Legislative Platform 2021

Platform Subject Areas

Programmatic

Access to Health Services
Animal Care and Control
Built Environment and Climate Change
California Children's Services Program
Cannabis – Medical/Adult Use
Chronic Disease Prevention and Wellness Promotion
Communicable Disease Control
Dental Health Education and Services
Drug & Alcohol Prevention and Services
Emergency Medical Services (EMS)
Environmental Health
First Five (Proposition 10)
Health Coverage/Health Care Reform
Health Equity
Health Information Technology
Health Realignment
Injury Prevention
Jail and Community Corrections Services
Maternal Child & Adolescent Health Services
Medi-Cal Administrative Activities/Targeted Case Management (MAA/TCM)
Public Health Emergency Preparedness
Public Health Infrastructure
Public Health Laboratories
Public Health Workforce
Tobacco Control
Vector Control
Vital Statistics

Administrative

Local Health Department Administration and Simplification
Mandates
Public Health Funding

PROGRAM ISSUE AREAS (listed alphabetically)

Access to Health Services

Platform: Support measures that enhance counties' and communities' abilities to deliver services through their hospitals and clinics. Favor proposals that would provide for the continued expansion of both county and community Federally Qualified Health Clinics (FQHCs). Support efforts to make the telehealth flexibilities issued by the Centers for Medicare and Medicaid Services and the California Department of Health Care Services permanent.
Brief Background: Public hospitals and clinics provide services to all patients in California, regardless of their insurance status or ability to pay. Counties are required to serve the medically indigent under Welfare & Institutions Code Section 17000. California's public hospitals and clinics are the core of the state's health care safety net. Though they represent just 6 percent of all hospitals in the state, public hospitals provide nearly half of the hospital care provided to uninsured patients. Public hospitals also provide comprehensive systems of care, including services that are essential for the entire community; they operate more than half of all top-level trauma centers and burn centers. They also deliver 10 million outpatients visits a year, and train 57 percent of all new doctors in California.

Some counties operate Federally Qualified Health Centers (FQHC) or FQHC "look-alikes" that provide primary health care to Medi-Cal patients as well as many underserved, underinsured or non-insured Californians. These clinics are eligible for enhanced Medicaid and Medicare reimbursements and reduced costs on both prescription and non-prescription drugs for outpatient care.

Telehealth, or the delivery of health care services through electronic information technology, is an effective means to ensure patients, regardless of physical location, can access safe and cost-effective health care. Since the passage of California's original telehealth law, the Telemedicine Development Act of 1996, widespread expansion of telehealth throughout the State has been slow and restricted. Broadly, the main factors that limit the widespread adoption of telehealth include restrictions in Medi-Cal reimbursements based on provider-type, telehealth modality (synchronous, asynchronous, and remote patient monitoring), and the patient's physical location. Although access to telehealth has slowly expanded over the past 20-plus years due to numerous legislative changes, the COVID-19 pandemic has rapidly accelerated the interest in the use of telehealth for both patients and health care personnel. The Centers for Medicare and Medicaid Services and the California Department of Health Care Services issued temporary policy changes during the COVID-19 pandemic that have reduced barriers to telehealth access by expanding the list of services that are eligible for reimbursement. Even without a public health emergency, these flexibilities would ensure more individuals have access to affordable health care in California.

Animal Care and Control

Platform: Support policies that enhance the ability of county animal controllers to provide cost effective and humane animal control services.

Brief Background: Each year almost one million unwanted and abandoned cats and dogs are born in California. Local governments spend more than $250 million each year to intake and care for those animals and ultimately euthanize approximately one third. Encouraging the spaying and neutering of cats and dogs is a reasonable, proven-effective and necessary means to greatly reduce the number of unwanted animals in California. Furthermore, local governments are responsible for the surveillance, prevention and control of animal rabies in California. This is achieved through local companion animal vaccinations and licensing programs, stray animal control, animal bite reporting, investigation and animal isolation along with public education.

Built Environment and Climate Change

Platform: Support legislation and funding that encourages the inclusion of health in all policies and consideration of public health impacts in the design and planning of healthy communities. Support efforts and funding to develop climate change mitigation and resiliency strategies to help protect against and address potential impacts on human health such as increased respiratory and cardiovascular disease, injuries and premature deaths related to extreme weather events, including fires, changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health, particularly for disadvantaged communities most vulnerable to the effects of climate change. Support legislation and funding that seeks to plan for and mitigate impacts and

related health inequities associated with extreme heat, sea level rise, extreme weather events, and poor air quality associated with climate change and wildfires.

Brief Background: Historically, public health has played a role in community design. Before planning became a separate discipline, local health departments performed many "planning" tasks. In the 1900s, local health departments advocated for separating noxious land uses from dwelling units and clamped down on rampant sanitation issues and poor conditions in tenement housing. Today's public health professionals are realizing that our modern built environment with poorly designed streets, lack of transportation options, air pollution and sprawl is negatively impacting health. Physical inactivity levels are significant among Californians of all ages and abilities. Individuals are not able to easily engage in daily physical activity due to unsafe communities, limited access to recreational facilities and substandard pedestrian and bicycle infrastructure throughout the state. These conditions create and exacerbate the symptoms of many chronic diseases such as heart disease, hypertension, asthma, bronchitis, stroke, diabetes, obesity, osteoporosis and depression while also increasing the risk of serious injury. Increasingly, local public health departments are getting involved in helping to mitigate these health risks. From traffic-calming to bike lanes to transit-oriented development, the public health "voice" can help inform land use and transportation decisions to help create safer, healthier communities.

Climate change is a complex phenomenon and diverse ecological effects may result. Human health and social equity may be directly or indirectly impacted by changes in water, air, food quality and quantity, ecosystems, agriculture and economy. Disadvantaged communities that experience the highest shares of pollution or have fewer resources to mitigate the effects of climate change may bear a disproportionate burden of these changes and the resulting effects on health. California has experienced an unprecedented number of wildfires over the last several years, with six of the largest fires on record in the state occurring in 2020 alone. The health effects of pervasive wildfire smoke and ash will have significant long-term impacts on the health of all Californians. In addition, exposure to poor and unhealthy air quality has increased significantly in association with wildfire smoke. Excessive heat events have become more frequent and of longer duration. Local health departments may be confronted with devising new strategies to deal with these unprecedented threats to the overall health of California's population.

California Children's Services Program

Platform: Support strategies to streamline funding and program complexities of the California Children's Services (CCS) program in order to meet the demands of the complex medical care and treatment needs for children in California with certain physically disabling conditions. Monitor the CCS program and seek protections against increased county program costs. Oppose any efforts to require counties to provide funding for the CCS program beyond their Maintenance of Effort (MOE). Explore opportunities to "realign" county share of cost for CCS back to the state. Advocate for CCS pilot project implementation strategies that do not destabilize the current CCS program. Ensure counties retain sufficient resources to meet their CCS responsibilities, including those remaining under the Whole Child Model.

