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February 17, 2015

TO: Christina Ghaly, M.D.  
Director of Health Care Integration, Chief Executive Office

FROM: Cynthia Harding, M.P.H.   
Interim Director, Public Health

SUBJECT: **PUBLIC HEALTH IN THE PROPOSED LOS ANGELES COUNTY HEALTH AGENCY**

This is in response to your memo dated January 21, 2015 which asked each department to compile thematic stakeholder input on the shift to a health agency model in Los Angeles County (LAC). The Department of Public Health (DPH) gathered stakeholder input during previously scheduled group meetings with external partners. In addition, many of our Executive Staff members received calls directly from stakeholders regularly engaged in public health activities relevant to their divisions and programs. During a recent DPH Program Directors Meeting, Senior Managers were asked to provide their feedback on the shift through a SWOT analysis exercise.

The aim of this memo is to summarize the many ideas, thoughts and opinions Public Health stakeholders have shared since the Board of Supervisors (Board) meeting on January 13, 2015. Major themes from external and internal stakeholders are outlined here in brief and further described below.

- **The importance of better integrating clinical resources for County patients is highly valued, yet improved integration does not necessarily require a new agency structure.** Alternate options such as creating Department Head accountability for collaboration on discrete issues, revisions to interdepartmental memorandum of understanding with new referral protocols between departments, or service co-location mandates may achieve the desired goal of improving integrated services without the significant investment required to fully implement the proposed Health Agency structure. DPH's involvement in a number of interdepartmental and other collaborative relationships has shown the key elements needed for successful collaboration and service integration: Board support; departmental will; leveraged funding and other resources; clearly defined goals; and mutual benefits—all of which may be accomplished outside of an agency structure.

- **Past combined organizational structures for health in LAC have been demonstrably detrimental to Public Health and resulted in sub-optimal programs to maintain and improve the health of all residents.** The lessons learned from those experiences should be heeded and similar structures avoided.
- **DPH has been extremely effective as a stand-alone department with the autonomy to focus and fulfill its mission since its separation from DHS.** Its mission is to protect and improve the health of every one of the County's 10 million residents. This has, in large part, been a result of its ability to direct fiscal resources to address disease burden in our communities, to recruit and retain a specialized and expert public health workforce, to publicize healthy lifestyle and health protection messages and address the many underlying determinants of health outside the clinical care system for populations at all stages of life.
- **The proposed restructuring could erode the reputation of LAC DPH as a national leader in public health protection and health promotion.** Of particular note is DPH leadership in preparedness for epidemics and other catastrophes that affect health, as well as prevention of chronic diseases. Moving DPH under another agency will make it more difficult to recruit a national leader as its Director and will likely lead to a diminished Department reputation, one consequence of which could be reduced revenue from competitive grants.
- **The missions of Department of Health Services (DHS), Department of Mental Health (DMH), and DPH are different.** Organizations that try to fulfill multiple distinct missions almost always wind up neglecting one or more. The relative size of DPH compared to DHS and DMH, coupled with the historic inability of Public Health to function optimally and effectively safeguard the public's overall health when positioned under DHS, strongly argues for consideration of other structures or solutions to enhance service delivery.
- **If the Board decides to proceed with an agency model, it would be important not to consolidate administrative functions such as human resources, finance, and contracting.** Past experience is clear that such structures will disadvantage Public Health, because history has demonstrated that individual patient care and hospital needs always trump the broader public health needs.

Based on the following historical experiences, stakeholder concerns and other feedback, and DPH's extensive background in establishing effective and collaborative partnerships, two distinct sets of recommendations are included for your consideration. The first set of three recommendations is focused on key clarifications and system and cost analysis to be done prior to the Board's final determination on how they would like to proceed. The second set of eleven recommendations is offered in the event the Board decides to proceed with implementing the health agency model. Those recommendations aim to establish metrics for success, propose guidelines for implementation, design of the structure and leadership roles, and suggest considerations for operationalization.

### **History and Background**

Stakeholders expressed a strong view that the planning process for the agency model must take into consideration the historical experiences of Public Health in LAC. In 1972, Public Health, which for many decades was a stand-alone department, was merged into the same department as Personal Health Services. During the 1980s and 1990s, public health resources and capacity was significantly eroded and disease rates in the County rose. During this same timeframe, the per capita investments of County resources in public health declined.

In 1997, the Los Angeles County Director of Health Services (DHS), Mark Finucane, outlined in a memo to the Board a number of adverse effects on public health programming and services under the Health Services agency. He cited a significant decline in local appropriations for public health relative to personal health, severe loss of capacity to perform basic public health functions (e.g. disease surveillance and prevention, community health activities), neglected prevention and control of chronic disease, and lack of any system-wide public health planning and quality assurance of health care services.

