpd-vac/pneumo/vac-PCV13-adults.htm (http://www.cdc.gov/vaccines/vpd-vac/pneumo/vac-PCV13-adults.htm) and http://www.cdc.gov/vaccines/vpd-vac/pneumo/vacc-in-short.htm (http://www.cdc.gov/vaccines/vpd-vac/pneumo/vacc-in-short.htm) for further information).
- **Adverse Events and Antiviral Use:** The most common adverse events associated with oral oseltamivir include a slightly increased risk of nausea and vomiting as compared to placebo, with nausea occurring in 10% of adults with influenza who received oseltamivir and 6% of people who received placebo in controlled clinical trials (3% and 4%, respectively, in children), and vomiting occurring in 9% of adults with influenza who received oseltamivir and 3% of people who received placebo in controlled clinical trials (15% and 9%, respectively, in children). These symptoms are generally transient and can be mitigated if oseltamivir is taken with food. Adverse events for inhaled zanamivir were not increased as compared to placebo in clinical trials, but cases of bronchospasm have been reported during post marketing; inhaled zanamivir is not recommended for persons with underlying airways disease (e.g., asthma or chronic obstructive pulmonary diseases). For people who received peramivir intravenously or intramuscularly in clinical trials, the most common adverse event was diarrhea, occurring in 8% versus 7% in people who received placebo.

Resources for Patient Education

Results from unpublished CDC qualitative research shows that most people interviewed were not aware that drugs to treat influenza illness are available. A fact sheet for patients is available at http://www.cdc.gov/flu/antivirals/whatyoushould.htm (http://www.cdc.gov/flu/antivirals/whatyoushould.htm).

Note the following important background information for patients:

- If you get the flu, antiviral drugs are a treatment option.
- It is very important that antiviral drugs are used early to treat hospitalized patients, people with severe flu illness, and people who are at high risk for flu complications because of their age, severity of illness, or underlying medical conditions.
- If you have severe illness or are at high risk of serious flu complications, you may be treated with flu antiviral drugs if you get the flu.
- If you have a high-risk condition, treatment with an antiviral drug can mean the difference between having milder illness instead of very serious illness that could result in a hospital stay.
- Other people also may be treated with antiviral drugs by their doctor this season. Most otherwise-healthy people who get the flu, however, do not need to be treated with antiviral drugs.
- Studies show that flu antiviral drugs work best for treatment when they are started within 2 days of getting sick. However, starting antivirals later can still be helpful for some people.
- If your health care provider thinks you have the flu, your health care provider may prescribe antiviral drugs. A test for flu is not necessary.
- Antibiotics are not effective against the flu. Using antibiotics inappropriately can lead to antibiotic resistance and may expose patients to unwanted side effects of the drug.
- Other practices that may help decrease the spread of influenza include respiratory hygiene, cough etiquette, social distancing (e.g., staying home from work and school when ill, staying away from people who are sick) and hand washing.

Additional Resources

- Summary of Influenza Antiviral Treatment Recommendations for Clinicians: http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm (http://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm)
- Clinical Description and Lab Diagnosis of Influenza: http://www.cdc.gov/flu/professionals/diagnosis/index.htm (http://www.cdc.gov/flu/professionals/diagnosis/index.htm)
- Guidance for Clinicians on the Use of RT-PCR and Other Molecular Assays for Diagnosis of Influenza Virus Infection: http://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm (http://www.cdc.gov/flu/professionals/diagnosis/molecular-assays.htm)
- Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities: http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm (http://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm)

- Influenza Virus Testing in Investigational Outbreaks in Institutional or Other Closed Settings: https://www.cdc.gov/flu/professionals/diagnosis/guide-virus-diagnostic-tests.htm (https://www.cdc.gov/flu/professionals/diagnosis/guide-virus-diagnostic-tests.htm)
- FDA Influenza (Flu) Antiviral Drugs and Related Information (including package inserts): http://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm100228.htm (http://www.fda.gov/drugs/drugsafety/informationbydrugclass/ucm100228.htm)

References

[1] Dobson J, Whitley RJ, Pocock S, Monto AS. Oseltamivir treatment for influenza in adults: a meta-analysis of randomised controlled trials. Lancet. 2015 May 2;385(9979):1729-37.
[2] Malosh RE, Martin ET, Heikkinen T, Brooks WA, Whitley RJ, Monto AS. Efficacy and Safety of Oseltamivir in Children: Systematic Review and Individual Patient Data Meta-analysis of Randomized Controlled Trials. Clin Infect Dis. 2017 Nov 23. doi: 10.1093/cid/cix1040. [Epub ahead of print]

[3] Hsu J, Santesso N, Mustafa R, Brozek J, Chen YL, Hopkins JP, Cheung A, Hovhannisyan G, Ivanova L, Flottorp SA, Saeterdal I, Wong AD, Uyeki TM, Akl EA, Alonso-Coell P, Smaill F, Schünemann HJ. Antivirals for treatment of influenza: a systematic review and meta-analysis of observational studies. Ann Intern Med. 2012 Apr 3;156(7):512-24.

[4] Doll MK, Winters N, Boikos C, Kraicer-Melamed H, Gore G, Quach C. Safety and effectiveness of neuraminidase inhibitors for influenza treatment, prophylaxis, and outbreak control: a systematic review of systematic reviews and/or meta-analyses. J Antimicrob Chemother. 2017 Nov 1;72(11):2990-3007.

[5] Venkatesan S, Myles PR, Leonardi-Bee J, Muthuri SG, Al Masri M, Andrews N, Bantar C, Dubnoy-Raz G, Gérardin P, Koay ESC, Loh TP, Memish Z, Miller E, Oliva ME, Rath BA, Schweiger B, Tanq JW, Tran D, Vidmar T, Waight PA, Nguyen-Van-Tam JS. Impact of Outpatient Neuraminidase Inhibitor Treatment in Patients Infected With Influenza A(H1N1)pdm09 at High Risk of Hospitalization: An Individual Participant Data Metaanalysis. Clin Infect Dis. 2017 May 15;64(10):1328-1334.

[6] Muthuri SG, Venkatesan S, Myles PR, Leonardi-Bee J, Al Khuwaitir TS, Al Mamun A, Anovadiya AP, Azziz-Baumgartner E, Báez C, Bassetti M, Beovic B, Bertisch B, Bonmarin I, Booy R, Borja-Aburto VH, Burgmann H, Cao B, Carratala J, Denholm JT, Dominguez SR, Duarte PA, Dubnov-Raz G, Echavarria M, Fanella S, Gao Z, Gérardin P Giannella M, Gubbels S, Herberg J, Iglesias AL, Hoger PH, Hu X, Islam QT, Jiménez MF, Kandeel A, Keijzers G, Khalili H, Knight M, Kudo K, Kusznierz G, Kuzman I, Kwan AM, Amine IL, Langenegger E, Lankarani KB, Leo YS, Linko R, Liu P, Madanat F, Mayo-Montero E, McGeer A, Memish Z, Metan G, Mickiene A, Mikić D, Mohn KG, Moradi A, Nymadawa P, Oliva ME, Ozkan M, Parekh D, Paul M, Polack FP, Rath BA, Rodríguez AH, Sarrouf EB, Seale AC, Sertogullarindan B, Siqueira MM, Skręt-Magierło J, Stephan F, Talarek E, Tang JW, To KK, Torres A, Törün SH, Tran D, Uyeki TM, Van Zwol A, Vaudry W, Vidmar T, Yokota RT, Zarogoulidis P; PRIDE Consortium Investigators, Nguyen-Van-Tam JS.. Effectiveness of neuraminidase inhibitors in reducing mortality in patients admitted to hospital with influenza A H1N1pdm09 virus infection: a meta-analysis of individual participant data. Lancet Respir Med. 2014 May;2(5):395-404.

[7] Fry AM, Goswami D, Nahar K, Sharmin AT, Rahman M, Gubareva L, Azim T, Bresee J, Luby SP, Brooks WA. Efficacy of oseltamivir treatment started within 5 days of symptom onset to reduce influenza illness duration and virus shedding in an urban setting in Bangladesh: a randomised placebo-controlled trial. Lancet Infect Dis. 2014 Feb;14(2):109-18.

The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national and international organizations.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HAN Message Types

- **Health Alert:** Conveys the highest level of importance; warrants immediate action or attention. Example: HAN00001
- **Health Advisory:** Provides important information for a specific incident or situation; may not require immediate action. Example: HAN00346
- **Health Update:** Provides updated information regarding an incident or situation; unlikely to require immediate action. Example: HAN00342
- **Info Service:** Provides general information that is not necessarily considered to be of an emergent nature. Example: HAN00345

###

This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, HAN coordinators, and clinician organizations.

