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California Department of Health Services
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Good morning Mr. Chairman and members. Thank you for inviting me to testify on California's public health system. My name is Richard Burton and I am the Associate Director of the California Department of Health Services. Prior to my joining the Department, I served as the Health Officer of the Placer County Department of Public Health, one of California's 61 local health departments. As a Navy Commander, I also served as a flight surgeon with the United States Marine Corps. I appreciate this Commission's ongoing interest in and support of public health programs.

The public health system is an interdependent network of health care professionals at the federal, state, and local level including components of both the public and private sector. Through cooperation and collaboration these many partners can maximize the various resources available with the common goal of providing for the health and well being of all Californians.

Fortunately, we have not been the target of biological terrorism. Nevertheless, preparing our public health and hospital systems for such an event is one of our Department's highest priorities.

In the midst of the urgent response to the anthrax scares and planning for the potential of other bioterrorism attacks, public health must continue to perform its traditional core functions. In California, this means combating new and emerging diseases, such as Hantavirus, as well as re-emerging communicable diseases like tuberculosis. And in California we are getting our first cases of West Nile Virus.

PUBLIC HEALTH FUNDING

The State, via the California Department of Health Services (CDHS), is one of many funding vehicles for public health services in California. In fiscal year (FY) 2001-02, DHS budgeted approximately $686.4 million (all funds) in support of public health activities conducted by various organizations, including but not limited to local health departments (but excluding direct medical service providers such as Medi-Cal physicians, as direct treatment services are not generally considered "public health" activities). Please note that we derived this estimate from DHS' local assistance and support budget line items, which include some funding for activities that may not meet a strict definition of public health activities, such as research or outreach.

In addition to the approximately $686.4 million of state support for public health activities in FY 2000-01, another major source of funding for local public health services was the realignment funds of $1,357,048,079. Counties use these realignment funds not only for local public health, but also for medical care to low-income, uninsured populations. Each county determines what percentage of its realignment dollars will be used for local

public health. Neither statute nor DHS dictate to the counties how to spend these funds.

Other sources of funding for local health departments (LHDs) include local revenues (e.g., county general funds, property taxes), the State (e.g., the Child Health Disability Program; Maternal and Child Health), the Centers for Disease Control and Prevention (CDC; e.g., bioterrorism preparedness grants), other federal agencies, foundations, and other private funders. There is no statutory requirement for LHDs to report their spending to CDHS, nor is there any mechanism in place for such reporting. However, one of CDHS' strategic plan goals continues to be cooperation with the county/city public health organizations on a mutually acceptable annual public health expenditure report for the collection of basic workforce and fiscal data.

CDC EMERGENCY BIO-TERRORISM FUNDING

The Emergency Supplemental Appropriations for Recovery from and Response to Terrorist Attacks on the United States Act, 2002 (P.L. 107-117, authorized by Section 319 of the Public Health Service Act, 42 USC 247 d) provide more than $100 million in support of state and local measures to strengthen against the threat of bioterrorism. California will receive the following share of these funds:

(1) CDC Cooperative Agreements for enhanced Public Health Preparedness:
   a. CDHS, $60,816,245 (includes $2.6 of currently budgeted funding)
   b. Los Angeles County, $24,591,171

(2) Health Resources and Services Administration (HRSA) Cooperative Agreements for hospital planning and preparedness:
   a. CDHS, $9,962,905
   b. Los Angeles County, $3,659,172

Approximately 73 percent ($44.2 million) of the $60.8 million available through the CDC grant will directly benefit local health jurisdictions, with the remaining 27 percent ($16.6 million) being used to enhance crucial state public health preparedness in the areas of scientific expertise, laboratory equipment, and communication technologies.