In 1998, the Board approved Mr. Finucane's proposal to reinvigorate public health, allocated an infusion of funding toward public health activities and Dr. Jonathan Fielding was appointed as Director and Health Officer. The vision of a newly invigorated public health infrastructure was achieved following a Board-approved \$15 million dollar increase in investment over three years and the creation of 241 new positions dedicated specifically to public health functions.

This restructure allowed community-specific leadership through eight Area Health Offices which increased accountability and responsiveness to the public; created a Public Health Communications Office to centrally coordinate external and internal communications; enhanced partnerships with private healthcare providers, managed care organizations and community-based organizations to facilitate broader public education and engagement; and developed important systems to collect health data and track performance measures in order to evaluate efficacy.

Yet, the challenges of Public Health being organizationally placed in a department focused on hospital delivered direct patient care persisted. For example, budget cuts made in 2001 to address fiscal challenges in acute and ambulatory care negatively affected public health fiscally and administratively. At that time, the administration division of Public Health was removed and administrative services were centralized within DHS leading to delays in routine and deferred maintenance of the health clinics, lags in employee recruitment and hiring, lengthy timeframes for contract executions, and weak space planning for Public Health. The Chronic Disease Division was eliminated along with four of the Area Health Officer positions, crippling DPH's ability to address chronic disease and population health improvement.

In 2006, the Board formally separated the Department of Public Health (DPH) from DHS under a motion from Supervisor Knabe which stated that the action would allow each department to focus on their different missions. Since the separation, DPH has objectively improved its efficiency and effectiveness and contributed to improved health outcomes in LAC. Independence has allowed DPH to advocate for and allocate its own administrative and fiscal resources to prioritize disease prevention and control efforts, develop effective partnerships for community health initiatives and evolve into a more prepared and responsive workforce when public health emergencies arise. Prior to his retirement, Dr. Jonathan Fielding issued a memo to the Board enumerating the many public health accomplishments achieved by DPH as an independent agency. It can be accessed at [http://file.lacounty.gov/bc/q3\\_2014/cms1\\_217633.pdf](http://file.lacounty.gov/bc/q3_2014/cms1_217633.pdf).

### **Opportunities and Potential Benefits**

Opportunities to improve patient service delivery and fiscal efficiencies by consolidating the three health departments under an agency structure are promising, yet largely aspirational. Most agree that the departments can better collaborate and that integration of some services is important for meeting the needs of patients and residents alike. Below are the potential beneficial outcomes raised by stakeholders should the Board elect to move the stand-alone departments under a single integrated health agency:

- ***Service Integration and Improved Departmental Coordination***

Stakeholders anticipate a combined health agency may increase service integration and improve coordination among DHS, DPH and DMH, leading to better clinical resource allocation and investment by reducing redundancies, increasing efficiency, and quickly identifying service gaps. It is also expected that more interdepartmental interaction will occur, facilitating stronger partnerships and better collaboration among the departments to maximize synergistic opportunities that will improve patient service delivery. An example frequently cited as having great potential for shared benefit, and as a key area for integration, is the creation of an integrated electronic health record (EHR) system that allows data sharing and improved surveillance of reportable diseases. More exploration to clarify its feasibility is still needed, and conversations by the IT-Data Analytics Consolidation Workgroup have already begun. Operationally, a health agency would have an opportunity to establish a unified vision and workforce practices towards the patient care mission; consistent policies and workforce expectations may enhance best practices for quality client care and cultural/linguistic competence. Consistent messaging may also strengthen advocacy efforts with Federal and State entities.

- ***Continuity of Client Care***

With service integration and improved care coordination, some stakeholders assume there will be better continuity of care and improved health outcomes for patients. Stakeholders believe integration could expand service provider referral networks and increase efficiency of referral linkages, thereby ensuring that clients quickly receive necessary and appropriate services. An integrated service system that spans population, personal, and behavioral health will generate a public expectation of a “one-stop-shop” designed to better provide seamless client care at more venues with access to a broader spectrum of preventive and clinical services.

- ***Fiscal Opportunities***

The Board has reassured the workforce that the proposed agency structure will not initiate employee layoffs. Expected cost-savings to the County could potentially come from reduced cost due to improved care coordination and service integration, particularly for high-use consumers of care. Stakeholders believe that the consolidation may expand opportunities to increase revenue and/or to leverage existing funding streams to support integrated patient service delivery and aligned priorities.

- ***Infusion of Public Health Practice***

If consolidated into an agency model, DPH will have an opportunity to infuse public health expertise and lend credibility to the agency’s broad scope of work. DPH would bring to the agency a public health lens in policy considerations, a commitment to evidence-based practice, a focus on environmental and social determinants of health, a vision for addressing health inequities, and a myriad of projects, partnerships and direct patient services aimed at decreasing incidences of infectious and chronic diseases that contribute to high rates of morbidity and mortality. DPH is also unique in its extensive contracting experience with a range of sectors to address disease burden across the County.