###

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Additional Resources

- HAN Archive By Year
- HAN Types
- Sign Up for HAN E-mail Updates
- HAN Jurisdictions

Information on Specific Types of Emergencies

Information for Specific Groups

Resources for Emergency Health Professionals

Training & Education

Social Media

What's New

Preparation & Planning

More on Preparedness

What CDC is Doing (https://www.cdc.gov/phpr/index.htm)

Blog: Public Health Matters (http://blogs.cdc.gov/publichealthmatters/)

(http://www.cdc.gov/zika/pregnancy/index.html)

(https://www.ready.gov/)

(https://emergency.cdc.gov/socialmedia/index.asp)

File Formats Help:

How do I view different file formats (PDF, DOC, PPT, MPEG) on this site? (https://www.cdc.gov/Other/plugins/)

(https://www.cdc.gov/Other/plugins/#pdf)

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SAN DIEGO Data Trend Report 2009-2013

(San Diego-Carlsbad-San Marcos, CA)

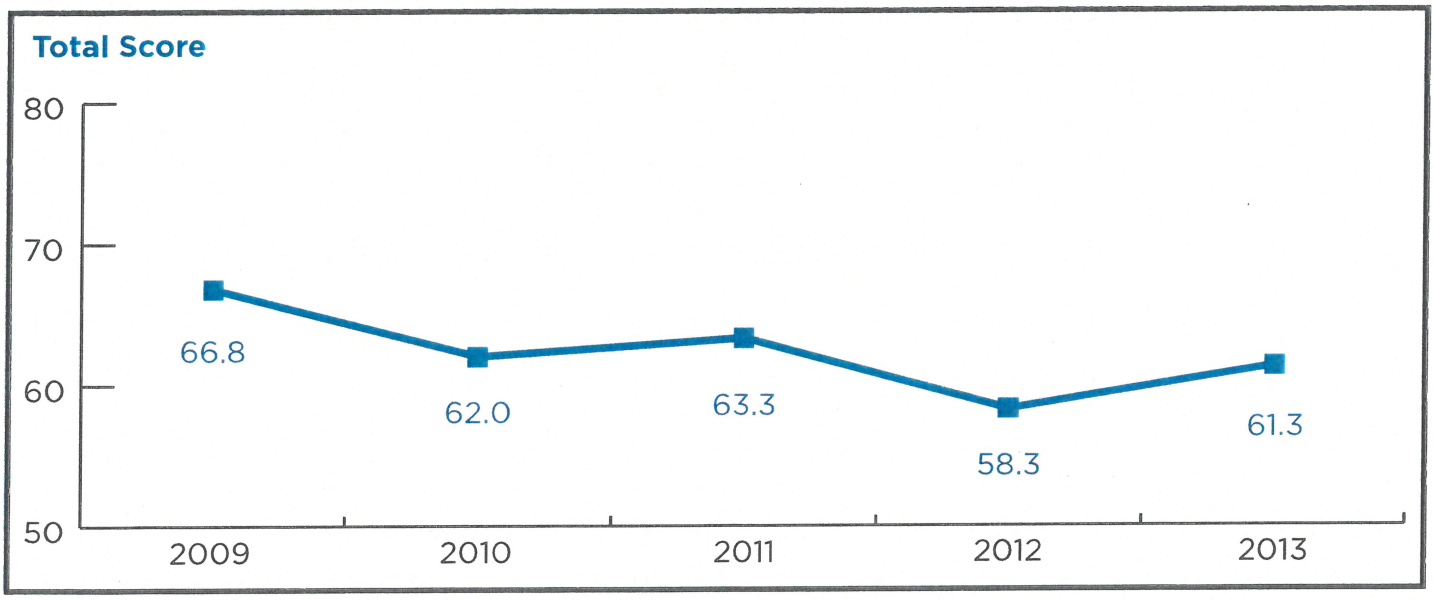
San Diego's total score has ranked among the top 20 metropolitan areas since 2009. Strengths include a high number of acres of parkland, a high percent of city land area as parkland, as well as a high amount of park-related expenditures per capita.

Top four improvements since 2009:

- The number of farmers' markets per 1,000,000 increased from 8.4 to 15.9.
- The percent with asthma decreased from 9.1% to 7.1%.
- The death rate per 100,000 for cardiovascular disease decreased from 204.2 to 162.3.
- The death rate per 100,000 for diabetes decreased from 22.2 to 19.1.

Total Score

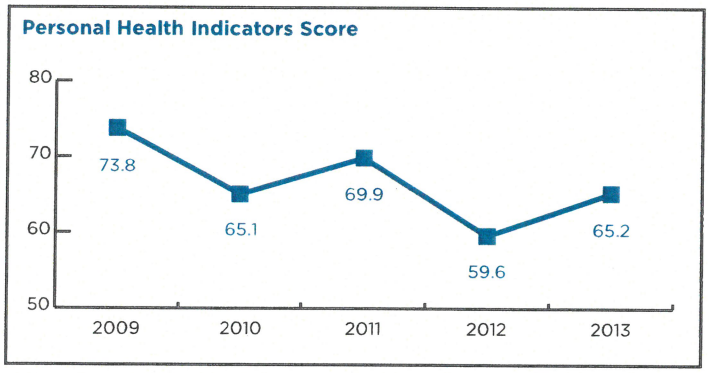
Measure	2009	2010	2011	2012	2013	% Change 2009-2013
Total Score	66.8	62.0	63.3	58.3	61.3	-8.2%
Total Ranking	8	13	13	16	14	

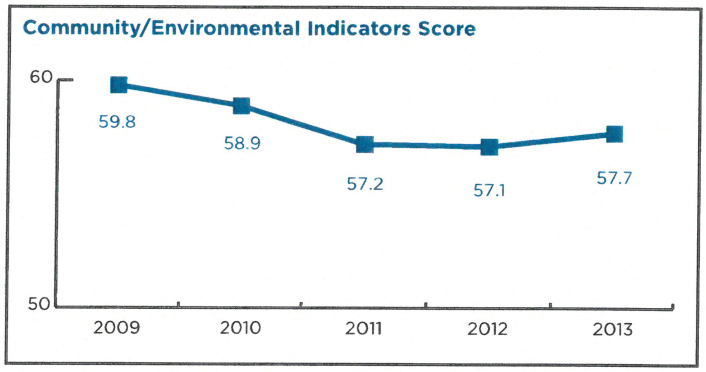


SAN DIEGO Data Trend Report 2009-2013

Personal Health Indicators

Measure	2009	2010	2011	2012	2013	% Change 2009-2013	GOAL
Personal Health Indicators Score	**73.8**	**65.1**	**69.9**	**59.6**	**65.2**	**-11.7%**	
PHI Rank	**7**	**15**	**9**	**16**	**12**		
% any physical activity last 30 days	79.1%	78.4%	79.9%	81.0%	79.6%	+0.6%	82.6%
% physically active	53.3%	53.3%	58.1%	58.1%	58.1%	+9.0%	54.4%
% 5+ fruits / veggies	31.0%	31.0%	28.9%	28.9%	28.9%	-6.8%	29.0%
% currently smoking	15.0%	14.5%	11.9%	13.0%	13.0%	-13.3%	13.1%
% obese	23.1%	23.5%	21.6%	26.1%	24.1%	+4.3%	21.3%
% in excellent / very good health	60.4%	54.3%	58.4%	57.6%	55.0%	-8.9%	61.0%
Days physical health not good, last 30 days	30.0%	34.3%	35.2%	36.5%	37.2%	+24.0%	30.4%
Days mental health not good, last 30 days	34.9%	37.1%	38.8%	34.6%	39.4%	+12.9%	29.2%
% with asthma	9.1%	8.1%	7.1%	7.7%	7.1%	-22.0%	6.5%
% angina or coronary heart disease	2.5%	3.4%	2.6%	4.1%	5.1%	+104.0%	2.8%
% with diabetes	7.8%	8.0%	8.2%	8.9%	9.9%	+26.9%	6.4%
Death rate, 100,000 for cardiovascular disease	204.2	185.9	174.3	172.0	162.3	-20.5%	167.1
Death rate, 100,000 for diabetes	22.2	22.2	18.6	19.5	19.1	-14.0%	17.0
% with health insurance	85.5%	83.3%	83.4%	82.3%	83.9%	-1.9%	91.2%





Community/Environmental Indicators

Measure	2009	2010	2011	2012	2013	% Change 2009-2013	GOAL
Community / Environmental Indicators Score	**59.8**	**58.9**	**57.2**	**57.1**	**57.7**	**-3.5%**	
C/EI Rank	**13**	**15**	**17**	**16**	**17**		
Parkland as % of city land area	21.9%	21.9%	22.7%	22.8%	22.6%	+3.2%	10.6%
Acres of parkland per 1,000	36.2	35.9	36.1	36.3	35.9	-0.8%	18.6
Farmers' markets per 1,000,000	8.4	15.0	16.0	15.4	15.9	+89.3%	13.1
% using public transportation to work	3.6%	3.4%	3.1%	3.3%	3.0%	-16.7%	4.3%
% bicycling or walking to work	3.4%	3.9%	3.4%	3.6%	3.4%	0.0%	2.8%
Ball diamonds per 10,000	2.3	2.3	2.2	2.2	2.2	-4.3%	1.9
Dog parks per 10,000	1.2	1.3	1.2	1.2	1.2	0.0%	0.9
Park playgrounds per 10,000	1.8	1.8	1.8	1.8	1.8	0.0%	2.3
Golf courses per 10,000	0.6	0.6	0.6	0.6	0.6	0.0%	0.9
Park units per 10,000	3.5	3.5	3.4	3.4	3.4	-2.9%	4.1
Recreation centers per 20,000	1.0	1.0	1.0	1.0	1.0	0.0%	1.0
Swimming pools per 100,000	1.0	1.0	1.0	1.0	1.0	0.0%	3.1
Tennis courts per 10,000	1.5	1.4	1.4	1.4	1.4	-6.7%	2.0
Park-related expenditures per capita	$122	$124	$120	$117	$106	-13.1%	$101.80
Level of state-required PE	3	3	3	3	3	0.0%	2.5
Number of primary care providers per 100,000	121.3	87.9	87.3	86.4	86.2	-28.9%	105.6

