

Community Health Commission (CHC)

COMMUNITY HEALTH COMMISSION MEETING AGENDA

Thursday, July 28, 2016 - 6:30 pm – 9:00 pm
South Berkeley Senior Center, 2939 Ellis Street
Berkeley, CA 94709

Preliminary Matters

1. Roll Call
2. Announcements & Introductions of any new members
3. Approval of Minutes from prior meeting (Attachment 1)
4. Confirm note taker
5. Public Comment (*Speakers will have up to 5 minutes each*)

Presentation Items

1. **Health Officer Update:** Janet Berreman
2. **Tony Wilkinson, Friends of Adeline Corridor:** will provide brief overview on the discussion points of this community group in relation to the Adeline Corridor project
3. **Work plan Progress:** All (Attachment 3)

Discussion Items

1. **Discuss the expansion of the Heart-2-Heart program** [Rosales]

Subcommittee Reports

1. **Health Equity Subcommittee Report**
2. **Public Outreach & Education Subcommittee Report**
3. **Other Subcommittee Reports**

Action Items

1. **Action:** Appoint new members to subcommittees [Nathan] (Attachment 4)
2. **Action:** Request letters of support from other City Commissions around recommendation for development of African American Holistic Resource Center [Kwanele & Stein]
3. **Action:** Send a letter to City Council requesting that the information on electromagnetic fields (EMF) be corrected and updated on the Berkeley HHS/PH website in accordance with the Data Quality Act [Stein] (Attachments 5-8)
4. **Action:** Move to form a CHC Task Group or assign to an existing CHC Sub-Committee or form a new CHC Sub-Committee to develop recommendations to Council to aim to reduce the existing reporting lag in Berkeley's own disease data that can exceed in some cases more than 3 years [Stein] (Attachment 9)
5. **Action:** Possible changes to Alta Bates report given Council action from July 12 (Attachments 10-11)

Information Items

1. **Commission Work Plans:** Council voted on July 19 to require that Commissions submit a work plan detailing goals and objectives for the year. Plans will be submitted at the start of the fiscal year, annually (Attachment 12)
2. **BMC enabling legislation for Community Health Commission:** Council voted on July 19 to refer to staff to write an ordinance based on the Community Health Commission

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recommendation with suggested changes by staff to address administrative authority, including reducing Commission size from 18 to 9 members

3. **Tobacco Tax Act:** Council voted on July 19 to adopt a resolution supporting the California Healthcare, Research and Prevention Tobacco Tax Act of 2016. This is a state ballot measure that would add a \$2 tax for cigarettes and other tobacco products (such as e-cigarettes) (Attachment 13)

Future Agenda Items

1. Update from staff regarding health resources at Berkeley Technology Academy [Staff]
2. Berkeley Police Department to provide overview on police data [Franklin/Staff]
3. Presentation by Healthy Black Families [Kwanele]

Adjournment

Attachments:

1. Draft minutes of 6/23/16 CHC meeting
2. Approved minutes of 5/26/16 CHC meeting
3. Community Health Commission work plan
4. Community Health Commission subcommittee roster
5. EMF study slides
6. EMF – International Scientist Appeal article
7. FCC report – Human Exposure to EMF
8. Berkeley resident communication – EMF radiation concerns
9. Disease data reporting – Biden article
10. Council action on 7/12/16 re: Alta Bates closure – Annotated Agenda excerpt
11. Council resolution re: Alta Bates closure
12. Council recommendation regarding Commission work plans
13. Council recommendation & resolution to support Tobacco Tax ballot measure
14. City Council and Community Health Commission timelines

The next meeting of the Community Health Commission is scheduled for September 22, 2016 with a deadline of September 8, 2016 for the public's submission of agenda items and materials for the agenda packet. Dates are subject to change; please contact the Commission Secretary to confirm.

Please refrain from wearing scented products to this meeting.

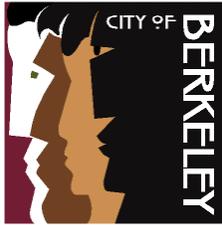
COMMUNICATION ACCESS INFORMATION

This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6346 (V) or 981-6345 (TDD) at least three business days before the meeting date.

Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. Please note: e-mail addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record. If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the commission secretary for further information.

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection at the North Berkeley Senior Center located at 1901 Hearst Avenue, during regular business hours. The Commission Agenda and Minutes may be viewed on the City of Berkeley website:

<http://www.cityofberkeley.info/commissions>.



Community Health Commission

Community Health Commission

Meeting Location: South Berkeley Senior Center
2939 Ellis Street, Berkeley, CA

Draft Minutes Regular Meeting, Thursday June 23, 2016

The meeting convened at 6:59 p.m. with Vice Chair Kwanele presiding.

ROLL CALL

Present: Commissioners Chen, Franklin, Kwanele, Lingas, Lopez, Namkung (7:01), Shaw (7:12), Stein (7:00), Teunis, Wertman (7:15), and Wong

Absent: Commissioner Speich

Excused: Commissioners Engelman, Nathan, and Rosales

Staff present: Janet Berreman and Tanya Bustamante

COMMENTS FROM THE PUBLIC

- 5 individuals provided comment regarding City Council's referral to the Community Health Commission to explore alternatives to providing acute care services in Berkeley, in light of the impending termination of these services at the Sutter Alta Bates Hospital campus.
- 1 individual provided comment regarding the Community Environmental Advisory Commission's cigarette butt litter proposal to the City Council

PRESENTATIONS

- None

ACTION ON MINUTES

1. M/S/C (Stein/Chen) Motion to approve the draft April 2016 minutes.

Ayes: Commissioners Chen, Franklin, Kwanele, Lopez, Namkung, Stein, Teunis, and Wong

Noes: None

Abstain: Commissioner Lingas

Absent: Commissioner Speich

Absent from vote: Commissioners Shaw and Wertman

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Excused: Commissioners Engelman, Nathan, and Rosales

Motion Passed.

ACTION ITEM

2. M/S/C (Chen/Teunis) Motion to approve amended report to City Council to address referral regarding Alta Bates hospital closure.

Ayes: Commissioners Chen, Franklin, Lingas, Lopez, Namkung, Shaw, Stein, Teunis, Wertman, and Wong

Noes: None

Abstain: None

Absent: Commissioner Speich

Absent from vote: Commissioner Kwanele

Excused: Commissioners Engelman, Nathan, and Rosales

Motion passed.

ACTION ITEM

3. M/S/C (Stein/Chen) Motion to support the recommendation to Council from the Community Environmental Advisory Commission regarding the pilot project to address cigarette butt litter and smoking in commercial zones.

Ayes: Commissioners Chen, Franklin, Kwanele, Lopez, Namkung, Shaw, Stein, Teunis, Wertman, and Wong

Noes: None

Abstain: Commissioner Lingas

Absent: Commissioner Speich

Excused: Commissioners Engelman, Nathan, and Rosales

Motion passed.

ACTION ITEM

4. M/S/C (Namkung/Lopez) Motion to approve the report to City Council recommending that Council support the \$2 cigarette tax November ballot measure.

Ayes: Commissioners Chen, Franklin, Kwanele, Lingas, Lopez, Namkung, Shaw, Stein, Teunis, Wertman, and Wong

Noes: None

Abstain: None

Absent: Commissioner Speich

Excused: Commissioners Engelman, Nathan, and Rosales

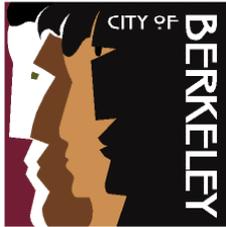
Motion passed.

NEXT MEETING

The next regular meeting will be on July 28, 2016 at 6:30 p.m. at the South Berkeley Senior Center.