Brief Background: The California Children's Services (CCS) program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under the age of 21 with CCS-eligible medical conditions. The CCS program is administered as a partnership between county health departments and the California Department of Health Care Services.

The growth in CCS caseloads and program costs has steadily increased over time. This increase places demands both on the service delivery side (particularly due to a decreasing pool of specialists and/or therapists and because county staff must review each case in order to authorize services) and on the financing of the program. As fiscal pressures have increased on the California State Budget, the State CCS program is now limiting the state's financial participation in the program, which is further de-stabilizing the program.

In 2016, SB 586 (Chapter 625, Statutes of 2016) was enacted, which transitions the care coordination and service authorization functions for Medi-Cal beneficiaries from the county (or state for dependent counties) to the managed care plan in 21 County Organized Health System (COHS) counties. Counties will continue to assume these functions for non-Medi-Cal CCS beneficiaries. Further, counties will continue to make initial and periodic financial, residential and medical eligibility determinations for all CCS beneficiaries. The Medical Therapy Program will also remain the county's responsibility. The non-COHS counties remain carved out of managed care until 2022 and until an evaluation of the WCM has been completed.

Cannabis – Medical/Adult Use

Platform: Support a statewide regulatory scheme for medical cannabis and/or adult use cannabis that ensures counties have the ability to set regulatory standards based on local needs and priorities. Support and track efforts to study the impacts of cannabis use and legalization on public health, particularly epidemiological surveillance of youth and adult cannabis use and the impacts of use on infant and youth brain development. Support regulations that address transactional limits on the purchase of edibles, beverages and other consumable products infused with THC. Advocate for efforts to increase education, youth prevention, environmental prevention strategies (e.g.: retail availability, retailer overconcentration), responsible adult use, and drugged driving prevention. Seek to ensure local health departments are adequately resourced as regulations and state law are implemented. Promote collaboration with state and local agencies through participation on workgroups and other key meetings. Support efforts to mitigate community level harms such as overconcentration as well as clustering with alcohol and tobacco retailers, especially for communities who have been historically disproportionately affected by cannabis criminalization. Refute efforts to pre-empt local controls promised by Prop 64, including efforts to remove or weaken local control over any market segment of the cannabis industry, from growth to manufacturing and from retails sales to mobile delivery.

Brief Background: In 1996, California voters approved Prop 215 which allows patients or their caregivers to possess or cultivate cannabis for medical purposes if recommended by a physician. In 2003, the California Legislature approved SB 420, which further defined the state's medical cannabis laws, guidelines, and practices, including the implementation of a voluntary identification card system (with cards issued by county health departments).

In 2015, Governor Brown approved a package of bills creating a comprehensive statewide regulatory structure for medical cannabis in the State recognizing the myriad of gaps created by Proposition 215 including the cultivation, processing, transporting, testing, and distribution of medical cannabis. One year later, voters passed Proposition 64, which legalized the adult use of cannabis in California. During the 2017 budget process, the Governor and Legislature agreed on a budget trailer bill to reconcile both the medical cannabis and adult use cannabis statutory provisions.

Chronic Disease Prevention and Wellness Promotion

Platform: Support a varied policy agenda addressing the prevention of chronic disease and promotion of wellness. Support a dedicated funding stream to fund preventive health services or activities that improve community health outcomes, such as proposals to develop a statewide funding source for public health prevention and wellness. Advocate for flexibility for California to design prevention programs to take advantage of California's state and local health department strengths and encourage the provision of base funding to state and local health departments with additional funding available on a competitive basis. Encourage the allocation of new revenue streams in an equitable manner across all local health jurisdictions. Seek to improve nutrition, obesity and fitness education programs as well as health literacy in California's population. Support efforts to increase access to healthy foods and food waste reuse, decrease access to unhealthy foods and beverages, and reduce food insecurity. Continue to support the goals of the Let's Get Healthy California Framework, the California Wellness Plan, the California State Innovation Model (CalSIM) Initiative, and Advancing Prevention in the 21st Century (P21), and the local public health role in realizing these goals.

Brief Background: In 2010 as part of the federal Affordable Care Act, Congress created the Prevention and Public Health Fund (PPHF) that was designed to expand and sustain the necessary infrastructure to prevent disease, detect it early, and manage conditions before they become severe. This fund created an unprecedented opportunity for local health departments to augment and expand existing chronic disease programs or to participate in new programs to address longstanding chronic disease issues in their communities. However, over the years, the PPHF has become increasingly vulnerable and has been diverted to fund other purposes, such as the 21st Century Cures Act passed in December 2016 and a shift of $750 million to the CHIP program in January 2018. Congress also cut an additional $1.35 billion over ten years from PPHF in February 2018.

Chronic diseases in California, such as heart disease, cancer, lung disease, stroke, diabetes and asthma, continue to plague our communities in ever larger numbers, particularly in low-income communities and communities of color. In addition, 40.7% of children in California ages 12-17 are overweight. Children who are overweight increase their risk for type 2 diabetes mellitus, asthma, and orthopedic problems. They are

also more likely to have risk factors for cardiovascular disease. Weight problems are complex with many causes including a person's diet and physical activity level; however, other aspects of everyday environment also can influence them. These may include a lack of recreation facilities, unsafe communities, or lack of access to low cost fresh fruits and vegetables. Furthermore, adverse childhood experiences (ACEs), including child abuse and family dysfunction, are linked to leading causes of adult morbidity and mortality. Finally, the growing number of people experiencing food shortages, insecurity and hunger concurrent with the reduction in social assistance programs, has gradually become recognized as a public health concern.

In 2012, the State of California issued the "*Let's Get Healthy California"* framework, which identified six strategic goals for California to improve the health of residents over a ten-year span. Those goals are: Healthy Beginnings for children; Living Well to prevent and manage chronic disease; ways to improve End of Life care; Redesigning the Health System to be more efficient, safe and focused on patient care; Creating Healthy Communities to enable healthier living; and Lowering the Cost of Care to make care more affordable and to reward value and health outcomes. As part of the framework, the state also developed a Dashboard with nearly 40 indicators to measure California's success. The "Let's Get Healthy California" framework also serves as California's State Health Improvement Plan (SHIP), a component necessary for public health department accreditation.

