



CALIFORNIA
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OF LOCAL
HEALTH OFFICERS

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August 8, 2008

Little Hoover Commission
925 L Street, Suite 805
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Dear Little Hoover Commission:

As President of the California Conference of Local Health Officers (CCLHO), it is a pleasure to address the Little Hoover Commission on the California Department of Public Health. The Little Hoover Commission endorsed formation of a separate Department of Public Health, and the health officers worked actively with the Legislature and Governor's Office to bring this about. Although the Department was not set up to report directly to the Governor as we had hoped, we celebrated the launch of the new department under the leadership of a physician health officer. As you know, most public health practice in the state takes place at a local level with expert assistance, guidance and coordination by the State. The State provides special services such as communicable disease and data management and is a vital link to Federal funding. Local health officers are physicians, and we appreciate the special skills of a physician health officer.

CCLHO works closely with Dr. Mark Horton, State Health Officer. Now, a year after the Department of Public Health began operations, we see professional leadership emerging within the Department. For example, the State exhibited good leadership in response to recent smoke/fire and heat emergencies and helped assure a science-based response throughout California. The Department has identified a contractor for electronic disease reporting and expects the process to be operational throughout the state in the next 18 months. The Department's web site has been reorganized, and includes helpful health information in the major languages spoken in the state. This met a specific need of local health departments for quality translations.

Shortly after its inception, the Department underwent a comprehensive strategic planning process. The Strategic Plan was a necessary and important step to improve administrative functioning, particularly in light of its role as the major contactor with local health departments to carry out public health functions. It is important to point out, however, that the strategic plan is administrative rather than programmatic, and does not address strategies for addressing emerging public health issues like health inequities, chronic diseases and global climate change.

In the area of emergency preparedness, the Department continues to make progress. The California Health Alert Network for emergency notification of the public health and medical sectors continues to improve in scope and ease of use. The Emergency Preparedness office contracted with the Health Officer's Association of California to carry out an on-site comprehensive evaluation of emergency

preparedness in almost every health department in the state. The assessment process helped local jurisdictions focus future efforts. The Department of Public Health subsequently led a multidisciplinary team to review the findings and prioritize the State's response. In fact, I would recommend that this tool be used periodically to assess our progress towards the goal of emergency preparedness to quickly identify threats and efficiently and fairly mount a response to protect the public's health.

Most of my comments that follow reflect the fundamental under-financing of the Department of Public Health. The Department was established to be "budget neutral," which actually was a cut to services considering the relocation costs, including the need to set up an independent information technology structure. Due the budget crisis this coming year, the funding gap will not be addressed and additional cuts will be made.

PUBLIC HEALTH LABORATORY

Since 2001, California has continued to make great strides in emergency preparedness and has expended significant resources towards this goal. Unfortunately, over the same time period, the core public health function has continued to deteriorate, which most certainly compromises our capacity to promptly and accurately identify infectious disease outbreaks, be they natural or due to terrorism.

One of the reasons a separate Department of Public Health was established was to focus attention on the core function of communicable disease control. With budget cuts, the communicable disease control infrastructure has taken a hit. Without a robust core infrastructure, emergency response is hindered. The network of state and local public health laboratories can assure that conditions of public health significance are diagnosed quickly and accurately. A private laboratory system cannot fulfill this function, since required tests may not be done frequently in a clinical setting or may not make a difference to the individual patient. The State has lost capacity to offer diagnostic services to counties and hospitals in outbreaks of influenza, measles, rabies, varicella/chicken pox, food borne illnesses, viral hepatitis, West Nile Virus and unexplained severe respiratory illnesses and deaths. The State laboratory has had to cease rapid testing for multi-drug resistance tuberculosis (TB). As a result, rather than getting an indicator of drug resistance in a few days, local health departments have to wait six weeks. Meanwhile, we could be treating individuals with inappropriate medication, exposing the patient to potential drug toxicity and possibly breeding more resistant TB. The State has also had to abandon plans to use advanced laboratory technology to help define the epidemic of multi-drug resistance staph aureus (MRSA) infections, and no other laboratory will take up the mantle of differentiating between hospital acquired and community acquired MRSA infections. Such information is vital in planning prevention and containment efforts. (See attachment for examples of functions lost to the Viral and Rickettsial Diseases Laboratory.)