CDC Emergency Bioterrorism Funding In Support of Local Health Jurisdictions	
$3,000,000	Public Health Subvention Backfill FY 2001-02
$7,500,000	Formula Allocation FY 2001-02
$28,448,665	Formula Allocation FY 2002-03 and FY 2003-04
$1,166,900	Level A Labs FY 2002-03 and FY 2003-04
$2,912,000	Level B Labs FY 2002-03
$170,000	Border County Labs FY 2002-03
$980,000	Software Licenses FY 2002-03
$44,177,565	**TOTAL** Local Health Jurisdiction Support
$60,816,245	**TOTAL CDC FUNDING**

CDHS has authority to provide an initial amount of $7.5 million to eligible local health jurisdictions (57 counties and 1 city health department) via a population formula using contracts. The purpose of these contracts is to assist jurisdictions in preparing local public health capacity and expenditure plans.

To date, DHS has received contracts from 50 of the 58 jurisdictions, with 41 fully executed contracts in place. Approximately $3.0 million in public health emergency preparedness and readiness-planning funds have been distributed to 29 local health jurisdictions that have submitted invoices to CDHS. Final payments to jurisdictions will be made upon receipt of the plans, which were due October 15, 2002.

The remaining $25.4 million of the local bioterrorism funds that were budgeted in FY 2002-03 (some funds remain to be allocated in FY 2003-04) will be distributed to eligible local health jurisdictions in accordance with Senate Bill 406 (Ortiz) and Assembly Bill 442 (budget trailer bill), both enacted this year. These bills call for submission of an application, local plan and budget. Local health jurisdictions will receive an allocation using a population-based formula. The first 25 percent of each jurisdiction's allocation can be released to local health jurisdictions once the local plan has been approved. The local jurisdictions' plans are due to CDHS on October 15, 2002. As the plans are found compliant with submission guidelines, the first quarterly payment will be sent to the local jurisdictions.

CDHS has alerted local health jurisdictions about the federal requirements against supplanting of existing levels of funds and incorporated the federal definition into its guidance document, for use by local health jurisdictions in preparing their plans and budgets. SB 406 and AB 442 require a certification by the city mayor/or the county board of supervisors that the local health jurisdiction will not supplant existing funds and a similar certification must accompany each expenditure report submitted by the jurisdiction. In addition, CDHS will require progress reports, developing the report format in collaboration with LHDs. Other tools for compliance available to the CDHS include program reviews and audits.

ASSESSING AND BUILDING CAPACITY AT THE LOCAL LEVEL

The primary responsibility for assessing local public health needs and the capacity for responding to those needs lies with local health departments. However, CDHS works closely with local health departments and local programs. Currently the State supports any local jurisdiction's request for assistance when needed and has the authority under the Health and Safety Code to step in and direct appropriate public health interventions when the local system is unable to provide these interventions for whatever reason.

CDHS has identified both long-term and short-term approaches to optimizing health public capacity in its strategic plan. Among our short-term goals are supporting use of a local public health department capacity assessment tool, working with local health departments on a mutually acceptable annual public health expenditure report including basic workforce and fiscal data, maximizing use at the State and local level of data generated by the California Health Interview Survey (CHIS), and supporting current

public health program integration/consolidation/simplification efforts. Our long-term approaches include working closely with local health departments, public health advocacy groups, and academia; enhancing coordination and communication with other departments, boards and commissions that share common target populations, programs, or missions; utilizing available federal monetary and professional resources; promoting full use of the allied and auxiliary public health workforce; encouraging regional approaches to public health programs by facilitating shared services and pooled resources among health jurisdictions; and cooperating with federal, State, and local public health agencies to integrate and consolidate health surveillance, data collection, and communication systems.

CDHS' assessments of LHDs' activities have focused on categorically funded programs more than on a system- or department-wide assessment. CDHS funding for local programs is generally controlled by contracts that include specified scopes of work and require detailed reporting of expenditures, including program reviews and financial audits.