ACSM AMERICAN FITNESS INDEX®

COMMUNITY *action* GUIDE

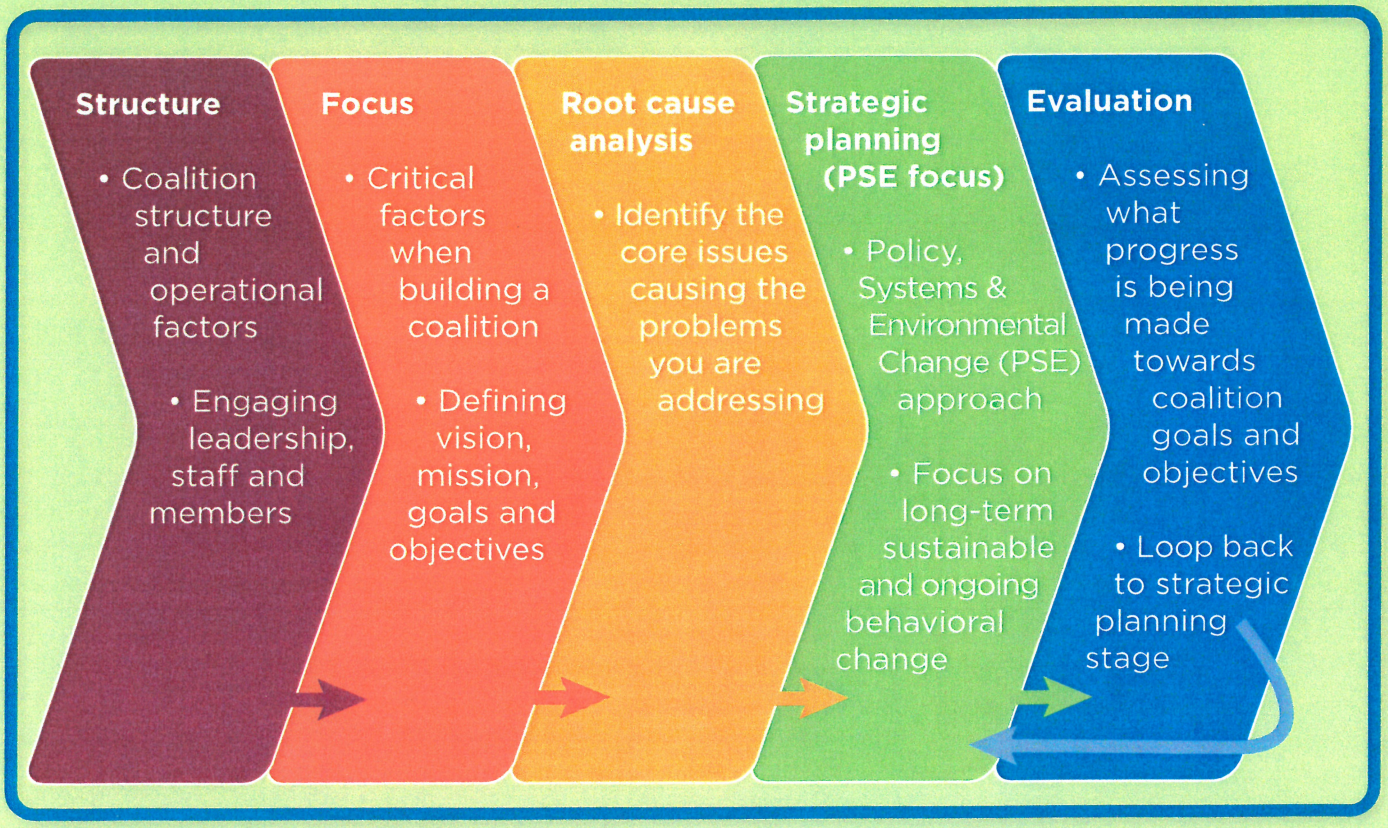
Anthem Foundation

community action framework

Quantitative Data
- AFI Data Report
- Other pertinent data

Qualitative Data
- Key informant interviews
- Case studies
- Focus groups, observations

COALITION



introduction

About the AFI Community Action Guide

The American College of Sports Medicine (ACSM) American Fitness Index® (AFI) Community Action Guide is a companion to the AFI Data Report presented annually by ACSM and the Anthem Foundation.

Whether you are just getting started or well on your way to addressing health and physical activity in your community, the AFI Community Action Guide provides an overview of the critical decisions and factors related to effective community action.

One effective strategy for community action is forming a diverse coalition of goal-oriented individuals and organizations working toward the same outcome. The subsequent sections of this guide will outline organizational and planning considerations for effective coalitions.

In addition, you'll find practical tools, examples and resources on the AFI website at www.americanfitnessindex.org.

Intended Audience

This guide is for anyone interested in addressing the overall health, emphasizing the level of physical activity, in your city, town or neighborhood. Some audiences for whom ACSM has created this guide include professionals working in the fields of:

- Public Health
- Smart Growth
- Community Development
- Parks
- Education
- Aging Services
- Health, Wellness and Medicine
- Faith-based organizations
- Planning
- Zoning
- Transportation
- Recreation
- Youth Services
- Physical fitness
- Local government
- Businesses

About the ACSM American Fitness Index Program

With support and funding from the Anthem Foundation, ACSM launched the AFI program in 2008 to help communities identify opportunities to:

- Improve the health of its residents
- Evolve the community to a culture of health and wellness
- Expand community assets to better support active, healthy lifestyles

The AFI program revolves around an annual data report, a reliable measure of community fitness for the country's 50 largest metropolitan statistical areas (MSAs). The report serves as a scientific, objective assessment of each MSA's strengths and challenges, and effectively informs local decision-making that can enhance the quality of life for its population.

For the purpose of AFI, the data report evaluates MSAs according to the U.S. Census Bureau. An MSA also can be referred to as a "community" and/or a "city." If referred to by city, the report is referencing the entire MSA or metro area, but uses the name of the largest principal city. For example, Atlanta is the principal city of the Atlanta-Sandy Springs-Roswell MSA. The Atlanta community and the nickname Metro Atlanta refer to the Atlanta-Sandy Springs-Roswell MSA.

The AFI Data Report reflects a composite of:

- Personal health measures
- Preventive health behaviors
- Levels of chronic disease conditions
- Environmental and community resources
- Policies that support physical activity

Benchmarks for each data indicator in the report highlight areas that need improvement.

In addition, demographic and economic diversity are included for each MSA to illustrate the unique attributes of each city. These description elements are not included in the data index calculation, but can be used for comparison purposes.

While the AFI Data Report provides detailed information for the 50 most populated cities at the MSA level, the My AFI community application tool integrates the components of the AFI program into a health promotion approach that can be used by other communities not included in the AFI Data

Report. Using this tool, leaders can understand the individual, societal and behavioral factors related to physical activity in their own community and implement culturally focused activities that are meaningful to its residents.

In recent years, the AFI program also has included:

- Technical assistance to low-ranking metro areas
- Trend reports that highlight the progress a city has made over a five-year period

The Need for Community Action

Being physically active is one of the most important ways individuals can improve and maintain his or her overall health.

Regular physical activity can reduce the risk of:

- Premature death
- Heart disease
- Type 2 diabetes
- Breast cancer
- Colon cancer
- Risk of falls

Physical activity also can:

- Decrease body fat
- Improve bone health
- Improve muscular strength
- Prevent the development of chronic diseases [1]

coalition basics

A coalition is a group of individuals and groups working together to achieve a shared goal. Coalitions function best when its members represent the diverse interests of the community.

To help assure success, coalitions need:

- A shared sense of direction among its members
- Defined objectives
- A realistic action plan
- Consistent communication
- Agreed upon measures of success

The functions of a coalition might include:

- Community awareness, community engagement and strengthening knowledge
- Educating policy makers
- Influencing public and/or private policy issues
- Building support for improvements in infrastructure
- Improving organizational practices

Emerging public health information suggests that to reach the U.S. Centers for Disease Control and Prevention's goal to improve health and fitness, prevent disease and disability, and enhance quality of life for all Americans through physical activity,

we must create a culture that integrates physical activity into our daily lives.

tip

As you begin to think about bringing together a coalition, don't get stuck on what to call your group. Additionally, avoid the temptation to debate whether your group should be labeled a "coalition," "collaborative," "partnership," "collective impact" or similar term.

What the group is called is not likely to matter, especially as the work is just beginning. After the group is organized and functioning, you can revisit the "What do we want to call ourselves?" question. For the sake of simplicity, this guide will use the word "coalition."

Some practical benefits of forming a coalition include:

1. There is strength in numbers, but a small group of quality leaders may be more efficient when beginning the process of forming a coalition.
2. People and organizations that work together can leverage their resources and skills.
3. Coalitions often command more attention than individual members.

Collective Impact as a Model for Community Action

Transforming communities into healthier places isn't a simple process. Rather, the process of increasing physical activity and helping people live healthier lives is a complex issue that will require many moving parts and several organizations working toward a common goal.

To achieve this common goal, many communities have adopted the definition of "collective impact" to incite action. For the purposes of this guide, we consider collective impact and coalition work to be similar.

Collective impact involves the same recipe for successful coalitions including:

- Common agenda
- Shared measurement
- Mutually reinforcing activities
- Continuous communication

The primary difference is that creating and managing collective impact requires a separate organization and a specific set of skills to serve as the **backbone** for the entire initiative and to coordinate participating organizations and agencies.

In this guide, you will find that many coalitions may have staff as well. For coalitions and collective impact to work, the role of leadership and staff should be to balance the tension and keep all parties coordinated and accountable, while staying behind the scenes in order to establish collective ownership.

An excellent source for learning more about collective impact is FSG, a nonprofit consulting firm focused on discovering better ways to solve social problems. [II] [III] [VII]

tip

Offering food and time for networking during meetings will entice new individuals to join and is an added value to membership.

Coalition Structure

In order to be effective, a coalition should determine how it will be structured and how it will function from an operational perspective.

Questions to answer:

- Who will lead the coalition?
- Who should make up the membership?
- What staff, if any, is needed? Does the staff need to be full- or part-time?

Additional operational considerations that need to be addressed:

- Who will chair meetings?
- How will the chair be selected?
- When, where and how often will the coalition meet?
- How will agendas be set?
- What is expected of members? Will the coalition use membership agreements to formalize commitments?
- Who is responsible for administrative functions such as meeting arrangements, agenda distribution, minutes, and follow-up?
- Will the coalition need a budget, and if yes, who will serve as the fiscal agent?

Leadership

Perhaps one of the most critical first steps in this journey is to identify and engage passionate, committed leaders. These few individuals are catalysts who can begin strategic planning, engage the community, recruit and develop a strong coalition, lead concerted public policy and advocacy efforts to create systems change in communities, and help assure sustainability of efforts.

