HEALTH AND SAFETY CODE - HSC

DIVISION 112. PUBLIC HEALTH [131000 - 131410] *(Division 112 added by Stats. 2006, Ch. 241, Sec. 34.)*

PART 1. GENERAL PROVISIONS [131000 - 131410] *(Part 1 added by Stats. 2006, Ch. 241, Sec. 34.)*

CHAPTER 1. Organization of the State Department of Public Health [131000 - 131021] *(Chapter 1 added by Stats. 2006, Ch. 241, Sec. 34.)*

131000. There is in the California Health and Human Services Agency a State Department of Public Health.

(Added by Stats. 2006, Ch. 241, Sec. 34. Effective January 1, 2007. Operative July 1, 2007, by Sec. 37 of Ch. 241.)

131005. (a) There is in state government an executive officer known as the State Public Health Officer, who shall be appointed by the Governor, subject to confirmation by the Senate, and hold office at the pleasure of the Governor. The State Public Health Officer shall receive the annual salary provided by Article 1 (commencing with Section 11550) of Chapter 6 of Part 1 of Division 3 of Title 2 of the Government Code.

(b) The State Public Health Officer shall serve as the director of, and have control over, the State Department of Public Health.

(c) Any statutory reference to “director,” “the Director of Health Services,” “the Director of Public Health,” or the “Director of the State Department of Public Health,” regarding a function transferred to the State Department of Public Health pursuant to Chapter 2 (commencing with Section 131050), is deemed to, instead, refer to the State Public Health Officer.

(d) Any statutory reference to “department” or “state department” regarding a function transferred to the State Department of Public Health pursuant to Chapter 2 (commencing with Section 131050), shall refer to the State Department of Public Health.

(e) The director shall be a licensed physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has demonstrated medical, public health, and management experience.

(Added by Stats. 2006, Ch. 241, Sec. 34. Effective January 1, 2007. Operative July 1, 2007, by Sec. 37 of Ch. 241.)

131006. Upon recommendation of the director, the Governor may appoint, not to exceed, two chief deputies of the State Department of Public Health, subject to confirmation by the Senate, who shall hold office at the pleasure of the Governor. The salaries of the chief deputies shall be fixed in accordance with law.

(Amended by Stats. 2007, Ch. 483, Sec. 37.5. Effective January 1, 2008.)

131010. The director shall have the powers of a head of the department pursuant to Chapter 2 (commencing with Section 11150) of Part 1 of Division 3 of Title 2 of the Government Code.

(Added by Stats. 2006, Ch. 241, Sec. 34. Effective January 1, 2007. Operative July 1, 2007, by Sec. 37 of Ch. 241.)

131019. There is in the State Department of Public Health an Office of AIDS. The State Department of Public Health, Office of AIDS, shall be the lead agency within the state, responsible for coordinating state programs, services, and activities relating to the human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), and AIDS related conditions (ARC). Among its responsibilities, the State Department of Public Health, Office of AIDS, shall coordinate Sections 120875, Section 120880, Chapter 2 (commencing with Section 120800), Chapter 4 (commencing with Section 120900), Chapter 6 (commencing with Section 120950), Chapter 8 (commencing with Section 121025), Chapter 9 (commencing with Section 121050), Chapter 10 (commencing with Section 121075), Chapter 11 (commencing with Section 121150), Chapter 12 (commencing with Section 121200), Chapter 13 (commencing with Section 121250), and Chapter 14 (commencing with Section 121300), of Part 4 of Division 105. Any reference in those provisions to the State Department of Health Services or the State Department of Public Health shall be deemed to be a reference to the Office of AIDS within the State Department of Public Health.

(Added by renumbering Section 100119 by Stats. 2006, Ch. 241, Sec. 17. Effective January 1, 2007. Operative July 1, 2007, by Sec. 37 of Ch. 241.)

