California Medical Leadership Forum for Public Health/Preventive Medicine
46th Meeting (19th using Video)
March 11th, 2025, 8:00-9:30 am PST
MINUTES

This meeting used a Zoom account from CAPM with phone access provided. "Handouts" (i.e., the agenda, last meeting's minutes,) were attached to the email notice. All attendees except those participating by phone could enter information in "Chat." Web references for agenda topics were embedded in the agenda.

Dr. Hattis officially began the meeting at 8:00 with a welcome and overview of the agenda noting that we will start out with Michelle Patterson from CDPH to discuss actions that have been taken in the background by CDPH in response to the fires. We will discuss this after approving the minutes and then get into the today's special topic in two parts. The first part will be about what public health is and what California has to maintain services if there are federal cutbacks noting that public health is more political than some people realize. Ron, Don Lyman and Jeff Klausner will present different aspects of these public health issues. We will hear reports from our different entities followed by the second phase of the topic which is about state public health and local public health. We will learn about state and local public health powers and responsibilities from Jessica Nunez de Ybarra and Kat De Burgh. Then we will receive information about the roles of non-governmental organizations from Connie Chan Robison from the Public Health Institute and Alicia Sanchez from CMA. We will spend a few minutes on legislation, including a bill that the California Academy of Preventive Medicine and Beyond AIDS Foundation are supporting. Ron noted, for the next meeting, he has tentatively rescheduled it for the third rather than the second Tuesday morning on June 17th, so that Dr. Erica Pan, the new director of CDPH and the state health officer, can address us, noting that she is interested in this group. Dr. Pan has past meetings before she became director. Ron asked if there were any problems with that agenda and none were noted.

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1) **Minutes of January 14, 2025:**

Ron asked if there were any additions or corrections to the minute followed by a request of a show of hands or the word aye to approve them. He asked if there were any objections, and none were noted, and the minutes were approved.

2) **Special Topic, Part I: Public Health Response to Recent Fires in Pacific Palisades and Altadena**

Michelle Patterson from the California Department of Public Health (CDPH) provided information on the Fires in Los Angeles County. She was in Los Angeles in January at the FEMA Joint Field Office interagency Recovery Coordination Center, representing The California Department of Public Health. Michelle talked about public health and public health practice, related to emergency preparedness and response component noting that

CDPH is responsible for the public health and medical aspects of emergency response in coordination with the California Emergency Medical Services Authority.

a. During the fires this year (and many other emergencies both natural disasters, infectious diseases, and many other things) they operate the Medical Health Coordination Center which is CDPH's Emergency Operations Center. They coordinate public health and medical resources that are needed at the local level when they're responding to any types of disasters.

b. This may include medical resources, public health, environmental health, epidemiological, and any kind of public health resource, they help adjudicate and try and fill those gaps for local partners.

c. CDPH also has the Center for Healthcare Quality, CHCQ, which is the regulatory body for many of our healthcare facilities here in California. In conjunction with them, they monitor the status of healthcare facilities during disasters.

c.i. During the California LA wildfires they worked very closely with CHCQ and their field offices to monitor the status of healthcare facility evacuations, healthcare facility repopulation, destroyed or damaged facilities. They do that in conjunction with another State Departments that are responsible for the physical aspects of the buildings.

d. There are many aspects to public health, and emergency preparedness is one of them. Michelle noted they also run CDC's public health emergency preparedness and response grants for the state as well as the hospital preparedness program from the federal HHS department.

e. Ron asked specifically what CDPH has been doing in the background for follow-up of fires noting, for example, that with the northern California fires a few years ago, including Paradise, there were shelters set up and CDPH helped with evacuations. He wondered if there were any specific activities that Michelle would like to mention. Michelle noted they are in a very significant recovery effort and many of their programs and staff are dedicated to supporting the local health jurisdictions with environmental health concerns related to vector control, checking whether it is healthy and safe to return home, how to deal with ash and debris, and many things like that. They support many aspects of public health including responding to requests for assistance at the local level. There were many shelters open, and CDPH worked with other state department colleagues through the Department of Social Services to monitor and provide additional resources. They were able to send out staff to help with some infection control measures at a couple of the shelters.