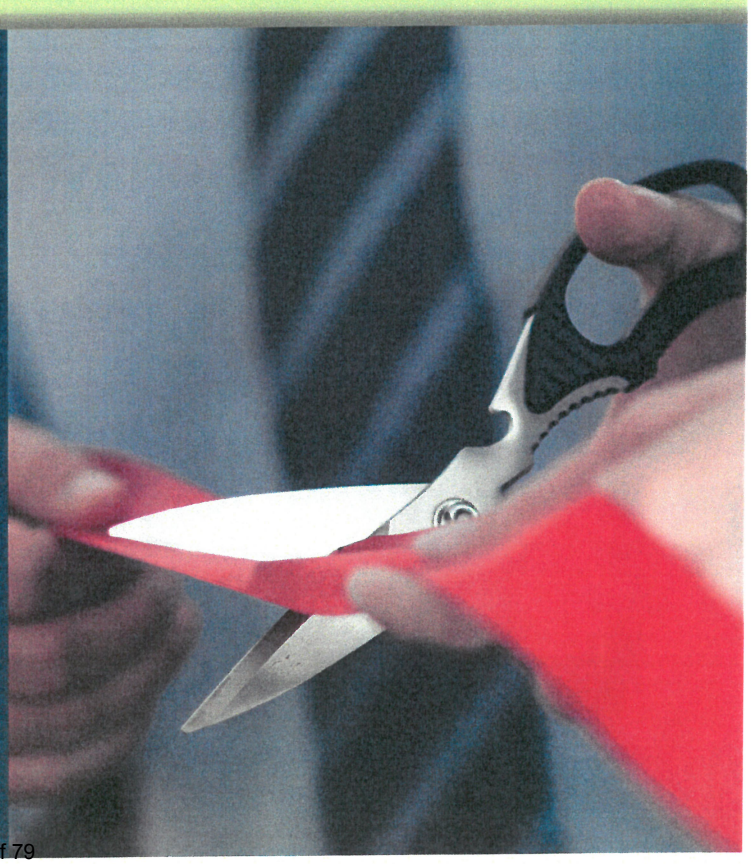
There are two types of volunteer leaders that might be involved in community action – figurehead leaders and actively engaged leaders.

Figurehead Leaders

A figurehead leader might be an individual, or individuals, who lend his or her name and image to efforts, but who might not provide much hands-on involvement. This type of

tip

Be realistic in your expectations. Prominent individuals usually have extremely limited free time. They might appear at high-profile events such as kick-off meetings, ribbon cuttings, or awards functions. But generally they are not going to be available to take part in operational activities of your community effort such as committee meetings.



Members

When selecting the members of a coalition, it's important to ask which persons or groups have a vested interest in improving the physical activity, health and wellness environment within your community.

The following list is not intended to be a complete inventory of the types of organizations, but serves as a guide to help you get started. The actual organizations you engage for your local action should be representative of your community, and the diversity, talent and resources that are available. Some examples are:

- Area businesses
- Chambers of commerce
- City and county health departments
- Community groups and organizations
- Developers/builders
- Environmental groups
- Exercise and rehabilitation professionals
- Faith-based leaders
- Farmers and community market groups
- Food/nutrition groups
- Government agencies
- Health agencies
- Health care professionals
- Health and fitness clubs
- Law enforcement or public safety
- Local universities and community colleges
- Neighborhood associations
- Parks and recreation department professionals
- Property managers
- Realtors/real-estate developers
- Retail establishments and shopping centers
- School districts
- Students
- Teachers
- Transportation experts
- Urban planners
- Zoning department

Coalition Building and Pitfalls

Coalition Building

There are excellent sources that outline approaches to coalition building – several are included in the Tools and Resources document available at www.americanfitnessindex.org. There are, however, a few factors that are critical to success that you should keep in mind, no matter what your coalition building process.

tip

Once a core group of stakeholders are engaged, you may want to consider being inclusive of anyone interested in participating, including community residents. Forming a coalition by only inviting members may overlook valuable partners that could provide long-term support and resources.

individual might be recruited as an "Honorary Chairperson" of a coalition or partnership. These individuals are typically celebrities, professional sports figures, CEOs of major businesses, or high-ranking elected officials. His or her position and other time commitments often preclude them from becoming engaged significantly in ongoing activities, but he or she can bring several important resources to the table. These include:

- The prominent status of some people is enough to attract others into a coalition or group.
- This type of leader is often able to facilitate networking opportunities and open doors to other resources that have value for the community initiative.
- If a community leader has significant resources at his or her disposal, he or she may be in a position to provide direct financial or in-kind support.
- Prominent community figures often are excellent spokespersons for your issue or cause, especially before policy-making groups, foundations and media.

Actively Engaged Leaders

An actively engaged leader is someone who has demonstrated leadership capabilities, is committed to improvement in the community, and is willing to give his or her time to be actively involved in your efforts. Initially you might identify a small number of these leaders to help your community initiative get off the ground. This type of leader is typically someone who is already engaged and passionate about your issue or cause. Actively engaged leaders might be an officer or senior staff member of an agency that shares common goals or missions with your community issues.

You might recruit several leaders who can function as an executive committee. The roles may transition as your coalition or group grows, though hopefully these leaders will remain involved and assume roles such as committee chairs.

Responsibilities for actively engaged leaders may include:

- Setting agendas
- Helping identify and recruit coalition members
- High-level strategic planning
- Facilitating meetings
- Identifying and securing resources (both financial and in-kind)
- Serving as a media spokesperson
- Building sustainability
- Making presentations to community and business groups

Questions to discuss during your leadership search:

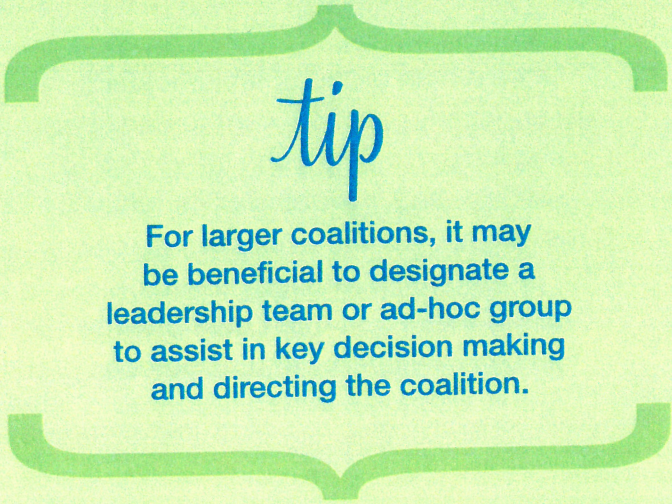
1. Does it make sense to have a figure-head leader for the group?
2. Who are prominent figures in your community with a passion for health and well-being?
3. Who are the people in your community with a reputation of getting things done?

Staff Leadership

Some community-based initiatives are fortunate to have assigned staff members. Staff might be individuals from a lead agency or organization whose time has been allocated specifically to the initiative. Alternatively, a grant or other funding mechanism might enable an initiative to secure a staff person (or people).

Staff who are involved in community-based initiatives at a leadership level, usually require many of the competencies of volunteer leadership. In addition, they are likely to also have responsibilities such as:

- Managing finances
- Preparing reports and updates for funders and other key partners
- Assuring that plans are developed and appropriately monitored
- Ensuring smooth operational functions of activities
- Providing adequate communication with leadership and coalition members
- Keeping track of volunteer assignments and assuring follow-up is conducted
- Serving as the point-of-contact for media and policy makers.



1. **Set clear goals.** Later in this guide, there is a chapter that addresses planning. A clear plan is vital to keep your efforts on track. This can be especially important if you have a diverse membership, since coalition members often bring their own organizations' goals and agendas to the table. As ideas and issues arise, continually ask the question, "How does this relate to the coalition's mission, goals and objectives?"

2. **Communicate clearly, adequately and regularly.**

3. **Listen to opposing points of view.** Often coalitions are comprised of like-minded individuals. But opposing views and opinions can provide insight and information that could be overlooked if it is not sought and valued. One way to gather this input is to talk with those who oppose your efforts. Find out why they oppose your efforts. What concerns do they have? Can you address those concerns? Are these individuals seeing potential problems that you are missing?

4. **Determine a decision-making process and stick with it.** It may be that decisions are made by a majority vote, consensus, or by sub-committees charged with making decisions on specific issues. Whatever process you have, stick with it and don't spend time rehashing or questioning decisions.

5. **Determine how tasks will be delegated and what the process for follow-up and reporting will be.**

6. **Recognize and celebrate successes and highlight members for his or her work in the coalition.** This provides momentum and helps eliminate burnout.

tip

Hosting training sessions may benefit a member's understanding of the coalition approach, while also adding value to the member experience.

tip

Under the Affordable Care Act, the Internal Revenue Service (IRS) now requires hospitals with 501(c)(3) status to conduct community health assessments and adopt an implementation strategy. Many have dedicated staff organizing these assessments through the use of community coalitions. Research active coalitions in your community to ensure you're not duplicating efforts already underway. [M]

Coalition Pitfalls

Often efforts at building an effective coalition fail. Be aware of potential pitfalls. Go through this list with your group and talk about how you can deal with these issues. You might consider setting up ground rules or bylaws.

- Lack of clear leadership
- No plan, unclear goals/objectives, or lack of data to support objective outcomes
- Trying to focus too broadly, rather than on a few strategic issues
- No defined decision-making process
- Impatience expecting change to occur instantly
- Inadequate, infrequent, or irregular follow-up
- Inadequate communication – especially between meetings
- One agency having too much perceived or real authority
- Competition or conflict among members
- Too many meetings, meetings that last too long, or hard to get to meeting locations
- Holding meetings too frequently or too infrequently
- Not enough funding to cover basic operating costs
- Staff/member turnover and burnout
- Language and cultural barriers in multi-lingual and multi-cultural communities

coalition planning

"Begin with the end in mind." This advice is the second "habit" from Steven Covey's quintessential self-help book, *The 7 Habits of Highly Effective People*. The same is true for effective planning: a clear vision and agreement of the end goals is imperative for success.

Effective planning:

- Provides a clear focus
- Supports monitoring and assessment of results and impact
- Facilitates new program development
- Enables an organization or coalition to systematically look into the future

tip

Visit the AFI Community Action Guide resources page available at www.americanfitnessindex.org for more information on coalition sustainability and other topics mentioned throughout the guide.

Most organizations and coalitions understand the need for annual program objectives and a program-focused work plan. Funders typically require them and they provide a basis for setting priorities, organizing work and assessing progress.

Upon launching a coalition, there needs to be a discussion and eventually agreement on the vision, mission, goals and objectives of the coalition.