### **Concerns and Possible Disadvantages**

The health-related functions of the County have been administered in a range of configurations over the years. Recognizing and avoiding unintended consequences of previous arrangements is critical to designing the best path forward to improve service delivery. The County is already recognized as a leader in California and the nation for providing effective collaborative community health, physical health, behavioral health and substance use disorder services. If changing the current configuration, the County must recognize and protect exemplary practices already in place. A shift of this magnitude merits a thorough review with sufficient time to seriously deliberate, weigh all possible options, and avoid unintended consequences. In nearly all stakeholder meetings and conversations, people are troubled by the speed in which the Board is requiring reports and plans for implementation of the agency model. Below are specific concerns and possible disadvantages voiced by stakeholders should the Board elect to move the stand-alone departments under a single integrated health agency:

- ***Specificity of Problems Being Solved***

The most common concern raised by stakeholders has been a lack of clarity about the specific problems or issues the agency structure will solve. People have commented that the Board motion did not specify any services in particular need of integration, other than the assumption of the environmental toxicology bureau functions from the Agricultural Commissioner. Many expressed frustration about the unknown, or unnamed, problems and specific services that are allegedly underperforming due to lack of integration. Some also spoke about a lack of evidence supporting the expectation that the shift of the three departments under an umbrella agency will result in better integration, improved service delivery, or resource efficiencies (fiscal or personnel).

- ***Increased Bureaucracy/Reduced Efficiency***

Stakeholders voiced concerns about additional bureaucracy and the potential for reduced efficiency. Three departments under one agency with consolidated administrative processes will slow, as opposed to facilitate, the work of DPH. Past experience has shown that without designated administrative support services, Public Health responsiveness and capacity is diminished. In general, larger structures are challenged with responding nimbly to emergent issues and pushing urgent public messages as more layers of reviews and approvals are required. Additional bureaucracy may result in slower decision-making and delayed implementation of critical programs.

Should the agency be implemented, it would be comprised of approximately 30,000 employees – roughly one third of the County workforce. This would require significant administrative and managerial oversight by the Agency Director. Stakeholders suspect that without an additional cadre of support staff and an infusion of additional funding, the Department Directors will retain their span of responsibilities but with diminished autonomy to make key decisions quickly. The long term goal of achieving cost savings from efficiencies, while potentially beneficial, may create pressures to reduce administrative functions inequitably between the agency departments, resulting in potentially less efficient service delivery to the public. Externally, clients may have more difficulty navigating services due to the shift to a larger, more complex system. Some community partners expressed concerns about how they themselves would find the right point of contact to reach for their areas of need.

- ***Different Missions and Target Populations***

Each of the three departments has its own distinct mission, culture and target populations. The missions of DPH and DMH both aim to achieve health improvements at the community level. DPH strives to serve all of the nearly 10 million people in LAC to prevent infectious and chronic disease, protect the public from disease outbreaks and public health emergencies, and promote healthy lifestyles and community well-being. DPH primarily serves all people, not just patients. In contrast, DHS serves a much smaller, and more specific, population of approximately 700,000 patients needing safety net hospital and ambulatory care services. Stakeholders are concerned that the stated emphasis on improving patient-centered services will overshadow and curtail investment in important individual-, school-, worksite- and community-based interventions as demonstrably occurred when DPH was under DHS until 2006.

Stakeholders have also pointed out that DPH conducts many regulatory activities for the purpose of protecting the public's health, representing a distinctly different nature and scope of work than DHS or DMH. Some examples of these types of activities include: housing and restaurant inspections; consumer protection; environmental protection; assessment and mitigation of toxic threats; water quality monitoring; and health facility inspections. DPH is required to maintain funding streams dedicated to its regulatory responsibilities.

- ***Lack of Funding and Budgetary Autonomy***

Historical experiences have caused many stakeholders to raise concerns about how public health funding streams from Federal and State sources, and County investments in DPH, will be maintained over time. Previously, when incorporated under DHS, public health activities and fiscal allocations were vulnerable to the budgetary deficiencies of the hospitals. The specific language in the Board motion about achieving "budgetary savings by sharing capital or administrative expenses" through the creation of a health agency has raised stakeholders' apprehensions that past experiences will be repeated. The potential drawback of sharing capital between the three departments is that public health activities, services, and priorities are curtailed or lost due to diversion of funding.

The majority of DPH funding sources are categorical and rigid based on the parameters set forth by the funding entity or relevant legislation. A significant portion of DPH's existing funds cannot be diverted as they must be spent on specified purposes. If the DPH budget is not properly programmed, services will suffer, and any unused funds must be returned to the funding entity which impacts future award amounts and can result in the loss of opportunities for the County. Since 2006, DPH has maximized its budgetary autonomy by directing fiscal investments to bolster critical public health activities and services, often obtained through highly competitive grant awards. One example is DPH's Chronic Disease & Injury Prevention (CDIP) division, which was dismantled under DHS and re-established after the separation in 2006. CDIP has been awarded the greatest amount of chronic disease grant funding, in comparison to all other U.S. jurisdictions, due to its consistent delivery of innovative programming, policy guidance of state and national significance, and excellent stewardship of public funds.

