County of Placer

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Good morning Chairman Alpert and commissioners. Thank you for inviting me to testify on this critical issue of public health preparedness, I would like to express my deepest thanks for the consistent leadership and professionalism that the Commission and your staff have brought to this most important discussion.

My Name is Dr. Richard J. Burton, M.D., M.P.H., I am the Health Officer and Director of Health and Human Services for Placer County. I am also testifying today on behalf of the California Conference of Local Health Officers (CCLHO).

CCLHO is composed of all legally appointed Health Officers in California and was established in 1947 (Health and Safety Code, Section 100925) to advise the State Department of Health Services, other departments, boards, commissions, the Legislature, officials of federal, state, and local governments and any other organization or association on matters affecting the health of California's residents.

CCLHO has identified three areas where opportunities exist to further enhance public health readiness, which include:

1) **Creation of a State Department of Public Health led by a physician State Health Officer through organizational redesign.**

2) **Training and hiring laboratory scientists for California's state and local public health laboratories**

3) **Administrative simplification and program integration.**

All of us bring unique training, expertise, talents, abilities and experiences to the areas we invest our lives in. Local Health Officers are physicians with advanced training and national certifications in pediatrics, internal medicine, family medicine, preventive medicine and medical research. On a daily basis, Health Officers blend clinical practice, research, and effective community wide health enhancing interventions.

My personal background includes over 15 years of clinical practice, 10 years of service with the Navy, international immunization research, a year as Associate Director of the California Department of Health Services and over 10 years as a local health officer.

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What I have come to recognize however, is that I have actually been involved with, and a beneficiary of public health professionals for my entire life. This combination of training and experiences drive my commitment to build on the foundations of those public health scientists that have gone before and created the strongest network of public health services anywhere in the nation, the state, city and county health departments of California.

Because public health physicians diagnosed my mother's active tuberculosis at my 6 week well child exam, she was provided 6 months of antibiotics at a dedicated TB treatment facility, so instead of both of us succumbing to the devastations of TB we have been able to share the many joys of life.

By the time I was 6 months old, I had lost one grandmother to a life long struggle with the consequences of polio that had kept her wheelchair bound since she was in her 20's. Yet because of public health scientific leadership in community wide polio vaccination campaigns, the International Commission for the Certification of Polio Eradication has certified the America's polio-free since 1994.

My father was a brilliant man, a dentist by training, who took time from his private practice to serve within the California Department of Health Services in the 1960s. Unfortunately, he died at 62 from lung cancer related to his addiction to tobacco. This addiction still impacts millions of Californians; the result of mis-leading advertising and industry practices that foster addiction. Yet public health leadership has resulted in California now experiencing an adult smoking rate of 15.4%, one of the lowest tobacco use rates in the country.

During my pediatric clinical practice, I had to sit with young parents to inform them of the death of their children from illnesses such as *Haemophilus Influenzae* type b and Pneumococcal disease. Because of public health leadership, laboratory scientists, and immunization campaigns, the fatalities from these infections are now much more uncommon.

I would expect that if we took a few minutes each of us could describe how we have personally benefited from the scientifically driven practice of public health.

Public health physicians, scientists, and laboratorians are uniquely capable of interpreting the latest research and designing community wide interventions that allow our residents to benefit from this research.

As the terrorist events of 2001 evolved, California appropriately looked to our state and local public health leaders for direction as we prepared our medical and public health response systems for future attacks, whether they be chemical, biological, radiological, nuclear, or explosive in etiology. At the time I was President of CCLHO.

Local health officers and our colleagues in the County Health Executives Association of California had long identified many aspects of our state and local public health capabilities that had degraded in recent years.

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State and local leadership partnered to leverage the federal funding made available in 2002 to prioritize and improve core public health capacities and address documented deficiencies.