The CDC bioterrorism grant offers a unique opportunity to require locally driven statewide inventories. The CDC requires completion of a Public Health Preparedness and Response Capacity Inventory. This inventory will provide information about local ability to respond to bioterrorism, outbreaks of infectious disease, and other public health threats and emergencies. It will assess progress toward meeting the benchmarks and critical capacities specified in the CDC grant. In addition, LHDs must assess the timeliness and completeness of the local reportable disease surveillance system, including epidemiologic capacity and response. They must also assess communication connectivity including needs assessment, redundant capacities, and security procedures. Further, counties or local health departments must assess training needs for bioterrorism, infectious diseases, and other public health threats and emergencies.

CDHS realizes the value of local health department capacity assessment tools in capturing the broader scope of local needs and interactions and encourages their voluntary use. Examples of such assessment tools or programs include the Health Officers Association of California Capacity Assessment, the CDC Local Public Health Performance Standards Assessment Instrument, and the emerging Project Public Health Ready.

MANDATED COUNTY PUBLIC HEALTH FUNCTIONS

Many state statutes and regulations govern the performance of “local public health.” The following functions are legally required and may be considered “public health services” depending upon how the local government is organized. Only minimal state funding is provided for these services.

The following basic services are required:

- Collection and analysis of public health statistics including birth, death, and morbidity data and population data. This is a core public health function that provides the basis for understanding community health needs and problems.

- Communicable disease control based on epidemiologic investigation and appropriate preventive measures. Programs are required for tuberculosis, sexually transmitted diseases, HIV/AIDS, vaccine preventable diseases, and other disease hazards in the community. Currently, over 80 infectious diseases including those that are possible agents of bioterrorism are reported to the local health department, which monitors, investigates, and intervenes to control the spread of disease. This is a core public health function that protects the community.

- Environmental health and sanitation services and programs in accordance with an annual plan and program approved by CDHS and including the following: food protection; housing and institutions; milk and dairy products; radiological health; water oriented recreation; safety; vector control; waste management; water supply; air quality; and land development and use. This is a core public health function that exists to identify, mitigate, and prevent environmental hazards.

- Laboratory services, provided by an approved public health laboratory in health departments serving a population of 50,000 or more. The laboratories provide consultation and reference services to support disease surveillance; diagnosis of new and recurring infectious and zoonotic diseases; environmental and vector testing; toxicology; monitoring the safety of drinking water, recreational water, and food supplies; and response to bioterrorist threats or acts.

- Jail public health services. Local health departments are required to investigate health and sanitary conditions in every jail and other publicly operated detention facilities at least annually. The health officer is required to submit a report to the Board of Corrections, the person in charge of the jail or detention facility, and to the governing body of the local health jurisdiction.

- Chronic disease control services, which include case finding, community education, and consultation or rehabilitation for preventing or mitigating any chronic disease. Chronic diseases are the leading causes of death, disability, and medical care expenditures. Programs at the local level include breast and cervical cancer screening, asthma, diabetes, and tobacco cessation programs.

- Public health nursing services for the preventive and therapeutic care of the population served. Public health nurses assess individual and community factors to identify health risks, recommend interventions, and advocate for the needs of

a specific individual or family. They participate in communicable disease identification and effective response to disasters and other public health emergencies.

- Maternal, child and adolescent health services. These services exist to improve the health of mothers and children.

- Family planning services. These services include pregnancy testing and all forms of birth control, sexually transmitted disease services, and AIDS education.

- Health education programs including staff education, consultation, community organization, public information, and individual and group teaching. Promoting healthful behavior is a core public health function.

- Nutrition services including education and consultation.

- Occupational health services to promote the health of employed persons and a healthful work environment.

- Other services that affect health, which may include community planning, counseling, consultation, education, and special studies.

PUBLIC HEALTH WORKFORCE

CDHS is committed to cultivating a public health workforce that is adequate in number, appropriately trained, and culturally competent, and maximizing opportunities to encourage public health and staff retention on both the state and local levels. Through networking with various individuals and organizations within the state and around the nation, CDHS also effectively accesses the best expertise available for any given subject area.