Additionally, DPH has expanded its roles and responsibilities over the years as a public safety and emergency response agency. With competitive grant funds from the Centers for Disease Control & Prevention (CDC) and Measure B funding, DPH has developed a robust response capacity with on-staff expertise, real-time surveillance capabilities, a one-of-a-kind

partnership with the FBI for threat assessment, and a highly equipped Public Health Laboratory to rapidly identify and respond to biological, chemical and radiological acts of terrorism, as well as to natural threats such as SARS, Ebola, new influenza strains and resurgence of measles, whooping cough and other very communicable diseases.

- ***Operations and Administrative Consolidation Concerns***

Stakeholders have indicated that a transition to an agency model may shift focus away from important population health issues affecting all people in LAC, regardless of their primary point of health care, and place a premium value on the needs of patients only within the DHS system of care. Some stakeholders have asked for clarity on the level of autonomy DPH will have after the consolidation to elevate the hiring, contracting, and budgetary needs of public health and to have those needs met within the agency structure. Prior to 2006, lack of control over administrative functions and budget resulted in an inability to hire necessary public health experts and programmatic support staff, and maintain sufficient funding levels for population health priorities. This resulted in a dampened ability to consistently fulfill public health roles and responsibilities which were eclipsed by the immediate hospital and personal health issues dominating DHS' time and energy.

According to a letter issued from the Director of Public Health and Health Officer, Dr. Jonathan Fielding, to Supervisor Gloria Molina on February 22, 2006 the focus on personal health services in DHS resulted in delays in processing Public Health's requests for personnel acquisitions, supplies and equipment, and repairs and maintenance. For example, Dr. Fielding documented delays in the ordering and receipt of laboratory supplies and necessary reagents, which compromised the laboratory's ability to culture and identify pathogens in time for public health interventions in the field. He also cited significant delays of up to 12 months in finalizing contract agreements required by Federal funds, resulting in prolonged delays in service provision to residents.

- ***Reduced Visibility and an Independent Voice for Population Health***

Stakeholders have raised questions about the future role of DPH under the agency structure. Due to the emergent nature of some DPH activities, stakeholders indicate that it is imperative for DPH to communicate directly with the Board, CEO and the public at large about emerging public health issues and threats. Currently, DPH sends more correspondence to the Board than any other County department, with the exception of the CEO. Since the separation, DPH has issued over 2,500 Board memos. In contrast, DHS and DMH issued far fewer, approximately 1,650 and 1,030 respectively, during the same time period.

Many also expressed concerns that DPH would be less visible in informing health promoting policies. DPH has partnered with cities and unincorporated areas across the County to build healthy communities. These successful efforts have improved the infrastructure of communities by creating bike lanes and safer walk to school routes, promoting smoke-free environments, supporting community gardens, and the use of EBT credit at local farmer's markets. These interventions have resulted in positive social cohesion, increased physical activity, and lower smoking rates. An agency model may diminish the focus of public health activities to address significant community health burdens and shift priorities away from community-level efforts that improve overall population health.

As a stand-alone department, DPH raised public awareness of the local Health Officer role. Some stakeholders have expressed concerns that the Health Officer's visibility and credibility may be reduced. Throughout his tenure, Dr. Fielding was highly visible to the public on emergent issues that required public reassurance and accurate information. Some examples include SARS, H1N1, various food recalls, and local radiation monitoring after the tsunami's damage to the nuclear plant in Fukushima, Japan. Dr. Jeffrey Gunzenhauser, the Interim Health Officer, is now highly visible to the public on current public health concerns including measles, Ebola, and whooping cough. If the Health Officer is not given the appropriate stature in the Health Agency, it may diminish this important public health role.

- ***Reduced Weight of Public Health in Agency Prioritizations***

A potential drawback to shifting to an agency structure is that the priorities set for the three departments will largely depend on the goals and preferences of the Agency Director. Stakeholders often indicated having a perception that the structure and design of the agency is a "done deal" and that Dr. Mitchell Katz will be appointed to serve as the Agency Director and the DHS Director simultaneously. They are concerned that preferential prioritizations may occur if the DHS Director and Agency Director are one and the same. While many acknowledge that Dr. Katz has a well-suited professional background and broad expertise from his time in San Francisco overseeing a similar configuration, many caution that LAC is not San Francisco (e.g. scale and different political, geographic and demographic landscapes) and there is no guarantee that he will remain in this County for the remainder of his career. Stakeholders have concerns that a future Agency Director may not have the same comprehensive background or expressed value of public health within a larger agency with competing demands. Others have noted size differentials between the three departments, both in number of staff and annual budgets which will automatically place DPH at a disadvantage when arguing to have its work prioritized against the competing demands and fiscal investments of DHS and DMH.