This meeting was adjourned at 9:04 p.m.

Respectfully Submitted, Tanya Bustamante, Secretary.



Community Health Commission

Community Health Commission

Meeting Location: South Berkeley Senior Center
2939 Ellis Street, Berkeley, CA

Minutes Regular Meeting, Thursday May 26, 2016

The meeting convened at 6:35 p.m. with Vice Chair Kwanele presiding.

ROLL CALL

Present: Commissioners Chen, Engelman (6:37), Kwanele, Lopez, Namkung, Rosales, Speich (7:39), Stein (6:48), Teunis, and Wong (6:39)

Absent: Commissioner Shaw

Excused: Commissioners Franklin, Nathan, and Wertman

Staff present: Janet Berreman and Tanya Bustamante

COMMENTS FROM THE PUBLIC

- 16 individuals (including Councilmember Kriss Worthington) provided comment regarding City Council's referral to the Community Health Commission to explore alternatives to providing acute care services in Berkeley, in light of the impending termination of these services at the Sutter Alta Bates Hospital campus.

PRESENTATIONS

- **Public Health Priorities & City Budget Overview** – Janet Berreman
- **Public Health Accreditation Overview** – Tanya Bustamante

ACTION ON MINUTES

1. M/S/C (Chen/Rosales) Motion to approve the draft April 2016 minutes.

Ayes: Commissioners Chen, Engelman, Kwanele, Lopez, Teunis, and Wong

Noes: None

Abstain: Commissioners Namkung and Rosales

Absent: Commissioner Shaw

Absent from vote: Commissioners Speich and Stein

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Excused: Commissioners Franklin, Nathan, and Wertman

Motion Passed.

ACTION ITEM

2. M/S/C (Stein/Teunis) Motion to approve edited and revised recommendation and resolution to City Council opposing Sutter Health Corporation's plans to cease operations at Alta Bates Hospital in Berkeley.

Ayes: Commissioners Chen, Engelman, Kwanele, Lopez, Namkung, Rosales, Speich, Stein, Teunis, and Wong

Noes: None

Abstain: None

Absent: Commissioner Shaw

Excused: Commissioners Franklin, Nathan, and Wertman

Motion Passed.

NEXT MEETING

The next regular meeting will be on June 23, 2016 at 6:30 p.m. at the South Berkeley Senior Center.

This meeting was adjourned at 9:03 p.m.

Respectfully Submitted, Tanya Bustamante, Secretary.

Community Health Commission Work Plan 2016

Guiding Philosophy: To look at health through the lens of equity, and to address, ameliorate, and abolish health inequities in Berkeley through our work while advancing other public health efforts.

Mission/Purpose:

1. Work with the community and the Berkeley Public Health Division to eliminate health inequity by:
 - Representing the community through the diversity of this commission
 - Advocating for good policy to council that has the potential to improve the health of Berkeley residents that can be implemented, monitored, and evaluated.
 - Increasing the public education/social marketing efforts, understanding, and awareness of issues
 - Advocating together with the residents of Berkeley most affected by institutional, social, organizational inequities/disparities
 - Being the bi-directional conduit of information and resources between community and PHD

2. Achieve general public health progress by being responsive to community needs and facilitating general health and safety.

Overall goals, issues & priorities: All issues can be addressed through a health equity lens.

1. Make progress toward realizing an African American Holistic Resource Center
2. Advocate for the expansion of the Heart-2-Heart Program
3. Increase community access to healthy food while reducing unhealthy food
4. Further address more social determinants of health, such as affordable housing
5. Expand community communication to generate a more informed and engaged coalition
6. Work to have community health data measures documented in a timely manner

General steps and actions needed to meet priorities:

1. Better follow up with council implementations
2. Collaborate with other commissions to share resources and support recommendations
3. Focused/specialized subcommittees / ad hoc sub committees (funnel intelligence/knowledge into smaller groups)
4. Keep track of state policy and data flow

Specific steps and actions needed to meet priorities:

- ❖ Subcommittees
 - Healthy Food Security
 - Identify food deserts
 - Connect communities with resources
 - Propose policies to mitigate unhealthy food consumption
 - Food surplus
 - Change perception of tossing food & poor hygiene
 - Policy tracking
 - Track City Council minutes, state, and national legislative actions
 - Health Equity Subcommittee
 - Continue work to get a resource center in South Berkeley
 - Chronic Disease Prevention
 - Focus on diabetes, heart disease
 - Structural/Institutional Inequity Issues Sub Committee
 - Wider scope than Health Equity Subcommittee to identify and address social determinants of health that are less proximate causes of health inequities
 - Public Education and Outreach
 - Continue efforts to share health information and empower the community
 - Collaborate with community partners
 - Novel subcommittees as needed to quickly address City Council referrals
 - Other subcommittees on issues that are not heavily addressed due to lower incidence rates, yet have high severity
 - Human trafficking
 - Neurological Conditions
- ❖ Liaisons to other commissions
 - Housing Advisory Commission
 - Homeless Commission
 - Zero Waste Commission
 - Mental Health Commission
 - Human Welfare and Community Action Commission
 - Community Environmental Advisory Commission
 - Sugar Sweetened Beverage Panel collaboration with regular meetings about progress

Community Health Commission
2016 Subcommittee Roster

District	Last	First	Subcommittees							
			Acute Services for Berkeley	Health Equity	Public Outreach & Education	Healthy Food Security	Policy Tracking	Chronic Disease Prevention	Envisioning Future of CHC & Workplan	Structural/ Institutional Inequity Issues
1	Engelman	Alina								
1	Vacant									
2	Vacant									
2	Vacant									
3	Kwanele	Babalwa		X					X	X
3	Vacant									
4	Stein	Antoinette		X						
4	Wong	Marilyn	X	X	X				X	
5	Teunis	Niels								
5	Wertman	Holly	X			X				
6	Franklin	Linda	X		X	X	X		X	
6	Lingas	Elena								
7	Nathan	Neal		X			X	X	X	X
7	Lopez	Enrique			X					
8	Chen	Leona			X				X	
8	Namkung	Poki							X	
M	Rosales	Ces		X	X				X	
M	Shaw	Mia				X				

NTP Toxicology and Carcinogenicity Studies of Cell Phone Radiofrequency Radiation

Michael Wyde, PhD, DABT

**National Toxicology Program
National Institute of Environmental Health Sciences**

June 8, 2016

BioEM2016 Meeting, Ghent, Belgium





Hyperplastic Brain Lesions in Male Rats

	Control	GSM Modulation			CDMA Modulation		
	0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg
Number examined	90	90	90	90	90	90	90
Malignant glioma [‡]	0*	3 (3.3%)	3 (3.3%)	2 (2.2%)	0	0	3 (3.3%)
Glial cell hyperplasia	0	2 (2.2%)	3 (3.3%)	1 (1.1%)	2 (2.2%)	0	2 (2.2%)

[‡] Historical control incidence in NTP studies: 11/550 (2.0%), range 0-8%

* Significant SAR-dependent trend for CDMA exposures by poly-6 ($p < 0.05$)



Hyperplastic Brain Lesions in Female Rats

	Control	GSM Modulation			CDMA Modulation		
	0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg
Number examined	90	90	90	90	90	90	90
Malignant glioma [‡]	0	0	0	1 (1.1%)	2 (2.2%)	0	0
Glial cell hyperplasia	0	0	1 (1.1%)	0	1 (1.1%)	1 (1.1%)	1 (1.1%)