At the direction of the Governor and the California Health and Human Services Agency, CDHS and the University of California (UC) Office of the President have created a registry of expert consultants to advise on preparedness and response issues. The topic areas range widely and include human health, animal health, environmental hazard, and infrastructure concerns. These experts have agreed to be available through the UC Office of the President upon request by the Governor's Office of Emergency Services (OES) to provide consultation in their areas of expertise.

As one of the partners in the State's health care delivery system, CDHS is working closely to assist the Emergency Medical Services Authority (EMSA), Governor's office of Emergency Services, and the Governors Office of Volunteerism, hospitals, healthcare providers, and local health jurisdictions to enhance the current mutual aid capabilities. EMSA is the lead state agency in this area.

CDHS has two nationally recognized programs to train person for public health leadership positions. CDHS' Preventive Medicine Residency Program trains public

health physicians who can provide leadership in California public health agencies. CDHS' California Epidemiologic Investigation Service (Cal-EIS) training program prepares epidemiologists for public health leadership positions.

In January, Governor Davis announced a three-year, $60 million Nursing Workforce Initiative (NWI). The financing was derived from the Governor's 15 percent discretionary fund from the federal Workforce Investment Act dollars that flow into California. The Department of Employment Development has primary responsibility for implementing the initiative. An inter-agency workgroup including CDHS has been instrumental in planning and developing this project. The Initiative contains several key strategies:

- $24 million over three years for regional collaboratives to design and implement innovative programs to address local nursing workforce needs.

- $3 million for health care facilities that design and implement career advancement programs to assist health care workers to move into RN licensure.

- $1 million to licensed nurse employers to encourage workforce reforms designed to improve nurse retention.

- Standardization of pre-nursing prerequisites and nursing education curriculum to create a seamless system among and between the community college and California state universities.

- $6 million over three years to expand the Central Valley Health Careers Training Program to educate an additional 300 nurses focusing on ethnically and racially underrepresented and economically disadvantaged students. Will serve in part to augment the Central Valley initiative taken on by the California Endowment to address the nursing shortage in the Central Valley.

- $1 million for evaluating the NWI and for further research of nursing workforce needs. This project will be spearheaded by the CHHSA.

- Data collection by the Board of Registered Nursing for future workforce strategic development planning.

- $24 million over 3 years to nursing programs to expand the number of students, with a goal of educating and training an additional 2400 RNs and LVNs.

- The NWI also contemplates an outreach and recruitment effort, which was not specifically funded.

In addition to these workforce development programs, hundreds of hours of disaster preparedness trainings have been provide to professionals across all the disciplines and to communities at large. These have been provided through strategic partnerships in

venues such as medical staff grand rounds, professional conferences, community level professional society meetings, web casts, videotapes, and satellite down links. Community health providers, fire, law, EMS, National Guard, and military members have rapidly assimilated this enhanced level of awareness to the new environment in which we all must operate. As we continue these efforts the department will benefit greatly from the expertise and recently federally funded program development in these areas at the University of California, Los Angeles and the University of California, Berkeley.

Examples of trainings include:

- August 27-30 Cascadia Subduction Zone - Earthquake and tsunami exercise. This exercise was a combined state, local, and federal tabletop exercise that included medical and health issues associated with a disaster response in the North Coast region. This exercise included approximately 200 staff from 60 agencies.

- September 18, 2002 Oakland - Federal Bureau of Investigation cosponsored smallpox tabletop exercise. Issues associated with mass vaccination, detection, and protective actions were discussed among federal, state, and local agencies.

- September 18, 2002 City of Huntington Beach and Orange County - Joint bioterrorism response exercise. This exercise included the request for regional, state, and federal resources, including access to the National Pharmaceutical Stockpile, a repository of medical supplies, antibiotics, and chemical antidotes.

