

CALIFORNIA CONFERENCE OF LOCAL HEALTH OFFICERS

Policy Platform

FALL 2010



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Introduction

The California Conference of Local Health Officers (CCLHO) developed this Policy Platform to establish guiding principles, determine public health priorities, and assist Health Officers in educating local and state policy and opinion makers on population-based health needs and priorities.

CCLHO believes that all residents have a right to protection from avoidable health hazards that are beyond their control, whether naturally occurring or human made, unplanned or deliberate. Protection of the public's safety and health is a fundamental responsibility of state and local government. A strong, well-funded, and resourced public health system composed of local, state, and federal agencies is crucial to protecting and promoting the public's health.

The mission of public health is to create conditions in which people can be healthy. As an agent of the state and an institution of local government, a local health department must provide leadership to assure a healthy community. This is accomplished by organized community efforts that assess needs, provide services, and promote policies that protect and preserve health and well-being. Public health agencies are responsible for demonstrating strong leadership for the promotion of social, economic, and environmental conditions that improve health and well-being and prevent disease and injury. To fulfill its mission, CCLHO espouses key principles of public health policy that are essential to create healthy communities for the citizens of California.

The mission of public health is to create conditions in which people can be healthy.



**PRINCIPLES
OF EFFECTIVE
PUBLIC HEALTH
PRACTICE**

State law mandates that CCLHO serve in an advisory capacity to state and local government.

In that role, the Conference is committed to working actively with other parties to formulate, clarify, and strengthen public health in the coming decades. The Conference believes that effective public health policies are based on the following nine principles:

- **Public health services improve the health and wellness of communities.** Public health prevention services are organized community efforts initiated by local health departments in collaboration with the community. Public health services identify and respond to disease outbreaks, environmental contamination, natural disasters, and other emergencies. They also promote good health through health education activities and address the environmental, behavioral, and social determinants of health crucial to community health. The public health infrastructure must be maintained and strengthened to deal with the challenges of the future, including potential acts of bioterrorism.
- **Core public health functions lay the groundwork for healthful communities.** Public health services are population-based and operate at the community level. A national consensus panel of health experts identified the following “Ten Essential Public Health Services” as the core responsibilities of public health:
 - Monitor health status to identify community health problems;
 - Diagnose and investigate identified health problems and health hazards in the community;
 - Inform, educate, and empower people about health issues;
 - Mobilize community partnerships to identify and solve health problems;
 - Develop policies and plans that support individual and community health efforts;
 - Enforce laws and regulations that protect health and ensure safety;
 - Link people to needed personal health services and assure the provision of health care if sufficient resources exist;
 - Assure a competent public health and personal health care workforce;
 - Assess effectiveness, accessibility, and quality of personal and population-based health services; and
 - Research for new insights and innovative solutions to health problems.

Public health services improve the health and wellness of communities.

- **Prevention, an effective approach to averting disease and disability and improving the quality of life, is a core public health commitment.** Primary prevention strategies lower the risk of illness and injury by preventing the development of risk factors, such as smoking and obesity, by eliminating risk factors, or by mitigating the health effects of risk factors to keep individuals healthier for longer periods of time. Secondary prevention treats disease early, when possible, to avoid more serious effects of illness. Tertiary prevention emphasizes preventing unnecessary complications and maintaining quality of life. Good public health practice requires that all people within a community be included in public health measures and programs aimed at primary prevention.
- **Epidemiology is the principal scientific base for defining problems, developing interventions, and measuring results in public health.** Public health practice is based on science and is increasingly evidence-based.
- **Public health services must be provided by local government in collaboration with the private and public sectors and state and federal governments.** Without the cooperation of the entire community – employers, insurers, architects, health care providers, community planners, and so on – public health efforts will fall short of optimum public health goals. Services must be consistent with unique local circumstances, while meeting minimum statewide standards. The organization of public health services at the state level must be compatible with and supportive of the delivery of services at the local level. The state Department of Public Health should have adequate epidemiological, laboratory, electronic resources, and staffing to coordinate population-based surveillance efforts; assist local jurisdictions with investigations and direct them when needed; spearhead disease prevention and health promotion efforts; promulgate statewide standards; promote professional training; conduct practical research to improve laboratory methods and community and behavioral interventions; and take the lead in planning for meeting future public health needs.
- **Public health should advocate for universal health care access.** Lack of access to health care accounts for approximately one in 10 premature deaths in this country. Universal access to health care is critical for achieving optimal population health.

Public health practice is based on science and is increasingly evidence-based.



- **Local communicable disease control surveillance and reporting activities are the backbone of the state's communicable disease control efforts.** Without an effective local reporting and surveillance system, control of communicable diseases is not possible in California. CCLHO supports efforts to obtain adequate resources for every local health jurisdiction to monitor the health of its community, including monitoring chronic diseases. Local health departments should have real time electronic access to health information, including patient data, to permit assessment of health trends in the community and to facilitate case management in cases of public health significance. Local health departments must respond quickly to disease outbreaks, both natural and intentional; assure that necessary interventions are implemented; communicate effectively with the public; and assist in the development and evaluation of prevention measures, research strategies, and policy options.
- **Social justice is a philosophical underpinning of public health.** The realm of population health is broad: income, employment, housing, transportation, education, physical environment, and social engagement are key factors that contribute to the well-being of all persons in society. Public health services and advocacy strive to reduce inequities in health status due to unequal access to health, educational, and economic opportunities. Efforts to identify and reduce causes of disparities between racial and ethnic groups must be enhanced.
- **Consideration of health in all policies is necessary to achieve healthy people and healthy communities.** Policies related to housing, transportation, agriculture, climate change, environmental quality, criminal justice, education, parks, jobs, and other issues all significantly influence the physical, economic, and social environments in which people live, shop, work, study, and play. These environments directly and indirectly influence health outcomes and make it more or less difficult for individuals to choose behaviors that promote or diminish health. By considering health when formulating policy, public officials recognize the influence on the health of individuals and communities of policies in many other sectors. Public health must work across sectors to help policymakers understand the ways in which their programs and policies impact health. Public health also must collaboratively identify policy and program options that promote healthy behavior or mitigate any adverse health consequences.

Public health services and advocacy strive to reduce inequities in health status.

DEFINING A HEALTHY COMMUNITY

A healthy community is one that meets the basic needs of all residents, ensures quality and sustainability of the environment, provides for adequate levels of economic and social development, achieves health and social equity, and assures social relationships that are supportive and respectful.

A healthy community provides for the following through all stages of life:

■ **Basic needs**

- Safe, sustainable, accessible, and affordable transportation options;
- Affordable, accessible, and nutritious healthy foods;
- Affordable, high quality, socially integrated, and location-efficient housing;
- Affordable, accessible, and high quality health care;
- Complete and livable communities, including affordable and high quality schools, parks and recreational facilities, child care, libraries, financial services, and other daily needs; and
- Access to affordable and safe opportunities for physical activity.

■ **Healthy and sustainable environment**

- Clean air, soil, and water, and environments free of excessive noise;
- Free of tobacco and smoke;
- Preserved natural and open spaces, including agricultural lands;
- Minimized waste, toxics, and greenhouse gas emissions; and
- Affordable and sustainable energy use.

■ **Health and social equity**

■ **Supportive and respectful social relationships**

- Robust social and civic engagement; and
- Socially cohesive and supportive relationships, families, homes, and neighborhoods.

■ **Safe communities, free of crime and violence**

The principles and ideas for a healthy community provide a sound foundation for the CCLHO Policy Platform. To understand the full scope of CCLHO and its positions on public health practice, this document includes a description of the Conference, including its function, structure, and affiliated partners; the role of the local Health Officers; structure of the public health system; discussion of public health programs and services; exploration of emerging special issues in public health; and description of personal health services provided by local jurisdictions.

A healthy community is one that meets the basic needs of all residents.

Description of the California Conference of Local Health Officers

The California Health and Safety Code mandates that CCLHO advise state government on the organization and conduct of local health programs and services.



CCLHO is the chief intermediary on public health issues between the state and local governments.

FUNCTIONS

- CCLHO advises and make recommendations on rules, regulations and other matters affecting health to the California Department of Public Health, other departments, boards, commissions, and officials of federal, state, and local agencies, the Legislature, and other organizations. CCLHO is the chief intermediary on public health issues between the state and local governments.
- CCLHO provides a forum for discussion of significant health issues in order to develop recommendations for appropriate health policy.
- CCLHO gathers information and initiates or conducts studies on health problems and practices.
- CCLHO carries out statutory responsibility to advise the director of the Department of Health Services (now the Department of Public Health) on standards for professional and technical personnel employed in local health departments; on the organization of local health departments; and on all rules and regulations related to local health departments and other matters affecting health (Health and Safety Code Sections 100290, 100295, 100925 and 100950).
- CCLHO develops recommendations for legislative solutions to statewide and local health problems.

DESCRIPTION OF CCLHO

STRUCTURE

- Members include all legally appointed city and county physician Health Officers in California.
- The Conference meets semiannually, with representation from the affiliate organizations, the California Department of Public Health, and other departments and agencies.
- The Conference elects a board of directors that meets monthly to take action on issues of immediate concern, including legislative and regulatory review and implementation of policies developed by the Conference.
- The Conference appoints appropriate program committees for consideration of technical and policy issues and development of proposed CCLHO positions. The Conference's committees are:
 - Chronic Disease Control and Prevention;
 - Communicable Disease Control and Prevention;
 - Data and Health Information;
 - Emergency Preparedness and Response; and
 - Environmental Health.

CCLHO AFFILIATED ORGANIZATIONS

The Conference has 13 affiliated organizations comprising associations of professionals and managers from local health departments and other local organizations involved in community and public health. Affiliation is by mutual consent and constitutes a partnership dedicated to promoting public health and addressing public health issues. These organizations are:

- California Association of Communicable Disease Controllers (CACDC);
- California Association of Public Health Laboratory Directors (CAPHLD);
- California Conference of Directors of Environmental Health (CCDEH);
- California Conference of Local AIDS Directors (CCLAD);
- California Conference of Local Directors of Health Education (CCLDHE);
- California Conference of Local Health Data Managers (CCLHDM);
- California Conference of Local Health Department Nursing Directors (CCLHDND);
- California Conference of Local Health Department Nutritionists (CCLHDN);
- California Maternal, Child and Adolescent Health Directors (MCAH Action);
- California Sexually Transmitted Disease Controllers Association (CSTDCA);
- California Tuberculosis Controllers Association (CTCA);
- Emergency Medical Services Administrators Association of California (EMSAAC); and
- Mosquito and Vector Control Association of California (MVCAC).

Role of a Local Health Officer

In California, the local Health Officer is an official appointed by the local governing body to provide public health leadership for the entire community. He or she is a physician responsible for assessing the community's health status and for medical and technical direction of the local government's mandated health protection functions. The Health Officer is expected to keep the governing body informed about all health issues that affect the jurisdiction, to act as a consultant to the governing body, and to provide advice and opinions on medical and public health policy issues.

The Health Officer provides leadership in public health matters for the entire community. He or she is the visible medical authority who interacts with all segments of the community to lead in the development of public health policy and implementation of effective public health programs. In addition, the Health Officer has the experience and training to exercise authority in a public health emergency, including a bioterrorism event.

The Health Officer is responsible for assessing and reporting on the health status of the community, using multiple epidemiologic, survey, and statistical methods. The Health Officer is responsible for assuring the effectiveness of the mandated health protection functions of local government, including services related to communicable disease control, maternal and child health, emergency services and disaster preparedness, sudden infant death, family planning, public health laboratory services, environmental health, vital statistics, public health nursing, nutrition, and chronic diseases.

The Health Officer is the only health practitioner authorized to exercise police powers, such as isolation and quarantine, to prevent further spread of disease. He or she is charged with enforcing local health orders and ordinances, the orders and rules prescribed by the California Department of Public Health, and the statutes related to public health. The very nature of most public health law makes it imperative that an experienced public health physician carries out the duties. Many health laws are quite general and require considerable medical expertise for sound interpretation and rational enforcement. The Health Officer is the local medical/public health authority and consultant to a variety of individuals and agencies, such as physicians, hospitals, schools, elected officials, jails, retirement boards, environmental health specialists, and the general public.



The Health Officer is the only health practitioner authorized to exercise police powers.

The sphere of public health concern is exceptionally broad; any factor that affects health status and can be influenced by public education or public policy is a legitimate concern of public health. Therefore, the Health Officer must evaluate health risks and communicate this information effectively. He or she must be able to facilitate interaction of the complex mix of public agencies and community based organizations that impact public health and public policy.