131019.5. (a) For purposes of this section, the following definitions shall apply:

(1) “Determinants of equity” means social, economic, geographic, political, and physical environmental conditions that lead to the creation of a fair and just society.

(2) “Health equity” means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

(3) “Health and mental health disparities” means differences in health and mental health status among distinct segments of the population, including differences that occur by gender, age, race or ethnicity, sexual orientation, gender identity, education or income, disability or functional impairment, or geographic location, or the combination of any of these factors.

(4) “Health and mental health inequities” means disparities in health or mental health, or the factors that shape health, that are systemic and avoidable and, therefore, considered unjust or unfair.

(5) “Vulnerable communities” include, but are not limited to, women, racial or ethnic groups, low-income individuals and families, individuals who are incarcerated and those who have been incarcerated, individuals with disabilities, individuals with mental health conditions, children, youth and young adults, seniors, immigrants and refugees, individuals who are limited-English proficient (LEP), and lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities, or combinations of these populations.

(6) “Vulnerable places” means places or communities with inequities in the social, economic, educational, or physical environment or environmental health and that have insufficient resources or capacity to protect and promote the health and well-being of their residents.

(b) The State Department of Public Health shall establish an Office of Health Equity for the purposes of aligning state resources, decisionmaking, and programs to accomplish all of the following:

(1) Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities.

(2) Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health.

(3) Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services.

(4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and inequities.

(c) The duties of the Office of Health Equity shall include all of the following:

(1) Conducting policy analysis and developing strategic policies and plans regarding specific issues affecting vulnerable communities and vulnerable places to increase positive health and mental health outcomes for vulnerable communities and decrease health and mental health disparities and inequities. The policies and plans shall also include strategies to address social and environmental inequities and improve health and mental health. The office shall assist other departments in their missions to increase access to services and supports and improve quality of care for vulnerable communities.

(2) Establishing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities. The strategies and recommendations developed shall take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan shall be developed in collaboration with the Health in All Policies Task Force. This plan shall establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. This plan shall be updated periodically, but not less than every two years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. This plan shall be included in the report required under paragraph (1) of subdivision (d). The Office of Health Equity shall seek input from the public on the plan through an inclusive public stakeholder process.

(3) Building upon and informing the work of the Health in All Policies Task Force in working with state agencies and departments to consider health in appropriate and relevant aspects of public policy development to ensure the implementation of goals and objectives that close the gap in health status. The Office of Health Equity shall work collaboratively with the Health in All Policies Task Force to assist state agencies and departments in developing policies, systems, programs, and environmental change strategies that have population health impacts in all of the following ways, within the resources made available:

(A) Develop intervention programs with targeted approaches to address health and mental health inequities and disparities.

(B) Prioritize building cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity.

(C) Work with the advisory committee established pursuant to subdivision (f) and through stakeholder meetings to provide a forum to identify and address the complexities of health and mental health inequities and disparities and the need for multiple, interrelated, and multisectoral strategies.

(D) Provide technical assistance to state and local agencies and departments with regard to building organizational capacity, staff training, and facilitating communication to facilitate strategies to reduce health and mental health disparities.

(E) Highlight and share evidence-based, evidence-informed, and community-based practices for reducing health and mental health disparities and inequities.

(F) Work with local public health departments, county mental health or behavioral health departments, local social services, and mental health agencies, and other local agencies that address key health determinants, including, but not limited to, housing, transportation, planning, education, parks, and economic development. The Office of Health Equity shall seek to link local efforts with statewide efforts.

(4) Consult with community-based organizations and local governmental agencies to ensure that community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

(5) Assist in coordinating projects funded by the state that pertain to increasing the health and mental health status of vulnerable communities.

(6) Provide consultation and technical assistance to state departments and other state and local agencies charged with providing or purchasing state-funded health and mental health care, in their respective missions to identify, analyze, and report disparities and to identify strategies to address health and mental health disparities.