Specific improvements include:

1) **A statewide, secure, 24/7, California Health Alert Network that connects not only public health officials and laboratorians, but many jurisdictions have also included law enforcement, hospitals, clinics, private physicians, schools, EMS agencies, fire services, local government officials, and others.**

2) **Improvement in state and local laboratory capacity.**

3) **Increased protocol development, standardization, dissemination, and training in communicable disease investigations, Standardize Emergency Management Systems, public information, and community preparedness across a number of public and private professional disciplines.**

4) **Demonstrated capability to implement a phased strategy for smallpox vaccination when adequately staffed and funded in an identified threat environment as determined by federal authorities.**

5) **Hospital surge capacity has been improved.**

6) **Partnering with local and regional colleagues in EMS, law, and fire service to appropriately use other available federal "Homeland Security" funds.**

7) **A statewide local public health capacity assessment has been piloted, funded and will begin this summer.**

8) **Routine exercises are held to test systems and identify opportunities for improvement.**

9) **Most importantly, state leadership has effectively transitioned through the change of Administrations with Secretary Belshe, Director Shewry, and State Health Officer Dr. Richard Jackson, M.D., M.P.H., each bringing the full breadth of their giftedness, experience and training to assure we continue to strengthen our public health system.**

I felt it was crucial to frame CCLHO's recommendations in the long demonstrated capability for California's state and local public health professionals to effectively utilize resources and to identify and implement strategies to enhance the lives of every man, woman, and child of this state. I will now proceed to discuss my perceptions of barriers to further enhancement of preparedness and California's Local Health Officer's recommendations regarding opportunities that lay ahead.

Research has clearly demonstrated that both organizations and individuals can best achieve their desired outcomes by identifying the strengths in themselves and others and then using those strengths to improve on areas of weakness.

My experience has been that every public servant I have had the privilege to work with at the federal, state, and local level are driven to bring their best to their work, striving within real or perceived boundaries to serve the residents of this state.

It is CCLHO's belief that the Legislature, the Administration, and the residents of our communities desire our public health system to be science based, effective, efficient, responsive to emerging issues, and transparent with areas where we should look for innovative opportunities to improve the quality of our services.

CCLHO Recommendations for the future:

1) Creation of a State Department of Public Health led by a physician State Health Officer through organizational redesign

Since September 2001, both administrations have sought to address what had been an obvious absence of physician presence in the director's office in recent years. I had the privilege of serving Dr. Bonta as Associate Director and State Epidemiologist during 2002, Dr. Gilberto Chavez, M.D., M.P.H., served in the same position following my return to Placer County and Dr. Chavez remains the State Epidemiologist. State, local, and private health professionals were thrilled with the appointment of Dr. Jackson as Chief Deputy Director for Public Health Programs and State Health Officer in 2004. Dr. Jackson's national recognition and visionary leadership will certainly benefit this state for years to come.

A physician State Health Officer is absolutely vital. CCLHO agrees with those who have recognized the parallel need at the state level, to what already exists at the local level, for focused public health physician oversight and policy leadership within the Department of Health Services, namely a State Health Officer. CCLHO is convinced that now is the time to legislatively affirm the crucial role of the physician State Health Officer leadership over core public health programs just as the position of physician Local Health Officer is currently in California law.

CCLHO believes that the combined importance and complexities of the administration of publicly funded healthcare such as Medi-Cal is deserving of the dedicated focused leadership of it's own department and director.

CCLHO believes that creating a more focused state Public Health Department, directed by a physician State Health Officer such as Dr. Jackson, will assure that the Governor, the Secretary of HHS, local Health Officers, and the residents of California are provided the sort of scientifically based leadership that is necessary for this state to remain economically strong, environmentally sustained, and health enhancing to the lives of Californians for generations to come.

To this end, CCLHO is sponsoring SB 162 authored by Senator Ortiz for consideration in the next legislative session.

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2) Training and hiring laboratory scientists for California's state and local public health laboratories

CCLHO agrees with Director Shewry and Dr. Jackson in identifying our scientific public health laboratories as the most appropriate focus of immediate attention in an attempt to restore the staffing and funding reductions of recent years.

Between fiscal year (FY) 1990-91 and 2004-2005 the number of positions authorized for the Prevention Services laboratories declined 36.1% from 308.8 to 197.2.