The Health Officer must have a blend of medical, scientific, political, administrative, and personnel management skills. All of these attributes are important, but it is the physician's medical education and experience that provide the essential core of knowledge and professional credibility. To fulfill these mandates and trusts, the Health Officer must be a physician who has broad skills and knowledge, including clinical medicine; public health, including epidemiology, biostatistics, communicable disease control, environmental health, disaster and emergency response, maternal and child health, and chronic disease prevention; management/administration; and effective communication skills. Above all, the Health Officer must have integrity, honesty, and compassion.

In order for the Health Officer to determine priorities and allocate resources for public health problems, he or she must be assured a high degree of control, or direct decision making influence, over the budget and activities of the local health department. If the Health Officer is also the director of the local health department, as state regulations permit, this is usually assured. If the department is not under the direction of the Health Officer, the governing body must assure that the Health Officer has sufficient authority, time, and resources to perform state-mandated duties and that the organizational structure does not impede the Health Officer from carrying out those duties.

Although the role of Health Officer has changed over the years, the basic functions and responsibilities remain among the most important functions of local government. As local governments respond to fiscal pressures and rapid social change, efforts to reorganize health and human services are both inevitable and necessary. The challenge is to create organizations that ensure the Health Officer's ability and authority to perform critical community advocacy, protection, and public safety functions and to provide important public health leadership. CCLHO will work to ensure that this challenge is met and that local Health Officers continue to make their unique and vital contributions in a variety of different organizational frameworks.

Efforts to reorganize health and human services are both inevitable and necessary.

Structure of the Public Health System

ADMINISTRATIVE AND OTHER RELATED SERVICES

The United States public health system is a continuum of federal, state, and local health agencies working in concert to provide essential public health services. In California, the state public health system consists of multiple state agencies that provide technical support and assistance and administrative oversight to local health jurisdictions. Local health departments are the operational arm of the state in enforcing public health laws and implementing public health programs.

Role of the State

The state provides support services and technical assistance and works with local health departments to set standards for public health programs. The California Department of Public Health should provide leadership, policy direction, and clear communication of general statewide priorities for public health and should:

- Represent the interests and concerns of local health departments to federal agencies in order to coordinate national resources and support public health programs;
- Obtain and allocate funding equitably;
- Coordinate and provide resources, technical assistance, and training to local health departments and to other local public and nonprofit agencies;
- Collect, analyze, and disseminate data needed for program management in a timely fashion;
- Enforce current state law relating to the authority and responsibility of local Health Officers and local health departments; and
- Work with CCLHO to review and analyze state laws that pertain to the administration and implementation of public health services and programs.

In California, the state public health system consists of multiple state agencies.



STRUCTURE OF THE PUBLIC HEALTH SYSTEM

Role of Local Public Health Agencies

Local public health departments and agencies are formal organizations established by law and mandated to enforce laws to protect the public health and to operate core public health programs. Local health departments assume a leadership role in the development of such public health programs through their influence in national, state, and local professional and community organizations. Local health departments shall:

- Determine the health needs and priorities of the population served and, using that information, effectively provide the Ten Essential Services of Public Health in partnership with communities;
- Implement and evaluate the effectiveness of public health programs;
- Coordinate resources with other public and nonprofit agencies involved in health protection;
- Ensure that environmental health, managed care providers, hospitals, health care providers, and other programs carry out their mandates with public health oversight and coordinate with other public health activities; and
- Advocate for programs and policies that promote and protect the public's health.

RURAL COUNTIES' PUBLIC HEALTH SERVICES

Effective planning and consideration must be given to the provision of public health services in sparsely populated rural counties, whose resources and needs differ from those of urban and suburban counties. Among the factors that complicate the provision of public health services are isolation and inadequate transportation, shortages of health care and public health professionals, and the high percentage of people who lack health insurance. Economies of scale cannot be achieved in rural counties. Given seasonal variations in population and geographic isolation, disproportionate resources may be necessary to provide adequate public health capabilities.

The California Department of Public Health should ensure that residents of rural counties receive all publicly supported public health services available in the other, more populated subdivisions of California. CCLHO encourages the development of regional approaches among small counties or collaborations with larger counties to optimize resources, particularly in their response to bioterrorism events and other public health emergencies.

Effective planning and consideration must be given to the provision of public health services in rural counties.

Public Health Programs and Services

CHRONIC DISEASE PREVENTION AND CONTROL

The leading causes of death in California are heart disease, cancer, lung disease, and stroke. Other chronic diseases – such as cirrhosis of the liver, diabetes, arthritis, and asthma – also contribute greatly to excess morbidity and mortality and health care costs. Each of these chronic diseases is, in large part, preventable through a focus on shared risk factors, such as smoking, obesity, and lack of universal access to health care, including community and clinical preventive services. Addressing community conditions that support or hinder healthy choices is fundamental.

General Public Health Principles Related to Chronic Disease Control

CCLHO recognizes that root causes are responsible to a large degree for chronic disease risk and health inequities. (For more on this, see section on Achieving Health Equity in Public Health.) These root causes include poverty; racism; sexism; poor educational opportunity and attainment; inadequate job skills training and unemployment; real and perceived public safety; inadequate personal and community resilience; environmental injustice; inequitable community design; and disparate contaminant exposure. An important part of the work of local health departments is to address such social determinants of health directly by partnering with other public and private community agencies to improve education and economic opportunities. CCLHO supports institutional and societal changes that reduce the root causes of chronic disease risk, with an emphasis on vulnerable populations.

CCLHO recognizes that land use, transportation planning, and community design determine the built environment in which we live. The built environment determines opportunities for the enjoyment of physical activity, good nutrition, safety, clean air, and clean water. These, in turn, determine to a great extent our risk for chronic disease. Efforts to develop and implement local, regional, and state policy that improve the built environment will improve the health and well-being of Californians. CCLHO supports the following strategies and interventions:

- Inclusion of public health policy in county and city general plans and ordinances to promote access to good nutrition and physical activity;
- Smart growth practices that include more compact, mixed-use residential and commercial community design to encourage walking and bicycling;



CCLHO supports institutional and societal changes that reduce the root causes of chronic disease risk.



- Land use policy that preserves agriculture lands for production of nuts, fruits, and vegetables;
- Pedestrian and motor vehicle traffic policy that improves the perception of neighborhood safety and protects pedestrians, passengers, and bicyclists from injury and death;
- Collaboration between health departments and planning departments to incorporate public health strategies into local land use, transportation, and community design;
- Joint-use agreements to make school grounds available to neighborhood residents to increase physical activity opportunities, especially in areas of high need for parks and recreational facilities; and
- Healthy food, physical activity, and breastfeeding policies in the workplace, government, private enterprises, community organizations, and congregations.

To reduce the morbidity and mortality associated with chronic disease and to enhance quality of life throughout the lifespan, CCLHO supports effective community prevention strategies and funding that spur improvement in the physical environment; the development of social capital; place-based neighborhood mobilization; and healthy development. Efforts to increase physical activity, improve healthy eating, eliminate exposure to secondhand smoke and reduce tobacco, alcohol, and drug use are also central to reducing the prevalence and severity of the major chronic diseases. These efforts must be addressed in communities in conjunction with coordinated local, state, and national program and policy efforts.

A solid health database, including disease registries, is necessary for local health departments to plan and implement appropriate programs and analyze mortality. Survey data from such measures as behavioral risk factor surveys, the National Health and Nutrition Examination Survey (NHANES), and the California Health Interview Survey (CHIS) are important contributors to this database. Statewide surveys need to be designed so that they are useful at the local level. As chronic disease is the major cause of about 80 percent of morbidity and mortality in California, CCLHO supports expanded chronic disease reporting to local Health Officers and the California Department of Public Health.

Access to primary preventive screening – such as cholesterol checks or evidence-based cancer screening procedures like Pap smears – needs to be readily available to all, along with access to care to address abnormal

***CCLHO supports
effective
community
prevention
strategies.***

findings. Outreach efforts to vulnerable and underserved populations should be increased. CCLHO supports enhanced reimbursement to health providers for evidence-based preventive screening and early education and intervention.

People with chronic diseases can greatly benefit from a patient-centered medical home with participation in patient activation programs and improved health literacy. Health reform should promote these concepts. Additionally, electronic health records should provide evidence-based treatment guidelines for clinical management of chronic diseases.

**Risk-Specific
Issues
Related to
the Control
of Chronic
Diseases**

Tobacco use, poor nutrition and physical inactivity, and alcohol and drug abuse contribute significantly to preventable illness and premature death.

Tobacco use is the greatest single known cause of preventable illness and premature death. The Conference strongly endorses the call for a smoke-free society and supports all measures to protect our youth from tobacco addiction and to limit exposure to secondhand smoke. CCLHO supports the prohibition of tobacco marketing and advertising and supports increased taxes on all tobacco products, with an allocation of tobacco taxes to local health departments for tobacco cessation and control activities and other prevention activities. CCLHO opposes the federal preemption of state and local statutes and supports an adequately funded Food and Drug Administration authority over the manufacture, sale, and labeling of tobacco products. CCLHO also supports Proposition 99 Tobacco Control efforts that have demonstrated the effectiveness of media campaigns, when combined with local community-based efforts.

**CCLHO
strongly endorses
the call for a
smoke-free
society.**

The Conference urges health departments to:

- Work with volunteer and community groups and law enforcement agencies to promote and enforce laws against smoking in the workplace, in public places, and in smoke-free multi-unit housing;
- Vigorously enforce the prohibition of sales of tobacco products to young persons under 18; and
- Support local tobacco retail licensing with license fees earmarked for enforcement of laws prohibiting tobacco sales to minors and the provision of culturally competent education and tobacco control activities to counter the effects of tobacco product advertising.

Poor nutrition and physical inactivity, which can lead to obesity, overweight, diabetes, and cardiovascular disease, are leading causes of preventable disease in the United States. The Conference urges health departments to work with appropriate community groups and health care providers to promote healthy eating and physical activity to prevent premature chronic disease. Effective strategies address social norms, institutional practices, marketing practices, and policy development and propose altering the physical environment to support access to and promotion of healthy foods and physical activity. CCLHO supports community food system assessments; community, school, and backyard gardens; farmers' markets; community supported agriculture; and other efforts to promote local, fresh, healthy, sustainable food production, processing, distribution, consumption, and waste disposal. CCLHO urges provision of healthy food choices in all preschools, day care centers, K-12 schools, colleges, and universities and limiting snack and soft drink industry access and advertising in schools. Specifically, CCLHO supports a requirement that school meal programs follow U.S. dietary guidelines and offer easily available and affordable healthy choices for all foods served and sold on campus. In addition, the Conference supports increased daily physical activity requirements in all preschools, day care centers, K-12 schools, and institutions of higher education. After school and after work athletic and recreational opportunities should be enhanced for all, including community planning to facilitate walking and access to exercise opportunities. In addition, parents should be encouraged to limit children's video game time and television viewing time and to promote physical activity.

**CCLHO
urges healthy
food choices
and increased
physical activity.**



CCLHO supports reducing access to and consumption of sugary and sugar-sweetened food and beverage products, as well as beverages that contain high fructose corn syrup. These high calorie products lack important nutrients and contribute to the obesity epidemic. CCLHO also supports the gradual reduction of sodium in many processed and packaged foods, due to the link to chronic illnesses, including hypertension, cardiovascular disease, and end-stage renal disease. The Conference supports the recommendation by the Institute of Medicine in April 2010 that the Food and Drug Administration take regulatory action to limit the level of salt in processed foods.

Alcohol abuse remains a highly significant cause of preventable death, disability, and social disruption in the United States. The Conference supports efforts aimed at reducing the overall consumption of alcohol in California and the excessive consumption of alcohol by individuals. The Conference endorses campaigns to

reduce drinking and driving under the influence (DUI), underage drinking, excess drinking among college-age youth, and consumption by pregnant women. The costs and health consequences of excessive consumption should be addressed. Increased taxes on alcohol should be instituted, with funds dedicated to alcohol abuse education, prevention, and treatment. CCLHO supports maintaining the minimum drinking age of 21; enacting comprehensive graduated driver license laws; lowering the adult DUI legal limit to >0.08 percent blood alcohol content; decreasing hours of retail sale; and reducing alcohol outlet density.

The abuse of controlled substances (e.g., cocaine, heroin, amphetamines, prescription narcotics, marijuana) causes death, disability, and social disruption.

The Conference supports efforts that reduce or eliminate abuse of controlled substances and other drugs. The Conference also supports the development of appropriate, accessible, and affordable treatment facilities and programs, regardless of ability to pay. The decriminalization of minor drug possession in conjunction with alternative drug treatments should be examined. The Conference supports requiring alcohol and drug abuse treatment coverage by health insurers in parity with other health care coverage benefits.

CCLHO supports efforts that reduce or eliminate abuse of drugs.