[‡] Historical control incidence in NTP studies: 2/340 (0.3%), range 0-2%

- No exposure-related change in the incidence of brain lesions in female rats



Hyperplastic Heart Lesions in Male Rats

	Control	GSM Modulation			CDMA Modulation		
	0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg
Number examined	90	90	90	90	90	90	90
Schwannoma [‡]	0*	2 (2.2%)	1 (1.1%)	5 (5.5%)	2 (2.2%)	3 (3.3%)	6** (6.6%)
Schwann cell hyperplasia	0	1 (1.1%)	0	0	0	0	3 (3.3%)

[‡] Historical control incidence in NTP studies: 9/699 (1.3%), range 0-6%

* Significant SAR-dependent trend for GSM and CDMA exposures by poly-3 ($p < 0.05$)

** Significant different than controls poly-3 ($p < 0.05$)



Hyperplastic Heart Lesions in Female Rats

	Control	GSM Modulation			CDMA Modulation		
	0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg
Number examined	90	90	90	90	90	90	90
Schwannoma [‡]	0	0	2 (2.2%)	0	2 (2.2%)	0	2 (2.2%)
Schwann cell hyperplasia	0	0	0	0	1 (1.1%)	1 (1.1%)	1 (1.1%)

[‡] Historical control incidence in NTP studies: 4/699 (0.6%), range 0-4%

- No exposure-related change in the incidence of heart lesions in female rats



Schwannomas Observed in Male Rats

	Control	GSM Modulation			CDMA Modulation		
	0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg
Number examined	90	90	90	90	90	90	90
Heart [‡]	0*	2 (2.2%)	1 (1.1%)	5 (5.5%)	2 (2.2%)	3 (3.3%)	6** (6.6%)
Other sites	3 (3.3%)	1 (1.1%)	4 (4.4%)	2 (2.2%)	2 (2.2%)	1 (1.1%)	2 (2.2%)
All sites (total)	3 (3.3%)	3 (3.3%)	5 (5.5%)	7 (7.7%)	4 (4.4%)	4 (4.4%)	7 (7.7%)

[‡] Historical control incidence in NTP studies: 9/699 (1.3%), range 0-6%

* Significant SAR-dependent trend for GSM and CDMA exposures by poly-3 ($p < 0.05$)

** Significant different than controls poly-3 ($p < 0.05$)



Schwannomas Observed in Female Rats

	Control	GSM Modulation			CDMA Modulation		
	0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg	1.5 W/kg	3.0 W/kg	6.0 W/kg
Number examined	90	90	90	90	90	90	90
Heart [‡]	0	0	2 (2.2%)	0	2 (2.2%)	0	2 (2.2%)
Other sites	4 (4.4%)	1 (1.1%)	3 (3.3%)	2 (2.2%)	0	2 (2.2%)	2 (2.2%)
All sites (total)	4 (4.4%)	1 (1.1%)	5 (5.5%)	2 (2.2%)	2 (2.2%)	2 (2.2%)	4 (4.4%)

[‡] Historical control incidence in NTP studies: 9/699 (1.3%), range 0-6%

- No exposure-related change in the incidence of schwannomas in female rats



- Body weights at birth and throughout lactation in rat pups exposed *in utero* tended to be lower than controls
- In general, survival was greater in all groups of GSM or CDMA RFR-exposed rats compared to controls
- Increased incidence of schwannoma was observed in the hearts of male rats at 6 W/kg
 - Significant SAR-dependent positive trend (GSM and CDMA)
 - Significant pair-wise increase at 6 W/kg (CDMA)
- There was a significant SAR-dependent trend for increased gliomas in the brain of rats exposed to CDMA-modulated RFR
- No exposure-related effects were observed in the brains or hearts of female rats



Why not wait and release all study data?

Attachment 5

- Given widespread global usage, even a small increase in incidence of disease resulting from RFR exposure could have broad implications for public health
- High level of public and media interest
- Tumor types observed in this study are similar type to those observed in some epidemiology studies of cell phone users
- Supports IARC conclusions of potential carcinogenic potential of RFR



- The hyperplastic lesions and glial cell neoplasms of the heart and brain observed in male rats are considered likely the result of whole-body exposures to GSM- or CDMA-modulated RFR.
 - There is higher confidence in the association between RFR exposure and the neoplastic lesions in the heart than in the brain.
- Exposure of female rats to GSM- or CDMA-modulated RFR resulted in no biologically significant effects in the brain or heart.



Acknowledgements/Collaborations

Attachment 5



National Institute of
Environmental Health Sciences
Research Triangle Park, NC



Chicago, IL



Boulder, CO



Zurich, Switzerland



**To: His Excellency Ban Ki-moon, Secretary-General of the United Nations;
Honorable Dr. Margaret Chan, Director-General of the World Health Organization;
Honorable Achim Steiner, Executive Director of the U.N. Environmental Programme;
U.N. Member Nations**

International Appeal: Scientists call for Protection from Non-ionizing Electromagnetic Field Exposure

We are scientists engaged in the study of biological and health effects of non-ionizing electromagnetic fields (EMF). Based upon peer-reviewed, published research, we have serious concerns regarding the ubiquitous and increasing exposure to EMF generated by electric and wireless devices. These include—but are not limited to—radiofrequency radiation (RFR) emitting devices, such as cellular and cordless phones and their base stations, Wi-Fi, broadcast antennas, smart meters, and baby monitors as well as electric devices and infra-structures used in the delivery of electricity that generate extremely-low frequency electromagnetic field (ELF EMF).

Scientific basis for our common concerns

Numerous recent scientific publications have shown that EMF affects living organisms at levels well below most international and national guidelines. Effects include increased cancer risk, cellular stress, increase in harmful free radicals, genetic damages, structural and functional changes of the reproductive system, learning and memory deficits, neurological disorders, and negative impacts on general well-being in humans. Damage goes well beyond the human race, as there is growing evidence of harmful effects to both plant and animal life.

These findings justify our appeal to the United Nations (UN) and, all member States in the world, to encourage the World Health Organization (WHO) to exert strong leadership in fostering the development of more protective EMF guidelines, encouraging precautionary measures, and educating the public about health risks, particularly risk to children and fetal development. By not taking action, the WHO is failing to fulfill its role as the preeminent international public health agency.

Inadequate non-ionizing EMF international guidelines

The various agencies setting safety standards have failed to impose sufficient guidelines to protect the general public, particularly children who are more vulnerable to the effects of EMF.

The International Commission on Non-Ionizing Radiation Protection (ICNIRP) established in 1998 the “Guidelines For Limiting Exposure To Time-Varying Electric, Magnetic, and Electromagnetic Fields (up to 300 GHz)”¹. These guidelines are accepted by the WHO and numerous countries around the world. The WHO is calling for all nations to adopt the ICNIRP guidelines to encourage international harmonization of standards. In 2009, the ICNIRP released a statement saying that it was reaffirming its 1998 guidelines, as in their opinion, the scientific literature published since that time “has provided no evidence of any adverse effects below the basic restrictions and does not necessitate an immediate revision of its guidance on limiting exposure to high frequency electromagnetic fields”². ICNIRP continues to the present day to make these assertions, in spite of growing scientific evidence to the contrary. It is our opinion that, because the ICNIRP guidelines do not cover long-term exposure and low-intensity effects, they are insufficient to protect public health.

The WHO adopted the International Agency for Research on Cancer (IARC) classification of extremely low frequency electromagnetic field (ELF EMF) in 2002³ and radiofrequency radiation (RFR) in 2011⁴. This classification states that EMF is a *possible human carcinogen (Group 2B)*. Despite both IARC findings, the WHO continues to maintain that there is insufficient evidence to justify lowering these quantitative exposure limits.

Since there is controversy about a rationale for setting standards to avoid adverse health effects, we recommend that the United Nations Environmental Programme (UNEP) convene and fund an independent multidisciplinary committee to explore the pros and cons of alternatives to current practices that could substantially lower human exposures to RF and ELF fields. The deliberations of this group should be conducted in a transparent and impartial way. Although it is essential that industry be involved and cooperate in this process, industry should not be allowed to bias its processes or conclusions. This group should provide their analysis to the UN and the WHO to guide precautionary action.