California Department of Health Services
Budget Change Proposals since 1998

Year	Request	Outcome
98-99	2 Microbiologists	Approved
01-02	6 Microbiologists	Denied
01-02	Salary adjustment	Denied
01-02	Salary adjustment	Denied
01-02	2 Microbiologists	Denied
02-03	Equipment & contract staff	Denied
03-04	4 Scientists	Denied
03-04	1 Scientist	$ yes/ staff no
04-05	SARS / WNV (4 Micros)	Denied

As a consequence of reduced staffing at the state public health laboratory, the following tests are no longer available as tools for disease identification and management:

Tests	Discontinued or Reduced	Consequences
M. tuberculosis		
Rapid drug sensitivities	no staffing to initiate	impaired management
Avian influenza		
Anti-viral resistance	no staffing to initiate	impaired management
Anti-body testing	no staffing to initiate	impaired management
Bordetella pertusis	2002	impaired management
Bartonella henselae	2002	impaired management
Brucella IgG CF	2001	impaired management
Legionella	2002	impaired management
Parasitology test	2004	impaired management
Fungi testing	2004	impaired management

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While local labs are taking the initiative to develop the staff micobiologists they need, there is acute shortage of eligible and available laboratory scientists that can step into positions of local laboratory leadership as current laboratory directors retire. Current analysis by local laboratory directors, state leadership, and local health officers would indicate that California should take prompt action to restore the laboratory director training programs discontinued in the last decade.

In the interim, CCLHO, CHEAC, and Public Health Laboratory Directors are partnering with Director Shewry and Dr. Jackson to identify both interim and sustainable service redesign models that will assure that Californians restore what was once the premiere laboratory system in the nation.

The ever increasing globalization of communicable disease prevention and technological advancement of laboratory sciences present us with two clear options, we can either train, hire, and support appropriate laboratory scientists and the tools they need to carry out their work, or we knowingly ignore the very real, and very imminent threat of pandemic outbreaks of agents such as SARS and influenza. To a great extent our state and local laboratories have been functioning in a "surge capacity mode" but they cannot sustain this level of service without restoration of long vacant scientist allocations at the state.

3) Administrative simplification and program integration

Before, during, and after my service at the Department of Health Services I observed burdensome, duplicative, unnecessarily complicated administrative procedures delay the flow of available fiscal resources to our state and to the local jurisdictions. These administrative inefficiencies have long existed at the federal, state, and local level in the numerous "silos" of categorical funding streams with which Public Health has been traditionally funded. When challenged to react in an efficient, timely manner, the existing culture was frequently stalled in negotiating real or perceived restrictions. The cultural norms frequently complicate the sort of cross training and functioning of state and local public servants in both our routine and disaster response roles. At a minimum these administrative inefficiencies unnecessarily consume human and fiscal resources.

Director Shewry and Dr. Jackson have done a phenomenal job enhancing contract management and program leadership. Empowering Dr. Jackson with direct line authority over numerous public health divisions and appointing Betsey Lyman, M.P.H. as the Deputy Director of the Emergency Preparedness Office have been remarkable structural improvements.

The sort of efficient contracting approval redesign process implemented by Director Shewry this year, could further benefit from the simplified and consolidated public health contracting model that CDHS and Placer County Health and Human Services implemented under the leadership of Secretary Belshe when she was Director of the Department of Health Services. This more efficient and service enhancing approach to contracting has been referenced by this Commission, the California Performance Review, the Foundation Consortium, and is broadly supported by local health jurisdictions.

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It is important to acknowledge that the state and local governments are currently implementing Medi-Cal redesign, Child Welfare Services re-design, Mental Health Services re-design, and the numerous other re-design efforts. It is our responsibility as local Health Officers to remain focused on not only what we perceive as the most desirable outcome, but to continue to partner with our state colleagues to identify the incremental steps that we can collaboratively take to help us all achieve the desired outcomes we share.

I began this testimony with a few of the many emerging issues public health professionals and policy makers have effectively addressed in just the last few decades.

We are living today in a world of emerging infectious disease vulnerabilities as we face SARS, avian influenza, and the reality that terrorists exist.