(7) Provide information and assistance to state and local departments in coordinating projects within and across state departments that improve the effectiveness of public health and mental health services to vulnerable communities and that address community environments to promote health. This information shall identify unnecessary duplication of services.

(8) Communicate and disseminate information within the department and with other state departments to assist in developing strategies to improve the health and mental health status of persons in vulnerable communities and to share strategies that address the social and environmental determinants of health.

(9) Provide consultation and assistance to public and private entities that are attempting to create innovative responses to improve the health and mental health status of vulnerable communities.

(10) Seek additional resources, including in-kind assistance, federal funding, and foundation support.

(d) In identifying and developing recommendations for strategic plans, the Office of Health Equity shall, at a minimum, do all of the following:

(1) Conduct demographic analyses on health and mental health disparities and inequities. The report shall include, to the extent feasible, an analysis of the underlying conditions that contribute to health and well-being. The first report shall be due July 1, 2014. This information shall be updated periodically, but not less than every two years, and made available through public dissemination, including posting on the department's Internet Web site. The report shall be developed using primary and secondary sources of demographic information available to the office, including the work and data collected by the Health in All Policies Task Force. Primary sources of demographic information shall be collected contingent on the receipt of state, federal, or private funds for this purpose.

(2) Based on the availability of data, including valid data made available from secondary sources, the report described in paragraph (1) shall address the following key factors as they relate to health and mental health disparities and inequities:

(A) Income security such as living wage, earned income tax credit, and paid leave.

(B) Food security and nutrition such as food stamp eligibility and enrollment, assessments of food access, and rates of access to unhealthy food and beverages.

(C) Child development, education, and literacy rates, including opportunities for early childhood development and parenting support, rates of graduation compared to dropout rates, college attainment, and adult literacy.

(D) Housing, including access to affordable, safe, and healthy housing, housing near parks and with access to healthy foods, and housing that incorporates universal design and visitability features.

(E) Environmental quality, including exposure to toxins in the air, water, and soil.

(F) Accessible built environments that promote health and safety, including mixed-used land, active transportation such as improved pedestrian, bicycle, and automobile safety, parks and green space, and healthy school siting.

(G) Health care, including accessible disease management programs, access to affordable, quality health and behavioral health care, assessment of the health care workforce, and workforce diversity.

(H) Prevention efforts, including community-based education and availability of preventive services.

(I) Assessing ongoing discrimination and minority stressors against individuals and groups in vulnerable communities based upon race, gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation, disability, and other factors, such as discrimination that is based upon bias and negative attitudes of health professionals and providers.

(J) Neighborhood safety and collective efficacy, including rates of violence, increases or decreases in community cohesion, and collaborative efforts to improve the health and well-being of the community.

(K) The efforts of the Health in All Policies Task Force, including monitoring and identifying efforts to include health and equity in all sectors.

(L) Culturally appropriate and competent services and training in all sectors, including training to eliminate bias, discrimination, and mistreatment of persons in vulnerable communities.

(M) Linguistically appropriate and competent services and training in all sectors, including the availability of information in alternative formats such as large font, braille, and American Sign Language.

(N) Accessible, affordable, and appropriate mental health services.

(3) Consult regularly with representatives of vulnerable communities, including diverse racial, ethnic, cultural, and LGBTQQ communities, women's health advocates, mental health advocates, health and mental health providers, community-based organizations and advocates, academic institutions, local public health departments, local government entities, and low-income and vulnerable consumers.

(4) Consult regularly with the advisory committee established by subdivision (f) for input and updates on the policy recommendations, strategic plans, and status of cross-sectoral work.

(e) The Office of Health Equity shall be organized as follows:

(1) A Deputy Director shall be appointed by the Governor or the State Public Health Officer, and is subject to confirmation by the Senate. The salary for the Deputy Director shall be fixed in accordance with state law.

(2) The Deputy Director of the Office of Health Equity shall report to the State Public Health Officer and shall work closely with the Director of Health Care Services to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities.