Collectively we also request that:

1. children and pregnant women be protected;
2. guidelines and regulatory standards be strengthened;
3. manufacturers be encouraged to develop safer technology;
4. utilities responsible for the generation, transmission, distribution, and monitoring of electricity maintain adequate power quality and ensure proper electrical wiring to minimize harmful ground current;
5. the public be fully informed about the potential health risks from electromagnetic energy and taught harm reduction strategies;
6. medical professionals be educated about the biological effects of electromagnetic energy and be provided training on treatment of patients with electromagnetic sensitivity;
7. governments fund training and research on electromagnetic fields and health that is independent of industry and mandate industry cooperation with researchers;
8. media disclose experts’ financial relationships with industry when citing their opinions regarding health and safety aspects of EMF-emitting technologies; and
9. white-zones (radiation-free areas) be established.

¹ <http://www.icnirp.org/cms/upload/publications/ICNIRPemfgdl.pdf>

² <http://www.icnirp.org/cms/upload/publications/ICNIRPStatementEMF.pdf>

³ <http://monographs.iarc.fr/ENG/Monographs/vol80>

⁴ <http://monographs.iarc.fr/ENG/Monographs/vol102/>

Initial release date: May 11, 2015

This version's date: April, 27, 2016

Inquiries, including those from qualified scientists who request that their name be added to the Appeal, may be made by contacting Elizabeth Kelley, M.A., Director, EMFscientist.org, at info@EMFscientist.org.

Note: the signatories to this appeal have signed as individuals, giving their professional affiliations, but this does not necessarily mean that this represents the views of their employers or the professional organizations they are affiliated with.

Signatories

Armenia

Prof. Sinerik Ayrapetyan, Ph.D., UNESCO Chair - Life Sciences International Postgraduate Educational Center, Armenia

Australia

Dr. Priyanka Bandara, Ph.D., Independent Env.Health Educator/Researcher, Advisor, Environmental Health Trust; Doctors for Safer Schools, Australia

Dr. Bruce Hocking, MD, MBBS, FAFOEM (RACP), FRACGP, FARPS, specialist in occupational medicine; Victoria, Australia

Dr. Gautam (Vini) Khurana, Ph.D., F.R.A.C.S., Director, C.N.S. Neurosurgery, Australia

Dr. Don Maisch, Ph.D., Australia

Dr. Elena Pirogova, Ph.D., Biomed Eng., B. Eng (Hon) Chem. Eng., Engineering & Health College; RMIT University, Australia

Dr. Mary Redmayne, Ph.D., Department of Epidemiology & Preventive Medicine, Monash University, Australia

Dr. Charles Teo, BM, BS, MBBS, Member of the Order of Australia, Director, Centre for Minimally Invasive Neurosurgery at Prince of Wales Hospital, NSW, Australia

Austria

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Dr. Gerd Oberfeld, MD, Public Health Department, Salzburg Government, Austria

Dr. Bernhard Pollner, MD, Pollner Research, Austria

Prof. Dr. Hugo W. Rüdiger, MD, Austria

Bahrain

Dr. Amer Kamal, MD, Physiology Department, College of Medicine, Arabian Gulf University, Bahrain

Belgium

Prof. Marie-Claire Cammaerts, Ph.D., Free University of Brussels, Faculty of Science, Brussels, Belgium

Brazil

Vânia Araújo Condessa, MSc., Electrical Engineer, Belo Horizonte, Brazil

Prof. Dr. João Eduardo de Araujo, MD, University of Sao Paulo, Brazil

Dr. Francisco de Assis Ferreira Tejo, D. Sc., Universidade Federal de Campina Grande, Campina Grande, State of Paraíba, Brazil

Prof. Alvaro deSalles, Ph.D., Federal University of Rio Grande Del Sol, Brazil

Prof. Adilza Dode, Ph.D., MSc. Engineering Sciences, Minas Methodist University, Brazil

Dr. Daiana Condessa Dode, MD, Federal University of Medicine, Brazil

Michael Condessa Dode, Systems Analyst, MRE Engenharia Ltda, Belo Horizonte, Brazil

Prof. Orlando Furtado Vieira Filho, PhD, Cellular&Molecular Biology, Federal University of Rio Grande do Sul, Brazil

Canada

Dr. Magda Havas, Ph.D., Environmental and Resource Studies, Centre for Health Studies, Trent University, Canada

Dr. Paul Héroux, Ph.D., Director, Occupational Health Program, McGill University; InvitroPlus Labs, Royal Victoria Hospital, McGill University, Canada

Dr. Tom Hutchinson, Ph.D., Professor Emeritus, Environmental and Resource Studies, Trent University, Canada

Prof. Ying Li, Ph.D., InvitroPlus Labs, Dept. of Surgery, Royal Victoria Hospital, McGill University, Canada

James McKay M.Sc., Ecologist, City of London; Planning Services, Environmental and Parks Planning, London, Canada

Prof. Anthony B. Miller, MD, FRCP, University of Toronto, Canada

Prof. Klaus-Peter Ossenkopp, Ph.D., Department of Psychology (Neuroscience), University of Western Ontario, Canada

Dr. Malcolm Paterson, PhD. Molecular Oncologist (ret.), British Columbia, Canada

Prof. Michael A. Persinger, Ph.D., Behavioural Neuroscience and Biomolecular Sciences, Laurentian University, Canada

China

Prof. Huai Chiang, Bioelectromagnetics Key Laboratory, Zhejiang University School of Medicine, China

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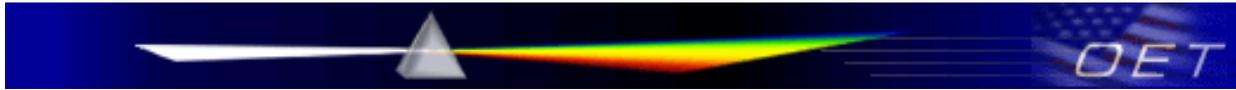
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**Federal Communications Commission
Office of Engineering and Technology
Laboratory Division**

October 23, 2015

**RF EXPOSURE PROCEDURES AND EQUIPMENT AUTHORIZATION
POLICIES FOR MOBILE AND PORTABLE DEVICES**

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attenuations are applied to determine compliance, the most conservative operating configurations and exposure conditions must be evaluated. The minimum *test separation distance* required for a device to comply with mobile device exposure conditions must be clearly identified in the installation and operating instructions, for all installation and exposure conditions, to enable users and installers to comply with RF exposure requirements. For mobile devices that have the potential to operate in portable device exposure conditions, similar to the configurations described in § 2.1091(d)(4), a KDB inquiry is required to determine the SAR test requirements for demonstrating compliance.

When a device qualifies for the categorical exclusion provision of § 2.1091(c), the minimum *test separation distance* may be estimated, when applicable, by simple calculations according to plane-wave equivalent conditions, to ensure the transmitter and its antenna(s) can operate in manners that meet or exceed the estimated distance.⁶³ The source-based time-averaged maximum radiated power, according to the maximum antenna gain, must be applied to calculate the field strength and power density required to establish the minimum *test separation distance*. When the estimated *test separation distance* becomes overly conservative and does not support compliance, MPE measurement or computational modeling may be used to determine the required minimum separation distance.⁶⁴

When a device does not qualify for the categorical exclusion provision of § 2.1091(c), routine evaluation using MPE measurement or computational modeling is required to determine compliance. For mobile devices operating in mostly stationary configurations; for example, on walls or ceiling, where a sufficiently large separation distance is inherent in the installation conditions, MPE estimates instead of measurements or numerical simulation may be acceptable with prior FCC confirmation through a KDB inquiry.⁶⁵ However, when numerical simulation is used for MPE evaluation, a PAG is required. The following procedures should be considered for mobile devices when guidance is not available in the *published RF exposure KDB procedures*.