**Disease-Specific
Issues Related
to the
Control of
Chronic Diseases**

The Conference supports continued investigation, funding, and involvement by state and local jurisdictions to further understand the epidemiology and prevention of important chronic diseases, such as atherosclerotic cardiovascular diseases, cancer, asthma, and diabetes mellitus, not in isolation as single diseases, but in the context of a healthy community (see Introduction).

The Conference strongly encourages the use of surveillance, evaluation, evidence-based practice, and local needs assessment data (including social determinants of health) to drive the development of chronic disease public health policies, programs, and services.

- **Cardiovascular Disease:** Atherosclerotic cardiovascular disease (CVD) causes more deaths in California than any other single cause. The Conference supports continued state and local health jurisdiction involvement in prevention and education efforts to reduce the morbidity and mortality associated with CVD.
- **Cancer:** The network of regional cancer registries, working with the state-wide registry, provides useful information on the incidence and distribution of cancer. These registries can provide needed information on cancer prevention and treatment modalities, as well as assist in analyses of cancer screening efficacy and detection of racial disparities. The registries must be adequately

funded to support these tasks. The Conference urges local health jurisdictions to work with cancer registries and the California Department of Public Health to respond to and investigate reports of suspected cancer clusters and evaluate data relevant to possible environmental causes.

- **Asthma:** Asthma incidence, morbidity, and mortality are increasing in California. The Conference supports evidence-based asthma prevention strategies, such as minimizing exposure to secondhand smoke and air pollution (including reducing vehicle miles traveled). Continuing epidemiologic and environmental research, including social determinants of health, is important to the development of additional prevention strategies. Research has shown that asthma care management systems that include case management, integrated databases, and education of providers, patients, and caregivers reduce hospitalization and mortality from asthma. Access to these comprehensive services should be part of an available system of care.
- **Diabetes Mellitus:** The increase in obesity rates has led to an epidemic of diabetes mellitus in both children and adults. The Conference supports prevention efforts that increase physical activity and healthy nutrition in schools and communities and strategies that create a healthier food system. Comprehensive screening and care management systems that can significantly reduce the morbidity and mortality of diabetes must also be part of an available system of care.

The increase in obesity rates has led to an epidemic of diabetes mellitus.

**COMMUNICABLE
DISEASE CONTROL
AND PREVENTION**

Communicable diseases are the fourth leading cause of death in the United States and the leading cause of death worldwide. Emerging infectious diseases such as pandemic H1N1 influenza, SARS (severe acute respiratory syndrome), H5N1 avian influenza, West Nile Virus, and hantavirus join a list of long-established communicable disease threats, such as seasonal influenza, hepatitis C, HIV, tuberculosis, syphilis, and fluoroquinolone-resistant gonorrhea. Healthcare-associated infections and the development of antibiotic resistance remain areas of concern. In addition, food safety issues resulting from the globalization of the food supply and a trend towards mass production are now recognized as priorities for intervention. The threat of bioterrorism requires Health Officers to be prepared to recognize and respond to possible cases or intentional outbreaks of unusual diseases such as smallpox, plague, anthrax, or botulism. This growing list of threats to individual and community health highlights the critical need for a strong and effective public health communicable disease control and prevention infrastructure.

Control of communicable disease is a core public safety function of government at the local, state, and federal levels. Fulfilling this function requires a sustained infrastructure that monitors, evaluates, and responds to communicable disease threats. To protect public safety, a communicable disease control and prevention infrastructure must include data systems, a laboratory network, and well-trained staff expert in epidemiology, communicable disease response, and public health risk communications. The system also relies on close coordination and partnership between governmental public health and the medical community.

The communicable disease control and prevention infrastructure in California is fragmented and severely compromised by a lack of funding at both the state and local levels. There is every reason to believe that this erosion will continue unless and until state and local governments recognize the need and commit the resources necessary to maintain a robust infrastructure. While state statute mandates that state and local governments engage in activities to control communicable diseases, the statute does not define mandatory activities nor provide standards for the amount and type of resources that a governmental entity must provide.

Of all the communicable diseases affecting public health, only HIV, sexually transmitted diseases (STDs), tuberculosis, and vaccine-preventable diseases have categorical funding support from the federal and state levels. (For most diseases, the state levels of funding are decreasing.) Most diseases causing outbreaks require substantial local and state public health resources, yet have no dedicated categorical funding support (examples include food borne diseases and infectious diseases that have emerged in the past two decades, such as SARS and West Nile Virus). Public health resources to carry out surveillance and response to these communicable diseases and outbreaks vary significantly between local jurisdictions.

Disease control activities are designed to prevent and control cases and outbreaks of disease. Communicable diseases are kept in control only by continuing vigilance and ongoing effort, even when a threat may not be apparent. The California Department of Public Health should continue to work with the members of the Conference, its affiliate organizations and other state and federal agencies, where appropriate, to develop general policies and capabilities as well as disease-specific guidelines for surveillance and control of communicable disease in California.

***Control of
communicable
disease is a
core public
safety function
of government.***

**General Public
Health Activities
in Communicable
Disease Control
and Prevention**

Epidemiology and Surveillance

Control of communicable diseases is based on epidemiology, the study of the distribution, causes, and transmission of communicable diseases within the population. Surveillance is a crucial tool for epidemiology. It is the continuous collection, analysis, and interpretation of data related to communicable diseases. Only through this ongoing observation of trends in time, place, and persons can changes be identified or anticipated and appropriate action taken, including investigation and control measures.

Essential tools for epidemiology and surveillance include the following:

- **Adequate staff with training and expertise is the foundation of communicable disease prevention and control.** Prevention and control programs need staff with expertise in laboratory, epidemiology, data management and analysis, outbreak response, and case and contact investigation. Adequate resources must be available to maintain staffing levels and provide for staff development activities, such as training in communicable disease-specific functions. The capacity to perform outbreak investigations and appropriate follow up must be available in every county, and expert consultation and local assistance should be available to local jurisdictions from the California Department of Public Health. Capacity must also be maintained that will allow for a surge in activities associated with recognized outbreaks or other communicable disease emergencies, such as pandemic influenza, that necessitate substantial increase in surveillance for weeks to months.
- **Public health laboratory services are vital for communicable disease diagnosis, assessing potential environmental threats, follow up of cases and carriers of disease, and monitoring the effectiveness of vaccines and other control measures.** Recent budget cuts have crippled both local and state public health laboratory services. Of great concern is the lack of availability of services previously available through the state public health laboratory system. Imposing any additional budget cuts on the state public health laboratories will pose significant risks to the public's health as the state loses the ability to rapidly detect – and rapidly respond to – very real public health threats (for instance, the development of drug resistance and resulting widespread transmission of select strains of pathogenic organisms such as Salmonella species).

***Public health
laboratory
services
are vital.***



- **CCLHO is also concerned about a trend toward decreasing laboratory confirmation of diagnoses in the clinical health care sector of a number of important communicable diseases.** This shift away from confirmation is, to some extent, the result of disincentives built into capitated or otherwise “managed” payment systems. While rapid initiation of empiric treatment and reporting to public health are essential both to the individual and for the community, sustained lack of laboratory confirmation will make it difficult, if not impossible, to monitor specific disease spread in the community. This may result in incorrect assumptions about the amount of disease in the population. It also could delay recognition of important changes in either the etiologic agent of the disease (e.g., increases in transmissibility and development of drug resistance) or distribution of disease within the population (e.g., new risk groups) hampering control efforts. Public health laboratories may need to perform testing to compensate for decreased testing by the clinical providers.
- **Data systems, including electronic data systems, provide essential situation status information about communicable diseases in our communities.** Public health agencies must attain access to data from electronic medical records systems as they are developed and implemented in clinical care settings. While early reporting of communicable diseases by astute physicians and clinical laboratories remains essential to the prompt initiation of critical public health investigations and rapid control of outbreaks and emerging infectious diseases, the ability to access electronic health information regularly provides a critical opportunity to monitor syndromes and diseases before a final disease diagnosis is established. Electronic access to anonymous and aggregate data from large health care systems and hospitals would allow for significantly improved baseline data on disease processes in the community, while simultaneously providing for more rapid detection of trends that warrant investigation.

Data systems provide essential information about communicable diseases.

**Communicable
Disease Response**

Optimal control of outbreaks and emerging infectious diseases requires capacity at both the state and local levels. At the local level, there must be adequate local public health staff, including epidemiologists and laboratorians, dedicated to the surveillance and investigation of emerging infectious diseases and diseases causing outbreaks. This must include the rapid detection, monitoring, investigation, and control of outbreaks due to diseases not supported by categorical funding. Similarly, the California Department of Public Health must continue to provide

expert guidance to local health departments by staff trained in outbreak investigation and response.

Local health jurisdictions must maintain adequate capacity to respond to individual cases of communicable diseases. Adequate case and contact investigation must be culturally and linguistically appropriate and should include most or all of the following, regardless of disease:

- Case interview and elicitation of contact information;
- Contact tracing;
- Provision of disease and risk-specific health education to case and contacts;
- Assurance of access to high quality appropriate treatment services;
- Partner notification, if indicated; and
- Case management, if indicated, including communications and consultation with private medical providers, where appropriate.

Prompt appropriate treatment is essential to control of communicable diseases.

Local communicable disease control and prevention program staff should also provide partner notification services for cases of HIV, syphilis, gonorrhea, and chlamydia, either directly or through community partnerships.

Prompt appropriate treatment of cases is essential to control of communicable diseases and is in society's best interest. Treatment services should not be dependent upon citizenship or an individual's ability to pay. Communicable diseases are not confined by geopolitical boundaries, so immigration status or residence must not be considered in the evaluation and treatment of patients and the investigation, education, and treatment of any contacts that need services.

There should be regulatory oversight and enforcement capability for the control of communicable disease sources in all sites where food is prepared for groups. These sites include restaurants, schools, day care facilities, congregate living facilities, licensed health care facilities, correctional facilities, and recreational facilities, as well as all water sources. There must be close cooperation at the state and local level between environmental health services and communicable disease control programs.

The statutory powers of the Health Officer are an essential tool in the control of communicable diseases and must be continually reviewed and revised to reflect experience with new or emerging infectious and communicable diseases.



It is important that both local health departments and the California Department of Public Health develop and maintain expertise in public information and risk communications, particularly with respect to outbreaks and other communicable disease emergencies, such as pandemic influenza. Public health agencies must be able to communicate clearly and quickly with the public by multiple means to ensure that the public has accurate, reliable information to help inform choices and minimize fear and social disruption.

Services directed at the prevention and spread of communicable and other infectious diseases play a vital role in public health. Successful prevention and control of communicable diseases can occur only with dedication of adequate resources for prevention activities.

Culturally and linguistically appropriate health education is critical to empowering individuals and communities to protect themselves from known risks, both environmental and behavioral, and from communicable and other infectious diseases. The Conference supports such health education programs as essential disease control activities.

Ongoing efforts to educate both the medical and lay populations on screening recommendations are important to decrease the serious effects of many communicable diseases, including chlamydia infections and other sexually transmitted diseases (STDs), HIV, and hepatitis B and C. Local health jurisdictions should advocate for educational programs shown to reduce communicable diseases and provide data to support their adoption, in lieu of programs shown to be ineffective. For example, in-depth, comprehensive, age-appropriate education on sexuality has proven to decrease STDs and should be provided in every school beginning in 4th grade or earlier. Knowledgeable local health department staff should be available to encourage and facilitate sexuality education and to provide local data and resources. Reliance on abstinence-only sexuality education approaches is harmful, ineffective, and a misappropriation of scarce resources.

Public education is an important means to prevent the spread of HIV disease, one of the most devastating communicable diseases, particularly if tailored to those persons likely to engage in high-risk activities. More emphasis is needed on HIV prevention education for persons infected with HIV. All levels of government must be involved in this effort, as well as educational institutions (including those preparing future health professionals), private organizations (foundations, community-based organizations, faith-based organizations), and others.

Culturally and linguistically appropriate health education is critical.