(f) The Office of Health Equity shall establish an advisory committee to advance the goals of the office and to actively participate in decisionmaking. The advisory committee shall be composed of representatives from applicable state agencies and departments, local health departments, community-based organizations working to advance health and mental health equity, vulnerable communities, and stakeholder communities that represent the diverse demographics of the state. The chair of the advisory committee shall be a representative from a nonstate entity. The advisory committee shall be established by no later than October 1, 2013, and shall meet, at a minimum, on a quarterly basis. Subcommittees of this advisory committee may be formed as determined by the chair.

(g) An interagency agreement shall be established between the State Department of Public Health and the State Department of Health Care Services to outline the process by which the departments will jointly work to advance the mission of the Office of Health Equity, including responsibilities, scope of work, and necessary resources.

(Added by Stats. 2012, Ch. 23, Sec. 43. (AB 1467) Effective June 27, 2012.)

131020. All officers or employees of the department employed after July 1, 2007, shall be appointed by the director.

(Added by Stats. 2006, Ch. 241, Sec. 34. Effective January 1, 2007. Operative July 1, 2007, by Sec. 37 of Ch. 241.)

131021. (a) The Legislature finds that having access to a statewide stockpile of personal protective equipment in the event of a pandemic, wildfire smoke event, or other health emergency is vital to the health and safety of its health care and essential workers, as well as the general population, which both relies on this workforce and is susceptible to disease transmission should members of this workforce needlessly be infected with transmissible disease.

(b) The following definitions apply for purposes of this section:

(1) “Department” means the State Department of Public Health.

(2) “Office” means the Office of Emergency Services.

(3) “Agricultural worker” means a person employed in any of the following:

(A) An agricultural occupation, as defined in Wage Order No. 14 of the Industrial Welfare Commission.

(B) An industry preparing agricultural products for the market, on the farm, as defined in Wage Order No. 13 of the Industrial Welfare Commission.

(C) An industry handling products after harvest, as defined in Wage Order No. 8 of the Industrial Welfare Commission.

(4) “Essential workers” means primary and secondary school workers, workers at detention facilities, as defined in Section 9500 of the Penal Code, in-home support providers, childcare providers, government workers whose work with the public continues throughout the crisis, and workers in other positions that the State Public Health Officer or the Director of the Office of Emergency Services deems vital to public health and safety, as well as economic and national security, including, but not limited to, agricultural workers.

(5) “Health care worker” means any worker who provides direct patient care and services directly supporting patient care, including, but not limited, to physicians, pharmacists, clinicians, nurses, aides, technicians, janitorial and housekeeping staff, food services workers, and nonmanagerial administrative staff.

(6) “Personal protective equipment” or “PPE” means protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, including, but not limited to, N95 and other filtering facepiece respirators, elastomeric air-purifying respirators with appropriate particulate filters or cartridges, powered air purifying respirators, disinfecting and sterilizing devices and supplies, medical gowns and apparel, face masks, surgical masks, face shields, gloves, shoe coverings, and the equipment identified by or otherwise necessary to comply with Section 5199 of Title 8 of the California Code of Regulations.

(7) “Provider” means a licensed clinic, as described in Chapter 1 (commencing with Section 1200), an outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of, a health facility as described in Chapter 2 (commencing with Section 1250) of, or a county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of, Division 2, a home health agency, a physician’s office, a professional medical corporation, a medical partnership, a medical foundation, a rural health clinic, as defined in Section 1395x(aa)(2) of Title 42 of the United States Code, or a federally qualified health center, as defined in Section 1395x(aa)(4) of Title 42 of the United States Code, and any other entity that provides medical services in California.

(8) “Stockpile” means the personal protective equipment stockpile created pursuant to subdivision (c).

(c) Within one year of the effective date of this section, the department and office, in coordination with other state agencies, shall establish a PPE stockpile, upon appropriation and as necessary.