The California Department of Public Health (CDPH) released the California Wellness Plan (CWP) in 2014, which is in alignment with the "*Let's Get Healthy California*" framework. As part of the CWP, CDPH organized a statewide chronic disease prevention meeting (P21) resulting in a statewide chronic disease prevention agenda to make California the healthiest state in the nation by 2022. The four goals identified by the P21 conference to work on are 1) Healthy Communities, 2) Optimal Health Systems Linked with Community Prevention, 3) Accessible and Useable Health Information, and 4) Prevention Sustainability and Capacity.

Communicable Disease Control

Platform: Support increased, and flexible state and federal funding and resources directed at building the capacity of local public health departments to combat and control communicable diseases. Oppose efforts to reduce state and federal funding streams which would create cost shifts to local health departments. Support efforts to strengthen local health department capacity to provide sufficient contact tracing staff and oppose efforts to limit local health department capacity to collect data to support these contact tracing efforts. Support the equitable distribution of COVID-19 vaccines throughout counties once they are developed.

Brief Background: The control of infectious disease, through immunizations, surveillance, disease investigation, laboratory testing, and response activities has long been a fundamental and statutorily required responsibility assigned to local government public health agencies. However, resources to support these essential activities have been insufficient for years. Preventing and controlling communicable diseases such as sexually transmitted diseases, seasonal influenza, vaccine preventable diseases such as measles and pertussis, hepatitis, HIV/AIDS, and tuberculosis remain ongoing challenges for local health departments. In addition, new and re-emerging infectious diseases, including pandemic influenza, multi-drug resistant tuberculosis, West Nile Virus, Methicillin-resistant Staphylococcus Aureus (MRSA), Meningococcal Disease, Severe Acute Respiratory Syndrome (SARS), Ebola, Valley Fever, Middle Eastern Respiratory Syndrome (MERS), Zika, Dengue, and Chikungunya have increased the need to build capacity.

In 2020, the world experienced a global outbreak of a highly contagious coronavirus, SARS-CoV-2, that originated in Wuhan, China. The first confirmed case of COVID-19 infection in the state was announced on January 26, 2020. Local health departments mobilized their response efforts early during the outbreak as the state had many early cases and accepted the repatriation of American citizens from China where the outbreak began. The state of California declared a state of emergency in response to the virus on March 4 and issued a mandatory stay-at-home order on March 19th. California has experienced the highest number of cases nationwide though the state is ranked 20th in terms of cases per capita. The size and scope of the outbreak will continue to strain the capacity of local health departments to respond.

Dental Health Education and Services

Platform: Favor proposals to expand access to dental health services for low-income Californians. Support efforts to increase Denti-Cal reimbursement levels to encourage qualified dentists to participate

in providing care to low-income children. Support water fluoridation efforts. Encourage dental health education program expansions including adequate funding.

Brief Background: Many Californians, including hundreds of thousands of children, have unmet oral health needs. Untreated dental problems result in days missed at school or work and increased susceptibility to other more damaging health problems such as ear and sinus infections or heart disease. It's estimated that only 30% of California's water supply is fluoridated. Public health strategies such as water fluoridation and dental health education programs are not widely supported or funded. In 2016, voters approved Proposition 56, which increased California's tobacco tax by $2.00 per pack. This initiative included an annual $30 million appropriation for dental care services. Much of this funding will be used to develop or expand local oral health programs to create and expand capacity to educate, prevent, and provide linkages to treatment programs.

Drug & Alcohol Prevention and Services

Platform: Support the creation of alcohol or other drug mitigation fees with funding dedicated to prevention and treatment services. Enhance the ability of local health agencies to reduce and prevent substance use disorder (SUD) related problems, including the protection of SAMHSA block grant funding for prevention. Enhance the ability of local health agencies to decrease SUD disparities in communities and populations at highest risk for SUD, including communities of color, rural communities, LGBTQ, homeless, or justice-involved populations. Support legislation that would make a range of SUD treatment services available to adolescents. Support efforts to adequately fund Drug Medi-Cal services and ensure access to substance use disorder services, including Medication for Addiction Treatment (MAT) and Withdrawal Management. Support legislation that allows for better integration of substance use disorder treatment and physical healthcare. Support funding of professional development for substance use disorder clinicians and other professionals, including incentives and partnerships for recruitment and retention.

Brief Background: Substance use disorders are chronic health conditions that adversely impact individuals and communities across California. It is estimated that the State spends at least in excess of $10.4 billion annually to address alcohol and other substance use disorders with most of the funding directed towards law enforcement and prisons rather than prevention and treatment services. Opioid or opioid synthetics, such as fentanyl, prescription drug, and methamphetamine use, continue to impact California communities with estimates of up to 10% of the state's population suffering from the physical and mental health effects of substance use disorders. In addition, the demand for treatment far exceeds statewide treatment capacity. Increasingly, overdose data is indicating a rise in illicit opioid overdoses where fentanyl or fentanyl-contaminated heroin is detected. In 2018, California experienced 2,428 opioid overdose deaths, including 786 deaths specific to fentanyl.

Many rural communities are disproportionately impacted by the opioid crisis and overdose death rates. Furthermore, substance use disorders disproportionately affect certain groups, such as people who are justice-involved, communities of color, homeless, and LGBTQ, at higher rates compared to the general population. To decrease these disparities, specific funding and resources are required to support these communities. Evidence based, promising practices, and innovative primary prevention programs, integrating trauma-informed care and health equity lenses are needed at much higher levels than are currently available or funded. Parenting education, youth reliance programs and opportunities for youth to serve as leaders at their schools and in their neighborhoods are necessary.

Additionally, there is a need for substance use disorder treatment to deter youth from a lifetime of dependency. Such treatment is often not available, but attention and resources are required to grow the currently limited provider network. As a result, costs associated with substance use disorders among youth continue to grow. The lack of adequate adolescent substance use disorder treatment services impacts the health and safety of the entire community.

In 2011, funding for the Drug Medi-Cal program was realigned as part of a broader criminal justice realignment to counties; in addition, in 2014, the state expanded the scope of Drug Medi-Cal benefits available to Medi-Cal recipients. Counties are now also responsible for funding the Drug Medi-Cal program through a combination of realigned funding and federal funds.

In 2015, the Center for Medicare and Medicaid Services (CMS) approved California's Drug Medi-Cal Organized Delivery System Waiver amendment. Under the terms of the waiver, counties may opt to

participate in this pilot program to provide a continuum of services to eligible beneficiaries including early intervention, outpatient services, intensive outpatient services, short-term residential services, withdrawal management, opioid/narcotic treatment program services, recovery services, case management, and physician consultation. Pilots will be phased in over time and are subject to state/federal approval.