- a) Except when certain sectors of an antenna are permanently blocked or restricted from access by the nature of the installation conditions, MPE compliance must be assessed in all directions surrounding the antenna and radiating structures of the device. When symmetrical exposure conditions are expected; for example, from an omni-directional antenna, such conditions must be clearly demonstrated in test reports to avoid testing in all directions. RF exposure evaluation equipment with isotropic sensors designed to measure the orthogonal field components is required to determine the total exposure field.⁶⁶ Either peak or spatially averaged results may be applied to determine compliance; and with respect to plane-wave equivalent power density limits when ≥ 300 MHz, and electric and magnetic field strength limits when < 300 MHz.
- b) Depending on the radiating characteristics of an antenna, for non-directional antennas, the evaluation points in horizontal planes should be along radials extending from the antenna (axis) that are approximately 45° apart. The direction of maximum exposure should be aligned with one of the radials. When the minimum *test separation distance* from the antenna is > 60 cm, the evaluation points should be along radials that are $\leq 30^\circ$ apart. For exposures in the vertical orientation, spatial averaging is not required in horizontal planes and should not be applied, except when the exposed

⁶³ The type of calculations used to estimate minimum test separation distance for MPE compliance must be appropriate for the type of antenna(s) and exposure conditions evaluated.

⁶⁴ Computational modeling requires PAG.

⁶⁵ While simple calculations may be acceptable for estimating the far-field exposure conditions of fixed transmitters (§ 1.1307), the distances estimated with similar calculations for mobile exposure conditions (§ 2.1091) are often not suitable or impractical for the installation conditions required for mobile devices. When routine evaluation is required for mobile exposure conditions, MPE estimates are unacceptable without prior FCC confirmation.

⁶⁶ Additional information on test equipment is available in OET Bulletin 65 Edition 97-01.

July 12, 2016

Objection to proposed installation of a new small cell antenna near 1642 Arch Street, Berkeley

Site ID: SF90XSB54A

My husband, two kids (ages 1 and 4 years old) and I live at 2370 Hilgard Avenue in Berkeley. Our home is less than one block away from one of Mobilitie's proposed sites for a new small cell antenna near 1642 Arch Street in Berkeley (Site ID: SF90XSB54A). I ardently object to installation of this antenna for the following reasons:

1. **Health Effects from Radiation:** I understand that the City of Berkeley cannot consider health effects of cellular tower radiation in zoning decisions because of the Telecommunications Act of 1996. However, numerous municipalities in California, Maine, New York, Oregon, and Connecticut and throughout Europe, Canada, and New Zealand have passed ordinances requiring setbacks from schools and day care facilities. There are two elementary schools (Berkeley Rose School at 2138 Cedar Street and German International School at 1581 LeRoy Avenue) and one preschool (Hearts Leap School at 2220 Cedar Street) located within blocks of this proposed site. The decision not to place cell antennas near schools is based on the likelihood that children are more susceptible to this form of radiation.
2. **Location Preference:** According to the City of Berkeley's Aesthetic Guidelines based on section 16.10.050 of the City of Berkeley's Municipal Code, this proposed site is third in the order of preference for selecting locations in the public right-of-way because it is located in a residential district. Mobilitie must show that a site located in the nearby commercial district would not reasonably close its gap in coverage.
3. **Proximity to a City Landmark:** This proposed site is also located approximately one city block from a property designated as a City Landmark (Hillside Club at 2286 Cedar Street).
4. **Neighborhood Aesthetics:** This proposed site is located on the west side of Arch Street, which does not currently have any utility poles. The addition of a new utility pole will be unsightly to the neighborhood.
5. **Property Values:** As a homeowner, I'm greatly concerned about a decline in property values in our neighborhood resulting from this installation.

The City of Berkeley can reasonably require Mobilitie (and the parent cell phone provider) to provide data showing coverage afforded by other existing sites nearby to determine whether a significant gap in coverage truly exists, and to show data that a significant gap in coverage can only be closed with placement of a new small cell antenna at this residential site.

I appreciate your prompt and careful review of this proposed installation and urge you to reject any permit applications Mobilitie submits for installation near 1642 Arch Street. I would be happy to discuss my concerns at any time.

Sincerely,

Monique Webster, MPH

2370 Hilgard Ave, Berkeley, California 94709

415-902-2561

The Washington Post

To Your Health

Biden threatens funding cuts for researchers who don't report clinical-trial data

By **Laurie McGinley** June 29

An impatient Vice President Biden threatened Wednesday to cut funding to research facilities that fail to report clinical-trial results quickly enough and took a swipe at drug companies that jack up the prices of cancer drugs.

At an all-day cancer summit he convened at Howard University in Washington, Biden showed flashes of anger as he expressed concern that many medical institutions that receive millions of dollars in government grants weren't reporting results to a publicly accessible database in a timely fashion.

"Doc, I'm going to find out if it's true," he said. "And if it's true, I'm gong to cut funding. That's a promise."

Biden addressed the hundreds of researchers, oncologists, data experts, and patients who gathered for lengthy brain-storming sessions at Howard. Thousands of people attended 270 regional summits around the country.

Biden has repeatedly prodded researchers to share data as he campaigns for his "cancer moonshot" effort. On Wednesday, he cited a December story by STAT, a Boston-based news organization, that found many top medical research institutions were too slow to report clinical-trial results or failed to ever do so.

Under a 2008 law, data is supposed to be submitted within a year of a trial's completion to ClinicalTrials.gov, which is run by the National Institutes of Health. But the law lacks enforcement mechanisms, NIH Director Francis Collins said following Biden's comments.

[IN DEPTH: Watson's next feat? Taking on cancer. IBM's computer brain is training alongside doctors to do what they can't]

Collins said the administration is close to issuing a final rule with "teeth." Under the proposed rule, for example, NIH could withhold grants from institutions if their researchers didn't submit the required data. And drug companies could be fined \$10,000 a day for not complying with the requirement to submit the results.

"This issue is going to be solved," he said.

Biden also tackled cancer-drug costs on Wednesday. He said that some prices "are astronomical," with treatments costing far more now than they did when they came on the market years ago. "Tell me, tell me, tell me," he said. "What is the justification for that?"

The event at Howard University had the star power of emcee Carol Burnett, who introduced Biden. The actress said her "heart soared" when President Obama announced the moonshot effort earlier this year, and that she called Biden immediately to offer her help. She noted the "unfortunate bond" connecting them: Burnett's daughter, Carrie, died 14 years ago of cancer at age 38, and Biden's son Beau died of cancer last year.

While at times he expressed frustration about the pace of progress, Biden mostly cheered on his audience, who spent hours in closed-door meetings trying to develop new ways to attack the cancer problem. "Look at what you have done on HIV/AIDS," he said. He added: "We're on the cusp of breakthroughs that can get us there."

Timothy Turnham, executive director of the Melanoma Research Foundation, said he was pleased that Biden talked about cancer-drug costs, a topic of growing concern as companies develop expensive combination therapies. Overall, he said it would be impossible to know the real impact of the meeting for at least another year, "when you see what gets done."

Before the meeting started, Biden's office announced dozens of new initiatives in the anti-effort cancer. Many involve novel collaborations between federal agencies; for example, the Department of Energy is

teaming up with the Department of Veterans Affairs to use supercomputers to better understand the genesis of cancer. Other commitments include pledges from cancer charities to raise more money for research or from businesses and philanthropies to create lucrative prizes to award breakthroughs.