Once those details are established, the coalition should then address these critical questions:

- What needs to change in the community?
- What do we expect to accomplish?
- Who needs to be at the table?
- What are the various roles and responsibilities of coalition members?
- Will the coalition need sub-committees to address specific issues?
- To whom is the coalition accountable?
- What resources are already in place or available?
- What resources are needed?
- What is the intended timeframe for the coalition?
- What is the plan for sustainability?

Vision

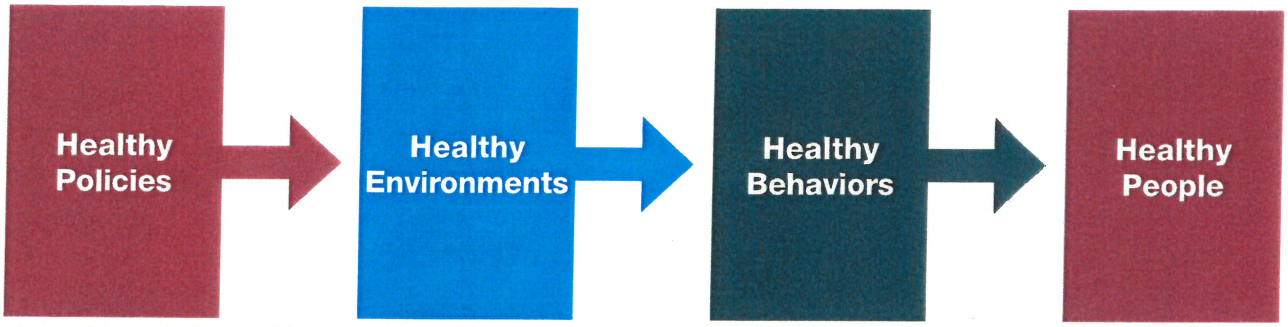
Step one for successful planning is to define the vision. The vision states the ideal conditions for your community and how things would look if the issues were perfectly addressed.

An effective vision statement is:

- Easily understood
- Broad enough to allow for diverse perspectives
- Inspiring and uplifting
- Easy to communicate

In this age of social media, a good rule to follow is for your vision statement to be 140 characters or less. If that's not enough, it should be brief enough to fit on a T-shirt.

What is Policy and Environmental Change?



Advocacy is the act of supporting or recommending a cause or course of action. As a supplement to a PSE approach, advocacy focuses on educating the public, community decision makers and policy makers.

In the area of physical activity, governmental, business and community leaders need to understand the impact of your mission, using information that is credible and valuable.

Monitoring and Evaluation

A critical step of effective planning is monitoring and evaluation. The evaluation process helps form a clear understanding of what progress is being made toward your goals and objectives. You will be able to distinguish between what is working and what is not working.

Other benefits of evaluation include:

- Enables you to measure and celebrate success
- Builds trust within your coalition
- Assists funding partners in making future funding decisions
- Provides an opportunity for you to prioritize, revise or discontinue strategies.

Additional questions to consider when planning evaluation:

1. Who will use the evaluation information?
2. What is being evaluated?
3. What methods will be used to conduct the evaluation?
4. How will the data be analyzed?
5. How can the results be put to use?
6. Would the coalition benefit from a sub-committee focused on evaluation?
7. Does the coalition need outside assistance with evaluation?

tip

The impact of coalition efforts will take time before significant improvements are measurable in a community. Celebrate the small successes and look for both long-term organizational strategies and diverse, long-term funding in order to create sustainable change in the culture of health for a community.

Mission
Taking the vision a step further, the mission statement should convey what your coalition is going to do and why it's going to do it.

A well-crafted mission statement is:
- Concise
- Outcome-focused
- Inclusive

Root Cause Analysis
A root cause analysis is a strategic means of identifying the problem(s) causing the issues you are addressing. Without this step, your action plan may not include solutions that address the core issues.

To get to the root causes, it's important to create an exhaustive list of the underlying factors responsible for the problem. This process should involve a great deal of brainstorming and a wide variety of stakeholders.

It is not feasible or desirable for a coalition to target each of the factors identified during the root cause analysis process. To narrow down the factors to a manageable and appropriate list, each factor needs to be scored and ranked. The highest ranked factors will then be used to develop coalition goals and objectives.

Goals and Objectives
The next step in planning is to prepare goals and objectives. Goals are generalized statements describing the desired change or outcome. Ideally, goals answer these three questions:
- What is the problem?
- How will change be directed?
- Who is the target group?

tip

Allow for some flexibility with goals and objectives to be in different stages such as planning, implementation and evaluation.

Taking the goals a step further involves developing objectives. **SMART** is an acronym for the five components of effective objectives:
- **Specific** – target a specific area for improvement
- **Measurable** – quantifiable or at least suggest an indicator of progress
- **Attainable** – what can be realistically achieved, given available resources
- **Relevant** – supports or is in alignment with other goals
- **Time-specific** – specify when the result(s) can be achieved

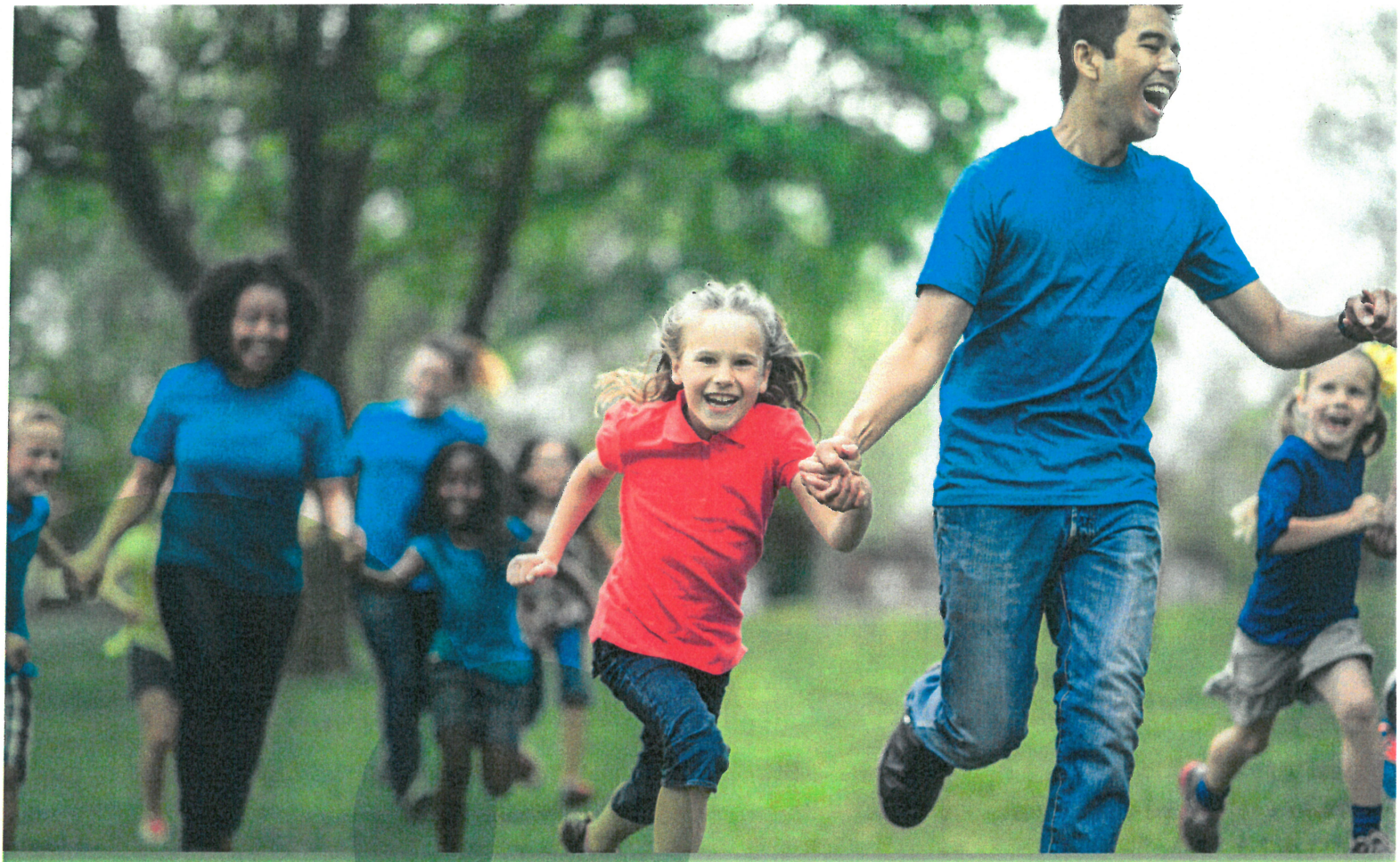
Note: measurable objectives are essential for monitoring and evaluation.

Strategic Planning
Strategies explain how the coalition will achieve its objectives. Generally, coalitions will plan a wide variety of strategies that include people from all the different sectors of the community. An action plan will detail exactly how the strategies will be implemented to accomplish the objectives.

Many communities develop programs and events as part of its strategic plan, but a more sustainable approach to gain traction is known as "Policy, Systems and Environmental Change" (PSE). The major difference between PSE compared to traditional approaches such as events and programs is that the PSE approach is aimed at long-term, sustainable and ongoing behavioral change.

The reason PSE is useful for improving health in a community is because encouraging people to live healthier lives isn't just about changing individual behaviors and creating good habits. Communities need to be places that encourage and promote healthy choices. A PSE approach makes healthier choices a real, feasible option for every member of the community by looking at the laws, rules and environments that impact behavior.

PSE Definitions:
- Policy interventions are laws, ordinances, resolutions, mandates, regulations or rules (both formal and informal).
- Systems interventions are changes that affect all elements of an organization, institution or system.
- Environmental interventions involve physical or material changes to the economic, social or physical environment.



moving forward

By reviewing this guide, you've taken an important first step in addressing community-level issues to improve health and fitness of your community. Now it's time to get moving!