3) **Special Topic, Part II:** "**An Introduction to the Public Health System in California," A Critical but Realistic Look at a Mix of Politics and Science**

a. Ron provided three theoretical ideas that are ideological and optimistic about what public health is supposed to be, along with his own definition about how activities must be politically approved and funded. There are always political limitations on what public health can do because it uses public funding.

a.i. Private foundations and organizations can fill in, but often they get grants from government. Only when funds come from totally non-governmental sources are is there freedom from political limitations, and even then, objections from the public can be a limiting factor so consensus is needed.

b. Establishing a public health program in a state would be on the basis of recommendations from experts. In order to establish a new public health program through the legislature there needs to be discussion with constituents and introduction of a bill. He noted, however, public health programs can be influenced by a single family or organization that approaches an influential legislator.

c. Budget Process in California: When a bill passes it doesn't usually include the funding. The governor has control with the budget that is submitted to the legislature. Then the legislature negotiates about it with the governor and can sometimes change it.

c.i. Ron noted that it is hard to have total confidence that a program once begun will be continued. An example is that the governor's budget in 2023-2024, approved by the Legislature, included $300 million extra for the future of public health, but the following year he eliminated the funding totally because it was a tough budget year. However, the legislature saved it by it by 'spreading the pain' among many state departments, so it ended up with only an 8% cut.

c.ii. There is a public health budget "roller coaster" from year to year that has been true throughout human history. When public health programs succeed and disease incidence and prevalence go down, there is pressure to cut the budget for public health services, and then when the diseases recur, they increase the budget again.

d. To define what public health consists of you cannot be limited by what public health departments do.

d.i. Ron notes that some things public health should do have never been funded or set up while some programs that are not strictly core public health functions have been assigned by state government to public health.

d.ii. Additionally, some programs that are related to public health are no longer in public health departments because of reassignment to other departments, although in many cases they started in public health.

d.iii. Despite these limitations, our public health colleagues try to make those programs under their jurisdiction as scientific and as equitable as possible. For those programs that are no longer run within public health agencies, of course, we cannot guarantee that those principles are being followed.

d.iv. The U.S. system of government is very decentralized. We have the Constitution that is the ultimate power, supposedly. Then federal law, followed by state law, then state regulations and local ordinances. As you go down that chain, you cannot violate higher regulations or laws or the constitution. If it is not prohibited or assigned elsewhere by the higher organizations, then your level of government can act within that range.

1) CDC is our premier federal health agency. The way CDC tries to get the states to implement public health programs that are consistent is to pay states to do various programs by giving grants. Unfortunately, it is usually like a block grant because they generally do not monitor that the money is going for everything that is in CDC

recommendations that they funded. Also, because we have a federal system with a lot of power belonging to the states, the federal government gets states to do things by giving it money but not necessarily monitoring how the money is spent. CDC, nevertheless, has been admired and copied by other countries. Even China established a center for disease control modeled on CDC.

2) Ron posed the question:What if all federal funding for immunizations disappear, can California go its own way and continue to have these programs**?** This will be addressed in Part III of the special topic later in this meeting.

3) Within the state of California, there is also decentralization and dependence on local public health jurisdictions. However, there are 58 counties and four cities that have health departments. In past years, CDPH did not monitor much about how the money that they get from the state gets spent, and he looks forward to learning from Jessica Nunez's presentation whether that is still the case.

4) Organizations like CCLHO and their affiliates, e.g., nursing directors, health educators, environmental health directors, etc. meet and try to get consensus and common practices. Unfortunately, some counties are so small and it is very difficult for them to conduct all of the public health functions. We used to have a system called "Contract Counties" in which they could put a portion of a salary into a State position that would serve them and some neighboring counties for communicable disease or environmental services, but that program disappeared. Ron asked whether consideration should be given to reviving or replacing this with something similar, and he looks forward to Part III of today's program for that question to be addressed.

5) The main staffing that a small county has is public health nurses and environmental health sanitarians (if environmental health has not been spun off to a separate department), and sometimes primary care staff with a smattering of health educators, an epidemiologist, and if they are lucky communicable disease investigators, or contact tracing staff that were given during the COVID epidemic. Those staff are supposed to implement programs mostly for communicable diseases and maternal child and adolescent health. If a health officer wants to start a different program staff and funds would have to be borrowed from these components unless a special grant is received.

6) Primary care has been assigned to public health departments in quite a few counties, not because it's a core public health responsibility, but so that the health department, which may have clinics in various parts of the jurisdiction, can refer procedures, surgery, and admissions to the county hospital. Having the public health perform primary care is also a boon to the indigent population if there are very few doctors accepting MediCal or uninsured patients, but ideally, the primary care that local health departments deliver should be special. It should be prevention- oriented and help implement public health priorities. Unfortunately, it does not always do so.