The individual microbiologists and physicians who work in the State laboratory system are not at fault. The system for recruitment, training and retention is broken. State Public Health Microbiologists earn

30 percent less than they could working similar jobs in the private sector or at the county level. The Department has taken measures to increase salaries within the constraints imposed by the state and union structure, but it is too little too late. Vacancies of public health microbiologists run 30 percent, putting added strain on those who remain. The workforce is aging, as fewer young people join on, and older workers hold on for retirement. The Department needs help from the Governor and the Department of Personnel Administration to make an extraordinary salary increase for public health microbiologists to save the State Public Health Laboratories and protect the health of the public. There is precedent for such salary increases in the Mental Health Department in response to an exodus of their employees to the prison system for much higher salaries. The last time the Department assessed microbiologist vacancies and shared this information with CCLHO was a year ago. (See attached.) After several years of CCLHO and the California Association of Public Health Laboratory Directors documenting the demise of the State public health laboratory system, including meeting with Secretary Kim Belshé, the demise continues. State laboratory staff has convened a committee of State staff, local public health laboratory directors and health officers to talk about the issue. It feels like a positive step, but may be too little, too late.

REAL-TIME SURVEILLANCE

Previous assessments by the Little Hoover Commission have emphasized the importance of a real-time surveillance system that can quickly detect the emergence of contagious disease, whether naturally occurring or the result of bioterrorism. The State roll out of electronic reporting of reportable diseases is a step in the right direction but it is not "real time" and it does not address prospective surveillance for developing conditions of public health significance. The local health officers realize that in order to implement real-time surveillance, we must have electronic access to hospital data rather than relying on hospital personnel faxing or calling us with clinical information as we do now. Federal law, or HIPPA, permits such access to public health and CCLHO succeeded in getting SB 1430 enrolled in February 2006 to clarify State law to allow public health electronic access to hospital data. Achieving this goal has been one of CCLHO's priority issues in the last three years. We are not there yet, even though the public and many public officials expect that we have the means to identify emerging conditions quickly and accurately. Very few local health departments have instituted electronic syndromic surveillance of hospital encounters, and their programs are limited. Los Angeles has a program with 36 hospitals. They are a very large and well funded department that actually operates a number of its own hospitals. San Diego participates in Biosense, an electronic system for surveillance of syndromes facilitated by the federal Centers for Disease Control. The California Hospital Association acknowledges that public health has the legal right to electronic access to hospital data but, until very recently, insisted that they were never the less unwilling to grant public health that access because of liability concerns. Through the federally funded and state administered Hospital Emergency Preparedness funding, the State actually has both the carrot and the stick to bring hospitals along towards this goal. Furthermore, the Department is responsible for hospital licensing and could take steps through this division to reassure hospitals about the property and necessity of allowing appropriate electronic access to public health.

CCLHO has pleaded with the California Department of Public Health to take leadership on this issue but the Department has not acted to further the goal of a real-time surveillance system.

REDUCING OF ILLNESS AND DEATH RESULTING FROM HOSPITAL-ACQUIRED INFECTIONS

AB 739, which was enrolled last year, directed the formation of an advisory committee to help plan for reducing illness and death resulting from hospital-acquired infections. The Department of Public Health employs recognized experts in this field, who have already produced a practical plan for defining the epidemic of MRSA, a major cause of serious hospital-acquired infections. For lack of resources, the State laboratory will not be able to perform the laboratory testing that is the cornerstone of the epidemiologic analysis called for in this plan. The Advisory Committee is scheduled to meet soon, and will have to plan without optimum laboratory support services. The Department of Public Health has allocated resources to reducing hospital-acquired infections, but this seems to be another instance where the failing laboratory infrastructure will inhibit development of optimum public health practice.

MRSA is a hot button issue in the State. The Legislature is currently considering two additional bills aimed at controlling MRSA, one of which could actually overturn AB 739. As I stated, recognized experts in this field work for the California Department of Public Health. Unfortunately, the experts have not been encouraged or allowed by the Department of Health and Human Services to serve on legislative advisory committees on this topic, and have not been sent by the Department to hearings on the bills. As a result, we have public health policy potentially being established by politicians without adequate scientific input. It is not clear whether this short coming reflects the administrative style of current leadership. Perhaps the judgment was made that the bills could not be fixed and should be vetoed by the Governor. Never the less, it has been frustrating for the local health officers who work with the legislature not to have our State physician colleagues at the table. The risk of limiting subject matter expert's availability of task forces and at hearings may be inherent since Public Health is not a cabinet level department.

THE FUTURE OF PUBLIC HEALTH

Dr Julie Goebarding, Director of the Center for Disease Control, has said that health disparities and inequities are the single biggest health issue facing our nation. The first goal of the federal Health People 2010 is to increase life expectancy for all. The second goal is ELIMINATION of health inequities. For lack of resources, the California Department of Public Health has not been able to develop a comprehensive practice to support this goal. The Department does not track data documenting inequities. It is relatively easy to do, and several local health departments do it.