One of the efforts involves IBM's supercomputer Watson, known for its "Jeopardy" prowess, which is forming a partnership with the VA in a bid to revolutionize cancer care for veterans.

Under the IBM-VA partnership, Watson technology will be provided free for two years to the VA's precision-oncology program. The artificial intelligence system will analyze genomic information, pinpoint cancer-causing mutations and help identify potential treatments for as many as 10,000 patients.

David Shulkin, VA's undersecretary for health, said the health system currently uses groups of experts to analyze patients' sequenced genetic data and to figure out treatment plans. Using Watson, he said, clinicians will be able to treat many more patients, much more quickly. Physicians will feed tumor information to the computer and, "within a matter of hours, we will be able to get an individual interpretation that allows doctors to make the very best treatment decisions."

Other initiatives heralded as part of the summit Wednesday included a new program by the NIH, drug companies and philanthropies to invest in "pre-competitive" cancer research, in which the data would be shared, as well as a revamping of information about cancer clinical trials to make it easier for patients to find the right trials. In addition, changes will rejigger the way the Food and Drug Administration approves cancer-related products.

Read more:

[You have a few more days to tell the government what to do about cancer](#)

[Biden unveils open-access database for cancer research](#)

[Federal panel approves first test of CRISPR gene-editing in humans](#)

[IN DEPTH: Watson's next feat? Taking on cancer. IBM's computer brain is training alongside doctors to do what they can't.](#)

Laurie McGinley covers health and medicine for The Washington Post.

 Follow @lauriemcginley2

Action Calendar – Old Business

Tuesday, July 12, 2016 ANNOTATED AGENDA Page 15

35. Opposition to Sutter Health Corporation's Plans to Cease Operations at Alta Bates Hospital in Berkeley, and Further Requesting City to Identify Opportunities to Seismically Retrofit the Current Location *(Continued from June 28, 2016)*

From: Councilmembers Worthington, Anderson, and Arreguin

Recommendation: Adopt a Resolution opposing Sutter Health Corporation's plans to cease operations at Alta Bates Hospital in Berkeley, and request that city departments identify opportunities to seismically retrofit the current location.

Financial Implications: See report

Contact: Kriss Worthington, Councilmember, District 7, 981-7170

Action: Item sponsors amended to be Councilmembers Worthington, Droste, Capitelli, and Moore. Item Moved to Consent Calendar. Adopted Resolution No. 67,615–N.S. as amended in Supplemental Reports Packet #1.



Kriss Worthington

Councilmember, City of Berkeley, District 7
2180 Milvia Street, 5th Floor, Berkeley, CA 94704
PHONE 510-981-7170, FAX 510-981-7177, EMAIL
kworthington@ci.berkeley.ca.us

Amendment to Item 35
CONSENT CALENDAR
July 12, 2016

To: Honorable Mayor and Members of the City Council
From: Councilmember Kriss Worthington
Councilmember Lori Droste
Councilmember Laurie Capitelli

Subject: Revised Resolution Opposing Sutter Health Corporation Plans to Cease Operations at Alta Bates Hospital in Berkeley

RECOMMENDATION:

That the Council adopt the attached revised resolution opposing Sutter Health Corporation plans to cease operations at Alta Bates Hospital in Berkeley.

BACKGROUND:

See resolution,

FINANCIAL IMPLICATIONS:

Minimal.

ENVIROMENTAL SUSTAINABILITY

Consistent with Berkeley's Environmental Sustainability Goals and no negative impact.

CONTACT PERSON:

Councilmember Kriss Worthington 510-981-7170

Attachment:

1 Resolution Oppose Sutter Health Corporation's Plan to Cease Operation

RESOLUTION NO. ##,###-N.S.

Resolution to Oppose Sutter Health Corporation's Plan to Cease Acute Care Hospital Operations at Alta Bates Hospital in Berkeley, Further Requesting City Departments to Identify Pending or Future Applications Sought in Furtherance of Such Closure and Report Such Applications.

WHEREAS, Alta Bates Summit Medical Center, has been providing "full service" Acute Care hospital services in Berkeley, the East Bay and in Alameda and other counties for decades, and

WHEREAS, Alta Bates Summit Medical Center is licensed for 944 acute care beds with more than half of them in Berkeley, and 347 of those at the Ashby facility; and

WHEREAS, Alta Bates Summit Medical Center's Ashby facility is crucial for providing timely healthcare services for the people of Berkeley and cities beyond Berkeley's border; and

WHEREAS, from 2002 through 2015, records from CA's Office of Statewide Health Planning and Development, OSHPD, revealed very high utilization of acute care services at Alta Bates' Berkeley facility, including over one million total days that hospital beds were occupied; which consisted in part of the following:

- 559,136 days patients were treated in Medical units;
- 228,498 days babies treated in Neonatal Intensive Care;
- 103,157 babies delivered;
- 111,946 admissions through the Emergency Departments;
- 73,612 adult Critical Care patients treated; and

WHEREAS, these numbers do not reflect the full scope of the amount of patients treated at the Berkeley facility because census data reported to CA's OSHPD agency does not include patients in "observation" status despite stays of up to 48 hours with "observation" patients; and

WHEREAS, these numbers reflect only the Ashby facility and not the Alta Bates Summit census data at the Oakland Summit site; and

WHEREAS, Sutter Health Corporation has announced its intention to dramatically reduce services by closing the Alta Bates' Berkeley facility in light of SB 1953; and

WHEREAS, the consolidation of hospital services results in loss of services as happened when Alta Bates Hospital merged with Summit Medical Center in 2000, and despite Sutter Health arguing that services would be enhanced, not reduced, when many in the community opposed the merger at that time, Alta Bates Summit afterwards experienced the loss of many services in the past 15 years, overwhelmingly at the Alta Bates and Herrick campuses; and

WHEREAS, the national average for bed capacity per 1000 residents is 2.9 beds according to World Bank statistics. In Alameda County, the bed capacity is at 1.8 beds and neighboring Contra Costa at 1.4 beds, a figure that does not reflect the final phase of the 2015 closure of Doctor's Medical Center in San Pablo; and

WHEREAS, many hospital departments are often at capacity, and all of the local Emergency Departments already have large delays in service, which will only be exacerbated by the merging of the two full-service Acute Care Hospitals with their Emergency Departments to one Oakland location, increasing even further wait and admission times; and

WHEREAS, the University of California, has 37,581 Undergraduate and Graduate students who depend heavily on hospital services at the Alta Bates campus, including the Alta Bates Emergency Department in close proximity to campus, to address the students' life-threatening illnesses and injuries, and need for medical care; and

WHEREAS, the Berkeley, North Alameda, West Contra Costa area recently suffered the closure of an acute care hospital in San Pablo, and the loss of acute care hospital services as a result, and further, is subject to severe earthquakes, frequent urban interface with wild fires, industrial chemical releases and mass traffic casualties—all of which require emergency services; and

WHEREAS, when Berkeley's first responders are mandated to travel to Summit Campus in Oakland, they are unavailable for service for the rest of Berkeley for prolonged periods of time presenting a significant danger to the lives of Berkeley residents, and forcing an unacceptable standard of healthcare upon them; and

WHEREAS, closures and relocations of corporations on the community, impacting an array of businesses including family-owned businesses, with losses often doubling or tripling those who either lost jobs or had to relocate; and

WHEREAS, when access to healthcare is made more difficult, patients often delay healthcare but also stop seeking the care that is necessary; and

WHEREAS, the stated mission of corporate Sutter Health is to "enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellences" in health care services; and

WHEREAS, Sutter Health as a non-profit corporation pays little or no property taxes for

operations which are non-profit, such as its non-profit hospitals (as opposed to its for-profit operations) and is a highly profitable healthcare corporation whose total assets in the billions grow substantively each year, as shown:

- 2011: \$11,820,000,000
- 2012: \$12,390,000,000
- 2013: \$14,215,000,000
- 2014: \$14,290,000,000
- 2015: \$14,344,000.000

WHEREAS, Sutter Health needs to live up to its stated mission, be held accountable for its actions, and provide the necessary healthcare for Berkeley residents, and must not be allowed to put profits before lives nor endanger the residents of Berkeley; and

WHEREAS, the Berkeley City Council has a role and responsibility to provide resources to the public to promote and protect its health with no regional body researching the health needs of the greater community; and

NOW THEREFORE, BE IT RESOLVED that the Mayor and City Council of the City of Berkeley oppose Sutter Health Corporation's plan to close its acute care services at Alta Bates Hospital and calls upon Sutter Health to cease and desist all actions in furtherance of any and all plans to close Alta Bates hospital; and

BE IT FURTHER RESOLVED that the Mayor and City Council shall establish open forums to inform and educate Berkeley residents of the possibility of Sutter Health's seismically retrofitting Berkeley's Alta Bates facility; shall ensure the residents of Berkeley are notified of any and all forums under the City of Berkeley's purview; and ensure a full service acute care general hospital for future generations; and

BE IT FURTHER RESOLVED that the Mayor, City Council, and City Departments pledge to cooperate fully to facilitate this process such that it is expedited as much is legally permitted.

Exhibits

A: Sutter Plans Closure of Berkeley's Alta Bates Hospital, ER

<http://ww2.kqed.org/stateofhealth/2016/04/28/sutter-plans-closure-of-berkeleys-alta-bates-hospital-er/>

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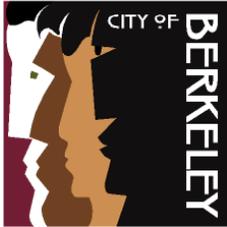
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Lori Droste, District 8
Susan Wengraf, District 6

CONSENT CALENDAR
July 19, 2016

TO: Honorable Mayor and City Council

FROM: Councilmembers Lori Droste, Susan Wengraf,
Linda Maio, and Kriss Worthington

SUBJECT: Commission Work Plans

RECOMMENDATION

Commissions—with the exception of the Board of Library Trustees, Design Review Committee, and the Zoning Adjustments Board—will submit a work plan detailing its goals and objectives for the year. Plans will be submitted at the start of the fiscal year, annually.

FINANCIAL IMPLICATIONS

Although additional staff time will be needed to assist commissions in drafting work plans, staff time will be reduced overall if misaligned commission referrals are reduced. In addition, if boards and commissions do not direct city staff to perform research, gather information, or otherwise engage in activities involving projects or matters that are not aligned with the City's Strategic Plan, staff will be able to make more efficient use of their time.

BACKGROUND

The City of Berkeley is in the process of introducing its first strategic plan. To ensure that Berkeley's commissions are in alignment with the overall mission of the City, commissions should submit annual work plans. Each work plan should contain the following information:

1. Commission mission statement
2. What are the commission's goals? In order to achieve these objectives, please specify:
 - a. Resources
 - i. What specific resources are needed and available to achieve desired change? (i.e. staff time, \$, time, materials, equipment)
 - b. Program activities
 - i. What will the commission do with its resources?
 - ii. Processes, tools, events, technology, actions that are employed to bring about the intended objectives.

- c. Output(s)
 - i. What will be the direct results of commission activities?
 - ii. How much will be done? (i.e. Number of forums/meetings held, # of participants reached, etc.)
- d. Outcomes
 - i. The specific changes desired/achieved in the short-term (1-3 years) and long-term (4-6 years)

Outcomes should be measurable, action-oriented, and realistic (W. K Kellogg Foundation, 2004).

ENVIRONMENTAL SUSTAINABILITY

Not applicable

CONTACT PERSON

Lori Droste, City Councilmember District 8, 510-981-7180

Susan Wengraf, City Councilmember District 6, 510-981-7160

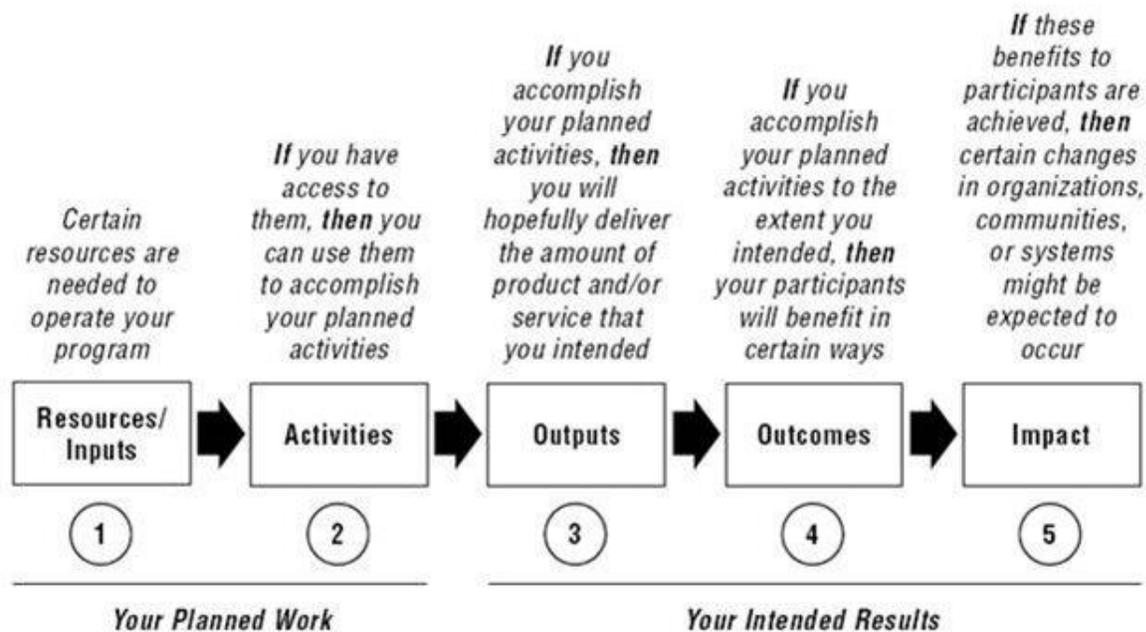
Attachments:

1: Logic Model Summary (W.K. Kellogg Foundation)

Logic Model Summary

A logic model brings program concepts and dreams to life. It lets stakeholders try an idea on for size and apply theories to a model or picture of how the program would function.

The program logic model is defined as a picture of how your organization does its work – the theory and assumptions underlying the program. A program logic model links outcomes (both short- and long-term) with program activities/processes and the theoretical assumptions/principles of the program.



The Basic Logic Model components shown above are defined below. These components illustrate the connection between your planned work and your intended results.

They are depicted numerically by steps 1 through 5.

YOUR PLANNED WORK describes what resources you think you need to implement your program and what you intend to do.

1. Resources include the human, financial, organizational, and community resources a program has available to direct toward doing the work. Sometimes this component is referred to as Inputs.

2. Program Activities are what the program does with the resources. Activities are the processes, tools, events, technology, and actions that are an intentional part of the program implementation. These interventions are used to bring about the intended program changes or results.

YOUR INTENDED RESULTS include all of the program's desired results (outputs, outcomes, and impact).

3. Outputs are the direct products of program activities and may include types, levels and targets of services to be delivered by the program.

4. Outcomes are the specific changes in program participants' behavior, knowledge, skills, status and level of functioning. Short-term outcomes should be attainable within 1 to 3 years, while longer-term outcomes should be achievable within a 4 to 6 year timeframe. The logical progression from short-term to long-term outcomes should be reflected in impact occurring within about 7 to 10 years.