7) Ron concluded his slides and called upon Don Lyman to share some anecdotes from Public Health.

e) Don Lyman introduced himself, noting he is retired now from public health, but for about 40 years, was the senior civil service physician first in New York State

and then California. He managed to keep his positions over all 40 years noting they went through lots of ups and downs during those times, but it was a "perch" from which he could see how the world works for us. Don spoke about public health and spin-offs noting that if you look at an organization chart for your jurisdiction, whether it's federal, state, or local, you will see the chief executive and then a lot of little boxes underneath with little lines connecting them. If you checked each of the little boxes of organizational units, departments, agencies, for those that got their start in public health sometime in the past. About 30 to 50 percent of what happens inside your jurisdiction was generated in public health, which starts off a lot of things that get spun off to different agencies.

a.i. Don humorously provided a favorite example of motor vehicles noting that about 100 years ago, somebody in the health department looked out the window and noticed that there were people on the street who were vertical and there were others who were horizontal with tire tracks over them and said, my goodness, where did that come from, look at that morbidity and mortality out there. From that observation and assumption and authority by the health officer we developed rules and regulations for what to do about highways and cars and things like that. From that came a requirement that drivers need to take a course and then you had to get a piece of paper signed by the appropriate official and pay a fee and then you could drive your vehicle. That was the driver license. Once we did that, we had an income stream, and our legislative body declared that since we were now doing something with an income stream doctors should not be in charge of that. You need a businessman, so that was taken away and set up as a separate agency that became the Department of Motor Vehicles. Since then, other things have spun off as well.

a.ii. Don reminded Ron that as we work with leading causes of death, disease, disability, and mental illness, and set up these agencies, which gives us space to do some more creative applied research and development (R&D), that those agencies know where they came from. When they get in trouble, they are back to consult the state health officer. They know where their parentage is, and we do stick together on these things.

a.iii. In a different way of looking at that, when the feds fail in their role as technical provider of money and lots of other things then the locus of authority shifts down a notch. In our constitutional system, that is the states that pick up the slack when administrations in Washington fail. That's us. He remembers when Reagan came in as president and flushed out the technical expertise at the Environmental Protection Agency (EPA). About two weeks later the health officer in Florida called him as he had trouble trying to figure out how to handle what we call the killer muffins episode. There was a pesticide in Duncan Heinz muffin mix. He (the Florida legislator) could find no one at home at the Federal EPA. They had

been pushed out by the Reagan administration. He turned first to Texas where he found no help at all. Then he turned to us and California was setting up a lot of environmental things at that time. He knew we had the expertise. And we set up a national effort that brought a lot of the federal EPA stuff back together again highlighting that we are all tied together, and we do work together. We are an applied R&D place, and we do that well.

a.iv. Don said that the two big states he worked with went through changes in administration that caused temporary instability in public health. There is some variation each and every time there is a change in administrations, a three-to-six-month period in which the incoming administration wants to get rid of the old administration and it always happens. First the politically-appointed people get pushed out, then there is a series of people in the administration who are neither political appointees nor civil servants. We call them CEAs, Career Executive Assignments, and they try to get rid of those people. But the theme here is that when the new administration zealots come in trying to eliminate things and make space for the programs they want, their target is usually people. It is very seldom any concerted effort to change statute on which those hires depend. And that is what we are seeing in Washington right now with a combination of people being pushed out as well as suggestions to closing down agencies. When that happens, there is a lot of damage. In public health, we have to decide how much effort we should put in to try and block things like that and the answer really is there's not too much you can do to block the destructive element, but they tend to disappear after about 6-12 months. Then the new administration sits down to assess the damage. Our role is to be sure we register what happens, who's being pushed out and what expertise and programmatic follow-through are we going to lose? Then, we watch what does happen, what actually does get destroyed. And then the new administration will come back in some way and ask public health to help clean up the mess. That is an opportunity public health to help them, no matter who they are, whether you like them or not. We can help them observe that some of the things that they have killed off were things we did not like anyway, but we can say other stuff is very, very important and it has to be reconstructed. And they will depend on us to help them through those steps. And it is a sad time as we go through six months to a year of a new administration where not a whole lot gets done. It's destruction and then reconstruction. But they do depend on us. They know we have expertise when the dust settles, and they want to put it back together. And that is where we play a very significant role. Don remarked that's a curious view of what's going on in Washington now noting that there is sort of good news at the end of this thing. They will turn back to and ask us how to reconstruct things. We should be ready with our list.

Keep a close eye on what disappears, who gets bludgeoned, who gets pushed out, what expertise disappears with them, what we shall need to recreate and what things can be put back together again so they are better than what we had before. We complain about how things do not work quite right. Well, there is an opportunity right there, an opening. That is Don's special look on destruction caused by new administrations: a curse but also a blessing.

a.v. Howard Hu said he liked the anecdotes about the Reagan administration, a Florida llegislator, and California, noting that at this particular time it would seem that there are states other than California that have strong public health, e.g., New York, Massachusetts, and Wisconsin. He asked is there a network of senior public health leaders or surgeon generals that can provide a bulwark or some safety net of information? It might be informal but it's a something that can support us through this very difficult time.