- September 19, 2002 Diablo Canyon Nuclear Power Plant – nuclear disaster exercise. DHS staff participated in the dress rehearsal for the FEMA -graded exercise, which included coordinating public health and medical resources for local, state, and federal response. The graded full-scale drill will be held October 23rd at Diablo Canyon.

- September 23-26, 2002 San Luis Obispo - Disaster Medical Operations Class. The Governor's Office of Emergency Services, California Specialized Training Institute held the class for EMS and public health staff. The class included lectures and exercises related to medical response to a disaster.

- September 27, 2002 Redding - National Pharmaceutical Stockpile exercise. DHS held this question and answer workshop for the federal and state response related to the request, receipt, and distribution of the National Pharmaceutical Stockpile. The workshop was held in conjunction with the Region III Regional Disaster Medical and Health Coordinator's meeting.

DISEASE SURVEILLANCE

CDHS works in partnership with local, national, and international health officials and health care providers to conduct surveillance, investigation, prevention and control of

communicable diseases of public health importance. Data resulting from surveillance and investigation activities also help inform public health policy decisions.

The foundation of communicable disease surveillance in California is the requirement for reporting of specified conditions to public health by health care providers and by clinical laboratories. Providers and labs submit these reports to the LHDs, usually by fax or phone. The LHDs, after investigation, routinely submit surveillance information from these reports to CDHS via an automated system. CDHS receives approximately 160,000 communicable disease reports annually, and participates in hundreds of disease investigations and case management decisions as requested by local jurisdictions. In an urgent situation (e.g., outbreak), the State is notified by phone. CDHS aggregates and analyzes surveillance data and submits portions to the CDC on a weekly basis. In order to improve reporting of potential bioterrorism agents, CHDS promulgated new emergency reporting regulations in October 2001. These regulations added provider and laboratory reporting requirements for specified diseases of bioterrorist concern, both for conditions that were already reportable (e.g., new time frames for reporting anthrax, brucellosis, and tularemia) and for new conditions (smallpox and varicella deaths). Other strategies are also used for the surveillance of many diseases. A few examples include special projects (e.g., FoodNet, unusual or unexplained death surveillance), "active" surveillance (e.g., AIDS case finding), and sentinel surveillance (e.g., influenza, mosquito-borne viruses). In addition, the public health laboratories (both local and state labs), participate in surveillance efforts (e.g., PulseNet).

Using its network of state and local laboratories, California has strengthened its public health system to provide diagnostic services for all major bacterial bioterrorism agents. The state public health laboratories perform over 4 million tests annually. These crucial and highly technical tests are the underpinnings of timely and appropriate public health intervention. Fortunately, ten years ago the State recognized its need for a new laboratory that would have the capacity to address new and emerging infectious diseases, as well as test for genetic diseases and toxic exposures. California is fortunate to have a new state-of-the-art diagnostic laboratory facility in the Richmond Laboratory Complex. The first phase of the lab has been open for more than a year. The second phase, consolidating all CDHS laboratory assets in the new facilities, will be complete later this year. The laboratory complex provides essential testing for bioterrorism agents and will serve as the western regional reference laboratory for chemical exposure diagnostics. Staffing for the laboratory is being expanded through the use of CDC bioterrorism funds to attract top-notch scientists to conduct these key public health functions.

The key improvements needed in surveillance capacity to analyze public health threats and rapidly detect infectious disease problems are in the areas of timeliness, complete data, data standards/ integration, and evaluation/pilots of other surveillance strategies. Approaches to address the first three needs, and often the fourth, involve electronic information systems and other modern technologies. Timely delivery of complete surveillance information from sources to LHDs and to CDHS is critical if rapid

responses, alerts/communications, and state-level assessments are to be accomplished. Information sharing between program-specific surveillance systems, both those in existence and those to be developed, will also improve surveillance. The key to successful and cost-efficient development of such systems is a standards-based approach (see NEDSS below). Many of these improvements in capacity, and other novel surveillance strategies (e.g., syndromic surveillance), need to be evaluated and piloted in order to assess their utility and efficiency.