A national opioid epidemic has led to local health departments throughout the state working in conjunction with entities such as medical providers and community-based organizations to stem the rising tide of opioid overdose and death. The California Department of Public Health (CDPH) in 2017 administered a one-time $3 million Naloxone Grant Program with the goal of reducing the number of fatal overdoses in California from opioid drugs by increasing access to the life-saving drug naloxone. Local health departments distributed naloxone products to local programs, agencies, and community-based organizations within their jurisdictions.

Additionally, California was awarded $44.7 million in federal funding for the Opioid Targeted Response Grant in 2017. The California Department of Health Care Services (DHCS) is tasked with administering the Medication Assisted Treatment (MAT) Expansion Project which will expand MAT services to populations with limited access to services, included rural areas. DHCS will establish 15 “hub and spoke” systems where a narcotic treatment program will serve as a “hub” and “spokes” are regional physicians approved to prescribe MAT. For counties that do not have a narcotic treatment program, the lead entity could be the county, an alcohol and other drug facility, an FQHC, or other group. The MAT Expansion Project will also fund prevention activities and services related to opioid misuse and disorders.

Proposition 64, passed in November 2016 to legalize the adult use of marijuana, contains provisions to address substance use disorder treatment for both adults and youth. These include the Community Reinvestment grant program with funding for substance use disorder treatment and funding provided for youth education programs focusing on accurate information, prevention, early intervention, school retention and timely treatment services. However, concerns remain that due to the legalization of cannabis use, increases in youth access and use will surge as was seen in both Washington and Colorado. Research has shown that when youth use cannabis their memory, learning, and attention are harmed with potential life-long effects.

Emergency Medical Services (EMS)

Platform: Maintain existing laws and regulations governing the role of counties in the oversight of pre-hospital emergency medical services including but not limited to medical first response ambulance services. Support legislation or regulatory reform that would enhance county authority and increase funding for such oversight. Oppose any efforts to decrease county authority to oversee the emergency medical services system and to reduce the mandated roles of the local EMS agency in planning, implementing, evaluating and regulating EMS systems. Oppose any efforts to limit the authority of the local Emergency Medical Services Medical Director over pre-hospital patient care including disciplinary actions over licensed or certified personnel. Support legislation that will enhance the provision of emergency and/or trauma services and increased funding for the various components of emergency and trauma care systems, including operations, equipment, infrastructure, ancillary services, public health interventions, and physician reimbursements.

Brief Background: In 1980, California enacted major legislation to promote the development, accessibility and provision of a statewide system for Emergency Medical Services. Health and Safety Code Division 2.5 became effective January 1, 1981.

The intent of the law is to provide efficient and effective pre-hospital emergency medical care throughout California’s 58 counties. In addition to addressing EMS manpower and training, communications, transportation, hospital and critical care centers, public information/education, and disaster response, the law emphasizes medical control system organization and effectiveness.

Counties should retain responsibility for local medical control and operational authority to reduce system fragmentation, to ensure system financial viability, and to assure that all county residents have access to emergency medical services, even in remote areas of the county. Changing the system to a jurisdiction-by-jurisdiction operation would greatly fragment and threaten the integrity of a system that is currently designed to assure for uniformity of high quality and equity of service level and cost to all citizens regardless of their jurisdiction. A fragmented system would be wrought with a high degree of variability in

quality, cost, and services level, and would likely also increase overall system cost due the loss of efficiency that currently exists in today's uniform, integrated and coordinated system.

Environmental Health

Platform: Support legislation and funding that promotes safe and healthy living and working environments for all California residents. Support scientifically proven and best practice efforts that prevent or reduce community exposure to toxins and other environmental contaminants that impact human health. Support efforts to protect and ensure the quality and safety of California's food supply. Support efforts to promote the development of safe "alternative water" sources, e.g., recycled water, storm water, rainwater, and gray water, for both outdoor and indoor use.

Brief Background: The improvements in technology which allow identification of small concentrations of environmental contaminants combined with increasing public concern about adverse health impacts have given rise to an extraordinary quantity of state and federal law and regulation on environmental issues. Local environmental health departments, whether a separate local agency or integrated into local public health departments, enforce these laws on behalf of Californians. This may include air quality, water quality, restaurant inspections, hazardous materials and hazardous waste management, land use, liquid and solid waste, and vector control.

Food and water are basic human needs. Public health has long had an interest in the availability of a safe food supply. During the early 20th century, contaminated food, milk, and water caused many foodborne infections. Public awareness dramatically increased during this time and led to the passage of the federal Pure Food and Drug Act. In the early 21st century, food safety and security continue to be the focus of public health interest. The national recall of Kellogg's Honey Smacks and Goldfish crackers in 2018 is a reminder that all foods must be safeguarded and that impurities at any step of production can have widespread public health impacts. With the concern of drought in California ever present, efforts to conserve the water supply have increased. The development of alternative water sources promotes efficient use of available water.

First Five (Proposition 10)

Platform: Support the efforts of local First Five commissions to enhance the health and early growth experiences of California's children. Oppose any efforts to reduce funding to county-based programs on the assumption that local First Five commissions will fill the revenue gap created by the withdrawal of state funds (i.e. supplantation). Oppose any restrictions on the decision-making authority of the county First Five commissions and Boards of Supervisors as set forth in the text of Prop 10. Oppose any attempts to repeal Prop 10 via legislation or state-wide ballot initiative.

Brief Background: Proposition 10, the California Children and Families Act of 1998, created the California Children and Families Program, now known as First Five, to promote, support and improve the early development of children from the prenatal stage to five years of age.

Health Coverage/Health Care Reform

Platform: Protect scarce resources to fulfill our mandated responsibilities in ensuring the health of our communities. Advocate for sufficient resources provided to local jurisdictions to respond to changes in the health care landscape at the federal and state levels. Support efforts to ensure all eligible residents are enrolled in Medi-Cal or Covered California in an efficient and timely manner and can retain continuous coverage that minimizes burdens on the beneficiary. Advocate for adequate coverage, access to care, affordability, prevention, streamlining and evaluation components in Medi-Cal and Covered California. Oppose further Medicaid/Medi-Cal reductions at either the federal or state level without data-driven analysis.

Also, continue support the simplification and streamlining of Medi-Cal enrollment for participants and providers. Oppose efforts that create disincentives to enrollment and utilization, such as co-payments and premiums or overly burdensome restrictions in information sharing that prevent participants and their case managers or authorized representatives from assisting them in retaining coverage. Support expanded access to dental services, maximization of federal financial participation and increased provider rates.

Advocate for programs and funding, at the state and federal level, that encourage greater coordination of physical and behavioral health services and social services to the overlapping beneficiaries. Support state

efforts to secure or renew federal waivers that provide funding and flexibility to pilot or continue innovative practices aimed at improving the health and well-being of Californians. Oppose efforts to shift health care financing costs to local health departments.