a.vi. Diana Ramos, the state Surgeon General, responded that she has pulled together an informal group of the public health Surgeon Generals throughout the United States also noting that there's only five states with surgeon Generals aside from ourselves (Arkansas, Florida, Louisiana, California, Pennsylvania, Michigan), but they have informally met and are communicating. Ron inquired if Diana's position was a political position. She stated that she is an appointed position and is bi-partisan. Ron also noted that Linda Rudolph added a chat comment that although there have been precedents for cutbacks and reorganization, this does seem to be the most extensive and perhaps the most disruptive administration change ever.

f. Ron introduced Jeffrey Klausner from USC to present "Core Functions of Public Health."

a.4.i. Jeff noted he would do this in five minutes to keep us back on schedule and that he really appreciated that historical perspective and appreciated the sense of optimism that Don provided in his presentation.

a.4.ii. Jeff noted that Ron asked him to give a quick overview of core functions of public health. Jeff is currently a professor at University of Southern California with former public health roles with CDC (Epidemic Intelligence Service Officer, CDC Medical Officer) and former Deputy Health officer, San Francisco Department of Public Health. A lot of core functions were laid out in a key publication by the Institute of Medicine, which is now the Academy of Medicine almost 40 years ago.

a.4.iii. In the book called The Future of Public Health (which really could be considered a public health bible), the core functions of public health were three main areas: assessment, policy development, and assurance. It is key that people working in public health actually understand these three different areas.

a.4.iii.1) *Assessment*: people are familiar with aspects of assessment in terms of monitoring health status. We do that through surveillance and epidemiology, a key aspect to that, which does vary over time and by jurisdiction, might be population-based surveys and sharing those surveys and surveys results with key stakeholders and constituents, particularly elected official. When Jeff worked in San Francisco, they actually had a monthly report that went out to every elected official and key stakeholder that shared statistics on the area that he was working in regarding HIV and sexually transmitted infections and women's health. This provided a great mechanism for elected officials and policymakers to maintain awareness on this area. Secondly, they diagnose and investigate health problems. Often, we do that passively based on suspected outbreaks, but that could be actively done as well, which in some jurisdictions does occur. And then they collect and analyze data to identify health needs.

a.4.iii.2) Historically, a nice example was the former health officer for California, Tomas Aragon, had prepared a morbidity and mortality summary for the jurisdiction looking at leading causes of death, attributable causes of death, etc.

a.4.iii.3) *Policy Development:* We're very familiar with developing evidence-based recommendations. A lot of experience obviously to that in the response to COVID, but lots of different areas of public health from issues of public water fluoridation to vaccine and school entry requirements. He notes that to advocate for health policies, advocacy is often a little bit tricky as there is a fine line between lobbying and education, but our elected officials do look at public health leaders for education. Ron and Jeff do a lot of that up in Sacramento. And, then implement these policies to protect and improve health through our services and our partners and the people who work as investigators, etc. Often there's a gap between policies that do get passed, particularly at the state level, and implementation. And often we do not have the resources or support to actually implement and then evaluate the implementation of those policies, unfortunately.

a.4.iii.4) *Assurance:* this may be one of the more difficult areas to fully understand, but examples include:

(a.4.iii.4.i.a) Mobilizing community partnerships. In his own experience as an AIDS advocate and as a public health official related to HIV, AIDS, it was community partnerships that were instrumental in ability in public health in San Francisco to achieve common community goals;

(a.4.iii.4.i.b) Providing direct health services which often overlaps with providing healthcare for lower income and indigent individuals in some jurisdictions. This is not

something that public health necessarily has the resources to do, but there may be partnerships to assist;
(a.4.iii.4.i.c) Ensuring access to quality health care which is a key function of public health, and we certainly know at the state level they monitor, they inspect, they respond to compliance.
(a.4.iii.4.i.d) Regulating enforcement of health standards, which to the public there are things like restaurant inspections, water safety, environmental safety.

a.4.iii.5) Jeff showed a few additional slides which were created from the American Journal of Preventive Medicine focus document from December. Jeff quickly reviewed slides that went further into some additional examples of assessment, policy development and increasingly the use of health economics and cost benefit, cost-effective analysis to understand policies and what's going to be the most effective at the population level. Issues about assurance include how to make sure that the conditions under which people live are supportive for our goals of improved population health.

a.vi.i.a.i.4. **Roll Call: Dr. Hattis handed it over to Dr. Sumedh Mankar to start roll call.**

California Academy of Preventive Medicine

1. Dr. Hattis, President, led the meeting.
2. Dr. Mankar Vice President facilitated this roll call.
3. Dr. Lyman**,** present and presented earlier.