- ***Competing Demands***

Stakeholders are concerned that shifting to an agency model may impact each department's ability to respond to the different demands and challenges each confronts in fulfilling their missions, roles and responsibilities. Current DPH priorities such as working on underlying social determinants of health (e.g. housing, social cohesion), addressing health disparities (e.g. Black Infant Health), ensuring public health protection from outbreaks and communicable disease emergencies (e.g. measles contact tracing, Ebola preparedness), and improving public health infrastructure (e.g. staff training on evidence-based practice and economic evaluations of public health interventions) do not align with the mission of DHS or DMH and could be vulnerable to competing priorities. Some examples of specific work that stakeholders are concerned may be impacted are health impact assessments, data reports on key health indicators and public health issues, community- and city-level work to implement tobacco prevention policies, and public education campaigns designed to spur healthier choices related to sexual health, community resiliency against disasters, portion control, tobacco use, and pet health. These services and campaigns do not directly intersect with the County's clinical patient care system.

- ***Importance of Substance Abuse Prevention & Control (SAPC)***

Many stakeholders connected to the substance abuse treatment and prevention work conducted by DPH and its contracted partners have expressed concerns that SAPC may be moved from DPH to DMH or DHS. In 2009, the CEO conducted an analysis of a proposal to shift SAPC into DMH. The conclusion of that analysis was that it was not appropriate to consolidate SAPC into DMH for the following reasons: there is a need to maintain a purposeful prevention focus in addition to the delivery of treatment services in LAC; the priority of substance use disorder (SUD) services would be diminished in a larger department tasked to address behavioral health issues; and SAPC interventions have historically been different from DMH interventions, requiring different staffing expertise, different types of contracts, and different community models.

Additionally, SUD providers and stakeholders are concerned that should SAPC be moved from DPH to DHS or DMH at this time, it would severely jeopardize the County's ability to participate in the 1115 Drug Medi-Cal (DMC) Waiver, which has the potential to significantly transform the delivery of SUD services in LAC. The DMC Waiver would allow LAC, for the first time, to develop an organized system of care to provide a full continuum of SUD services to County residents based on medical necessity. Any change in SAPC's reporting structure at this critical stage would be considerably disruptive and may negatively impact LAC's ability to meet the State requirements for participation in the DMC Waiver.

SUD services are already disadvantaged due to public and professional stigma, relative small size, disproportionately inadequate funding, and regulatory barriers. Stakeholders worry that consolidation will result in further minimizing the importance and visibility of SUD services within the overall County health care system. Stakeholders have raised concerns that the agency will preferentially direct SAPC services toward DHS patients. Currently, SUD services are provided directly by DPH and a robust network of contracted partners located in areas of greatest disease burden. It is important to note that approximately 20% of the current SAPC clients have also received Medi-Cal covered medical services, but not all of these have received those services in a DHS facility.

Stakeholders have expressed apprehensions that consolidation will result in the over-medicalization of SUD services. They are also concerned that changes could result in the closure of community-based programs that serve hard-to-reach populations with high levels of co-occurring health and mental health conditions, loss of employment for staff in these programs, and further underservice for these disenfranchised persons. For community-based programs able to operate despite these challenges, additional and more complicated policies, procedures, and contractual requirements will result in higher administrative costs and less resources for patient care, reducing positive program and patient outcomes.

Stakeholders acknowledge that there are people with co-occurring physical health, mental health and substance use disorders that may benefit from integrated service delivery, yet many, if not most, individuals with substance use disorders do not have mental health conditions that meet the eligibility criteria for the public mental health system, nor have a need for specialty physical health care. Such people still benefit from single focus SUD treatment and should have access to such services. This access may be threatened if all services are delivered only in integrated facilities, particularly for people facing stigma for their substance use problems.

- ***Minimal Shared Clinical Service Population***

Aside from SAPC treatment populations, stakeholders are concerned that presumptions are being made about the population seeking clinical public health services (e.g. immunizations, tuberculosis treatment, sexually transmitted disease screening and treatment) at the DPH Health Centers. Surveys of clients utilizing DPH clinics show that only about 20% have used DHS services. The majority of clients have non-DHS sources for care. It is important to note that DPH is already utilizing e-consult with DHS for patients without a medical home who require care for primary and other specialty care. Yet, for many of our clients, DPH also works directly with their community provider/medical home.