We live in a world with the knowledge that we as a culture are causing second hand obesity and secondary sedentary life styles among our children that will lead to pre-mature death and compromised quality of life of life.

We live in a state with such rapid land development that public health needs to either champion the solid science behind “Smart” land use polices or prepare for the enormous burden on the health care system that results from poor land use practices.

We live in a world of informed business communities, acutely aware of the economic costs of shortsighted public policy and of the desirability of establishing and growing businesses in communities that can provide healthy and thriving individuals and families to meet workforce needs.

Throughout this testimony I have used terms such as physician, scientist, systems, organizations, and resident. While accurate terms as used, they also have a great potential to be heard, discussed, and debated without an acute awareness of the truth that what we are really discussing are people, and how we choose to work with one another for each other’s shared benefit.

Public health and public service exists to help us collectively experience the hope and promise of transformed lives and transformed communities. CCLHO is confident the sort of recommendations we have advocated today will nurture the cultural adaptations required to effectively address evolving challenges that face us today.

The slide below reflects that public health really achieves our desired outcomes through relationships with our colleagues and our communities. Relationships that can celebrate our varied training, giftedness, and roles. Relationships forged through sincerely valuing each other, where we are willing to be vulnerable, embrace our interdependency, surface areas of conflict, and respectfully work through the conflict to create a healthy and thriving California where our children will have the opportunity to experience their dreams what ever they might be.

All of us have a number of hours left to invest today, may we all utilize them wisely for the benefit of others.

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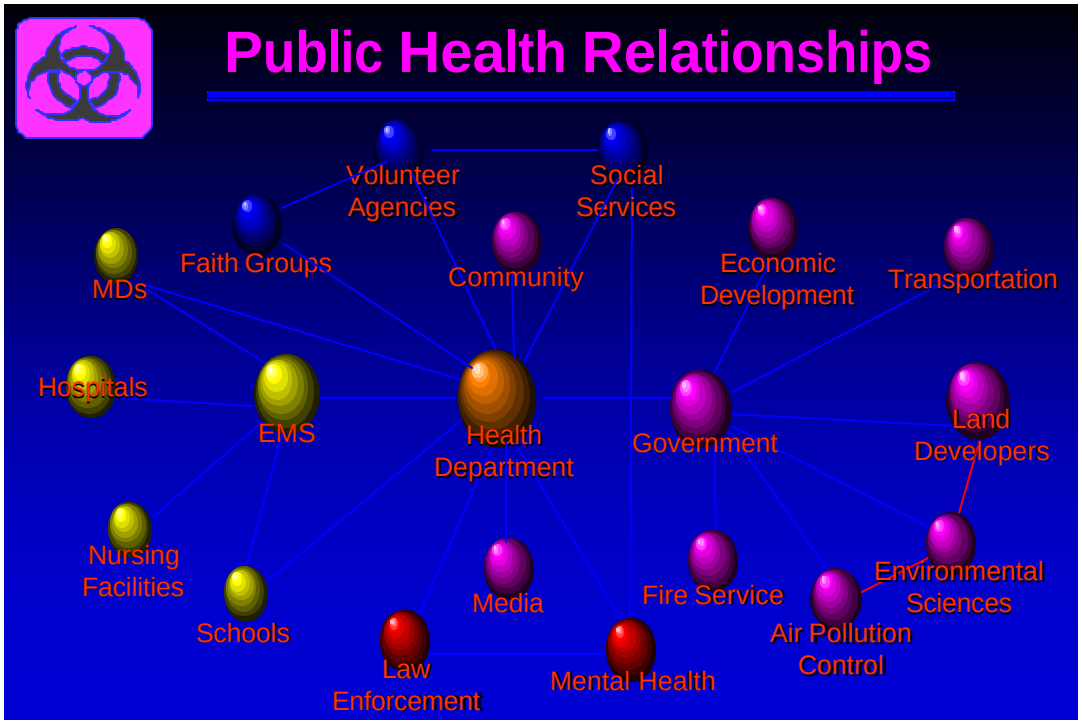

Sincerely,

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