California Medical Association

1. S. Alecia Sanchez, present. Alecia did not have anything additional to add.

Public Health Institute

1. Linda Rudolph, present. Linda noted that she had to get off shortly, but that Connie Robison is now here and able to talk about PHI. In reference to question Ron asked about impact of spending cuts, she noted that PHI has had many, many, many programs related to USAID that have been completely decimated. That's probably the biggest impact on PHI of what's going on. The other thing that's really affecting people around the country is that they are rapidly cutting all of the programs related to climate and environmental justice.
2. Connie Chan Robison, present. Executive director of the Public Health Institute Center for Collaborative Planning based in Sacramento. Connie presented in Part III of the special topic, below.

Health Officers Association of California

1. Kat De Burgh, present.

California Department of Public Health

1. Jessica Nunez de Ybarra, present, with the California Department Of Public Health Planning. I serve as the community health medical administrator in our new office established with Future of Public Health funding. Jessica shared that Friday they will be hearing about whether the budget will be passed in a way that is supportive of Medicaid and Medicare without cuts**.** There are concerns that the wildfire support for those in LA is going to not be in the budget, which would be devastating for our state.

Office of Surgeon General, State of California

a.1. Lauren Gross: Special Advisor to Dr. Ramos at the Office of the California Surgeon General. They are working on their Strong Start and Beyond Movement to reduce maternal mortality throughout the state. A video has been posted on Facebook: Supporting Children, Families, and Teachers Through the Trauma of Natural Disasters. This may be helpful for families and for educators for students and the children who may be experiencing trauma from the fire.

a.2. Dr. Ramos: Surgeon General, spoke earlier.

Medical Schools:

Stanford

a.1. Dean Winslow: present; Professor of medicine and pediatrics at Stanford University. Dr. Winslow shared that he does adult and pediatric infectious disease and is on sabbatical at University of Oxford in the UK with his wife, Dr. Julie Parsonnet. He noted that a lot of people in the UK are quite interested in our US experience during COVID and also the work he did when he was on leave as the chief medical officer for the Unaccompanied Children at the southwest border and serving as senior advisor for the resettlement of Afghan refugees. He noted, personally, he is very concerned about some of the things that have occurred over the last two months. Stanford, like USC, is a very research-intensive institution. They're quite concerned about the freeze and NIH grants. And from a humanitarian perspective, the decimation of U.S. Agency for International Development and PEPFAR.

a.2. Julie Parsonnet: present. She is a professor of medicine and epidemiology at Stanford. Julie noted she has traditionally done a lot of global health and the people she works with are just in crisis right now. Some of the people she has worked with, especially in South Africa, and the grants that we are putting in are in jeopardy. They had a large grant that they were about to put in on health disparities in farm workers in the central valley but they decided not to submit it. They knew that it would not get funded because "every word in the title was one that is not allowed to be used." She notes that it

makes her really worried for the most vulnerable people in our state who are really jeopardized by the current administration.

UCLA (University of California, Los Angeles)

1. Priyanka Fernandes, preventive medicine program director at UCLA. Priynaka reported that they are in this phase of uncertainty with particularly the preventive medicine and public health training program as well as maternal and child health training program, both of which are HRSA funded.

a. The maternal and child health training program grant was up for renewals, but a lot of language again that was in the RFP is now in the 'do not use' lists and there's been little communication from project officers.

b. For the preventive medicine grant, while they have the grant, they do not know for this upcoming year whether they are going to continue receiving the grant. Because they are in the match season, they have to commit to trainees but then do not know about the funding.

c. Another source of funding through the VA has (has been affected by) a discussion about layoffs and what is being counted and what is not so that has also been really stressful.

d. Priyanka agrees with the importance of bringing the group together and wondered if there would be advice from legal professionals and non-governmental sources of funding for this important work, at least in the immediate future because even in the best of times with best of governments we have had funding cuts**.**

USC (University of Southern California)

1. Howard Hu, present; Physician epidemiologist and former chair of the Department of Population and Public Health Sciences at the University of Southern California and now on sabbatical. In terms of news, Howard stated that he is aware of two private efforts to do research on the environmental health consequences of the LA fires. And he's sorry to say that a whole bunch of our faculty is very research intensive, and cuts are going to be massively disruptive.

2. Jeffery Klausner, present, is a former CDC medical officer and former local San Francisco deputy health officer for STDs and HIV. He presented earlier in the meeting.

a. Ron asked Jeff if his HIV projects in Africa been jeopardized, and Jeff noted everything has been jeopardized or cut. He was at the AIDS meeting in San Francisco noting there is a huge amount of frustration. People are responding with models of the number of people who will die, the number of people who will be infected, the number of babies will be born with HIV with these cuts. One of the most sobering statistics was that of the people in sub-Saharan Africa on PrEP, the medication to prevent HIV, 90% were funded by USAID. Now, that is essentially gone except they are allowing (but no one's been able to confirm) PrEP to continue in pregnant women. This is a serious crisis about which we all need to mobilize, articulate, and get together.

b. Ron stated that Secretary of State Rubio said yesterday that 18% of USAID programs will survive and inquired if Jeff knew if PEPFAR was one of those. Jeff stated that we don't know and that PEPFAR is up for reauthorization March 15th, so we will see. Historically it has had a lot of bipartisan support. Ron added that it began as a Republican program under a George W. Bush.