The most cost-effective means of preventing transmission of communicable diseases is early identification and appropriate treatment of persons already infected. The Conference recognizes and supports the following for targeted screening and treatment of communicable diseases:

- **Partner Services have been proven to play an effective role in preventing and controlling HIV and other STDs.** All persons with newly diagnosed or reported HIV infection or early syphilis should receive partner services, with active health department involvement. Partner services programs should use surveillance and disease reporting systems to assist with identifying persons with newly diagnosed or reported HIV, syphilis, gonorrhea, or chlamydia who are potential candidates for partner services. Fully funding partner services and restoring funding for other HIV prevention activities must be a high priority for the California Department of Public Health.
- **HIV testing and pre-/post-test counseling**, in both anonymous and confidential testing programs, must continue to be free and readily available in all local health jurisdictions. Increasing use of confidential testing is to be encouraged. Priority should be given to restoring funding to HIV testing programs.
- **Post-exposure prophylaxis** for sexual and needle exposure to HIV should continue to be evaluated and applied more widely as appropriate.
- **Identification and treatment of latent TB infection** is an important step in moving toward TB elimination. Targeted screening of high-risk groups is important for finding persons with latent TB infection and offering appropriate treatment.
- **Action to improve the prevention effectiveness of overseas screening** and domestic follow-up of persons newly arriving in the United States from high incidence countries is important.
- **CCLHO supports increasing Medi-Cal reimbursement for TB control.** CCLHO will advocate for closing gaps in Medi-Cal coverage for undocumented persons, especially those with multi-drug resistant TB.
- **Public health screening and broader provision of the vaccine will help control human papillomavirus (HPV).** The emergence of new technologies for testing and surveillance for this sexually transmitted disease has clarified the importance of HPV in the pathogenesis of cervical cancer.

Public education is an important means to prevent the spread of HIV disease.

Strategies designed to target behaviors that increase risk for communicable diseases, known as **harm reduction strategies**, are an important and cost effective communicable disease prevention approach. Harm reduction programs that reduce or halt the transmission of HIV, hepatitis B, and hepatitis C among intravenous drug users should be supported. The Conference supports the provision of needles and syringes at pharmacies without a prescription and supports local implementation of properly designed and evaluated programs that offer sterile syringes in conjunction with comprehensive outreach, education, counseling, and behavior modification.

**Vaccine-Preventable
Disease Programs**

Immunization is the single most powerful tool for the prevention and control of communicable and other infectious diseases, with remarkable successes in eradicating diseases like smallpox. Immunization, along with the mass distribution of antibiotics or other health care elements, is increasingly recognized as part of the essential capacity needed for response to potential bioterrorism or other public health threats. Immunization programs must have resources, trained staff, and professional leadership to be effective in their response to new threats, such as pandemic H1N1 influenza. Vaccines must not be sacrificed to the unfounded concerns of a vocal minority. At the same time, public health professionals should be involved in a scientific assessment of issues of public concern and should disseminate evidence-based answers or acknowledge gaps in scientific knowledge.

The future successes of vaccination campaigns are threatened by the increasingly fragile structure of vaccine manufacture and distribution in the United States. The provision of vaccines is essential to the health of our children and elderly and must not be compromised by free market considerations. CCLHO supports a change in national policy that assures the appropriate development, production, and distribution of vaccines necessary to protect the public's health. Other recommendations:

- Optimal immunization levels for all vaccine-preventable diseases must be aggressively pursued through immunization programs that are assured of continued adequate funding for vaccine purchase, delivery, outreach and education, especially for high-risk populations.



***Immunization is
the single most
powerful tool
for prevention of
communicable
disease***

- Strategies should include universal infant immunization, required school entrance and advancement immunizations, and a continued focus on immunization of high-risk groups.
- Immunization registries are vital to ensuring timely and up-to-date vaccinations. The Conference supports development of county and statewide internet-based immunization registries linked to electronic health records, with appropriate restrictions to maintain confidentiality. The registries should be developed with consideration of the special needs of both large urban and small rural counties.
- Recommended immunizations for control of diseases in adults should be provided in all comprehensive immunization programs.

Public health information provides the basis for understanding community health needs.

**DATA AND HEALTH
INFORMATION**

One of the core responsibilities of public health is to collect and analyze data on health outcomes and disseminate that information to inform and empower individuals and community partners. Public health information provides the basis for understanding community health needs and problems. Epidemiology and data analyses are essential for identifying health problems; planning, implementing, and evaluating public health interventions; addressing health inequities; assessing the health impact of policy decision by health impact assessment (HIA); integrating health in environmental impact reports (EIR); and targeting program services to populations at risk. Timely, reliable, and valid information is fundamental to the effective and efficient operation of local health departments.

Population-based public health data should be available at a relevant geographic level to facilitate planning to improve the health of the community, prevent outbreaks, and reduce premature deaths. It is increasingly important to move towards electronic submission of public health data, such as communicable disease reporting (including laboratory results), immunization registries, death registration, and chronic disease registries. Cogent analysis of data is needed for health officers to be able to promote the concept of “health in all policies” with local governments. Each local health department needs access to services of a public health epidemiologist.

Automated health information systems should be an integral part of all such agencies. The continued development of automated health information systems is essential to the support and further development of the public health infrastructure. Integration of information systems, including standardization of data sets, resolution of confidentiality issues, and assurance of technological capacity development should be actively addressed with state and federal representatives. Traditional community health data sources include vital statistics (deaths, fetal deaths, and births), population demographics, disease surveillance and reporting, health interview surveys, service utilization records, behavioral data, enforcement/compliance data, and administrative/management data. Health Officers need expanded access – including electronic access – to data from a wide variety of sources, including hospitals, medical providers, health plans, and Medi-Cal. Linkage of public health information systems with information systems of other agencies, including education, welfare, criminal justice, mental health, and medical provider organizations, will improve the community health assessment capability of local health departments and must continue to be accomplished in ways that assure confidentiality. Mutual interest in health data can foster productive relationships with these partners.

The increased availability of electronic data has made data acquisition and analysis more complex, presenting both a challenge and opportunity for public health practitioners. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and the California Confidentiality of Medical Information Act (CMIA)** specifically allow health officers to access electronic health information for public health purposes. However, hospitals and medical providers have not felt compelled to grant public health electronic access to health information, generally because of concerns about legality and accountability. Additional state legislation may be needed. This effort may be assisted by “meaningful use” criteria of health information exchange efforts, which require enhanced public health surveillance.

State and local public health agencies need to play an active role in federal and state planning and implementation of health information exchange (HIE). Local health departments both contribute and use data and should be active nodes in



***Health Officers
need expanded
access to data.***

* 45 CFR 164.512(b) and 45 C.F.R. §164.502(b)(2)(v)

** California Civil Code § 56.10

the California Health Information Network (CHIN) and National Health Information Network (NHIN). Integration of information systems, including standardization of data sets, intra-operability, resolution of confidentiality issues, and assurance of technological capacity development should be actively addressed on the state and federal level. “Meaningful use” criteria to assess HIE include public health purposes, such as real-time surveillance of communicable and chronic diseases, and electronic reporting of communicable diseases and electronic population of public health registries, such as the immunization registry. Just as clinicians are getting financial and technical support from the HIE effort, local health departments should receive financial and technical support for training informatics staff and expanding capacity, particularly in Geographic Information Systems (GIS). As a “neutral” partner, public health is well situated to integrate and analyze data streams from health care partners to promote cost effectiveness, prevention, improvement in outcomes, and reduction of health disparities. One example of the public health role in HIE would be to monitor data from multiple health systems in a geographic area to understand the total burden of disease, inform prevention strategies, and facilitate outcome measurement and quality assurance.

CCLHO recommends appropriate levels of funding for federal, state, and local public health information and analytical capacity. CCLHO supports secure information exchange and policy discussions, including GIS mapping capability for assessing and managing appropriate issues, and the use of video or audio conferences as an adjunct to (but not a replacement for) statewide meetings.

Local health jurisdictions and the California Department of Public Health must embrace a common vision for – and collectively commit to – integrated state and local public health information systems in California.

Local health departments should receive support for training informatics staff.

**EMERGENCY
PREPAREDNESS
AND RESPONSE**

The local Health Officer has the ultimate authority and responsibility for preparing for, responding to, mitigating, and recovering from all medical and/or health emergencies and disasters impacting the local jurisdiction, including man-made and intentional actions (such as bioterrorism); non-intentional events (such as toxic spills); environmental/natural catastrophes (such as earthquakes, floods, or fire); or infectious outbreaks (such as pandemic influenza). Overall objectives are to save lives; minimize impact on populations, the environment, and the economy; and enable as quick and complete a recovery as possible.

Areas of responsibility may include communicable disease surveillance and control, safety of food and water and the environment, risk communication, and occupational health and safety. Among many functions, the Health Officer ensures the coordination of casualty triage and treatment; medical aspects of sheltering and mass care; ethical allocation of scarce resources; initiation of non-pharmaceutical counter measures; evacuation of populations and/or health care facilities; mass vaccination or prophylaxis campaigns; provision of resources along the entire continuum of care (including hospitals, government-authorized alternate care sites, and homes); and provision of emergency medical supplies, such as ambulances, emergency medical personnel, and any other resources necessary to mitigate an event and save lives.

Funds designated for infrastructure improvement in public health agencies in the name of bioterrorism and pandemic influenza control efforts offer a unique opportunity to strengthen disease surveillance and control capabilities in each department. The fundamental basis for a response to bioterrorism is communicable disease control. The same systems that monitor, detect, evaluate, respond, and treat naturally occurring communicable diseases (including pandemic influenza) are those that would be utilized in an intentional bioterrorism threat or attack. In order to have the operational surge capacity to meet the demands of any and all hazards, local public health systems must be well staffed, well equipped, and well trained at all times.

In addition to response at the local jurisdictional level, the local Health Officer and health department have the obligation in all emergencies and disasters to communicate effectively with regional and state partners and to request resources, if needed, during events. CCLHO supported legislation to create the Medical/Health Operational Area Coordinator (MHOAC) function at the local level. This



The fundamental basis for a response to bioterrorism is communicable disease control.

role is normally filled by the county Health Officer and local emergency medical services (EMS) agency administrator (or designee) and is responsible for the development of a medical and health disaster plan. As the single point of contact from the jurisdiction to the region and the state, the MHOAC also serves as the coordinator of medical and health situational information and mutual aid during emergencies and disasters.

A common operational framework, including performance guidelines, for the environmental, public health, and emergency medical response systems must be employed in a rapid, efficient, and coordinated manner to reduce the impact of any event. To assist the Medical/Health Operational Area Coordinator in performing this role, CCLHO has worked collaboratively with the California Department of Public Health (CDPH), the Emergency Medical Services Authority (EMSA), the California Emergency Management Agency (Cal EMA), and representatives from the Regional Disaster Medical and Health Coordinator/Specialist Program (RDMHS/RDMHC) to develop an Interim California Disaster Health Operations Manual (CDHOM). This will complement the California Disaster Medical Operations Manual (CDMOM) developed by EMSA. The ultimate vision is to integrate the two documents into a single California Disaster Medical/Health Operations Manual (CDMHOM) to reflect the fact that the local level medical and health responses are typically either closely coordinated (in a larger county) or carried out by the same people (in a small county). This single document would serve as the Operations Manual for Emergency Function 8 of the California Emergency Plan.

A common operational framework must be employed to reduce the impact of any event.

CCLHO will continue to:

- Advocate for legislation to guarantee that 70 percent of federal public health emergency preparedness and response funds go to the local jurisdictions;
- Advocate for legislation to support the funding and training of a fully qualified state and local work force to support public health departments at a level that ensures surge capacity for emergencies and disasters (including laboratory and epidemiology capacity);
- Support the integration of the California Disaster Health Operations Manual (CDHOM) and the California Disaster Medical Operations Manual (CDMOM) into a California Disaster Medical/Health Operations Manual (CDMHOM);

- Support that local Health Officers should be physicians to ensure continued recognition and support of the Health Officer physician roles and responsibilities and the legal authorities allowing effective response in emergencies and disasters;
- Advocate for a strong California Department of Public Health, including laboratories with staffing levels, expertise, and experience sufficient to provide the required technical expertise and support for local health departments in emergencies and disasters;
- Support the role of Emergency Medical Services Authority (EMSA) in forming statewide EMS policy and in pursuing adequate funding for organized and centrally coordinated EMS systems at the county, regional, and state levels. Funding should support staffing levels sufficient to assure a medical surge during emergencies and disasters, with seamless coordination of medical mutual aid across jurisdictional boundaries as required and based on need;
- Foster a collaborative relationship with all state agencies essential in emergency and disaster response;
- Support legislation that clarifies and expands the role of the local Health Officer in recognizing, evaluating, and leading the response to a bioterrorism event or other health or medical emergency. This includes the need for information sharing with law enforcement (FBI security clearance, Fusion Centers, and so on);
- Support the development of collaborative electronic work technologies and redundant communication systems;
- Support regional approaches to emergencies and disasters, including sharing inventory, coordinating communication systems, and standardizing procedures to allow for consistent and coordinated response and efficient information and resource sharing across jurisdictions;
- Support efforts at the state level for the coordination, integration, standardization, credentialing, liability coverage, alerting and notification, and training and exercising of all volunteer organizations, such as Disaster Service Workers (DSW), California Disaster Health Volunteers (DHF), Community Emergency Response Team (CERT), Medical Reserve Corps (MRC), Citizens Corps (CC), and Voluntary Organizations Active in Disaster (VOAD). The goal is to best match volunteers with needs and gaps in response;

CCLHO will continue to support regional approaches to emergencies and disasters.