- ***Conflicts of Interest***

Stakeholders have flagged that an agency model may unnecessarily complicate, and possibly pose conflicts of interest, should the regulatory functions or priority partnerships of DPH overlap with the services provided by others within the same agency. For example, Health Officer Orders are a regulatory function under the Health & Safety Code. Occasionally the Orders can cause conflict. The October 2013 "*Health Officer Order for Annual Influenza Vaccination Programs for Healthcare Personnel or Masking of Health Care Workers during the Influenza Season*" caused consternation within the health care worker community and the unions that serve them. This will be a challenge within an agency model that includes DHS hospitals, should the hospitals not implement the Health Officer Orders, particularly if the Health Officer is a subordinate to the Agency Director. The agency model may also present challenges related to current contractual agreements between the departments. Clarity on the oversight and contract monitoring will be required should the shift to an agency model move forward. For example, DHS hospitals and facilities are California Children's Services (CCS) and Child Health and Disability Prevention (CHDP) providers, with a DPH contract managed by the Children's Medical Services division. Should DPH be consolidated with its contractor under one agency, there will be inherent challenges for DPH to evaluate, examine and regulate the DHS providers of these specific services to children.

Another potential conflict is the fact that DPH regularly partners with hospitals and health care providers outside the DHS system to conduct surveillance activities, mitigate risks to patients and health care workers, and exercise emergency plans. For example, when preparing for a possible Ebola case, DPH prioritized collaborations with hospitals across LAC to ensure any risks would be minimized for hospital staff and patients should a case arise. DPH has made a conscious investment of resources and energy toward building strong relationships with hospitals through the Hospital Outreach Unit, which was designed to enhance and improve rapid disease and outbreak reporting between hospitals and DPH. DPH is the lead County department for controlling disease outbreaks. In an increasingly competitive health care environment due to the ACA, DPH needs to have independence and be able to work with all health care systems in the County. If DPH is placed under an Agency Director who also oversees DHS, there could be negative impacts on existing and effective external partnerships that may potentially disadvantage other health care systems.

- ***Why an Agency Structure?***

The discussion at the Board on January 13<sup>th</sup> clarified that there would still remain three separate departments led by separate directors with separate budgets. Some stakeholders have stated that it is not apparent that the agency structure will provide any benefit. There are also concerns that instituting a new agency structure alone will not achieve its stated

objectives of better service integration for patients and cost savings. Many noted that the three departments could remain separate as proposed savings would be elusive without some form of staff reductions (e.g. layoffs or hiring freezes on new vacancies as employees retire from service). The agency model in LAC is new and untested; stakeholders caution the possibilities of unintended consequences. Many indicate that the clear areas where the departments can better integrate (i.e. creating a shared EHR and/or a universal registration process) should not require the establishment of an umbrella agency to be achieved. Several stakeholders indicated that if there is a will, and the three departments are held accountable, service delivery improvements could be instituted in the current configuration. Moreover, stakeholders suggest that alternative, non-structural changes designed to improve coordination, collaboration, and integrate clinical services are just as, or perhaps even more, likely to achieve the desired goals, while avoiding both the threats that a structural realignment present and the significant investment of resources needed to implement a new agency structure.

### **Current DPH Collaborative and Integration Efforts**

Multiple stakeholders have expressed their hope for stronger partnerships and better collaboration among the departments to maximize opportunities to improve service delivery. Strategic integration of services to improve client care largely requires departmental will and a strong commitment to sustained collaborative efforts. Continuing to develop and implement an agency structure to achieve this vision will likely delay, rather than accelerate, this process, acting as an administrative distraction from the important programmatic work already taking place and other immediate opportunities for service integration.

The collaborative nature of DPH work already necessitates substantial engagement with partners across multiple sectors as part of the Health in All Policies (HiAP) ethos. DPH routinely engages community, labor, academic, business and government entities, ranging from cooperative to collaborative partnerships, by aligning priorities to advance health goals. Past and current efforts have led to robust collaborations with not only DHS and DMH, but also a wider network of other County Departments, community-based organizations, cities, school districts, and research institutions. DPH routinely circumvents silos to ensure its mission is met. For example, DPH ensures the environmental protection of communities with its prominent role on the LAC Toxic Threat Strike Team, a high-level, interdisciplinary team of regulatory and technical experts working to evaluate and help abate the impact of industrial pollution on surrounding neighborhoods. DPH works closely with DHS, DMH, and other stakeholders to quickly respond to emergent clinical threats, such as H1N1 and Ebola, and to ensure sustained support to combat endemic infectious diseases, such as HIV and tuberculosis. DPH also provides and obtains specialty care consultations for patients through DHS's eConsult system.

DPH's varied involvement in a number of interdepartmental and community collaborations have resulted in many outcomes that the proposed agency structure is meant to accomplish. These include improved population health, increased access and utilization of health services, and coordinated behavioral and SUD services.

DPH's collaborative efforts have also received recognition from the LAC Productivity and Quality Commission. Over the last seven years, 19 of the 25 awards granted by the Commission were shared with a diversity of County partners. Collaborators included DMH, DHS, Office of Public Defender, Office of District Attorney, Probation, Children and Family Services, and Community and Senior Services. From 2009 to 2011, DPH was honored with a Best Interagency Cooperation or Best Teamwork Award.