CDHS is pursuing a number of strategies to improve communicable disease surveillance capacity. Among them are two electronic systems currently under development and an initiative to implement standards for such systems. The California Electronic Laboratory Disease Alert and Reporting (CELDAR) system is currently in the pilot phase, testing electronic communicable disease reporting from a number of laboratories (e.g., clinical, public health, veterinary) to a centralized system. The data will be immediately available for both local and State evaluation and analyses, and the system generates alerts to appropriate public health officials based on specified rules (e.g., single request for anthrax testing, excess number of cryptosporidiosis reports). The State's Microbial Diseases Laboratory (MDL) has developed an Internet-based extension of its laboratory information system providing access to its customers. Electronic submission of test requests and electronic reporting of results will increase speed and efficiency in both directions, and will be a source of earlier and faster surveillance information to CELDAR. Lastly, the National Electronic Disease Surveillance System (NEDSS) is a CDC initiative to support the overarching infrastructure and standards for surveillance systems (e.g., architecture, data standards and structure, data messaging, security, interfaces, data analyses and visualization). CDHS successfully competed for CDC funds for NEDSS and is in the third year of NEDSS activities. NEDSS implementation provides efficiencies in system development, permits information sharing across systems when appropriate, and facilitates shared approaches to common surveillance system functions. CDHS' NEDSS activities include assessments, collaboration across programs, common infrastructure developments, and continuing NEDSS-compliant efforts in a number of programs (e.g., both CELDAR and MDL, although bioterrorism-funded, are NEDSS-compliant projects).

Another approach to acute disease surveillance is exemplified by Sandia National Laboratories' Rapid Syndromic Validation Project (RSVP), a real-time database focused on syndromic surveillance. In contrast to other sentinel networks, RSVP tracks outbreaks of syndromes - signs and symptoms - before positive diagnoses of specific diseases. CDHS and LHDs occasionally use syndromic surveillance tools for certain conditions such as flu-like illness during influenza season.

PREVENTING DISEASE AND CONTAMINANT IMPORTATION

The U.S. Food and Drug Administration (FDA) has primary responsibility for examining food, drugs, medical devices, and related products at the border. The FDA inspects approximately one percent of products coming in. Since the events of September 11, 2001, FDA has considerably increased staffing to address the international borders. In the last two years, cantaloupes imported from Mexico have been found to be

contaminated with *Salmonella poona*, a pathogen. Two separate shippers and growers have been identified. FDA has since put these shippers and growers on automatic import detention. When problem products are identified, CDHS works closely with FDA in embargoing products.

CDHS routinely coordinates with FDA to address known problems (e.g., candy products coming from Mexico with excessive levels of lead). CDHS has memoranda of understanding with FDA and the California Department of Food and Agriculture (CDFA) to work cooperatively on issues of mutual interest. In addition, CDHS meets regularly with these agencies to address shared workload and current activities. As a result of the terrorist events of 2001, CDHS works closely with CDFA to address bioterrorism as it relates to food and agriculture security. In addition, CDHS' Office of Binational Border Health will expand its food safety and security activities and coordinate these activities with many agencies in addressing border health issues.

SMALLPOX

CDHS and local public health leaders have actively sought to incorporate federal guidance into state and local smallpox preparedness plans. As of the time of the preparation of this testimony, federal authorities have not finalized a strategy for the use of the smallpox vaccine in the United States. California will implement the federal guidance as it is released. Under the auspices of the State Strategic Committee on Terrorism, a smallpox workgroup is currently developing model protocols and plans to implement likely national strategies as well as California-specific guidelines. CDHS has identified a public health physician to coordinate smallpox preparedness and response between state and local levels. This physician has extensive experience in both emergency medicine and immunization practice.

SURGE CAPACITY

CDHS has defined roles within the state emergency plan and will carry out these responsibilities in coordination and with the Governor's Office of Emergency Services. All of these activities will be accomplished through implementing the Standardized Emergency Management System.