- Coordinate the sharing of best practices in public health emergency preparedness and response, such as the development of Public Health Incident Command Systems (PHICS), through the utilization of electronic means such as websites, email listservs, and other means of social networking; and
- Facilitate vertical communication between local Health Officers and key partners, officials, and policymakers at the state level (e.g., California Department of Public Health, California Department of Health Care Services, EMSA, the Legislature, the Governor's Office) through monthly board of directors' meetings, executive committee meetings, conference calls, and personal testimony.



Local health departments will:

- Develop and refine all public health and medical emergency and disaster response plans and ensure their integration with all other all-hazards plans at the local jurisdictional level, as well as their consistency and compliance with current state laws and state plans, including the State of California Emergency Plan, the California Disaster Medical Response Plan, and the California Medical Mutual Aid Plan, as well as subsequent revisions and updates;
- Conduct local jurisdictional all-hazards risk assessments, including environmental health concerns, and advocate for nonstructural hazard mitigation;
- Prior to an emergency or disaster, ensure the development and use of effective public education campaigns and information regarding personal, family, and community preparedness, disaster response, first aid, and self-help;
- During an emergency or disaster, ensure the coordination of a timely, credible, and accurate risk communication campaign on the evolving nature and health and safety implications of the event, targeting all potentially affected persons, including diverse vulnerable and at-risk populations;
- Work with other local, state, federal, and private agencies to ensure that adequate redundant communication channels are established to enable efficient and effective response and communication during emergencies or disasters with partners, policymakers, health care providers, assisting and collaborating agencies, and the public;

***CCLHO will
coordinate the
sharing of best
practices in
public health
preparedness
and response.***

- Ensure the establishment of the Medical Health Operational Area Coordinator (MHOAC) function and the ability to open, staff, and sustain a medical/health branch of the Operational Area Emergency Operations Center (OAEOC) appropriate for the scale and duration of the event, with ability to effectively and efficiently communicate with the local Office of Emergency Services (OES), the region, and state partners in sharing information and requesting resources;
- Ensure round-the-clock capability to alert appropriate personnel to respond to the medical and/or health aspects of any emergency or disaster;
- Be involved in planning for all stages of emergency and disaster preparedness – prevention, mitigation, response, and recovery -- and including local, regional, and statewide drills, exercises, and trainings of medical and health staff in emergency and disaster preparedness;
- Actively support the activities of the RDMHC/RDMHS program and staff and California Department of Public Health, EMSA, and Cal EMA staff in the development of regional plans and cooperative agreements, including those across neighboring state and international borders;
- Ensure an understanding of Health Officer responsibility and authority in actively managing the medical and health response to an emergency or disaster through implementation of the Standardized Emergency Management System (SEMS), National Incident Management System (NIMS), and the Incident Command System (ICS), including appropriate and required levels of training for all field, general, and command staff in the medical and health arena;
- Support the development of data systems that would facilitate access to information on workplaces that store or use hazardous materials in the local jurisdiction, including the mutual sharing of information across neighboring and potentially affected jurisdictions; and
- At the local jurisdictional level, clarify with policymakers the Health Officer's role, responsibility, and authority, as well as the process for declaring local emergencies or local health emergencies.

CCLHO will be involved in planning for all stages of emergency and disaster preparedness.

**ENVIRONMENTAL
HEALTH**



Environmental health services exist to enhance and maintain physical, mental, and social well-being through environmental protection. California must have a strong, integrated state/local environmental health partnership effort with the goal of providing a safe and healthful environment through the reduction of environmental threats and hazards. Ensuring the public's protection from environmental threats to health is a core public health activity and is best accomplished at the local level with formal environmental health and other public health services in a single organizational unit. In local jurisdictions in which formal environmental health services are in a separate organizational unit from public health, formal policies and procedures for coordinated efforts to identify, communicate, mitigate, and prevent environmental hazards must be developed and implemented. Since workers often face the highest exposures to environmental hazards, environmental health interventions will also often mitigate occupational hazards and improve occupational health and safety.

Where health risk management is carried out by state agencies with environmental and occupational health responsibilities, there should be formal consultation with local Health Officers and formal interagency agreements between state agencies to minimize program overlaps. For local environmental, occupational, and public health programs, state departments and agencies should develop program standards and training programs, provide technical assistance and consultation, carry out research, and provide funding and general leadership.

Special districts, such as Mosquito Control Districts and Air Quality Districts, should have formal relationships with the Health Officers of their jurisdictions. These should include formal mechanisms to identify and mitigate vector borne diseases. A similar working relationship should be developed between Health Officers and local districts of the California Department of Industrial Relations (Cal/OSHA). Fees should either be structured to support the full range of public health activities necessary to identify, mitigate, and prevent environmental health hazards and threats or should be supplemented appropriately to ensure adequate resources.

Global climate change is a particularly sensitive issue for environmental health. Agricultural changes, potable water supplies, vector borne diseases, environmental heat stress, and other changes are likely to significantly impact human, animal, and plant health. Departments or Divisions of Environmental Health and Health Departments need to work closely and collaboratively to develop local assessments and mitigation plans.

California must have a strong, integrated state/local environmental health partnership.

CCLHO supports requiring continuing education for registered environmental health specialists (REHS). The ongoing education of the REHS work force is important for maintaining a proficient professional work force to protect the health of the public. CCLHO encourages the California Department of Public Health to clearly define the scope of practice of REHS to best ensure the safety of the public from environmental health threats.

**Food and
Consumer
Protection**

Food protection activities should be consolidated in public health agencies at federal, state, and local levels. Until then, agencies involved in food protection should cooperate in the development of a master plan to provide for adequate technical support and coordination for local retail food programs; effective evaluation of hazards; cooperative decision making; and the avoidance of unnecessary overlap, duplication, and gaps in services. The Department of Public Health should take the lead role and work closely with local health jurisdictions. CCLHO's recommendations on food and consumer protection include the following:

- Consumer protection should include uniform standards for food transportation, labeling for freshness and nutritional content, and listing of all (including non-nutritive) ingredients; certification and periodic recertification of food industry workers; and Hazard Analysis Critical Control Point (HACCP) based enforcement of regulations. In addition, because of the inherent dangers with certain food items (e.g., milk, eggs, poultry, and other meat products), there should be closer collaboration with the state Department of Agriculture on the necessary research, consumer and industry education, and regulation related to these products.
- CCLHO supports the Food Safety Initiative of the Centers for Disease Control and Prevention and the Food and Drug Administration's role in assuring the safety of imported and domestic food.
- CCLHO supports the principle of requiring managers of food services to report suspected food borne illnesses to local health authorities and coordinate with them on mitigation measures.
- CCLHO supports requiring inspection and permitting by local environmental health agencies of food preparation and serving facilities in schools, day care facilities, and all congregate living facilities, with appropriate funding or fee authority.

Food protection activities should be consolidated in public health agencies.



- CCLHO supports providing consumer divisions of local environmental health departments with sufficient resources to protect consumers' health.
- CCLHO supports collaborate efforts by local Health Officers and environmental health directors to promote healthy and nutritional food choices in homes, schools, and restaurants. Wherever appropriate, they should work with local agriculture commissioners and agricultural co-op extensions to provide information.
- CCLHO supports rigorous enforcement by local Health Officers and environmental health directors of restaurant food-labeling provisions during their inspections of food service establishments.

Air Quality **Efforts to determine and track the health and environmental impacts of air pollution should be continued and enhanced, particularly for toxic materials.** These impacts should be the basis for priority setting, risk management, and enforcement. Air quality control efforts must be integrated with planning for land use; solid and liquid waste disposal; transportation; energy production; and any other public or private activities with possible harmful environmental impacts. The adverse impact of indoor air pollution – including fungi, molds, mildew, volatile organic compounds, and particulate matter – is an increasing public health concern, particularly given efforts to conserve indoor heating energy.

Efforts to determine and track the impacts of air pollution should be enhanced.

Among the specific actions that CCLHO supports are the following:

- Indoor air quality should be considered in building design, modification, and construction and in ongoing maintenance and operations.
- Since exposure to secondary tobacco smoke has been demonstrated to cause adverse health effects, Health Officers should promote a smoke free environment in all public and private places.
- Research should be conducted on the link between respiratory and cardiovascular diseases and other diseases and air pollution. High levels of air pollution have been documented to increase asthma attacks, as well as cardiovascular mortality rates.
- CCLHO supports involvement in tracking of air hazards and pollutants through the Environmental Health Tracking Initiative, California Environmental Contaminant Biomonitoring Program, and other efforts.

**Environmental
Risk Assessment,
Management,
and Monitoring**

- Local Health Officers should network and train with local air pollution control officers to develop preparedness for response to air pollution emergencies.
- CCLHO should continue representation on the California Air Response Planning Alliance (CARPA).
- Non-burning alternatives for disposal of agriculture and forest waste should be supported as a way of reducing air pollution.
- The environmental justice implications of air pollution should be incorporated into public health goals.

The need is increasing to evaluate the health risk for any given chemical exposure or combination of exposures in the environment. Technological advances have made it possible to monitor the burden of toxic chemicals in the human population. CCLHO supports biomonitoring and the use of new technology to advance the science and knowledge of environmental risk assessment, as well as coordination at all levels of government.

A coordinated response mechanism is needed for environmental contamination since multiple environmental mediums (e.g., air, water, soil, food, and so on) may be involved in a release event or cleanup. The short- and long-term public health effects of releases or spills should be evaluated and mitigated, and other agencies should be educated about the importance of involving public health agencies.

Environmental health includes exposure and risk assessment of naturally occurring toxic hazards, such as toxins produced by blue-green algae. Local hazard information, including risk reduction measures, should be disseminated.

The role of birth defects registries, chronic disease registries, and mortality data analysis in environmental hazard evaluation should be recognized. Local and state data and expertise in these areas should be enhanced.

CCLHO supports the clear separation between risk assessment activities and risk management activities. The state must provide leadership in assessment of environmental risks. The public health model of epidemiologic investigation – risk assessment, necessary mitigation, and health education to prevent future episodes – is particularly well suited to address a variety of emerging environmental problems. These problems include acute or chronic toxic exposures of individuals or groups, the human health aspects of environmental impact reports, and undue concern arising from exaggerated fears of environmental toxins.

***The
environmental
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incorporated
into public
health goals.***

**Hazardous Materials
and Hazardous
Waste Management**

Hazardous material management is a public health concern, and responsibility for it should be coordinated at all levels of government. A coordinated hazardous materials data system should be developed to serve the needs of government agencies with hazardous materials responsibilities. Coordination should include formal planning, training programs, sufficient resources, and regular exercises so that hazardous materials emergencies can be handled in a timely, safe, and effective manner. Generators of hazardous wastes and users of hazardous materials should be encouraged to use alternative materials that will result in less hazardous waste production, when feasible. They should also be encouraged to treat and reduce waste volume and reduce the use of landfills. Hazardous waste generators should be assessed disposal fees. Underground tanks that store hazardous materials should receive diligent oversight, and releases should be mitigated in a manner that protects public health. Issues of environmental justice should be addressed, where applicable.

***Hazardous
material
management
is a public
health concern.***

Land Use

Public health agencies must be included in the development and review of general land use plans, community plans, and standards and regulations. Health Officers and environmental health professionals should play an increased role in community planning and architectural design to ensure that the built environment enables people to maintain healthy activities and behavior. Among the policies that land use planners should consider to enhance the health of communities are limiting the density of tobacco, alcohol, and fast food outlets and facilitating walking and bicycling.

Land use plans should be reviewed for their compatibility with environmental health principles and state and local requirements. Elements of review should include potable water supply, sewage disposal, solid and infectious waste disposal, food handling, community noise impact, vector control, toxic materials, recreational health, air pollution, proximity of potential sources of toxic exposures to sensitive sites, and other public health problems not yet recognized. For example, review of plans for a school near agricultural land should consider the possibility of pesticide drift, smoke exposure due to agricultural burning, and chemicals in irrigation runoff.

Liquid Waste **Adequate control of liquid waste remains a cornerstone of environmental health protection for the community.** Untreated liquid waste must be kept from direct contact with humans or animals and must not reach subsurface waters because of the potential for polluting potable waters. Agencies involved in community liquid waste disposal should be guided by a comprehensive master plan dealing with overlapping jurisdictions, duplication, and gaps in necessary services. Water reclamation standards and use should be under the jurisdiction of the California Department of Public Health. Reclaimed water should not be used directly for potable purposes until or unless appropriate standards, technology, and safeguards exist. CCLHO encourages the use of gray water (from showers, sinks, and laundries) when appropriate. But untreated gray water should only be used for subsurface irrigation. Reduction of wastewater production and alternative methods of disposal should be addressed in the review of proposed sewage projects. The California Department of Public Health and/or the Water Resources Control Board should take the initiative in developing minimum statewide standards for on-site sewage disposal.