As a stand-alone department, DPH has demonstrated the value of and ability to inspire resource sharing and collaborative efforts across County agencies and external entities. The following examples illustrate the key elements needed for successful collaboration and service integration: Board support, departmental will, leveraged funding and other resources, clearly defined goals, and mutual benefits.

- *HIV Interventions for Medically Vulnerable HIV Populations*

DPH partners with community-based health centers and DHS HIV clinics to deliver patient navigation services and HIV medical care coordination (MCC) designed to reduce morbidity, mortality, and transmission of HIV in LAC. DPH developed these interventions based on the HIV literature and national best practices and tailored them to the specific needs of persons living with HIV in LAC. Both programs coordinate behavioral interventions and support services meant to address the client's physical, behavioral, and socioeconomic concerns to improve access to medical care, adherence to HIV treatment, and improve health outcomes for medically vulnerable HIV populations.

Patient navigation links HIV-positive clients who are either newly diagnosed, or have fallen out of care and in need of re-engagement, to primary medical services. MCC co-locates multi-disciplinary teams in HIV clinics with the goal of integrating medical and non-medical case management with routine medical care to HIV-positive clients in order to address clients' complex needs and ultimately improve their health status. DPH continues to offer ongoing training and technical assistance to community and DHS providers to ensure that persons living with HIV in LAC are receiving comprehensive, patient-centered care.

- *Collaborative Efforts to Improve Women and Infant Health*

DPH has capitalized on multiple opportunities to collaborate with County departments and external stakeholders to advance women-focused preventive healthcare and infant health. DPH participates in the DHS-convened Women's Health Advisory Council (WHAC) and Women's Health Work Group (WHWG). The two groups consist of women's health providers (i.e., physicians, nurse practitioners and midwives) tasked with improving health care service delivery to women in the DHS Health System. DPH leads the WHAC Preventive Medicine subgroup which is responsible for developing practice guidelines on preventive care and serves as a consultant for the OB and GYN eConsult system portals as a WHWG member.

DPH also collaborated with DHS to earn "Baby-Friendly" hospital designations at three County hospitals. The "Baby-Friendly" designation is awarded to birthing facilities that successfully implement evidence-based practices shown to increase breastfeeding initiation and duration. DPH additionally worked with the Department of Human Resources to develop policies that support employees who choose to breast-feed and expand employee access to lactation rooms.

- *Los Angeles County Prescription Drug Abuse Medical Task Force*

The challenge of prescription drug abuse requires a combination of local approaches to mitigate this evolving problem that causes more than 500 deaths annually in the County. DPH has provided leadership on this issue by initiating and supporting a Task Force including representatives from DHS, Kaiser, the Community Clinic Association of Los Angeles County (CCALAC), the Hospital Association of Southern California, and the Los

Angeles County Medical Association. The Task Force has already implemented a set of guidelines for safe pain prescribing in the county's seventy-seven 9-1-1 Emergency Departments (EDs), including agreement with CCALAC to accept any patients referred from the EDs, and begun planning for outreach to the hundreds of urgent care centers in the County. The Task Force has collaborated with California's Department of Justice's CURES program, the Medical Board of California, the California chapter of the American College of Emergency Physicians, and the Urgent Care Association of America, and is reaching out to the California Department of Public Health to assure that state and local activities are aligned.

- *Co-Occurring Integrated Care Network (COIN)*  
COIN established a collaborative project integrating a SUD and mental health treatment approach for clients who reoffended under Probation supervision and demonstrate a high-need for intensive treatment services under Assembly Bill (AB) 109. Partners include the LAC Superior Court – AB 109 Revocation Court, Probation Department, District Attorney, Public Defender, DHS, DMH, DPH, and DPH's Antelope Valley Rehabilitation Center (AVRC), and DMH and DPH contracted providers. Program clients are referred through the AB 109 Revocation Court for residential treatment services at AVRC, with integrated mental health services provided on-site by DMH and receive primary care services through DHS. Residential treatment is followed by step-down outpatient counseling services funded through DMH.
- *California Department of Health Care Services' Medi-Cal Outreach & Enrollment Grant Project*  
Healthcare reform has advanced the need for departmental collaboration and integration to ensure the County remains competitive in a transformative healthcare landscape. In response, DPH initiated collaborative efforts with DHS, DMH, Department of Public Social Services, the Sheriff's Department, and a number of community-based organizations (CBOs) to enroll eligible, but unenrolled, individuals in Medi-Cal. They include highly uninsured populations who are traditionally most in need of services, but are generally hard to reach including: people with mental health needs; people with substance use disorders; homeless people; young men of color; post-incarcerated individuals; families of mixed immigration status; and people with limited English proficiency. The project affords the County a unique opportunity to maximize relationships with atypical partners to provide enrollment opportunities for distinct populations.
- *Interdepartmental Healthy Design Workgroup*  
In 2010 DPH received a large two-year Federal obesity prevention grant that incorporated strategies for designing communities to promote healthy eating and active living. DPH oversaw the Federal grant and sought a productive partnership with County's Department of Regional Planning (DRP) to develop a Healthy Design Ordinance for Board approval. With Board support, DPH was able to continue collaborative activities and expand their focus through the creation of the Healthy Design Workgroup, a high-level policy team comprised of representatives from DPH, DRP and the Departments of Public Works, Beaches and Harbors, Fire, Parks and Recreation, the Chief Information Office, and the Community Development Commission.