Background: In March 2010, the Affordable Care Act (ACA) was signed into law that for the first time in the United States put in place comprehensive health care reform and provided a tremendous opportunity to provide health care to all Californians. The ACA, among other things, expanded Medicaid eligibility to childless adults up to 138% FPL. It also established state health insurance exchanges that would allow individuals to purchase health insurance; in California, the health exchange is known as Covered California. Despite these coverage expansions, California has continued to fund Medi-Cal such that California ranks 48th in total Medi-Cal spending per Medi-Cal patient, one third below the national average. The ACA also included the Prevention and Public Health Fund, which provides funding for prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs.

This historic shift in the provision of health care services had significant impacts on county health systems. Counties support having effective systems in place to get people enrolled in Medi-Cal or the Health Insurance Exchange (Covered California). In addition, counties, through Welfare & Institutions Code Section 17000, continue to have a legal responsibility to provide care to "residual" populations that may remain uninsured in California.

Medicaid is a joint state/federal healthcare program for eligible low-income individuals. California's Medicaid program, Medi-Cal, is administered by the California Department of Health Care Services (DHCS). Coverage for older adults and persons with disabilities requires State and local coordination with the Social Security Administration. Under the ACA, California has expanded Medi-Cal eligibility to all adults up to 138% FPL. In 2015, as part of the State Budget, California extended Medi-Cal to all undocumented individuals under the age of 19, which began in May 2016. Furthermore, due to low reimbursement rates, California has the lowest percentage of physicians participating in the Medicaid program of any state in the union. The federal government has trended toward a value-based provider reimbursement so greater access and better quality of care are available to Medicaid beneficiaries. Section 1115 waivers, including the Medi-Cal 2020 waiver, have stimulated the transformation of a delivery system that will produce better outcomes and is cost effective through programs such as Whole Person Care. With the Medi-Cal 2020 waiver expiring in December of 2020, the State launched efforts in 2019 to reform and innovate the Medi-Cal program in the state's next federal waiver. These efforts, known as California Advancing and Innovating Medi-Cal or CalAIM, proposed to build on several of the successful programs of the Medi-Cal 2020 waiver. Given the COVID-19 outbreak in 2020, these activities have been put on hold until the pandemic ends, and the state has sought a short-term extension of California's existing Medicaid waiver.

Republican Congressional leaders, as well as the president, launched repeated attempts to repeal and replace the ACA since2017. In addition, a court case, *California v. Texas*, challenges the ACA's individual mandate requirement, and remains unresolved. If the ACA is struck down, it is unknown at this time what will replace it and will likely cause thousands of Californians to lose their health coverage. Meanwhile, conversations around universal health coverage (Medicare for All) and single payer efforts seem to be gaining momentum at both the state and federal levels.

Health Equity

Platform: Seek to reduce health disparities and inequities by working to eliminate barriers to good health and supporting the equitable distribution of resources necessary for health for California's diverse population. Support efforts, working with other sectors, to maintain and expand affordable, safe, and stable housing. Ensure that a health equity lens is applied to policy to identify and address unintended consequences and any potential effects on vulnerable populations. Support efforts to understand the health impacts of discrimination and bias.

Brief Background: Health disparities and inequities result from numerous interactions between community environments, social factors and economic conditions. These social determinants of health or the conditions in the environments in which people are born, live, work, play, and age affect a wide range of health, functioning, and quality-of-life outcomes and risks, and increasing evidence documents the role of racism, discrimination and bias particularly based on race, in determining health, social, and economic outcomes. In California, communities of color and rural populations have a well-documented higher

incidence of chronic diseases, higher mortality rates, and poorer health outcomes. Low-income residents, regardless of race, often lack access to regular medical care and lack adequate health insurance coverage, if they have any at all. They are also more likely to experience food insecurity, insufficient access to social supports, such as lack of housing, quality educational opportunities and secure community environments, that can lead to involvement in the criminal justice system. Local health departments have begun to emphasize programs to reduce these disparities; however, resources, staff, and community outreach must be increased in order to be effective. Local health departments nationwide have also started to issue declarations of racism as a public health issue, an important first step to advance racial equity and justice.

A lack of stable and affordable housing affects the health of many Californians. Housing instability is associated with negative behavioral outcomes in children, depression and anxiety; and at the most extreme expression of instability – homelessness – homeless Californians are at sharply increased risk of chronic and acute health problems. Unaffordable housing across the state negatively impacts mental health and reduces the income that households have available for other subsistence needs, including food, transportation, and health care expenses. Housing should be seen as fundamental right for all to have access to a safe, secure, habitable, and affordable home. In 2017, the California Legislature passed a package of bills related to affordable housing, including measures to streamline housing development projects in cities and counties and to place a $4 billion bond on the November 2018 ballot to support affordable housing development. Recent developments, including Project Roomkey and Homekey, have prioritized the conversion of hotels/motels and other buildings into affordable housing for vulnerable Californians.

Additionally, many counties throughout the state have been involved with the Whole Person Care (WPC) Pilot Program, administered by the Department of Health Care Services (DHCS). WPC is intended to target Medi-Cal patients with complex medical issues and frequent users of multiple health systems. These pilot projects coordinate physical and behavioral health care, as well as social services to improve the health and well-being of beneficiaries through an efficient and effective use of resources. Specific target populations of approved pilots include individuals recently released from institutions or incarceration, those with mental illness or substance use disorders, and those who are currently homeless or at risk of homelessness.

Health Information Technology

Platform: Monitor and advise the statewide development of a health information exchange system, the Medicaid Electronic Health Record (EHR) Incentive Program and the Health Information Technology Extension Program for hospitals and providers. Support proposals to provide funding to local health departments and health systems to support infrastructure and the staff development necessary to support the meaningful use of health information data and particularly the use of health information to advance understanding and improvement in population health strategies. Ensure any state HIT legislation is consistent with federal statute and regulatory requirements. Support efforts to allow bi-directional information sharing across county systems as well as with external partners in order to improve system efficiency.

Brief Background: As part of the American Recovery and Reinvestment Act (ARRA) of 2009, the HITECH Act (Health Information Technology for Economic and Clinical Health Act) authorized nearly $36 billion in federal funding for the nationwide development of health information technology. California developed an Operational Plan in early 2010 outlining the state's specific actions and roles of various stakeholders in the development and implementation of Health Information Exchange (HIE) services in the state. California's plan recognizes that Health Information Technology and HIE can support public health goals by allowing for the monitoring of population health outcomes, increasing outreach for and identifying priority prevention services, and supporting bio-surveillance and emergency response services throughout the state. Additionally, an increasing interest has been expressed at the local and regional level to better understand the health status of cohort populations, how those cohorts are utilizing a myriad of health, social, safety, and community services as well as monitoring the impact of population health strategies. In 2014, federal HITECH grant funding expired; however, California's HIT efforts continue through the California Association of Health Information Exchange (CAHIE), which is continuing work to establish a self-governance function for the trusted exchange of health information in California.