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California faces multiple urgent public health challenges for which we have almost no funding or staff resources, e.g. chronic illness, a major cause of morbidity and mortality, and climate change, which will have major impacts on public health far beyond heat waves, wild fires and air pollution. Responding to these challenges will require not only new funding, but also funding that is not siloed. We will have to address the physical/built and social environments that make it hard for people to make healthy choices, and work to change social norms and increase access to affordable health foods and physical activity.

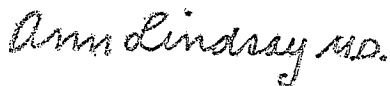
Health inequities often involve differences in susceptibility and treatment of chronic diseases, like diabetes and heart disease. The Department has several relatively small programs aimed at prevention of chronic disease, but a robust practice cannot emerge without support for infrastructure, support missing in this budget environment and given the priorities set by funding streams.

SUMMARY

Thank you for the opportunity to address the Little Hoover Commission. As President of the California Conference of Local Health Officers, I appreciate your ongoing commitment to public health excellence in California.

CCLHO remains in strong support of the California Department of Public Health and recognizes the dedicated staff of experts working to preserve the health of the public. We hope that strong leadership will continue to emerge. Serious deficits in the core structure of communicable disease control threaten not only emergency response, but day to day prevention and control of infections of public health significance, such as TB and hospital acquired infections. The Department is under-resourced as a result of a budget neutral transition and subsequent budget cuts. Without resources and staff, the Department of Public Health will not be able to work to eliminate health inequities, or respond to climate change and the growing burden of chronic illnesses.

Sincerely,



Ann Lindsay, MD
President
California Conference of Local Health Officers

Enclosure



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Roberta Lawson
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Executive Administrator

January 30, 2008

The Honorable Arnold Schwarzenegger
Governor of California
State Capitol Building
Sacramento, CA 95814

Dear Governor Schwarzenegger:

The California Conference for Local Health Officers (CCLHO), comprised of the legally appointed Health Officers from California's 58 counties and three cities of Berkeley, Long Beach and Pasadena, is charged with protecting and improving the health of California residents. CCLHO is concerned about budget cuts across the board of 10 percent to communicable disease control programs and is opposed to all cuts to public health laboratories.

CCLHO recognizes the key role that State Public Health Laboratories play in supporting local public health laboratories. Ideally State Public Health laboratories provide leadership, training, and serve as a reference laboratory for the locals. The State laboratories play a vital role in food borne illness outbreaks, West Nile Virus, rabies, unexplained severe respiratory and brain infections and deaths, viral hepatitis and other infectious diseases of public health significance. This vital role is at risk, and threatens public health statewide. Private laboratories and County public health laboratories cannot fill this reference laboratory role of the State laboratories.

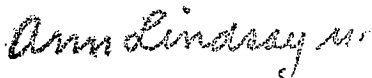
Prior to funding cuts proposed by the budget, the State Public Health Laboratories already have an unacceptable vacancy rate of Public Health Microbiologists (PHM), 30 to 50 per cent, which has already resulted in a curtailment of services and training, and longer turn around for tests that are performed. In addition, staff that remains is overworked and overwhelmed and less capable of responding to surges of activity.

The Governor's budget includes funding cuts to public health laboratories that would eliminate 5 of 20 staff positions in *each* of the Viral and Rickettsial Disease and Microbial Disease Laboratories and reduce facilities operations. Testing will be severely reduced. Additionally, only 10 of 14 students in the Laboratory Director Training Program will be funded. We have a critical shortage of qualified Laboratory Directors for local public health laboratories. The Laboratory Director Training Program was a welcome effort by your administration and the Legislature to begin to address this issue.

Governor Schwarzenegger
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CCLHO is opposed all cuts to the State Public Health Laboratories. If one were to balance a household budget, one would not make 10 percent cuts across the board, but might go out to eat less and continue to make the mortgage payment. Please consider the State Public Health Laboratories as vital infrastructure, like the mortgage payment that it is. Do not cut funding to laboratories.

Sincerely,



Ann Lindsay, MD
President
CCLHO

cc: Mark B. Horton, MD, MSPH, Director
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Budget Committee

Division of Communicable Disease Control
Public Health Micro Vacancy Rate

	VRDL			MDL			Combined
Year	Number of PHM vacancies	Total PHM positions	Vacancy rate	Number of PHM vacancies	Total PHM positions	Vacancy rate	Vacancy rate
2002	3	27	11%	2	35.5	6%	8%
2003	5	27	19%	6	43.5	14%	16%
2004	4	26	15%	5	41	12%	13%
2005	2	25	8%	6.5	36	18%	14%
2006	9	30	30%	13	41	32%	31%
2007*	7	31.5	22%	7	38	18%	20%

*September 2007

PHM classifications include:

- PHM I
- PHM II
- PHM Supervisor
- PHM Specialist

Impact of Lower Salary for Public Health Microbiologists on CDPH/VRDL