Schools of Public Health

UC Berkeley

1. Jared Mazanti, present, is the Director of Strategic Initiatives in the Dean's Office at the School of Public Health. Jared shared that the campus as a whole just had a stand up for science rally last Friday, it was quite well attended and got coverage from NPR, which was wonderful.

Special Guests

d.i.1. Cynthia Mahoney, present; Cynthia is with Voting for Climate and Health here as a guest. She notes she is grateful to to learn about public health in California.

a.vi.i.a.i.5. **Special Topics Part, III: The Shared Public Health Duties of the State, Local Jurisdictions, and Non-Governmental Organizations**

In this session, Jessica Nunez de Ybarra from CDPH, Kat De Burgh from HOAC, Connie Robison from PHI, and Alecia Sanchez from CMA provided information on their respective entities. Ron started with Jessica asking her to speak with focus on the dependence on federal funding for the operations of CDPH, and how the state relates to the local jurisdictions and a little bit about emergency powers. He asked if it is the Governor who has emergency powers in an epidemic or is it the state public health officer or both?

a. Jessica stated that anything that isn't described in federal law regarding health becomes the jurisdiction of the state. Our California Health and Safety Code has quite a bit in the area of state police powers that are given to the Governor, but he cannot practice medicine. That authority flows down to the state Public Health Officer. We're very fortunate that our state Public Health Officer is also the Director of our Department of Public Health, newly named Dr. Erica Pan who will be presenting to this group at our next meeting.

a.i. State police powers for the role of public health in the areas that Jeff just reviewed with us (the core functions of public health including assessment, policy development, and assurance) in this past COVID pandemic have been reconsidered by many jurisdictions because the thought that any entity has that kind of control over people, closing businesses, schools, dictating what the populace can and cannot do has really been difficult for people to overcome and feel good about. Jessica shared that from her work in public health 20 plus years, after 9/11 and the anthrax scare they would do different types of presentations, and it was fascinating to hear about the knowledge and science about the

effects of asking people to comply in a pandemic. She would read presentations that would say this could lead to unrest, civil frustration, fights, violence. And then we experienced it ourselves, so trying to earn back that trust, trying to be mindful of listening to communities, knowing that there are groups that will be disproportionately impacted and that those disparities are not only modern day, they are also historic in nature. Systemic influences and cultural norms make this very hard to of address in public health. When the federal government says to remove certain terms, that is tough for us in public health which is science based. She was reading through the list of all the federal terms that are no longer approved, like trauma-responsive leadership. Some of these are tools we use to be more holistic and comprehensive, so this is really a challenge for us.

a.ii. Regarding the point Ron mentioned about the federal funding that is at risk, Jessica noted that they do have a federal infrastructure grant coming to the department that is at risk. But that being said, the majority of the California Department of Public Health funding sources, e.g.,WIC, and all the different 200 plus programs have a federal element noting that it feels extreme adding that the universities are feeling it when research dollars are cut off too. Jessica noted we are fortunate in California to have a very large and powerful state infrastructure. If the federal funds are limited, we would have a degree of reserve and resilience in our people. Our people are our greatest asset. Jessica has faith but believes that it is going to be rocky, and agrees with the group that meeting together is important.

a.iii. Jessica concluded by noting that maybe historically the State Department of Public Health did not necessarily have a real understanding of how local jurisdictions spent various resources but today in 2025, any funding that flows from their department to local health jurisdictions has program oversight and they are very much in a bi-directional relationship with local health jurisdictions, and they give progress reports of how the funding is spent. There is no mystery and most are in extreme compliance and doing great work noting that we tend to really undervalue the role of the locals who also meet on a monthly basis. She stated that the local health officers have board of directors meeting where they share insights and information, adding that Kat De Burgh is going to speak more on that. Jessica concluded that she feels right now that we are unified in our efforts and know that the threats are real.

a.iv. Ron stated he was happy to be corrected (on departments understanding how funding is being spent) and asked if there is any chance that something like the old contract counties program could be revived within the next few years to help out these counties that only have a few thousand people all together and maybe three or four in the whole health department?