State and federal agencies must set standards and best practices for safe disposal options for biosolids/sewage sludge.

Recreation **The California Department of Public Health should develop legislation establishing standards for fresh water bathing, including artificial and natural lakes, streams, rivers, and quarries.** The Department, in consultation with local Health Officers and environmental health directors, should promulgate new regulations for public swimming pools. Private and public pools should be maintained to assure that vector control objectives are achieved.

Local Health Officers and environmental health directors should work together and partner with federal, state, and local park officials to promote active lifestyles, including walking, bicycling, and other active forms of recreation.

Adequate control of liquid waste remains a cornerstone of environmental health protection.

**Solid Waste
Management**

Local public health agencies should participate in the development, updating, implementation, and enforcement of county or regional solid waste management plans. Local and regional plans should exceed minimum state standards when necessary and compelled by local circumstances. Health protection should be an integral part of all plans. The California Integrated Waste Management Board should work closely with local health jurisdictions. CCLHO strongly supports recycling as an alternative to landfill expansion.

CCLHO supports the development of programs to manage pharmaceutical waste and discarded medical devices. The California Departments of Health Care Services and Public Health should develop legislation authorizing pharmacies to accept home-generated pharmaceutical waste and used needles.

Vector Control

Vector control is one of the core functions of public health agencies. Vector control efforts at the local level should be organized to minimize duplication. Vector control staffing and resources at the state level should be sufficient to provide consultative support to local agencies, as well as to support or carry out other activities not readily or appropriately carried out at the local level, such as maintenance of sentinel flocks and surveillance of West Nile Virus, plague, Lyme disease, hantavirus, and other vector borne diseases.

Vector control activities should be expanded to rural and urban areas where they are not currently offered. Vector control agencies must have authority to identify and mitigate hazards in swimming pools, standing water, and trapped water on private land, since such bodies of water facilitate mosquito breeding. To limit West Nile Virus infection and other mosquito borne illnesses, continued monitoring of disease vectors (mosquito pools) must be coordinated with data from sentinel chicken flocks, wild birds, and sentinel cases among horses and other susceptible species. Environmental health must disseminate balanced information on the potential health effects of vector control agents.

Vector control is one of the core functions of public health agencies.

Water Supply

State, federal, and local funds should be made available to assist small water systems in meeting state and federal drinking water standards. Correcting public health hazards should be assigned the highest priority, and construction should be coordinated with local health departments.

Bottled water and water vending machines should be regulated for public health and safety.

**Product
Stewardship,
Health, and
Green
Chemistry**

CCLHO supports the principle of product stewardship (also known as extended producer responsibility), which directs that all participants involved in the life cycle of a product share responsibility for the environmental and human health impacts that result from its production, use, and disposal. Product stewardship encourages manufacturers to take responsibility for managing their waste and to design products that are less toxic and more easily recycled. This approach emphasizes smart design of more durable, less wasteful products and supports conservation of resources and the protection of the natural environment and human health.

There are few convenient, safe, and environmentally acceptable alternatives for the disposal of unused and expired medications, which show up in the environment when discarded improperly. CCLHO and California Conference of Directors of Environmental Health should work together to advocate for a comprehensive national pharmaceutical take-back program.

California's Green Chemistry Initiative is expected to provide recommendations for developing a consistent means for evaluating risk, reducing exposure, encouraging less-toxic industrial processes, and identifying safer, non-chemical alternatives. Over the next 10 years, the initiative should ensure a comprehensive and collaborative approach to increase accountability and effectiveness of environmental programs across state and local governments.

***CCLHO supports
the principle
of product
stewardship.***

**HEALTH EDUCATION
AND HEALTH
PROMOTION**

Promotion of healthful behavior is an essential public health service.

Health education is the planned process through which individuals, groups, organizations, and communities acquire information and skills to prevent disease and protect and improve health. Health promotion is the use of health education and other interventions at individual, family, institutional, community, and environmental levels. Work at these levels includes education and promotion of policy and environmental improvements conducive to improved health. Reducing the costs of medical care is another potential benefit of effective health education and promotion efforts.

Each local health department should have the resources, program capacity, and funding available to:



- Plan, develop, implement, and evaluate health education and promotional programs and services based on needs identified by community groups, epidemiologic data, and local public health providers;
- Target efforts toward high-risk groups and special populations within communities. These groups may include low-income residents, people of color, the elderly, young people, and people with special needs;
- Establish positive relationships with local and regional media to convey health education and health promotion campaigns to the general public;
- Provide culturally and literacy-appropriate health promotion services; and
- Prepare appropriate health education messages to limit the impact and improve the recognition, evaluation, and response to bioterrorism events and other public health emergencies. Such preparation, to the extent possible, should be initiated in advance of the specific needs of an emergency or disaster response and should recognize the importance of coordinated messages within and between organizations at the local, state, and national levels.

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**INJURY CONTROL
AND VIOLENCE
PREVENTION**

Injury is the fifth leading cause of death in California and the primary cause of death for adolescents. CCLHO finds the “Strategic Plan for Injury Prevention and Control in California, 1993-97,” prepared by the State Injury Control Advisory Task Force, still relevant to injury control and violence prevention today. A more recent document, “Filling the Gaps: Strategic Directions for a Safer California, 2010-2013,” supplemented the plan to address gaps in data, policy, and practice; strengthen efforts in areas that need more focused attention; and serve as a catalyst for new and evolving areas of injury prevention. The goals of the plan are to:

- Compile injury data useful for state and local programs;
- Create a permanent infrastructure for injury prevention and control;
- Create awareness of injury as a public health problem, focusing on prevention; and
- Ensure that injury prevention and control activities are responsive to California’s diverse population, especially high-risk groups based on age, gender, disability, ethnicity, and socioeconomic status.



CCLHO supports community design (land use and transportation planning) features that decrease unintentional injuries and improve traffic safety for motorized vehicle users as well as pedestrians and users of non-motorized vehicles, such as bicycles and wheelchairs.

**LOCAL
DETENTION
HEALTH
SERVICES**

Local Health Officers share responsibility with jail administrators for communicable disease control in local detention systems. They are responsible for annually inspecting the detention facilities for health and sanitary conditions. CCLHO recommends that the jail's responsible physician, in conjunction with the facility administrator and the local Health Officer, develop a written plan to address the identification, treatment, control, and follow-up of communicable diseases. The plan should reflect the current local incidence of communicable diseases that potentially threaten the health of inmates and staff. Local Health Officers are concerned with reporting and notification of release or transfer of persons with active tuberculosis. CCLHO is committed to working with sheriffs, chiefs of police, jail medical administrators, and the Board of Corrections to accomplish these tasks and to increase cooperation and collaboration.

CCLHO supports establishment of a central point of contact for state prison issues that affect public health and for juvenile detention populations. The Department of Corrections and the California Youth Authority must assign and support coordinating responsibility for internal public health issues and public health interface issues at the state and local levels to a specific entity within their organizations.

Persons in detention facilities (including juveniles) are at increased risk of contracting or suffering from infectious diseases that are of major public health concern, including TB, chlamydia, hepatitis B and C, and HIV. CCLHO supports efforts of local jurisdictions to initiate chlamydia screening (especially in juvenile detention), hepatitis B vaccination, identification and management of individuals with hepatitis C, and HIV screening, and to develop discharge/transfer/release procedure plans with public health concerns in mind, including substance abuse. Local Health Officers should work with appropriate authorities to increase inmate and parolee access to health education and counseling on healthful personal behavior in the areas of sexual behavior, interpersonal violence, substance abuse, nutrition, and exercise.

Local Health Officers should work to increase inmate and parolee access to health education.

**MATERNAL, CHILD,
AND ADOLESCENT
HEALTH (MCAH)**

Maternal, Child, and Adolescent Health (MCAH) programs focus on prevention at an individual/family level and a community social/environmental level, as well as advocate for programs and policies that address the underlying determinants of health. The goal of MCAH is to improve the health of mothers, children, and young adults. Issues such as homelessness, substance abuse, family violence, foster care, lack of quality educational opportunities, and decreasing access to care, particularly for undocumented women, children, and families, increasingly complicate the lives of women and children and lead to the following policy recommendations:

- Family planning services must be available in accessible and acceptable settings and should encompass sexually transmitted diseases (STDs) and their complications, HIV/AIDS screening and education, pregnancy testing, and all forms of temporary and permanent birth control. These services should be provided with strict confidentiality to both males and females.
- Timely and appropriate perinatal services should be available to all pregnant women in California, including undocumented immigrants. Special efforts should be made to identify high-risk individuals and assure appropriate care.
- Comprehensive and sound medical practice in counseling pregnant women must include presentation of all options, including pregnancy termination. Any legislation or regulatory changes restricting a woman's free choice concerning pregnancy should be vigorously opposed.
- Prevention of adolescent pregnancy should be a focus for public health programs and should emphasize effective methods. The focus of teen pregnancy prevention needs to be expanded to address the role of the father, especially when there is an age differential. To reduce adolescent births and STDs, in-depth, comprehensive, age-appropriate education on sexuality should be provided in every school beginning in 4th grade or earlier. Local health departments should be available to encourage and facilitate this and provide local data and resources. Promotion of abstinence-only sexuality education approaches is harmful and ineffective and a misappropriation of scarce resources. Abstinence-only curricula should not be supported in this state.
- Emergency contraception should be available to all women whose primary birth control method fails or who have unanticipated intercourse. Educational efforts must be undertaken to make all women of childbearing age aware of the availability of emergency contraception and the need to access it within 48 to 72 hours to avoid unwanted pregnancy.

Prevention of adolescent pregnancy should be a focus for public health programs.



- The Conference recognizes the potential value of epidemiologic studies of MCAH issues at the local and state levels and encourages state and local jurisdictions to enhance their capacities to conduct epidemiologic studies of birth outcomes and diseases and conditions affecting mothers, babies, and adolescents, including determinants of effective immunization strategies.

For infant and child health services, the focus must be on prevention, rather than on more costly curative services. Examples include periodic screening linked to appropriate diagnostic and treatment resources, parent education on growth and development, specific broad-based community education on the importance of early brain development, immunization, oral health, and child abuse and neglect prevention programs. CCLHO makes the following policy recommendations:

- Comprehensive school-linked public health services can improve academic success by decreasing absenteeism, treating conditions and diseases that interfere with learning, and increasing knowledge and demonstration of healthy behaviors. These services include mental health and primary health care, immunization, and health promotion programs that utilize peer health education as a primary modality and involve the entire school community of students, families, staff, parents, and teachers.
- In view of the expansion of day care facilities, measures that safeguard the health and welfare of infants and young children in day care should be promoted. Health education and health promotion programs should be mandatory for day care operators and their employees and directed towards the control of communicable disease, the prevention of injuries, and early identification of physical and/or sexual abuse of children.
- The Conference supports the continued operation of the Birth Defects Registry. Local health departments should be involved in the prevention of birth defects through such programs as nutritional evaluation and support (especially promotion of folate supplements), aggressive management of pregnant diabetics, and counseling of pregnant women to avoid alcohol and teratogenic drugs and medication. The California Department of Public Health, in collaboration with local health departments, should investigate suspected clusters of birth defects and environmental concerns.

For infant and child health services, the focus must be on prevention.

**OCCUPATIONAL
HEALTH**

The work environment is an important place to focus public health efforts to prevent occupational disease and injury, especially since many Americans are working an increasing number of hours, often well beyond the traditional 40-hour workweek. The Conference urges local health departments to work with appropriate business and industry leaders, employee associations, and health care providers to encourage adoption of healthier work environments. Among our recommendations:

- Public occupational health programs should receive the funding, training, and technologic and laboratory support needed to assure that California's workers have healthy and safe working conditions.
- The statewide occupational health surveillance system should be maintained and strengthened. This reporting system should include the current International Classification of Disease (ICD) coding and should be used to provide analysis of occupational-associated morbidity and mortality. In addition to protecting workers, occupational disease surveillance can serve as an early warning system for potential environmental illness that may affect a wider community.
- Local Health Officers and the State Occupational Health Branch should work collaboratively to ensure that occupational health and safety activities, including training, investigation, and research, are conducted in their jurisdictions. These efforts are needed to ensure the safe working conditions of local health department workers, as well as those working in private firms.
- Certain workers are more likely to experience illness and injury in the workplace due to biologic, social, and/or economic characteristics, including workers aged 65 years and older, workers aged 16-19, immigrants, and people of color. Addressing the workplace health and safety of these workers will require alternative approaches and additional resources that are linguistically and culturally appropriate.