As you lay groundwork for your efforts, one of the best things you can do is be a role model and advocate for good health and physical activity. Here are a few simple steps:

1. Make a commitment to gradually increase your aerobic physical activity to at least 150 minutes of moderate-intensity, or 75 minutes of vigorous-intensity aerobic physical activity a week. For additional health benefits, muscle-strengthening activities that involve all major muscle groups also should be included two or more days a week.[VI]
2. Model healthy behavior by incorporating physical activity into the daily schedule and limiting sedentary activities.
3. Get a pedometer or physical activity tracker and start counting your steps and set targets to eventually accumulate 10,000 steps each day.
4. Write a letter to the editor of your local newspaper to educate the public and bring awareness to the physical inactivity epidemic in your community. Use data from the AFI Data Report to support your argument.
5. Join an existing coalition or create your own using the help of the AFI Community Action Guide!

For more information and resources on the topics mentioned throughout this guide, visit the AFI Community Action Guide resources page.

For more information on the AFI program, visit www.americanfitnessindex.org.

references

I. Centers for Disease Control and Prevention Web site [Internet]. Atlanta (GA): Centers for Disease Control and Prevention; [cited 2015 Oct 15]. Available from: http://www.cdc.gov/physicalactivity/basics/pa-health/.

II. FSG. Reimagining social change. [Internet]. 2015. [cited 2015 Oct 15]. Available from: http://www.fsg.org/.

III. Hanleybrown F, Kania J, Kramer M. Channeling change: making collective impact work. *Stanford Social Innovation Review*. [Internet]. 2012 Jan. 26. [cited 2015 Oct 15]. Available from: http://ssir.org/articles/entry/channeling_change_making_collective_impact_work.

IV. Indiana State Department of Health and the Indiana Healthy Weight Initiative Task Force. *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020.* Indianapolis (IN): Indiana State Department of Health; 2010.

V. Internal Revenue Service. [Internet]. 2015. [cited 2015 Nov 13]. Available from: https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act.

VI. Office of Disease Prevention and Health Promotion. [Internet]. 2015 [cited 2015 Nov 19]. Available from: http://health.gov/paguidelines/guidelines/summary.aspx.

VII. Turner S, Merchant K, Kania J, Martin E. Understanding the value of backbone organizations in collective impact: part 1. *Stanford Social Innovation Review*. [Internet]. 2012 Jul. 17. [cited 2015 Oct 15]. Available from: http://ssir.org/articles/entry/understanding_the_value_of_backbone_organizations_in_collective_impact_1

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ACSM American Fitness Index Community Action Guide Tools and Resources

Coalition Basics

Applied Leadership for Effective Coalitions.
(http://www.ncd.gov/publications/2001/Feb142001) The National Council on Disability developed this guide is designed to assist those interested in promoting leadership development and coalition building.

Centers for Disease Control and Prevention. Community Health Assessment and Group Evaluation (CHANGE)
(http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/change/downloads.htm) The CHANGE tool helps community teams (such as coalitions) develop their community action plan. This tool walks community team members through the assessment process and helps define and prioritize possible areas of improvement

Creating an Effective Coalition: An Eight Step Guide
(http://www.preventioninstitute.org/eightstep.html) From the Prevention Institute, this guide suggests eight specific steps for coalition development.

Elevation: A Community Health Practice Guide
(http://www.communityhealthresource.com/Cultivating_Community_Coalitions.doc) From Community Health Solutions, Inc., this guide outlines 10 steps for starting an effective community coalition and 15 strategies for sustaining a coalition.

Maintaining Effective Community Coalitions
(http://www.cchealth.org/groups/health_services/pdf/maintaining_effective_community_coalitions.pdf) Chuck McKetney and Julie Freestone. This report, from the Contra Costa County (CA) Health Services, provides useful, practical information on running efficient coalitions, evaluating coalition work, and knowing when to end a coalition.

Sustainability Planning Guide
(http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/pdf/sustainability_guide.pdf) A document from the Centers for Disease Control and Prevention to help coalitions develop a plan for sustainable, long-term impact.

Coalition Planning

Blueprint for Action: Developing Livable Communities for All Ages
(http://www.livable.org/storage/documents/reports/AIP/blueprint4actionsinglepages.pdf) From the National Association of Area Agencies on Aging, Partners for Livable Communities, and the MetLife Foundation, this guide provides tools to build the collaborations needed to create livable communities for people of all ages. The resources at the end of the guide can be used to find the information most immediately relevant to your community's priorities and challenges.

The Built Environment Assessment Tool Manual
(http://www.cdc.gov/nccdphp/dch/built-environment-assessment/) This manual explains the importance of understanding and measuring the built environment and provides a tool for doing so.

Centers for Disease Control and Prevention Evaluation Working Group
(http://www.cdc.gov/eval/) This website highlights of a framework, steps, and standards for program evaluation. Links to additional resources are provided.

Complete Streets Laws and Ordinances
(http://www.walkinginfo.org/library/details.cfm?id=3968) National Complete Streets Coalition of the Pedestrian and Bicycle Information Center offers sample policies, ordinances, and design manuals.

Designing & Building Healthy Places
(http://www.cdc.gov/healthyplaces/default.htm) A Centers for Disease Control and Prevention initiative promoting healthy community design. The interaction between people and their environments, natural as well as human-made, continues to emerge as a major issue concerning public health.

Designed to Move
(http://www.designedtomove.org/resources) Reports and research supporting the Designed to Move call-to-action.

Evaluation Tools and Resources
(http://www.samhsa.gov/capt/tools-learning-resources/evaluation-tools-resources) Resources available to support planning and management, implementation and analysis of data and evaluation.

Promoting Health Equity: A resource to Help Communities Address Social Determinants of Health
(http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf) Workbook for public health practitioners and partners interested in addressing social determinants of health in order to promote health and achieve health equity.

SMART: BRFSS City and County Data
(http://www.cdc.gov/brfss/smart/smart_data.htm) The Selected Metropolitan/Micropolitan Area Risk Trends (SMART) project uses the Behavioral Risk Factor Surveillance System (BRFSS) to analyze the data of selected metropolitan and micropolitan statistical areas (MMSAs) with 500 or more respondents. BRFSS data can be used to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs.

Smart Growth Principles
(http://smartgrowth.org/smart-growth-principles/) Suggested principles to building a community that supports physical activity and health.

Strategic Plan, Organizational Structure, and Training System. Chapter 8 Developing a Strategic Plan
(http://ctb.ku.edu/en/table-of-contents/structure/strategic-planning) This information covers seven issues: Overview of strategic planning; developing a vision and mission statement, creating objectives, developing strategies, developing an action plan, obtaining feedback from constituents, and identifying action steps to bring about community and systems change.

Sustainability Planning Guide
(http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/pdf/sustainability_guide.pdf) A document from the Centers for Disease Control and Prevention to help coalitions develop a plan for sustainable, long-term impact.

Sustainable Communities for All Ages
(http://www.sustainable.org/creating-community/building-partnerships/190-sustainable-communities-for-all-ages) This guide from Just Partners, Inc. includes planning worksheets, issues briefs, community checklists, assessment tools, communication tips, coalition building tools, and information on resource development.

YMCA Community Healthy Living Index
(http://www.ymca.net/communityhealthylivingindex/) This is a set of five community assessment tools that measure opportunities for physical activity and healthy eating in areas that impact an individual's daily life. These tools also facilitate discussion about how to improve the community environment to increase opportunities for healthy living.

Youth Risk Behavior Surveillance System
(http://www.cdc.gov/healthyyouth/yrbs/) The Youth Risk Behavior Surveillance System (YRBSS) monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults. The YRBSS includes a national school-based survey conducted by the Centers for Disease Control and Prevention (CDC) and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.

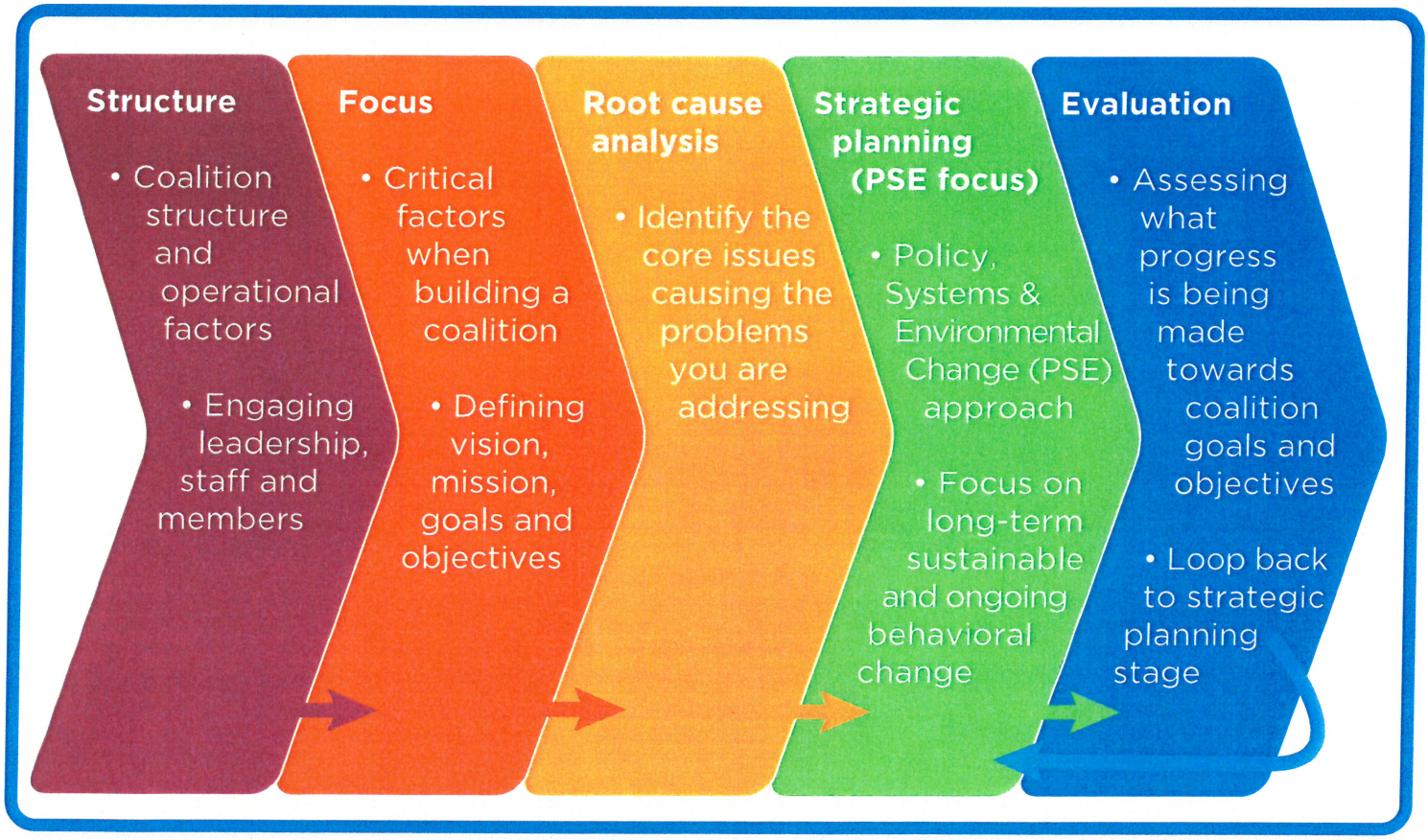
ACSM AMERICAN FITNESS INDEX®

COMMUNITY ACTION FRAMEWORK

Quantitative Data
- AFI Data Report
- Other pertinent data

Qualitative Data
- Key informant interviews
- Case studies
- Focus groups, observations

COALITION



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REPORTS
Legislative Communication

LAO Calls California Competes Tax Credit "Highly Problematic"

The Legislative Analyst's Office (LAO) released a report on the "California Competes" tax credit program this week and finds that the program is not meeting the broad needs of California's businesses and may, in fact, be harming some of them.