Health Realignment

Platform: Advocate for maintaining sufficient health realignment funding to ensure that counties have the resources to meet their obligations to fulfill their statutory public health and indigent health care mandates.

Brief Background: Legislation in 2013 made major changes to 1991 Health Realignment. As a result of AB 85, funds are diverted from Health Realignment to offset state General Fund costs for CalWORKs, under the rationale that counties no longer need the funds for indigent care with the implementation of the ACA. Counties continue to have indigent health care responsibilities under Welfare and Institutions Code Section 17000, and some jurisdictions expanded eligibility to address the residual uninsured and/or to populations beyond the scope of Welfare and Institutions Code Section 17000.

Another significant change to Health Realignment was the termination of the Coordinated Care Initiative (CCI) in the FY 2017-18 Budget Act, which reinstated the state-county sharing ratio for In-Home Supportive Services (IHSS) that existed prior to the CCI. Absent a mitigation strategy, roughly $626 billion in IHSS costs would be shifted to the counties. One of the mitigations adopted redirected health and mental health Vehicle License Fee Growth to Social Services to fund IHSS costs for 5 years (100% for three years and 50% for two years). It also diverted Sales Tax Growth from health and mental health to Social Services in FY 2016-17. In light of the economic recession due to the COVID-19 pandemic in 2020, counties were successful in securing up to $1 billion in Realignment backfill to ensure the continuity of critical services, including public health and indigent care services.

Injury Prevention

Platform: Support efforts to prevent injuries to California residents.

Brief Background: A great variety of laws or programs exist in California to protect residents from harm. These include car passenger restraint and child safety seat laws, helmet laws for both motorcycles and bicycles, poison control centers, gun control, and swimming pool fencing laws among others. According to the most recent data collected by the California Department of Public Health, in 2017 unintentional injuries, such as being passengers in vehicles, poisonings, or drownings, are the highest cause of death among children from 0-9 years of age. Local health departments provide some injury prevention programs to their communities, including fall prevention programs, child passenger safety programs, youth & gang violence prevention, and intimate partner/domestic violence programs; however, resources are scarce.

A comprehensive public health approach to violence prevention has increasingly become a priority of local health departments. Violence adversely impact Californians, particularly those in disadvantaged communities at disproportionate rates. Local health departments are leading efforts to address the disproportionate effects of injury and violence in communities of need and high burden through building safe communities, using data-informed approaches, pursuing trauma-informed care, and working with key partners to implement violence prevention strategies. Prevention efforts may include reducing risk factors, such as social isolation and lack of economic opportunities, and promoting or increasing protective factors, such as access to mental health and substance use and abuse services.

Jail and Community Corrections Services

Platform: Support efforts to make and retain state or federal financial participation available in the funding of medical facilities and medical care for inmates in county correctional facilities that were realigned to counties on October 1, 2011.

Brief Background: The growing number of inmates in state and local correctional facilities has had major impacts on public expenditures for facility development and operations. County costs have been rising not only because jail populations are expanding, but also due to court-mandated standards for care and the increasing prevalence of medical, mental health, and substance abuse disorders among inmates. The resources required to provide necessary medical care for these inmates is continually overlooked as the focus is on law enforcement and incarceration rather than medical treatment. Counties have a substantial financial commitment for jail medical services including emergency room evaluation or emergency hospitalization of individuals in the custody of police or sheriff prior to booking, medical screening of all inmates after booking, and outpatient and inpatient medical care of individuals in the custody of the sheriff after booking.

The 2010 Budget Act, AB 1628 (Chapter 729, Statutes of 2010) authorized the state to draw down federal financial participation to the extent available for acute inpatient hospital services provided off the grounds of the jail for stays longer than 24 hours. Counties continue to work with the Administration to minimize the loss of FFP and to ensure implementing protocols are feasible for counties to abide by.

In October 2011, California realigned certain offenders and parolees from state institutions to county facilities and/or oversight. This increase of inmates and parolees that may require medical, behavioral, and social services support could significantly impact counties ability to serve existing populations and stretch existing resources.

Maternal, Child & Adolescent Health Services

Platform: Support programs to reduce inequities in maternal, infant, and child health and designed to maximize the health and quality of life for all women, infants, children, adolescents, and their families in California. Support efforts to integrate trauma informed practices into both newly proposed or existing programs and services provided to women, infants, children and adolescents. Support policies and programs to reduce teen and unplanned pregnancy and assist with family planning.

Brief Background: Local health departments are responsible for the administration of a variety of programs designed to address the health priorities and primary health needs of infants, mothers, fathers, children, adolescents, and their families. These programs include the California Home Visiting Program, Black Infant Health, breastfeeding support, Women, Infants & Children (WIC), childhood lead poisoning prevention, teen pregnancy prevention, family planning services, children's health initiatives, and newborn screening. In California, there are still stark inequities in maternal and infant health outcomes. In 2015, the infant mortality rate of babies born to Black mothers was 9.3 compared to 3.5 for babies born to White mothers. For years 2011-2013, the three-year average for maternal mortality rates (maternal deaths per 100,000 live births) for Black women in California was 26.4 compared to 5.9 for all other women.

Evidence-based home visiting programs such as Nurse-Family Partnership and Healthy Families America, supported by the California Home Visiting program, have decades of research to show improved health and social outcomes for mothers, infants and children including reduced maternal mortality, better births outcomes, and reduced child abuse and juvenile delinquency.

During the 1980s, the first Adverse Childhood Experiences (ACEs) study pointed to the impact of intrafamilial stressors on the long-term health of exposed children. More recent research points to adverse social exposures in childhood stemming from poverty and racism as underlying, or in some cases, compounding routes to long-term impairment. Because of the wide-ranging health, social and economic impacts to individuals and communities, efforts to mitigate harm in early childhood are critical. These may include universal implementation of anti-racism education and trauma informed practice in health and social services and activities to improve the socioeconomic well-being of families (for example, through facilitated access to benefit programs and promotion of the Earned Income Tax Credit), as well as efforts to promote family function and well-being. Effective strategies to mitigate early harm must recognize and respond to both upstream and immediate, interpersonal and societal causes of health insult in childhood.

Medi-Cal Administrative Activities/Targeted Case Management (MAA/TCM)

Platform: Oppose proposals from the Centers for Medicare and Medicaid Services (CMS), Congress, or the Legislature to deny, reduce, cap, or eliminate MAA/TCM reimbursement or to make claiming more administratively burdensome.