As will be discussed by EMSA, there are many partners involved in the area of mutual aid and surge capacity. CDHS has made plans for the redirection of resources to meet planning and response requirements in partnership with the resources that exist at the federal and local level. For example, in response to a major disaster CDHS would activate and staff its Emergency Operations Center on a 24-hour basis.

GOVERNANCE

In the beginning of 2002, I was requested by the director of CDHS to provide specific leadership and cross-divisional direction to the department's emergency preparedness effort. There has been outstanding support within CDHS to enhance the department's preparedness to carry out the unique responsibilities it has in emergency response.

In the California *State Emergency Plan*, CDHS is the lead state department for the protection of the public health, and supports EMSA in their management of the medical response to disasters, including bioterrorism events involving mass casualties. CDHS acquires health personnel, supplies, and equipment for deployment to the affected area, and supports local response agencies in restoring and maintaining basic public health services. CDHS' disaster responsibilities depend on statutory authority to: assure the safety of public water supplies and food, drug and medical devises at the manufacturer or wholesale level; protect public health from radiation hazards; and ensure that health facilities are able to proved patient care. CDHS has lead responsibility for several tasks under the *Plan* related to the set up, maintenance, and operation of the Joint CDHS/EMSA Emergency Operations Center, or, in a less severe disaster that does not involve support of the medical response, a smaller Emergency Coordination Center. At the local level, during all-hazard disasters, local health officers bear the responsibility and authority to lead planning, response, and recovery efforts.

Local Health Departments

- Have broad powers to deal with disease within their jurisdictions.
- Are required to take measures as may be necessary to prevent the spread of any disease made reportable by DHS regulation or any other contagious, infectious or communicable disease (Health and Safety Code [HSC] 120175).
- Are required to report certain diseases to DHS (HSC 120190), and enforce all orders, rules and regulations concerning quarantine or isolation prescribed by DHS (HSC 120195).

California Department of Health Services

- Also has broad powers (e.g., HSC 120140, 120125, 100185). For example:
- Can quarantine, isolate, inspect and disinfect persons, animals, and property whenever necessary to protect or preserve the public health (HSC 120145).
- Can destroy property such as household goods or animals when ordinary means of disinfection are considered unsafe and when the property is an imminent menace to the public health (HSC 120150).
- Can take all proper and necessary actions to protect and preserve the public health (HSC 100170).