The work environment is an important place to focus public health efforts.

**ORAL HEALTH
SERVICES**

Preventable oral health diseases, including dental caries and periodontal disease, affect a majority of the population. The implementation of proven preventive measures could save Californians hundreds of millions of dollars in treatment costs annually.

Oral health diseases represent the most prevalent health problem of children. Consequently, state and local health departments should support and promote

the development of preventive oral health programs as integral components of maternal, child, and adolescent health programs. These programs should include access to cleaning, water fluoridation, dental sealants, and referrals to care. A state prevention program should be adequately funded to serve all high-risk children. The Conference supports periodic epidemiologic assessment of the state of oral health in the population.

Community water fluoridation is the safest, most cost-effective, and most equitable public health measure available for the prevention of dental caries. It should represent the highest priority oral health objective of every community. As of 2007, about 70 percent of Californians benefited from fluoridated drinking water, up from 17 percent in 1990, according to the California Dental Association. State and local health departments should work together to promote the fluoridation of community water supplies and adequate monitoring of fluoride levels. CCLHO continues to support additional legislation and funding that can remove practical barriers to community water fluoridation.



**PUBLIC HEALTH
LABORATORY
SERVICES**

Public health laboratory services are essential to perform the core functions of public health and must be strengthened. They are crucial for disease surveillance, diagnosis of new and recurring infectious and zoonotic diseases, environmental and vector testing, toxicology, and monitoring the safety of drinking water, recreational water, and food supplies.

Public health laboratory responsibilities include such essential activities as training, cooperative methodological development, surveillance projects, and referral practices, as well as direct bioanalytical support for health department programs. Public health laboratories also serve as reference laboratories for private, commercial laboratories in their respective service areas.

Laboratory resources are also critical in the recognition and evaluation of possible bioterrorist threat agents and other public health emergencies. The coordinated laboratory response to bioterrorism surveillance programs, such as Biowatch and Biosense, is the responsibility of the public health Laboratory Response Network. It is this network that would also respond to any bioterrorism threats or public health emergencies.

Plans to provide laboratory support for these functions at the state and local levels should be coordinated with and responsive to the role of state and local public health officials. Public health laboratories must have stable funding for

***Public health
laboratory
services must
be strengthened.***

core public health functions to assist in the diagnosis, control, and prevention of illnesses/conditions of public health concern. Funding must also be sufficient to assure surge capacity to respond to emerging infectious diseases, bioterrorism, and other public health threats and emergencies.

- It is essential that all health departments have available the services of an approved public health laboratory employing public health microbiologist (PHM) certified personnel. The state and local public health laboratories should continue to work with the California Department of Public Health, local Health Officers, state licensing organizations, and educational institutions to ensure that an adequate number of qualified public health microbiologists and public health laboratory directors exist. CCLHO supports continued enhancement of educational opportunities for new public health laboratory directors and public health microbiologists.
- An advisory committee composed of state and local public health laboratory directors should be established to coordinate an integrated network that would provide comprehensive and uniform laboratory capacity throughout the state. The committee should facilitate development of standardized training, real-time interactive communication systems, coordinated state-wide planning, and regulatory development and review.

**PUBLIC HEALTH
NURSING
SERVICES**

Public health nursing is population-focused, community-oriented nursing practice and is an essential component of the public health infrastructure.

Public health nurses go into the community to work with families, agencies, and schools to assess and coordinate services to address identified needs. Public health nurses are vital links between the local health department and the community. They accomplish this linkage by:

- Assessing the ecology of the individual's and family's living environments to identify health risks, recommend programs/interventions, and advocate for the needs of specific individuals and families, as well as the community as a whole;
- Participating in communicable disease surveillance and outbreak control activities, risk communication, and public education; and
- Facilitating networking of individuals/families and communities, supporting efforts in effective policy development, and linking with other service organizations to promote the availability of quality health services.

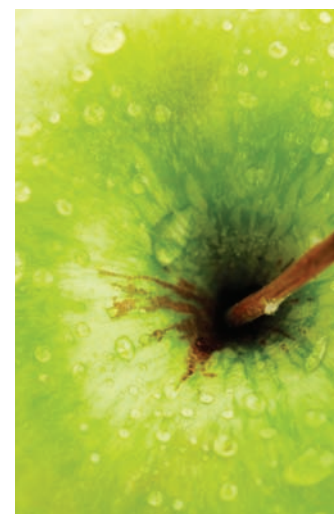
Public health nursing is an essential component of the public health infrastructure.

The current public health nursing infrastructure must be strengthened to increase the capacity to do preventive community public health, as well as address current and emerging public health threats. All local health jurisdictions must have available the services of a staff of public health nurses under the supervision of a qualified director of public health nursing who assures that regular training opportunities are available.

**PUBLIC HEALTH
NUTRITION
PROGRAMS**

CCLHO recognizes that good nutrition is fundamental to the attainment of optimal health. The epidemic of obesity threatens the basic health status of the United States and, if not halted, will overwhelm the capacity of the health care system to treat the resultant diseases in the future. Strategies to create access to and stimulate the desire for healthful foods work at multiple levels, from individual, family, and community, to addressing the built environment and school policy. Corporate marketing practices and the role of television, the Internet, and video games must be analyzed and addressed. CCLHO supports the following:

- Legislation and advocacy to eliminate “junk foods” (including sodas and sweetened beverages) from preschools, day care centers, and school campuses; to mandate adherence to scientifically-based nutritional standards for food served and sold in schools, including healthy fruits, vegetables, and whole grains; and to ensure easy access to drinking water;
- Outreach to disadvantaged populations with information on how to access appropriate, established food assistance programs such as the Women, Infants, and Children’s special supplemental food program (WIC), the Supplemental Nutrition Assistance Program (SNAP), and nutrition services provided through Title III of the Older Americans Act;
- Cooperation with food growers and manufacturers to provide the public with health-promoting food choices, including foods high in fiber, low in fat, and free of added sugar or salt, and to promote awareness of the food choices of diverse ethnic and cultural groups;
- Advocacy for availability of and access to full-service food stores for all communities;
- Promotion of measures that encourage and support women who breast-feed; and
- Promotion of locally produced food to reduce shipping costs and production of greenhouse gases in long-distance shipping.



Good nutrition is fundamental to the attainment of optimal health.

**SENIOR HEALTH
AND WELLNESS**

For the elderly, the focus of public health prevention programs is to support independence and quality of life throughout the lifespan. Achieving these goals requires promotion of healthful behaviors and environments starting well in advance of achieving senior status (primary prevention); early identification of treatable illness and disability (secondary prevention); rehabilitation for those suffering from illness and disability (tertiary prevention); and facilitating the transition, when appropriate, to humane and science-based end-of-life care.

The primary goal for seniors is to prevent or delay onset of chronic illness that leads to disability so that they can enjoy health and wellness as long as possible. Comprehensive care must be provided at the local, state, and national levels through a coordinated long-term care system. Case management in long-term care services is crucial for collecting health and functional status data, as well as monitoring the special health needs of seniors and their caregivers. CCLHO supports active involvement of seniors in decision-making related to their own care, such as the preparation of advance directives.

The goals of preventive health care for older adults should be to maintain independent functioning and maximize quality of life. Emphasis should move toward a comprehensive functional assessment, rather than a disease-specific assessment. CCLHO supports the following:

- Traditional prevention activities, such as immunization against influenza and pneumonia, and behavior modification (including dietary intervention) to prevent heart disease, hypertension, stroke, cancer, and intentional and unintentional injuries;
- Case finding and referral for specific functional defects, such as vision and hearing defects, poor dentition, depression, dementia, alcoholism, and sleep disorders;
- Early identification and prevention of treatment-related problems, such as a patient's use of multiple medications, nosocomial infections, and disability from premature or inappropriate nursing home placement and hospitalization;
- Linkages between public and private service providers serving older adults and community-based programs;
- Data collection on health and functional status by providers serving older adults and sharing with public/private health organizations to plan future services; and
- Community planning to promote healthy aging in place with enhanced options in housing, transportation, recreation, and social and medical support.

The primary goal for seniors is to prevent or delay onset of chronic illness.



Special Issues in Public Health

ACHIEVING HEALTH EQUITY IN PUBLIC HEALTH

There is increasing evidence that it may be more effective for public health practitioners to focus on strategies that address social determinants of health, rather than depend solely upon their traditional focus on risk factors that lead to increased prevalence of disease, injury, and mortality.

A significant return on investment may come from focusing resources and strategies on upstream factors, such as poverty, environmental contaminants, lack of educational opportunity and attainment, and access to quality affordable health care, which are a legacy of social injustices.

The International Society of Health Equity defines health equity as the “absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically.” Margaret Whitehead of the World Health Organization (WHO) defines health inequity as “differences in population health status and mortality rates that are systemic, patterned, unfair, unjust, and actionable, as opposed to random or caused by those who become ill.” Understanding both health equity and health inequity provides a basis for creating practical solutions that address the root causes of health inequities and create a public health system that cultivates and supports health equity.

The goal of public health is healthy people in healthy communities. The approaches to achieving this goal, however, vary widely. Health inequities must be addressed to achieve public health’s mission to assure conditions where people can be healthy wherever they live, work, play, and travel.

Systems changes can improve prevention, access, care, and treatment and impact individuals, families, communities, businesses, schools, and governments.

In order for local health departments (LHDs) to tackle this enormous challenge, an organizational transformation utilizing health equity tools may be necessary. Local health departments must embrace the principle of health equity and understand the evidence that supports it. They must also develop the will to ask hard questions about social injustice (see Table 1 in the Appendix) and commit to implement change. Once the LHD’s culture has been transformed, external transformation is needed at all levels of the community, which requires compelling data and information. Introducing health equity into public health practice

The goal of public health is healthy people in healthy communities.

also requires a proficient, culturally competent workforce that can explain health equity in unified health communications that reach populations with limited literacy and English proficiency. The prerequisites for transforming both LHDs and the community's understanding of health equity include:

- Awareness of the needs and capacity of the LHD and its community;
- Assessment of the magnitude of local issues;
- Adequate tools to establish priorities and compare with other agencies;
- Capacity to educate and influence constituents, partners, and elected officials; and
- Method to evaluate accountability (i.e., data) and disseminate findings.

The National Association of County and City Health Officials (NACCHO) has modified seven of the "Ten Essential Services of Public Health" to provide guidelines to assist LHDs to achieve health equity in their practice. The adapted essential services are as follows:

- Monitor health status and track the conditions that influence health issues facing the community (Guideline #1);
- Protect people from health problems and health hazards (Guideline #2);
- Give people information they need to act collectively in improving their health (Guideline #3);
- Engage with the community to identify and eliminate health inequities (Guideline #4);
- Develop public health policies and plans (Guideline #5);
- Maintain a competent public health workforce (Guideline #8); and
- Contribute to and apply the evidence base of public health and relevant fields (Guideline #10).

These guidelines have been linked to the framework for change described above and detailed in Table 2 in the Appendix.

In addition, the National Plan for Action (NPA) issued by the Office of Minority Health of the Department of Health and Human Services organizes strategies around five core areas of improvement: 1) awareness; 2) leadership; 3) health and health systems experiences; 4) cultural and linguistics competency; and 5) coordination of research/evaluation. These areas have also been linked to the framework domain (see Table 2 in the Appendix).

Finally, the World Health Organization (WHO) has made three overarching recommendations to address issues of health equity: 1) improve daily living conditions; 2) tackle the inequitable distribution of power, money, and resources; and 3) measure and understand the problem and assess the impact of action. These are also referenced in Table 2 in the Appendix.

In summary, LHDs can begin to introduce health equity into public health practice by implementing strategies to transform the organization, workforce, community, and data systems. Mechanisms for data collection, evaluation, and distribution are key to communicate the status of health inequities in communities and regions. It is crucial to establish priorities; assess the data through a social injustices lens; engage the community; focus on evidence-based principles; and disseminate the data/information in an understandable and meaningful manner to the public, stakeholders, and elected officials.

Utilizing this framework, factors that truly influence the prevalence of disease, injury, and death can be addressed, enabling us to work toward a future where everyone has equitable access to health care and services, where environmental strategies address social determinants of health, and where our communities and neighborhoods make it easy for us to make decisions in the best interest of our health.

Health inequities must be addressed to achieve public health's mission.

**BINATIONAL
PUBLIC HEALTH**

Binational health coordination is necessary to deal with national, state, and local health issues involving Mexico and the Central American countries from which large numbers of residents emigrate to the United States.

Enhanced border health projects that assure and improve the health of immigrants should be supported. Coordination with the California Department of Public Health's Office of Binational Border Health should be maintained.