The California Competes program was created in 2013 as part of the legislative package to eliminate the Enterprise Zone program, a program that was widely panned as an ineffective economic development tool that did not increase investment or jobs in the state. California Competes was one of three new economic development programs; its final new tax credits will be awarded in 2017-18. The tax credit may be claimed by businesses that meet certain investment and hiring criteria outlined in written agreements with the Governor's Office of Business and Economic Development (GO-Biz). The Franchise Tax Board (FTB) is then responsible for ensuring that the businesses have met the criteria outlined in these agreements. About $780 million was made available for the credits for 2013-14 through 2017-18.

The LAO evaluated the effectiveness of the tax credit for tradable and non-tradable sectors. Non-tradable goods are those produced where they are sold. For this sector, the LAO indicates that the tax credit is a windfall to most businesses, as the credit doesn't result in an overall increase in economic activity. The LAO goes further in suggesting that credits provided to the non-tradable sector harms the economy by providing state resources for an activity that was either already going to occur or came at the expense of other California businesses. About 15 percent of the dollar value of the California Competes tax credit (about 35 percent of total agreements) was awarded to businesses in the non-tradable sector.

For businesses in the tradable sector, businesses need not come at the expense of other California businesses because these businesses may easily be shipped, downloaded, or otherwise transferred to another part of the world. About 85 percent of the dollar value of the California Competes tax

Worth Noting: Legislature Expected to Focus on Sexual Harassment in Capitol Culture

Over the last several weeks, dozens of women have stepped forward to reveal specific and troubling incidents of sexual abuse and harassment in and around the State Capitol—many reportedly involving members of the Legislature and high-ranking staff. These reports have come in the wake of recent publicity around of high-profile sexual harassment scandals in the entertainment industry.

The Legislature is often criticized for explicitly exempting themselves from rules and standards imposed on other workplaces. With this as a backdrop, it is expected that there will be considerable legislative focus and likely a series of hearings to examine and address the culture in the State Capitol. Dates for the hearings have yet to be announced.

The *New York Times*' coverage of these developments can be read here. The *Los Angeles Times* also has explored allegations of sexual harassment in the Capitol in recent weeks.

credit was provided to the tradable sector. For these businesses, the LAO notes that it is very difficult to ascertain the impact of the tax credit on an individual business's plans to expand in the state.

The LAO recommends ending the California Competes tax credit and, if the Legislature is interested in providing tax relief to California businesses, replacing it with a broad policy change that benefits all California businesses, like reducing the corporate tax rate or reducing the minimum tax. If the Legislature decides to continue with the California Competes tax credit, the LAO suggests (1) more narrowly targeting the program to tradable businesses, (2) refocusing the program on its core mission as a tool for interstate economic development competition, and (3) modifying the small business provisions to eliminate the requirement to set aside 25 percent of the tax credits for small business and instead offering state-provided technical assistance to small businesses.

Governor Brown Weighs in on GOP Tax Plan

Governor Jerry Brown released a statement on the new tax plan released by congressional Republicans today: "The hurried tax proposal unveiled by Congress today transfers income from individuals and families to large and powerful corporate structures. This is bad economic policy and bad for the American people."

The GOP's plan includes reducing the corporate tax rate from 35 to 20 percent; reducing the number of tax brackets from 7 to 4 for individuals and families; doubling the standard deduction for individuals and families; capping local property tax deductions at $10,000; creating a new family tax credit; maintaining the mortgage interest deduction for home loans up to $500,000; doubling exemptions for estate taxes on inherited assets; repealing estate taxes after six years; eliminating the electric vehicle tax credit; and allowing small businesses to write off loan interest, among many, many other provisions. The President wants a tax package on his desk by Thanksgiving, while Senate Republicans have said their goal is to complete work on the tax package by the end of the calendar year. (*The Washington Post* put out a handy Q & A on the tax plan here.)

Earlier this week, Governor Brown sent letters to California's 14 Republican members of Congress, asking them to vote no on provisions in the tax plan to eliminate tax deductibility for state and local taxes.

Pretrial Detention Reform Workgroup Issues Report and Recommendations

In October 2016, Chief Justice Tani Cantil-Sakauye established a 12-member Pretrial Detention Reform Workgroup to assess the current bail system in California and to make recommendations about ways to improve pretrial release decisions. The workgroup issued its report last week, which advances 10 far-reaching recommendations.

First, a few notes about the process. The workgroup was chaired by Ventura County Superior Court Judge Brian Back; other members included 10 additional superior court judges and one court executive. The workgroup's undertaking was guided by a set of principles to help achieve the goal of making release decisions that treat people fairly, protect the public, and ensure court appearances. The workgroup took in-person input from more than 40 speakers from a range of disciplines and perspectives. In addition, members undertook an extensive review of research and policy materials; they also studied the models and considered the experiences of out-of-state jurisdictions that have implemented pretrial reform efforts. The workgroup studied the complex issues associated with the

current pretrial release and detention system in California, ultimately finding that today's system is unfair, does not improve public safety, and exacerbates socioeconomic disparities and racial bias.

These conclusions led to the workgroup's following recommendations, which are meant to be implemented as a whole. The recommendations contemplate sweeping reforms to and a complete rewrite of California's bail system.

1. Implement a robust risk-based pretrial assessment and supervision system to replace the current monetary bail system.
2. Expand the use of risk-based preventive detention.
3. Establish pretrial services in every county.
4. Use a validated pretrial risk assessment tool.
5. Make early release and detention decisions.
6. Integrate victim rights into the system.
7. Apply pretrial procedures to violations of community supervision.
8. Provide adequate funding and resources.
9. Deliver consistent and comprehensive education.
10. Adopt a new framework of legislation and rules of court to implement these recommendations.

The report offers a summary of the historic origins of bail and how it has evolved, more recent pretrial trends, the nationwide conversation about evidence-based risk assessment and detention decisions, the movement away from traditional bail practices, federal litigation regarding the constitutionality of money-based bail systems, and reforms in other states. It then takes a closer look at recent criminal justice reforms as well as the current bail system in California and how it has evolved since the early days of statehood.

The workgroup's fundamental conclusion is that a pretrial system based strictly on a defendant's financial position – rather than the risk he or she poses to community safety – is inherently unfair and unsafe. In presenting its 10 recommendations – which the workgroup exhorts must be implemented as a whole and not individually, the workgroup report asserts that the judicial branch and courts are uniquely qualified to lead bail reform. As it relates to the establishment of pretrial services in every county (recommendation #2), the workgroup specifies that the Judicial Council must establish guidelines for pretrial services to "foster trust and confidence by the courts;" it does not opine further on the structure or governance of county pretrial agencies. It further suggests a direct role for the Judicial Council in a range of other activities, including providing guidance on the proper administration and use of pretrial risk assessments. As for funding, the report highlights the need to provide significant new resources to support the recommended reforms, including an initial investment and ongoing funding. The report outright rejects any funding model that would rely on anticipated savings, predicting reforms will fail if they are not supported by new and adequate resources. Finally, the workgroup envisions a complete and comprehensive statutory rewrite and new rules of court to create the system of release and detention recommended in the report. Sufficient time to develop and implement the new system should also be provided, the workgroup suggests.

The report – which also offers extensive resources in its eight appendices – can be read in its entirety here; additional information on the workgroup can be read at this link.

Universal Health Care Hearings Begin

The Assembly Select Committee on Health Care Delivery Systems and Universal Coverage, co-chaired by Assembly Members Jim Wood and Joaquin Arambula, convened a two-day hearing in Sacramento on October 23 and 24 to discuss health care delivery systems in California and other countries. The committee includes Assembly Members Autumn Burke (D-Inglewood), David Chiu (D-San Francisco), Laura Friedman (D-Glendale), Tom Lackey (R-Palmdale), and Marie Waldron (R-Escondido). The Select Committee focused the October 23 hearing on an overview of California's current health care system. The second day included presentations on universal health coverage provided in other counties and offered an opportunity for public comment. All of the committee's Democratic members attended both days; no Republicans attended. It should be noted that Assembly Members Chiu and Friedman are co-authors of SB 562 (Lara), the single payer measure.

The first day of the hearing highlighted the serious federal challenges to the health care system and the federal resources at risk. While the hearing was framed to help members understand the complexity of the existing health system, members expressed some displeasure about "getting into the weeds." There was some discussion of short-term steps California could take to cover all Californians, including expanding Medi-Cal for undocumented adults or allowing higher income Californians to buy into Medi-Cal. Expanding Medi-Cal to undocumented adults is estimated to cost $1 billion.