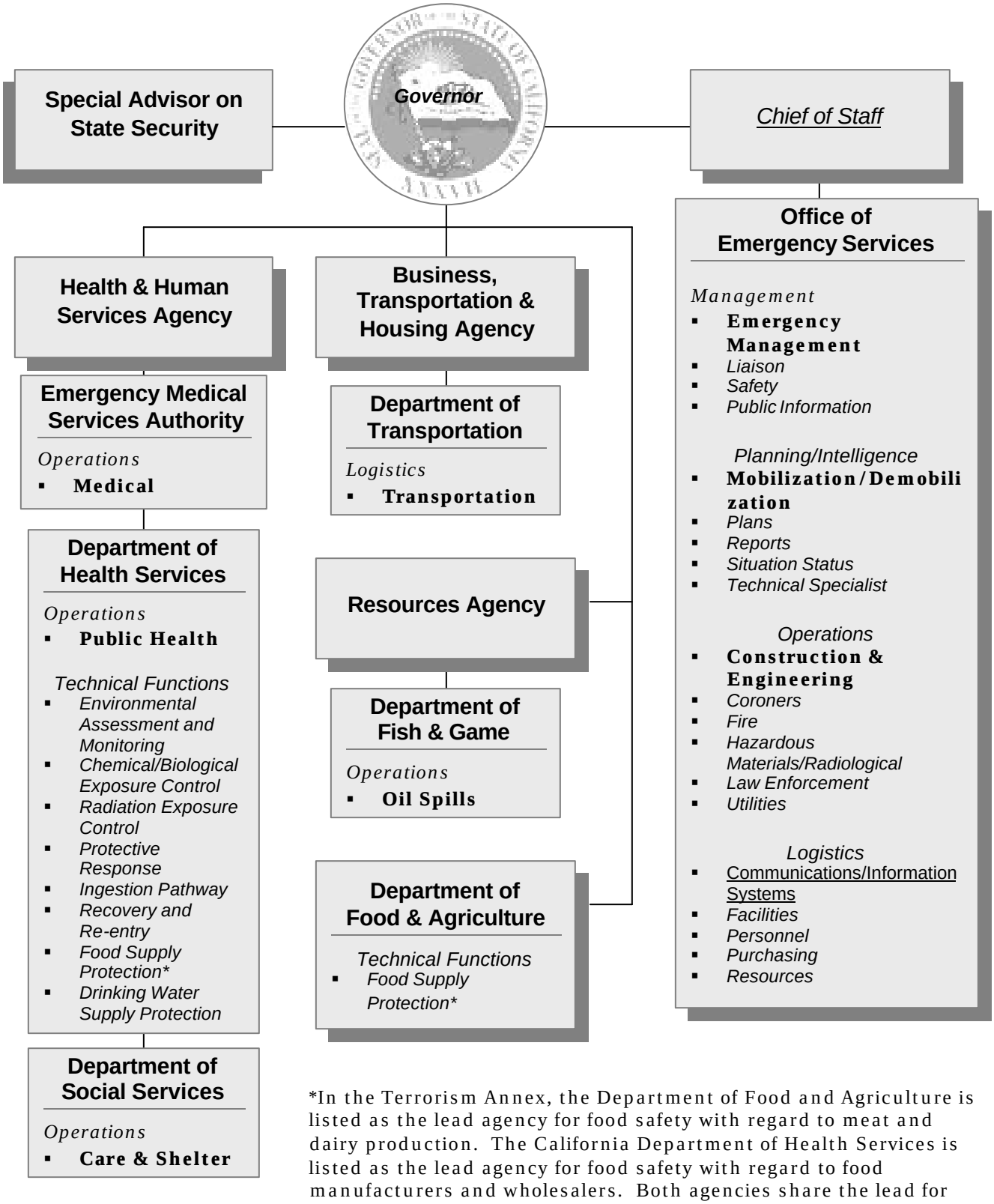
Governor

- Has broad powers to prepare for and respond to all kinds of emergencies under the Emergency Services Act (GC 8550 et seq.).
- Can establish and coordinate emergency plans and programs, both before and during emergencies (GC 8569, 8570, 8574.16, 8585, 8590).
- Can declare a state of emergency for "conditions of disaster or of extreme peril to the safety of persons or property," such as fire, flood, storm, epidemic, riot, drought, plant or animal infestation or disease (GC 8558). In a state of emergency, the Governor, for example:
- Has complete authority over all agencies of state government and the right to exercise all police power vested in the state by the Constitution and state laws (GC 8627).

- Can make, suspend, and enforce orders and regulations as he deems necessary (GC 8567).
- Can commandeer and utilize private property and personnel as he deems necessary, paying the reasonable value thereof (GC 8572).
- Can make expenditures from any fund legally available to deal with actual or threatened conditions (GC 8566, 8645).

See Attachment 1 for a graphic description of CDHS' roles and responsibilities during emergencies. In an emergency, OES acts as the lead to coordinate emergency response.

Attachment 1
Lead Agencies for Emergency Response
State Emergency Plan – Terrorism Annex



*In the Terrorism Annex, the Department of Food and Agriculture is listed as the lead agency for food safety with regard to meat and dairy production. The California Department of Health Services is listed as the lead agency for food safety with regard to food manufacturers and wholesalers. Both agencies share the lead for food safety with regard to crop production.