Brief Background: Counties provide Targeted Case Management (TCM) services to assist specific Medi-Cal eligible populations (including the severely mentally ill, women and children, or frail seniors) in accessing needed medical, social, educational, and other services.

The federal Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services has added additional administrative requirements for the TCM claiming process, resulting in recent disallowance of county claims. County administrative costs are rising including increasing costs for State positions to administer the program.

The Medical Administrative Activities (MAA) program allows counties to receive federal reimbursement for providing certain qualified activities targeting and improving the availability and accessibility of Medi-Cal

services to Medi-Cal eligible and potentially eligible individuals and their families. These services include Medi-Cal outreach, assisting individuals to apply for Medi-Cal, transporting Medi-Cal beneficiaries to non-emergency Medi-Cal covered services, and improving access to and the delivery of Medi-Cal covered services.

Public Health Emergency Preparedness
Platform: Continue to pursue and support fair and equitable funding to local health departments for public health emergency preparedness. Oppose any funding reductions for Public Health Emergency Preparedness at the federal level. Oppose any efforts to shift program costs to local health departments.

Brief Background: The anthrax attacks post-September 11 identified the need to increase preparedness efforts and local public health jurisdictions response capabilities for dealing with terrorism (including bioterrorism) at the local level. Hurricane Katrina in 2005 and wildfires continuing throughout California illustrate the impact of natural disasters on local, state and federal medical/health response capabilities, as well. Pandemic influenza, such as the COVID-19 outbreak in 2020, has overwhelmed an already fragile medical and public health system. Funding for these activities is most appropriate from either federal or state sources to ensure consistency across the state. Increases in funding are needed to augment local programs to prepare for, and respond to, all forms of terrorism, natural disasters, and other related public health emergencies.

Public Health Infrastructure
Platform: Support legislation that would provide continued funding and support for core local public health services and public health laboratories. Advocate for the distribution of federal funding to state and local health departments in order to maintain and build core public health infrastructure. Work with the Administration to ensure fair funding distributions from the State to local jurisdictions.

Brief Background: Public health infrastructure can be understood to be the capacities and resources that make the provision of essential public health services possible in a community. This includes an adequate and trained workforce to provide services, public health laboratories, communication and disease tracking systems, community involvement, partnerships and other components of contemporary public health practice. Public health capacities vary widely in California due to geography, population, and the availability of resources among other factors.

In addition, public health facilities in California were constructed in the 1960s or earlier and are now outdated and insufficient to support current state-of-the-art public health efforts. Federal public health preparedness funds have been used to rebuild and strengthen local public health infrastructure through the modernization of surveillance and communicable disease data systems, recruitment of community volunteers and disaster service workers, training of local staff and community healthcare workers in emergency response, preparation of hospitals and community clinics to address surge capacity issues, and the development of public risk communication plans. However, this federal infusion of funds is on the decline while rebuilt infrastructure needs are ongoing and need to be maintained in order to be effective in the long term.

Public Health Laboratories
Platform: Support legislation that increases state and local public health laboratory infrastructure, workforce, and technology to provide comprehensive and efficient public laboratory services at the local level. Support efforts to allocate funding to enact or support training programs for public health laboratory personnel.

Brief Background: County public health laboratories play a critical role in the control of infectious diseases, a core function of public health departments. Public health laboratories are essential in the management of COVID-19, West Nile Virus, tuberculosis, influenza, and food and waterborne illnesses, and public health labs are vital for public health emergency preparedness at the local and regional level.

There is a critical shortage of qualified public health laboratory directors in California. As current public health lab directors retire, local health departments are facing challenges finding qualified candidates. Efforts are needed to increase training for and pathways to become a California public health laboratory director.

Public Health Workforce

Platform: Support development and retention of a skilled and diverse Public Health Workforce through both state and federal advocacy efforts. Support partnerships with universities and community colleges to develop viable public health workforce programs and incentives. Support efforts to protect the safety and privacy of public health workers from threats and harassment.

Brief Background: The current public health workforce is aging rapidly with many local health departments struggling to fill critical positions including public health laboratory directors, public health microbiologists, public health and medical nurses, and registered environmental health specialists (REHS) among others. A study by the National Center for Health Workforce Analysis found that recruitment difficulty for public health professionals is widespread, and these recruitment problems affected the existing public health workforce. This inability to fill vacant positions typically has led to chronic understaffing and difficult working conditions. Many local public health departments report that they have learned to 'do more with less', but in many instances, they are unable to maintain necessary service levels.

Tobacco Control

Platform: Continue to support efforts to prevent or reduce the use of tobacco and its accompanying health and economic impacts on the state and its residents. Support efforts to reduce secondhand smoke exposure in our communities. Support efforts to prevent youth access to all tobacco products, including electronic smoking devices and flavored tobacco products including menthol. Maintain local health department tobacco control capacity and infrastructure. Oppose efforts to exempt electronic nicotine delivery systems, such as e-cigarettes, from current tobacco control laws and regulations. Enforce and/or enact federal and state laws that aim to regulate the sales and marketing of smokeless tobacco products. Support efforts to mitigate community level harms for disproportionately impacted communities.

Brief Background: Each year, more than 35,000 Californians die due to tobacco-related illnesses. With tobacco use rates on the decline in the state, a renewed focus on prevention education and smoking cessation programs should be encouraged. The use of electronic smoking devices, and other smokeless tobacco products, has been on the rise throughout the country. In 2018, the Surgeon General issued an advisory on the alarming surge of electronic cigarette use amongst youth, increasing from 11.7 percent in 2017 to 20.8 percent in 2018. Furthermore, the safety of electronic smoking devices has not yet been fully demonstrated. The U.S. Food and Drug Administration (FDA) has recently begun to assemble a regulatory framework around the manufacture, import, packaging, labeling, advertising, promotion, sale, and distribution of these new types of tobacco products.

In the U.S., consumption of flavored tobacco products such as little cigars, cigarillos, smokeless tobacco, shisha or hookah tobacco, and liquid nicotine solutions have increased in recent years. These products come in a variety of flavors particularly appealing to youth and are sold in colorful packaging that make them especially appealing to young people.

Recent declines in the prevalence of cigarette smoking among youth have coincided with an increased use of e-cigarettes and hookah tobacco. A 2015 study of adolescents ages 12 to 17 found that among those who self-reported ever experimenting with tobacco, the majority started with a flavored product. It also found that most current youth tobacco users reported use of flavored products. Flavorings help mask the naturally harsh taste of tobacco, making flavored tobacco products more appealing to youth and easier for youth to initiate and sustain tobacco use. In 2020, legislation was signed into law that banned the use of flavorings in most type of tobacco products (SB 793/Hill), however the referendum filed may delay the implementation of this measure.