5. Impact is the fundamental intended or unintended change occurring in organizations, communities or systems as a result of program activities within 7 to 10 years. In the current model of WKKF (W.K. Kellogg Foundation) grantmaking and evaluation, impact often occurs after the conclusion of project funding.

Compiled from:
W.K. Kellogg Foundation. "Logic Model Development Guide." (2004)



CITY COUNCIL

Darryl Moore
Councilmember District 2

CONSENT CALENDAR
July 19, 2016

To: Honorable Mayor and Members of the City Council

From: Councilmember Moore, District 2
Councilmember Worthington, District 7

Subject: Support the California Healthcare, Research and Prevention Tobacco Tax Act of 2016

RECOMMENDATION

Adopt a Resolution supporting The California Healthcare, Research and Prevention Tobacco Tax Act of 2016.

BACKGROUND

The California Healthcare, Research and Prevention Tobacco Tax Act of 2016 will increase California's cigarette tax by \$2 per pack, with an equivalent increase on products containing nicotine derived from tobacco, including e-cigarettes. The American Cancer Society Cancer Action Network, American Heart Association and American Lung Association in California are standing up to Big Tobacco to save lives and help smokers quit. This initiative:

Saves lives. Smoking is the number one cause of preventable death in California.¹ This initiative will save lives by preventing kids from getting hooked on tobacco, improving health care, and fighting cancer and other tobacco-related diseases.

Counters Big Tobacco's predatory attempts to hook a new generation of smokers. Thousands of youth become addicted to tobacco each year.² Now tobacco companies are targeting kids with candy-flavored electronic cigarettes containing nicotine. It has been proven that higher tobacco taxes reduce teen smoking.³

Asks smokers to pay their fair share to improve health care and fight cancer. This is simply a user fee on those who continue smoking. It will mean smokers help pay for cancer treatment, smoking prevention, health care, and research to fight cancer and other tobacco-related

This initiative will save lives.

Cancer and other tobacco-related diseases kill more people than car accidents, murder, suicide, alcohol, illegal drugs, and AIDS combined.⁴ This \$2 per pack user fee on

tobacco will save lives by preventing kids from getting hooked on tobacco, improving health care, helping people quit smoking, and researching cures for cancer and other tobacco-related diseases.

Increasing the tobacco tax will reduce teen smoking.

Studies show that 90 percent of smokers start before the age of 21.⁵ Nearly 17,000 California kids get hooked on smoking every year and half of them will eventually die from tobacco-related illnesses.⁶ Now the tobacco industry is targeting kids for a lifetime of addiction with candy-flavored electronic cigarettes containing nicotine. Teen use of e-cigarettes grew 10 fold in the past five years.⁷ Teens who use e-cigarettes are three times more likely to start smoking traditional cigarettes within a year.⁸

This user fee asks smokers to pay their fair share to improve health care and fight cancer. Because of smoking, California taxpayers spend \$3.5 billion dollars each year on treating cancer and other tobacco-related diseases through Medi-Cal.⁹ The majority of funds generated by this tobacco tax will be used to improve existing health care programs, prevent smoking, and fund research into cancer and other tobacco-related diseases.

Tough transparency and accountability measures keep Sacramento bureaucrats and politicians from diverting funds.

This initiative protects our interests by prohibiting bureaucrats and politicians from using the funds raised through this tobacco tax for any purposes other than those explicitly laid out in the measure. It strictly limits administrative spending to no more than 5 percent of the revenue generated by the tax. It also requires biennial audits by the nonpartisan State Auditor and that reports be made available to the public.

FISCAL IMPACT

None

CONTACT PERSON

Darryl Moore, Councilmember, District 2, 510 981-7120

Attachments:

1. Resolution

1. https://www.tobaccofreekids.org/facts_issues/toll_us/california
2. <http://www.lung.org/stop-smoking/smoking-facts/>
3. <http://www.tobaccofreekids.org/research/factsheets/pdf/0098.pdf>
4. <http://www.politifact.com/truth-o-meter/statements/2009/jun/29/george-will/claims-smoking-kills-more-people-annually-other-da/>
5. <https://www.tobaccofreekids.org/research/factsheets/pdf/0127.pdf>
6. https://www.tobaccofreekids.org/facts_issues/toll_us/california
7. <http://www.cdc.gov/media/releases/2016/p0414-youth-tobacco.html>
8. <http://stillblowingsmoke.org/#kids>
9. https://www.tobaccofreekids.org/facts_issues/toll_us/california

RESOLUTION NO. ##,### N.S.

SUPPORTING THE CALIFORNIA HEALTHCARE, RESEARCH AND PREVENTION
TOBACCO TAX ACT OF 2016

WHEREAS, cancer and other tobacco-related diseases kill more people than car accidents, murder, suicide, alcohol, illegal drugs, and AIDS combined; and

WHEREAS, California taxpayers spend \$3.5 billion dollars each year on treating cancer and other tobacco-related diseases through Medi-Cal; and

WHEREAS, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 will increase California's cigarette tax by \$2 per pack, with an equivalent increase on products containing nicotine derived from tobacco, including e-cigarettes; and

WHEREAS, studies show that 90 percent of smokers start before the age of 21; and

WHEREAS, nearly 17,000 California kids get hooked on smoking every year and half of them will eventually die from tobacco-related illnesses; and

WHEREAS, teen use of e- cigarettes grew 10 fold in the past five years, and teens who use e- cigarettes are three times more likely to start smoking traditional cigarettes within a year; and

WHEREAS, it has been proven that higher tobacco taxes reduce teen smoking; and

WHEREAS, the majority of funds generated by this tobacco tax will be used to improve existing health care programs, prevent smoking, and fund research into cancer and other tobacco-related diseases; and

WHEREAS, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 is carefully crafted to ensure that funds being raised by the tax will be utilized to fund tobacco-related education and healthcare; and

WHEREAS, the initiative also requires biennial audits by the nonpartisan State Auditor and that reports be made available to the public.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that it supports the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 to discourage the use of tobacco amongst our youth and to improve tobacco-related education and healthcare in the State of California.



Community Health Commission

CHC AGENDA ITEM SUBMISSION TIMELINE FOR 2016

CHC Meeting Date (Thursdays)	Agenda Items due to Commission Secretary	Secretary Reviews Final Agenda with Dr. Janet Berreman	Secretary submits agenda for posting
6/23	Wed 6/15 by Noon	Thurs 6/16 by 4 pm	Fri 6/17 by 10am
7/28	Wed 7/20 by Noon	Thurs 7/21 by 4 pm	Fri 7/22 by 10am
9/22	Wed 9/14 by Noon	Thurs 9/15 by 4 pm	Fri 9/16 by 10am
10/27	Wed 10/19 by Noon	Thurs 10/20 by 4 pm	Fri 10/21 by 10am
11/17*	Tues 11/8 by Noon	Wed 11/9 by 4 pm	Thurs 11/10 by 10am

* Meeting will be held on 4th Thursday due to Thanksgiving Holiday



Community Health Commission

COUNCIL ITEM SUBMISSION TIMELINE FOR 2016

City Council Meeting Date	Commission needs to take action by (Commission meeting dates)	Reports due to HHCS Director	Commission items
7/19	4/28	5/26	<ul style="list-style-type: none"> • BMC enabling legislation •
Summer Recess			
9/13	5/26, 6/23	7/21	
9/20	6/23	7/28	
9/27	7/28	8/4	<ul style="list-style-type: none"> • African American Holistic Resource Center
10/18	7/28	8/25	
11/1	7/28	9/8	
11/15	7/28	9/22	
11/29	9/22	10/6	
12/13	9/22	10/20	