a.v. Jessica stated that they have attempted to create a regional public health office structure, a hub system, and there's mutual aid as well noting as we've heard from Michelle even the largest counties like LA, there's a lot of state support. They go where the need is in the state indicating that she does not know if that model is necessary at this point, and we do have other structures. Jessica than handed it off to give Kat an opportunity to add her update.

b. Next, Kat De Burgh, Executive Director of the Health Officers Association of California (HOAC), provided information on local health officers in California.

b.i. California law states that every city and every county in California must take action as necessary to protect public health and prevent the spread of communicable disease. These are not optional activities. They are required under California law noting if a county or a city fails to do that then the state can take action against them. Part of that duty is they must appoint a health officer. A county must appoint a physician health officer, and a city must either appoint a health officer or make arrangements to be served by the county's health officer.

b.ii. In California, we have three cities that have their own health officer and their own health department, Berkeley, Pasadena, and Long Beach. There is also the city of Vernon, but all they have is an environmental health department, not a full health department, so they are not considered a HOAC member.

b.iii. The local health officer has over 170 distinct duties in the law, things they have to do such as prevent the spread of tuberculosis, prevent the spread of STIs, etc., noting there are lot of things that they are required to do. Health officers must be a physician, so they're always extremely educated, they always want to do good in the world. They're taking a civil service job instead of a private sector job and because of who they are, they often don't want to just prevent communicable disease, they also want to promote public health in general.

b.iv. Health officers see themselves as the community's physician, so they are not only taking action to, for example, exclude food handlers who have a diarrheal illness from working or putting people in a quarantine or isolation. They're also doing things like making sure that the food deserts in their community have access to healthy food, and that communities have access to places to exercise. They see themselves as the chief bridging officer and the chief health strategist of their communities, always trying to bring people together to support public health.

b.v. This is what the health officers do. Right now, they're facing a lot of uncertainty with funding, just like everybody else. We do not know what the future holds but do know that the state cannot backfill every federal dollar, and we know that counties cannot backfill every state dollar and are just waiting and seeing like everybody else.

b.vi. Ron asked how do officers, many part-time in smaller jurisdictions and also not the directors of their departments, actually manage to implement all the powers that are theirs without having line authority?

b.vi.1. Kat responded that they are about to do a survey of members to see who has line authority over what and how many hours per week these part-timers are.

b.vi.2. The state requires that every county with a population of over 25,000 have a full-time health officer. If you're under 25,000, you need to get approval from the state to have a part-time health officer. She noted that this doesn't always happen in practice, but that's what state law says.

b.vii. The law also assumes that the local health officer is the director of the local health department. However, because it was written in 1948 and since then a lot of things have changed, it is often somebody else, somebody more specialized in administration who is

the head of the department. Since 1996, Title 3 of the Government code of Regulations has contained a specific section #33202 that says: *"If the county health department or the administration of county health functions are not under the direction of the health officer, the county board of supervisors shall ensure that the health officer has sufficient authority and resources and the organizational structure does not impede the health officer from carrying out the duties required..."* (Posted in the Chat.)

c. Connie Chan Robison from Public Health Institute spoke next. Ron stated that PHI is an amazing operation, and that he thinks most of us do not realize how much it does, asking also how dependent is it on federal grants? Connie responded that we are living in very sobering times, as many folks have already expressed but she prides herself on being a very hopeful person and likes to think aspirationally.

c.i. PHI celebrated its 60th year anniversary last year, with its inception and founding in 1964. She has been with the organization for a little over half of that, she is very proud to say, noting that at this point, none of us are immune from what may be happening in the world. As Dr. Rudolph earlier mentioned, unfortunately, the growth and the evolution of our global health work has been significantly impacted in literally the last six weeks. That's been very sobering knowing amongst her colleagues how hard-fought those wins were in terms of the relationships built over the many years with many, many jurisdictions and health ministries across the world that the PHI has been very privileged to be able to partner with.

c.ii. In addition to the global health work, PHI has had a focus on immigrant rights. Immigrant health is one of those areas that all of us are very concerned about. As Jessica earlier mentioned, we have the most vulnerable populations right in our communities, that we have to pay a special attention to them.

c.iii. In her own work in Sacramento and with the Center for Collaborative Planning, she is involved in local and statewide work around behavioral/mental health, substance use prevention, and harm reduction. They continue to respond to requests for proposals that are coming out from SAMHSA and, also within the state. Connie added that fentanyl, opioid use, overdose, et cetera is a niche that we can happily say has yet to be touched and she is hopeful in that regard.

c.iv. The Public Health Institute does continue to have a strong presence in terms of some of its core functions and the ways that it delivers public health services. This is on three levels:

c.iv.1. One is around serving as a thought partner, even in the midst of this chaos. Ron interjected and asked what are the major sources of non-federal funding?