**CLIMATE CHANGE /
GLOBAL WARMING**

CCLHO is deeply concerned about humanity's effect on the planet, including non-sustainable energy policies, environmental degradation, and global climate change. These have far reaching consequences to our communities' health and, indeed, to the fate of this planet. CCLHO believes that Health Officers must demonstrate leadership in working with public and private partners and the community to address these serious threats to the public's health. We will partner with organizations and groups to make sure local public health is heard in these matters.

Global warming and climate change challenge all facets of society and span many issues of concern to CCLHO, including communicable diseases, chronic diseases, and environmental health. Changing weather conditions, including more frequent and more severe droughts, will significantly impact agriculture, potable water supplies, pest populations, and human health as disease vectors migrate into newly compatible geographic areas. These projected changes will provide unprecedented challenges to local public health departments over the next several decades. Proactive steps by local public health agencies will be required to adjust to and ameliorate these challenges.

With respect to urban and other greening initiatives, local health departments and environmental health divisions and departments need to form strategic alliances with a wide variety of institutions to work effectively. These include local departments of agriculture, parks, and recreation; air quality boards; pest abatement districts; and many others. Environmental health agencies need also to work with the local health department and other agencies to develop strategies that mitigate the adverse effects on the human, cultural, and physical environment.

Following are some climate change mitigation strategies that will help protect the human environment:

- Assessment of community vulnerability and resilience to climate change;
- Assessment of the impact of climate change legislation, regulations, and policies on public health;
- Development of mitigation and adaptation strategies that maximize health co-benefits;
- Participation in local greenhouse gas emissions inventories and climate change or sustainability action plans;

***Global warming
and climate
change challenge
all facets of
society.***

- Promotion of culturally appropriate risk communication, education, and outreach;
- Advancement of a climate change research agenda;
- Enhancement of climate change health impact surveillance; and
- Reduction of air pollution, in particular greenhouse gases, in partnership with local air quality management districts and planning agencies.

**COLLABORATION
BETWEEN
PUBLIC HEALTH
AND THE
PRACTICE
OF MEDICINE**

The Conference should develop strong collaborative relationships at the state level with the California Medical Association and at the local level with local medical societies. Through involvement with local medical associations, Health Officers can further collaboration between medicine and public health. There is an increasing need to work on issues of mutual concern, such as antibiotic resistance, obesity, asthma, language access, and the physical environment. Both public health and medicine can benefit from working collaboratively on issues that can be addressed from an ecological perspective that recognizes the importance of healthy communities. Recognizing and responding to acts of bioterrorism and other public health emergencies requires increased communication and cooperation between public health and medical care professionals before, during, and after such events. Specifically, the Conference supports the development of enhanced communications strategies for use in early warning, evaluation, and response to bioterrorism and other public health emergencies.

**COMPREHENSIVE
SCHOOL
SERVICES**

Educational attainment is the single most important resiliency factor in ensuring health in both individuals and populations. Good health is critical for academic success. Bringing public health prevention programs into schools is the most efficient and effective way to improve the health of children.

Approximately 40 percent of children in California's public schools are physically unfit, and almost one in three is overweight or obese – serious predictors of their likelihood of suffering lifetime chronic diseases such as hypertension, diabetes, and heart disease.

Collaboration between the California Department of Public Health and the California Department of Education, as well as between local health departments and county and local school districts, is endorsed and encouraged. The Conference supports comprehensive school health programs that include the following:



***Good health
is critical for
academic
success.***

- A safe and healthy school environment;
- Family and community involvement;
- A health education curriculum that enables students to maintain and improve their health, prevent disease, and reduce risk behaviors now and in the future;
- Health services, preferably on-site or easily accessible, that prevent, screen, identify, and treat or refer health problems, including school-based immunization programs;
- Nutrition services that provide nutritious, affordable, and appealing meals and snacks in an environment that promotes healthy eating behaviors;
- Planned, regular physical education that develops basic physical activity and athletic skills and promotes lifelong physical fitness; and
- Health promotion for staff (assessment, education, and fitness activities for staff who serve as role models for students).

GLOBAL ISSUES

Public health in California does not exist in a vacuum and is increasingly affected by international and global issues. The negotiation of international trade agreements has significant implications for health care and public health. CCLHO strongly advocates that international trade agreements recognize that medical care and public health concerns take priority over commercial interests. Trade negotiations must be conducted in a transparent manner, with full attention to medical and health concerns and with full participation by the public health community. CCLHO believes that any provision that could negatively affect health or health care, safe and sufficient water, and/or other vital human services should be excluded from these agreements.

International trade agreements have significant implications for health care and public health.

Personal Health Services

CALIFORNIA CHILDREN'S SERVICES

The California Children's Services (CCS) Program provides care and case management for high-risk children (through age 21) with certain severe and/or chronic medical conditions. High quality, specialized treatment is critical to the care of these children. Therefore, the program should either be maintained independent of managed care or strictly monitored as a part of managed care.

CHILDREN AND FAMILIES FIRST (PROPOSITION 10) PROGRAMS

Proposition 10, a constitutional amendment approved by the voters in 1998, provides revenues to improve the health and well-being of children from birth to age five. The Conference supports the use of these funds for programs and activities that are evidence-based and demonstrate the improvement of the health status and well-being of children and their readiness to learn. Public health programs such as WIC, Child Health and Disability Prevention (CHDP), Childhood Injury Prevention Program, and home visits by public health nurses to newborns fulfill these evidence-based requirements, as do educational programs such as pre-school. These programs must be carefully monitored and evaluated to ascertain the achievement of desired outcomes. There is adequate data to support the value of family-focused intervention efforts to improve and enrich the environment in which children are raised. Such interventions are often best delivered by home visitors. Interventions should emphasize the ongoing role of parents in multi-need families, rather than focus on interventions that address the immediate benefit of the child.



MEDI-CAL/ HEALTHY FAMILIES

Medi-Cal and Healthy Families programs are crucial entitlements that should be strengthened and expanded. They pay for the provision of health care for children and some adults below, at, or near the poverty level. Barriers to eligibility should be eliminated and adequate reimbursement to providers should be assured in order to maintain provider participation in all areas of the state.

Medi-Cal and Healthy Families programs should be strengthened and expanded.

PRIMARY CARE

Local public health departments should support the development of coordinated systems to meet the basic health care needs of the population, including private plans, managed care, and public services. Primary care systems should provide a full complement of clinical preventive services, including oral health, vision, and hearing services, and should be linguistically and culturally accessible. Public health must continue to advocate for universal health insurance coverage for all, including a single payer system. In addition, CCLHO:

- Supports the concept of medical homes and evidence-based clinical practice;
- Encourages development and utilization of chronic disease registries to promote quality care and facilitate outcomes evaluation;
- Supports personal health records for people with chronic disease to keep track of their own health care and continuity of care documents completed by authorized health care personnel to ensure that critical clinical information is available to medical providers, regardless of where a patient seeks care; and
- Supports patient activation and peer support groups to enhance health literacy and self-management skills.

Primary care systems should provide a full complement of clinical preventive services.

Summary

CCLHO intends for this Policy Platform document to serve as a tool that clearly describes the purpose, role, and core functions of public health, as well as CCLHO's explicit position in key areas. It is expected that this document will play a unique and valuable role for each of the targeted stakeholders. First, the document's primary purpose is to help local Health Officers to delineate CCLHO's position on key services, programs, and special issues germane to the mission of public health. Second, this document should aid state and local policymakers' understanding of the utility of CCLHO and its relationship to local public health jurisdictions. Finally, the information should support the efforts of CCLHO affiliates to coordinate and articulate common goals and messages and to develop future mutual strategic directions.

**COMPARING PERSPECTIVES
ON HEALTH EQUITY**

TRADITIONAL	SOCIAL JUSTICE
What interventions are necessary to address health disparities?	What generates health inequity in the first place? Why is there inequality?
How can we reduce inequity in the distribution of disease and illness?	How can we eliminate inequity in the distribution of disease and illness?
What social programs and services are necessary to address health inequity?	What types of institutional and social change are necessary to tackle health inequity?
How can individuals protect themselves against health disparities?	What kind of collective action is necessary to tackle health inequity?
How can we promote healthy behavior?	How can we reorganize land use and transportation policies to ensure healthy spaces and places?
How can we address risky behavior and target vulnerable populations?	How can we target the health depriving conditions and policies that make people vulnerable?
Why do people smoke?	What economic policies and social conditions predispose people to the stress that encourages smoking?
How can we create more green space, bike paths, and farmers' markets in disadvantaged neighborhoods?	What policies and institutional practices by government and corporations discourage access to transportation, recreational resources, and access to nutritious foods in neighborhoods where the population is poorest?
How can we promote greater personal responsibility for health?	How can we create social responsibility and public accountability to protect the public good?
How do we treat the consequences of health inequity?	How does the prioritization of profit over human need and ecological sustainability affect health inequity?
Overarching social justice questions	Why do those who make decisions that negatively affect health make those decisions? Why do they have that power?

FRAMEWORK FOR LOCAL PUBLIC HEALTH DEPARTMENTS' (LHDs)

Introduction of Health Equity (HE) into Public Health Practice

Domain Areas	STEP 1: ORGANIZATION (Internal Transformation)	STEP 2: WORKFORCE (Internal Transformation)	STEP 3: COMMUNITY (External Transformation)	STEP 4: DATA EVALUATION & DISSEMINATION (Internal & External Transformation)
Goal	Transform organizational culture to make health equity a priority	Transform workplace	Transform the broad definition of community	Transform information
Strategy	<ul style="list-style-type: none"> Institutionalize the health equity culture in all facets of the organizational structure Engage interagency departments & groups 	Create a competent workforce regarding HE & related topic areas (e.g., social injustice, cultural competency, health literacy)	Engage all levels of the community, including private sector organizations, schools, businesses, & other governmental entities	Generate data to assess & evaluate accountability
Tactics/ Actions	<ul style="list-style-type: none"> Incorporate HE into core values, mission, or principles of organization Achieve programmatic competency in health equity 	<ul style="list-style-type: none"> Assess and train workforce in concepts of HE & social injustice (SJ) Recruit a diverse, culturally competent workforce Incorporate HE/SJ in hiring & interview process Link work plans to strategic direction 	<ul style="list-style-type: none"> Educate all sectors Engage in committee planning efforts Engage community in assessment & implementation plans Explore areas for strategic partnerships 	<ul style="list-style-type: none"> ID measurable outcomes Develop monitoring process Engage committee in planning & evaluation process Disseminate findings Emphasize transparent communication (e.g., website, publications)
Results	<ul style="list-style-type: none"> Inclusion of HE as agency/ department priority Inclusion of HE in mission statement, strategic plan, policy (i.e., contract, human resources planning documents) Programmatic strategic alignment 	<ul style="list-style-type: none"> Conduct employee training Provide leadership development Include HE/SJ sensitive questions in interview process Provide health communication (i.e., health literacy, cultural competency, & LEP) training Develop policies that support unified health communication & other concepts of health equity Link to personnel performance and incentives 	<ul style="list-style-type: none"> Community Profiles Health Assessments Plans Health Improvement Plan Apply for joint funding opportunities 	<ul style="list-style-type: none"> Disparity report Committee profiles Convene community forum Ancillary support materials (e.g., fact sheets, reference documents, slide presentations)
NACCHO* Guidelines+	#4 #5	#2 #8 #10	#2 #4 #5 #10	#1 #2 #3 #10
OMH***	<ul style="list-style-type: none"> Awareness Leadership Health & health systems experience Coordination of research/ evaluation 	<ul style="list-style-type: none"> Awareness Leadership Health & health systems experience Cultural & linguistics competency Coordination of research/ evaluation 	<ul style="list-style-type: none"> Awareness Leadership Health & health systems experiences Cultural & linguistics competency Coordination of research/evaluation 	<ul style="list-style-type: none"> Leadership Cultural & linguistics competence Coordination of research/ evaluation
WHO***++	#1 #2 #3	#2	#1 #2	#3

* NACCHO = National Association of County and City Health Officials

** OMH = Office of Minority Health

*** WHO = World Health Organization

+ NACCHO Guidelines

- 1) Monitor health status and track the conditions that influence health issues facing the community
- 2) Protect people from health problems and health hazards
- 3) Give people information they need to act collectively in improving their health
- 4) Engage with the community to identify and eliminate health inequities
- 5) Develop public health policies and plans
- 8) Maintain a competent public health workforce
- 10) Contribute to and apply the evidence base of public health and relevant fields

++ WHO Recommendations

- 1) Improve daily conditions
- 2) Tackle the inequitable distribution of power, money, and resources
- 3) Measure and understand the problem and assess the impact of action



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