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May 28, 2014

CalEnviroScreen
c/o John Faust Chief, Community Assessment & Research Section
Office of Environmental Health Hazard Assessment
1515 Clay Street, Suite 1600
Oakland, CA 94612

Dear Dr. Faust:

We would like to commend the Office of Environmental Health Hazard Assessment (OEHHA) for leading efforts to protect and enhance public health and the environment throughout the state. The latest release of CalEnviroScreen (CES) Version 2.0 demonstrates OEHHA's responsiveness to public input and its ongoing commitment to refine and improve this tool.

Our organization, the Public Health Alliance of Southern California (Alliance), is a collaboration local health departments whose members are statutorily responsible for the public health of over 50% of the state's population. Our vision is that all Southern California communities are healthy, vibrant and sustainable places to live, work, and play. The Alliance advances multi-sector policy, systems and environmental change to enhance and support chronic disease prevention. Chronic long-term diseases include cardiovascular disease, diabetes, respiratory disease and cancers, and account for 80% of all deaths, as well as 80% of healthcare costs in California.

The Alliance has been following the implementation of Senate Bill 535 (SB 535) with great interest. This statute provides a 25% set-aside of the Cap and Trade Revenues for projects to support "disadvantaged communities." SB 535 statute language defines the identification of these communities as follows:

*Sec.2. Section 39711 is added to the Health and Safety Code, to read:
These communities shall be identified based on geographic, socioeconomic, public health, and environmental hazard criteria, and may include, but are not limited to, either of the following: (a) Areas disproportionately affected by environmental pollution and other hazards that can lead to negative public health effects, exposure, or environmental degradation; (b) Areas with concentrations of people that are of low income, high unemployment, low levels of homeownership, high rent burden, sensitive populations, or low levels of educational attainment.*

As public health professionals, we are pleased that public health is specifically mentioned as a consideration when identifying disadvantaged communities. Further, the statute provides for the identification of communities based on the underlying root causes of poor health, as stated in Sec. 2, part b. These factors, which include, poverty, unemployment and low educational attainment are known in our field as part of the “Social Determinants of Health” (SDOH) and are strongly associated with poor health outcomes. The SDOH and chronic disease burden are important factors in identifying public health disadvantaged communities.

CES is increasingly being used in various fund allocation processes to define “disadvantaged communities.” Although CES was not designed for this purpose, it is currently being used as the only tool to define disadvantage for SB 535. Given that, it would be valuable for local health departments and the public to understand how this decision was reached, and to provide an opportunity for public discussion and input.

We commend OEHHA for their recent enhancements of the tool in an effort to better serve applications it was not initially intended for. CES 2.0 includes substantial refinements in geographic scale, which enables a more precise spatial characterization of disadvantage and further demonstrates OEHHA’s commitment to continually improving the tool. It is in the interest of supporting this ongoing improvement, that we share the following concerns regarding the functioning of CES 2.0, particularly in defining “disadvantaged communities.”

The Alliance convenes a Data Committee that is comprised primarily of Epidemiologists and Analysts from member Public Health Departments. This committee has performed an analysis of the overlap between census tract CES 2.0 scores and poverty rates. Poverty rates were chosen as a referent value because poverty is a broadly understood and valued measure of socioeconomic vulnerability, a fundamental driver of public health, and is already included within the CES population characteristic domain. Our preliminary results found less than 50% of census tracts qualifying for “disadvantaged community” set-asides (upper decile) based on CES 2.0, were among the most impoverished. Additionally, over 1 in 4 of these CES 2.0 defined “disadvantaged communities” were not even in the highest 20% for poverty rate, suggesting deficiencies in how the tool is being used to identify socioeconomic vulnerability and, hence, public health disadvantage. The results of the analysis raise concern that the use of CES 2.0 as currently configured could result in insufficient delivery of considerable funds to the communities that most need them and, alternatively, distribution of significant funds to communities that may not have the greatest need. Our analysis suggests that the current weighting of variables, such as SDOH, under-represents factors strongly associated with public health disadvantage. In addition, some factors that would identify vulnerable and sensitive populations, such as pre-existing chronic diseases are absent. We suggest further refinement of the tool to address these concerns.

The Public Health Alliance of Southern California values the intended function of CalEnviroScreen in facilitating environmental justice, health equity, and data driven resource allocation, and greatly appreciates the opportunity to provide feedback on version 2.0. We are pleased that OEHHA recognizes the importance of public health and look forward to future collaboration to ensure that the identification of “disadvantaged communities” includes a public health perspective.

Thank you,



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cc: Mike McCoy, Executive Director, Strategic Growth Council