The second day was focused on what other countries' health care systems look like. The presenters talked about both publicly financed health care and publicly financed health insurance models. Of note, none of the other countries discussed provides comprehensive coverage to undocumented individuals. During public comment, many individuals affiliated with the California Nurses Association and supporters of SB 562 expressed frustration with the Assembly's process, making pointed comments about Speaker Rendon who put discussions about the "woefully incomplete" single-payer measure on hold earlier this year.

The agenda from the hearing can be found here; background materials and speaker presentations can be viewed here.

Future universal health care hearings will examine the following topics:

- Health care systems within American cities and states – both proposed and in operation – and the challenges they have faced in achieving health care for all
- Input from stakeholders on proposed universal coverage systems, including but not limited to ACA expansion, single payer and hybrid systems
- Identified challenges to achieving health care for all in California and what must be done to address them

Opioid Crisis: Trump Administration Declares Public Health Emergency

The Commission on Combatting Drug Addiction and the Opioid Crisis released its final report on November 1. The Commission provided 56 wide-ranging recommendations aimed at addressing the opioid crisis in the United States. The recommendations include expanded use of drug courts at the federal level, educational requirements for prescribers, media campaign to educate the public, stigma reduction, broader reimbursements for alternatives to opioids for pain management, as well

as expanded use and distribution of the opioid overdose reversal drug Naloxone. During an interview regarding the report, when asked what should be the "top thing to tackle," Commission member Bertha Madras, PhD responded with the notion of offering treatment on demand. The report does not identify additional funding for its recommendations. However, it does recommend block granting several substance use disorder funding streams.

Last week, the Trump Administration declared a public health emergency due to the opioid crisis. While the emergency declaration made by the Department of Health and Human Services makes only $57,000 available to address the issue, the White House pointed to the budget negotiations in the coming weeks as an opportunity for allocating additional funding. The declaration addresses the following:

- **Telemedicine.** A regulatory change to allow for the prescription of "medicine commonly used for substance abuse or mental health treatment" via telemedicine. It is anticipated that additional telemedicine in rural areas with substance use disorder to access care.
- **Personnel.** The declaration allows HHS, and states with governors who request it, to "make temporary appointments of specialists with the tools and talent needed to respond effectively" to the crisis.
- **Labor grants.** Subject to funding, the Department of Labor will issue "dislocated worker grants" to those displaced from the workforce due to the opioid crisis.
- **HIV/AIDS resource shifts.** The Administration is shifting resources within existing programs aimed at delivering HIV/AIDS care to better serve those with both HIV/AIDS and substance use disorder.

Assembly Discusses Housing Affordability

The Assembly Housing Committee held an informational hearing last week on housing affordability; the agenda can be viewed here. The October 24 hearing – *The Housing Affordability Crisis: Exploring the Effects of Renter Displacement* – was structured into two panels and opened with a speaker sharing her experiences as a tenant in San Francisco and Alameda County. The first panel included the Legislative Analyst's Office, the director of the UC Berkeley Urban Displacement project, and Alameda County's Public Health Director and Health Officer. The second panel included representatives from the Campbell Union School District and Asian Pacific Environmental Network and a professor from the California State University Sacramento, Division of Social Work.

The UC Berkeley Urban Displacement speaker offered an overview of strategies to address displacement (see page 4 of this document) and offered local data, including the following:

- One in 3 displaced households in San Mateo County reported some period of homelessness or marginal housing
- 33 percent of displaced households left the county
- Displaced into worse-off neighborhoods (with fewer economic opportunities)

Dr. Davis from Alameda County presented on the health outcomes affected by high rent, displacement, housing instability, and homelessness; his slides along with other presentation materials and background information can be reviewed here.

California Adaptation Forum Planned for August 2018 – Input Needed

The State of California and Local Government Commission have announced the dates of the 3rd California Adaptation Forum, which is a convening of climate leaders across a range of disciplines. The forum is designed to foster knowledge exchange, innovation, and mutual support to transition from adaptation awareness to planning and action through a series of engaging plenaries, sessions, workshops, and networking activities.

The forum, scheduled for August 28 and 29, 2018 – with pre-forum workshops also planned for August 27 – will be held in Sacramento. The event organizers are asking for input on priority topics. Interested parties can offer ideas for sessions, network meetings and workshop on the survey found at link.

Upcoming Hearings

A number of interim policy hearings on topics of interest have been scheduled through the end of the year and in to 2018. Agendas and materials can generally be found at the sponsoring committee's website (refer to relevant links for the Senate and Assembly).

Date / Location	Committee	Topic
Thursday, November 2 @ 10 a.m. - **Pasadena**	Assembly Select Committee on Regional Transportation Solutions	Advancing Sustainability in Regional Transportation Projects
@ 4 p.m. - **Pomona**	Assembly Select Committee on Local Public Safety and Emergency Preparedness	Regional Assessment on Pupil Susceptibility to Internet Abuse and Exploitation
@ 6 p.m. - **Fresno**	Assembly Select Committee on Diabetes and Heart Disease Prevention	Addressing Health Inequities and Implementing Effective Prevention Programs
Friday, November 3 @ 9 a.m. - **Heber**	Joint Legislative Committee on Climate Change Polices and Natural Resources	Air Quality in the Border Region
Monday, November 6 @ 11 a.m.	Assembly Select Committee on Asian Pacific Islander Affairs	The Status of Asian American and Pacific Islander Youth
@ 3 p.m. - **Seaside**	Assembly Select Committee on the Status of Boys and Men of Color	Identifying the Impact of Intersections of Justice, Education, Mental Health on Boys and Men of Color Living on California's Central Coast
Tuesday, November 7 @ 10 a.m. – **Isla Vista**	Joint Hearing of the Assembly Select Committee on Wine and the Senate Select Committee on California's Wine Industry	California Wine Industry: Preliminary Fire Recovery Update and Pest Management Awareness
Thursday, November 9 @ 10 a.m. – **San Jose**	Senate Transportation and Housing Committee	Jobs and Economy: Pre-apprenticeship and Disadvantaged Business Enterprise Programs for Transportation Infrastructure Projects
@ 10 a.m. - **Sacramento**	Senate Budget Fiscal Review Subcommittee No. 3 on Health and Human Services	Achieving and Maintaining Adequate Provider Networks in Medi-Cal Managed Care

Date / Location	Committee	Topic
Tuesday, November 14 @ 10 a.m. - **Sacramento**	Joint Hearing of the Senate Select Committee on Women and Inequality: Strategies to Promote Opportunity and the Senate Labor and Industrial Relations Committee	Implicit Bias and Its Impact on Women in the Workforce: Occupational Segregation
Wednesday, November 15 @ 1:30 p.m. – **Long Beach**	Joint Legislative Committee on Emergency Management	When Free Speech Crosses the Line: Protecting Public Safety in California
Tuesday, December 5 @ 1:30 p.m. - **Sacramento**	Assembly Joint Hearing on Higher Education and Education Committees	The Shortfall of Credential Teachers
Wednesday, January 17 @ 9:30 a.m. – **Sacramento**	Joint Hearing of the Senate Environmental Quality Committee and Senate Budget and Fiscal Review Subcommittee No. 3 on Resources, Environmental Protection, Energy and Transportation	California's Cap-and-Trade Program: the Air Resources Board's 2018 Scoping Plan

Please feel free to contact any one of us at Hurst Brooks Espinosa with questions ...

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New Laws of 2018 Series Part VIII: 2017 CSDA-sponsored legislation is now law

By Greg Orsini, CSDA Board President

Are you familiar with your county's Local Agency Formation Commission or LAFCO? LAFCOs administer and approve the formation, dissolution, and boundaries of local agencies, including cities and special districts. Each of California's 58 counties has one LAFCO, but they are independent from the county government. LAFCOs are composed of representatives from local cities, counties, and members of the public. Special districts may also have two representatives on LAFCO, if they choose to exercise this right. Since 1972, special districts have obtained LAFCO representation in 30 of the 58 counties.

It is valuable for special districts to obtain representation on their local LAFCOs, as LAFCOs determine what services they may provide, adjust the boundaries of the district, and perform a municipal service review of the district every five years. If you are not at the table, you may very well be on the menu.

With representation, your special district can influence LAFCO policy and decision making, providing a more balanced perspective on self-governance.

Previously, special districts could acquire representation on a LAFCO if a majority of special districts in a county passed a board resolution supporting such action within a one-year period. The most recent county to gain special district representation was Santa Clara County in 2012. Organization of the County's 20 special districts to vote on an individual board resolution within a one-year period required a well-funded campaign and a part-time organizer.

CSDA-sponsored Assembly Bill 979 (Lackey), simplified the existing process and will make it easier for your district to obtain representation on LAFCO. AB 979 allows special districts to vote on LAFCO representation in a meeting of the county's independent special districts selection committee. Every independent special district would have the opportunity to participate in the election process, either in-person or by mail, casting one vote for or against the matter at hand. The vote on special district representation can be combined with the committee's other duties, including selecting a representative for the countywide RDA oversight board, as required by law before July 15, 2018.

On behalf of CSDA, I would like to thank Assemblymember Tom Lackey (Antelope Valley) for his willingness to author this bill and his continued support of good governance and local flexibility.

We would also like to thank our members for their continued support, input, and feedback on our annual sponsored legislation. Stay tuned to hear about our 2018 sponsored bill, or visit our website to find ways to Take Action!

Check the map to see if your special district is represented on LAFCO. If it isn't, check with your local CSDA affiliated chapter or CSDA Field Coordinator to see what you can do to get representation.

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Thank you for reading CSDA's New Laws of 2018 Series, an eight-part series where experts explain legislation that was passed in 2017 and how it will impact special districts moving forward. Missed an article? The entire series is still available:

New Laws of 2018 Series

- Part I: The Benefits of Knowing the Full Cost of Debt Financing: SB 450
- Part II: New California Law Expands Baby Bonding Leave to Mid-Size Employers
- Part III: SB 231 and How Special Districts Can Help with Water Reliability
- Part IV: Changes to control guidelines detect and prevent financial errors and fraud
- Part V: Two Bills Addressing Pay Disparities – AB 168 and AB 1008
- Part VI: To indemnify and defend? SB 496 changes the rules for design professional contract
- Part VII: New Option Now Legal for Records Retention

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