(d) The department shall also establish guidelines for procurement, management, and distribution of PPE from the department. The department and office shall consider the recommendations of the Personal Protective Equipment Advisory Committee created pursuant to subdivision (f) in developing these guidelines. At a minimum, the guidelines shall take into account all of the following:

(1) The various types of PPE that may be required during a pandemic or other health emergency, including, but not limited to, wildfire smoke events.

(2) The shelf life of each type of PPE that may be obtained from the department and how to restock a portion of each type of PPE to ensure the procurements consist of unexpired PPE.

(3) The amount of each type of PPE that would be required for all health care workers and essential workers in the state during a 90-day pandemic or other health emergency, including, but not limited to, wildfire smoke events.

(4) Lessons learned from previous pandemics and state emergencies, including, but not limited to, supply procurement, management, and distribution.

(5) Guidance on how to define essential workers based upon different hazards.

(6) Geographical distribution of PPE storage.

(7) Guidance on how to establish policies and standards for PPE surge capacity to ensure that workers have access to an adequate supply of PPE during a pandemic or other health emergency, including, but not limited to, wildfire smoke events.

(8) The policies and funding that would be required for the state to establish a PPE stockpile.

(9) How distribution from any procurement shall be prioritized in the event that there is insufficient PPE to meet the needs of providers or employers of essential workers, including consideration of the following:

(A) The provider or employer is in a location with a high share of low-income residents.

(B) The provider or employer is in a medically underserved area, as designated by the United States Department of Health and Human Services, Health Resources and Services Administration.

(C) The provider or employer disproportionately serves a medically underserved population, as designated by the United States Department of Health and Human Services, Health Resources and Services Administration.

(D) The provider or employer is in a county with a high infection rate or high hospitalization rate related to the declared emergency.

(e) The development of the guidelines shall be informed by the recommendations of the Personal Protective Equipment Advisory Committee pursuant to subdivision (f). The guidelines shall not establish policies or standards that are less protective or prescriptive than any federal, state, or local law on PPE standards.

(f) The Personal Protective Equipment Advisory Committee is hereby established. The advisory committee shall consist of the following:

(1) One representative of an association representing multiple types of hospitals and health systems.

(2) One representative of an association representing skilled nursing facilities.

(3) One representative of an association representing primary care clinics.

(4) One representative of a statewide association representing physicians.

(5) Two representatives of labor organizations that represent health care workers.

(6) Two representatives of labor organizations that represent nonagricultural essential workers, as defined by paragraph (4) of subdivision (b).

(7) One representative of a labor organization that represents agricultural workers, as defined by paragraph (3) of subdivision (b).

(8) One representative of an organization that represents agricultural employers.

(9) One representative from the personal protective equipment manufacturing industry.

(10) One consumer representative.

(11) One representative from an association representing counties.

(12) One representative from the State Department of Public Health.

(13) One representative from the Office of Emergency Services.

(14) One representative from the Emergency Medical Services Authority.

(15) One representative from the State Department of Social Services.

(g) The Director of the Office of Emergency Services or their designee shall appoint the representatives from paragraphs (1) through (11), inclusive, of subdivision (f).

(h) The Personal Protective Equipment Advisory Committee shall make recommendations to the office and department necessary to develop the guidelines required pursuant to subdivision (d).

(i) Nothing in this section alters an employer's duty to provide respirators as required by Section 5141.1 of Title 8 of the California Code of Regulations.

(j) The department shall report to the Legislature, within six months of the effective date of the amendments to this section made by the act adding this subdivision, with regard to the amount of PPE in the stockpile, the amount of PPE from the stockpile that has been used, and the amount of anticipated future usage. The report shall be made pursuant to Section 9795 of the Government Code.

(Amended by Stats. 2021, Ch. 322, Sec. 1. (AB 73) Effective September 27, 2021.)