With the passage of Proposition 56 in 2016, California's tobacco tax increased by $2.00 per pack and imposed a tax for the first time on electronic smoking devices. Revenues from the tax increase have been dedicated to Medi-Cal costs, smoking prevention programs, and medical research of tobacco-related diseases.

Vector Control

Platform: Support legislation that would increase funding for: a) Vector-borne disease and vaccination research; and b) Vector and mosquito control services which include but are not limited to: source reduction, surveillance and monitoring, education and outreach, biological control, and chemical control. Support legislation that would allow for mosquito and vector control considerations in environmental evaluation and ongoing management and maintenance of stormwater and other infrastructure projects.

Support legislation that would grant state certified mosquito control personnel more authority to expeditiously access properties that are mosquito infested so intervention efforts can be initiated.

Brief Background: West Nile Virus continues to seriously impact the health of Californians. Since 2003, there have been over 6,500 West Nile Virus cases and nearly 300 deaths. In addition, California is increasingly vulnerable to the introduction of highly virulent mosquito-borne viruses of public and veterinary health concern, such as Zika, dengue, chikungunya, yellow fever, Japanese encephalitis, Rift Valley fever, and Venezuelan equine encephalitis viruses. California is also at increasing risk from tick and flea-borne diseases, including Hantavirus pulmonary syndrome, Rocky Mountain spotted fever, plague, and Lyme disease. If an existing or novel virus is detected, it is critical that local and state agencies are prepared to respond in a concerted effort to protect people and animals from infection and disease.

Vital Statistics

Platform: Support efforts to ensure local health departments have the infrastructure necessary to both provide quality vital records services to their constituents and to ensure robust health data collected from vital records to appropriately monitor the health of their communities.

Brief Background: Vital records and the statistics gleaned from them provide critical information for understanding public health and examining key health indicators such as fertility, mortality, and causes of death. Local health departments in California register all births and deaths within their jurisdictions, and issue birth and death certificates to their residents. Vital statistics also allow local health departments to use locally collected data to understand the overall health of the communities they serve and to target programs and services to those most disproportionately impacted by bad health outcomes.

ADMINISTRATIVE ISSUE AREAS

Local Health Department Administration and Simplification

Platform: Advocate for and support a simplified process of contracting with the California Department of Public Health to allow local health departments to develop a system for the delivery of comprehensive and coordinated public health services to their communities. And:

- Support legislative proposals, policies, and regulations that recognize the differences that exist amongst local health departments and resist any externally imposed systems that ignore statewide differences or that erode local determination.
- Ensure that legislation and regulation be considered from a county health system perspective, recognizing program and population interaction and overlap.
- Discourage complex administrative requirements or request for proposal (RFP) processes in favor of basic plan submission, subventions, or contractual obligations.
- Ensure local health departments are given maximum discretion as to how they implement or achieve the objective set by legislation; focus should be on performance expectations, not organizational structure, personnel, process, or procedure.
- Encourage funding consolidation (e.g., block grants) over categorical funding for target populations or problems to promote practical implementation.
- Seek maximum flexibility and avoid “strings” whenever possible.
- Legislative efforts aimed at “system” reform should specify objectives, funding commitments, and ultimate responsibility. Avoid attempts to split responsibility at the county level (county versus CBO, county versus state, etc.).
- Avoid creating new and independent governance and administrative structures at the local level to create or implement new social/health programs. Program initiatives can be better planned, organized, staffed, directed, and controlled by existing governmental structures that understand the historical, legal, and policy context of California local government. Counties meet these standards best. They bring a regional and population-based perspective to programs which equip them to adapt to the needs of ethnically and culturally diverse constituents. Governmental programs should be accountable to the public through elected representatives, which is a function the Board of Supervisors is already equipped to provide, and which is widely recognized by the public.
- Ensure local health department flexibility to conduct virtual services such as home visiting.

Brief Background: California's county and three city health departments have a basic legal responsibility to protect the public health of all state residents. In addition, on behalf of the state, local health departments administer a myriad of state and federal categorical public health programs. Each of these critical programs is part of the overall mission for California's local health departments.

Most of these public health programs have historically been developed and organized around categorical funding streams and target populations, rather than on core public health functions and sound principles. The result is a maze of contracts and administrative requirements. Each public health program has its own reporting, training, and staffing – with little consistency in program or administrative requirements.

CHEAC has been working collaboratively with the California Department of Public Health for a number of years on various ways to simplify public health funding and claiming, including the development of a uniform indirect cost rate for all CDPH programs.

Mandates

Platform:

- Oppose new mandates without specified, stable, and adequate funding commitments.
- When new mandates are accompanied with new or expanded funding, ensure those mandates are limited to funds available and/or allocated; avoid vague references to responsibilities or open-ended obligations.
- Ensure that if state subvention funds are reduced or redirected, whether through legislative or administrative action, state mandates or obligations should be similarly and correspondingly reduced.
- Seek to add language to tie existing mandates, standards, or requirements to the available funds or allocations.
- Ensure that funding increases for ongoing mandates is adequate.

Brief Background: The fiscal constraints being faced by most governments demand that all federal, state, and local budgets be viewed together as a single public budget bounded by voter preferences and resource limits. It is impossible and inappropriate to shift costs from one government's budget to another without overall adjustments in the revenues and priorities of the total public budget.

Public Health Funding

Platform:

- Protect and optimize funding for county/city health services.
- Avoid the creation of "winners and losers" among the counties when evaluating the allocation/subvention of funds or state benefits, formula development and adjustments to existing allowances. Seek processes, concepts, or funding allocations that are equitable and fair so that county consensus is possible – both short term and long term.
- Advocate for the protection of the Public Health and Prevention Fund and timely distribution of funding to state and local health departments in order to maintain and build core public health infrastructure. Prevention Fund programs must not supplant funding for core public health programs such as Ryan White, Maternal, Child and Adolescent Health (MCAH) and Woman, Infants and Children (WIC).

Brief Background: California's local health departments are mandated to provide a broad array of core public health services to their communities, and they provide these services through a variety of funding sources, including Health Realignment, county general funds, and state and federal categorical program funding. Local health departments are also responding to the changing healthcare landscape including focusing local efforts on chronic disease prevention and wellness promotion activities. It is essential that local health departments are provided the resources necessary to carry out their mandated public health activities as well as allow for the development of chronic disease prevention programs for their communities. Meanwhile, federal categorical public health funding has been in decline and prevention funding through the Public Health and Prevention Fund has mostly been competitively based and has been diverted for other purposes. Finally, many core health programs have seen an increase in administrative costs mandated by the State though funding remains flat or is declining.

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