c.iv.1.a. Connie noted that they do a lot of partnerships, certainly with the private foundations and some limited corporations. Business development is a part of their portfolio adding it needs to continue to grow and grow more robust.

c.iv.1.b. In terms of foundational support and philanthropy, that's an area that they are seen as a trusted partner and are often called upon to partner with them to implement certain programs that they have an idea around, particularly when it, for instance, comes to the opioid overdose body of work that came from the California Healthcare

Foundation's research. They took that research and partnered with them to bring forward the California Opioid Prevention Network, as well as the National Opioid Overdose Prevention Network. Ron added that the late mark Horton, who chaired this forum for most of its existence, worked closely with that network and with Public Health Institute.

d. Next, Ron asked Alicia Sanchez to discuss CMA has been involved with public health without federal funds. He also inquired if they have any bills that CMA is sponsoring that impacts on public health?

d.i. CMA is a membership organization, so they are not relying on federal funds. They have a Council on Science and Public Health, which develops organizational policy around public health and public health is a part of CMA's mission and they have been involved in many public health efforts over the years.

d.ii. Members participate through policy development to establish what policy we would have around these issues and then that helps to develop advocacy strategy. She noted that many people are most familiar with work at the state level in terms of legislative advocacy, but they also do federal advocacy and engage in the courts from time to time. They use policy in all of those venues.

d.iii. Alicia highlighted over the past few years they have been involved in responses to addressing the gun violence epidemic, tobacco control policy and legislation as well as prevention and addressing overdose deaths, like injury prevention. They supported some legislation last year on e-bike safety. They have also supported vaccine use, encouraging and supporting administration of vaccines, including leading the effort to remove the non-medical exemptions for school vaccination. She noted they engage across many different issues and also do some education,

d.iv. They continue to do the Grand Rounds that they started during the COVID pandemic in partnership with CDPH, which really focuses on public health topics, and it has been something that they are seeing quite a strong and remaining a strong interest in. Professionals who participate in the live grand rounds can receive continuing medical education for that. They also have online CME on gun violence.

d.v. With respect to legislation for this year Alicia mentioned explained an area they are not sponsoring but are actively involved noting California is one of only three states for which medical doctors do not currently have a physician wellness program. This is a program that physicians who maybe have some substance use disorder or substance use that could result in impairment or mental health conditions can access support. Other states allow for the physician to be referred by the medical board in lieu of discipline. California had a program in the early 2000's but it was eliminated. There is a new effort the medical board, which really incorporates a public health mindset as opposed to kind of the more punitive perspective that has been applied over the last almost 20 years now. CMA is really glad that the medical board has taken this under their effort and will be working to ensure that the best practices that the board has already established their support for, including confidentiality and this in lieu of discipline pathway remain in the bill.

d.vi. Ron asked what is the bill number and Alicia stated it is a spot bill right now, but it's AB 408 (Berman).

d.vi.1. She noted that there has been a lot of progress made in the realm of mental health, reducing stigma around seeking mental health support and in seeking care and treatment in substance use when there's issues around substance use in the general community, but physicians have not really had that in their licensing and in their practice. There continues to be a lot of stigma and we know there are high rates of burnout. We know there is a high rate of suicide in the physician community and they are hopeful that this will be one mechanism to address that.

a.vi.i.a.i.6. **Legislative update:**

a. Ron reported that CAPM which is actually sponsoring this forum, the California Academy of Preventive Medicine, is supporting SB 504 (Laird) along with the Beyond AIDS Foundation. SB 504 would protect providers, including physicians from liability for collaborating with public health on HIV care, noting that currently there are many penalties, civil and criminal, for disclosing any HIV information, and that providers have been reluctant, except at the moment of case reporting, to get back in touch with public health about referrals to services, including contact tracing if the patient hasn't yet reached undetectable levels and may have additional partners. Public health can do such partner services. If the patient is uninsured, the health department may know how to get them Ryan White coverage, including ADAP to cover the HIV expensive drugs, and so forth. This is a bill he thinks is important so patients can be helped through the HIV Care Continuum. If they drop out of care, public health staff can link them to a new source of care, and so forth. He is hoping that at the Council on Legislation of CMA on March 21st, this will be a consent calendar issue because CMA support is needed.

b. Kat said that HOAC is backing AB 309. This bill eliminates the sunset date on the law that allows pharmacists to furnish syringes to adults without a prescription.

7. **Topics for Next Meeting:** The next meeting will be on June 17 and will include Erica Pan and possibly Melissa from the Public Health Institute. If anyone has other ideas they can list in the chat or email him.

8. **Ron concluded the meeting at 9:32.**

Minutes submitted by Traci Stevenson, Secretary, with minor editing by Ron Hattis
Approved at meeting of June 17, 2025