DPH took leadership of the Healthy Design Workgroup in January 2013 and sustains collaborative efforts to identify and promote healthy community design standards for the County. The initiative adds a “health lens” to County policy by creating design standards that facilitate active neighborhoods and healthier lifestyles for all residents with the intent of decreasing incidences of chronic disease and ill health. These population health interventions will reduce the County’s healthcare cost burden over time. Currently, the workgroup meets regularly to develop and implement strategies for designing and building healthy environments. Many activities have cross-departmental benefits through the identification and leveraging of resources among the different departments to achieve their own goals and objectives.

### **Recommendations**

It appears that the primary goal of the shift to an agency model is better integration of patient services across the three departments, yet there is lack of clarity on the specific objectives to be achieved with a new governance structure. The following recommendations are intended to clarify for the departments and stakeholders alike the rationale for and value added by shifting the current configuration of departments into an agency structure. Additionally, we believe these three recommendations should be completed for the Board’s review prior to their final decision on how the County will proceed.

### ***Consideration of Alternative Solutions to the Agency Model***

1. Clarify in writing the concrete goals and objectives of the proposed governance change. The current approach lacks clear focus on the primary problems intended to be solved through establishing a health agency by the Board and has created a flawed process in which scores of high-level staff in all three departments are participating in ever-broadening discussions about a wide-range of issues not central to agency roles, operations or design. Without clarity on the key objective(s), current discussions and decision-making are occurring in a vacuum and are likely counter-productive, or at least wasteful.
2. Conduct and publish an analysis of health agency systems and other governance models in jurisdictions comparable to LAC. This analysis should explore the full range of alternative models, including those achieved through simpler, procedural changes or co-location mandates for clinical services that have led to improved collaboration or coordination. Stakeholder comments suggest that other non-structural changes are more likely to allow near-term focus and implementation of solutions for the specific objective(s) without all the process burden of creating a new organization. The analysis should compile and highlight best practices, lessons learned, evidence of organizational effectiveness, impacts on grant seeking and service delivery, and the overall level-of-effort required to successfully shift to each potential model from the current structure in LAC.
3. Complete and publish a thorough assessment of the costs needed to fully implement the range of options to better integrate clinical services in LAC. The cost-benefit analysis should either reflect clear and demonstrable cost savings or budget neutrality prior to any implementation of a new configuration of the three health-related departments.

The intent of the following recommendations is to advance optimal service delivery by the three departments for the benefit of all residents, if the Board elects to proceed with implementing an agency structure. While many stakeholders are doubtful that an agency structure is required to better coordinate services, the following recommendations are specific to preserving the core functions and services critical to assuring population health and DPH's mission should the department be folded under an umbrella health agency structure.

***Setting Metrics & Guidelines for Agency Implementation***

1. Establish a set of metrics, through a consensus-based process, involving the leadership of all three departments to identify and set baseline measures reflecting the efficiency of current operations which can be tracked over time to ensure the administrative and fiscal needs of each department are adequately and equitably maintained. Metrics may include: average timeframe to execute contract agreements, purchase equipment, and hire new employees; number of new employee classifications allocated to the departments; number of grant awards and contracts; etc.
2. Key administrative operations for each department should be maintained separately, such as human resources, contracting, and finance, for a minimum period of time (i.e. 2 years) once the agency is established to minimize disruption in service delivery and ensure an effective transition when appropriate.
3. Operating budgets for each department must remain separate, with each Department Director following current procedures and protocols to obtain Board approval of the departmental budgets. DPH has many grant funded services and must retain its ability to maintain, or advocate for increased, Net County Cost allocations should grant funding be reduced.
4. Prior to reassignment of any departmental functions or units from the departments to the agency, or between the departments, the Agency Director should make a formal proposal of the specific changes to the Board for their approval based on a thorough analysis of impacts.

***Agency Structure & Leadership Roles***

5. The agency structure should provide Department Directors equitable access to the Agency Director and equitable representation on the agency leadership team. The structure should also provide a method for the Department Directors to elevate critical concerns and unaddressed needs directly to the CEO and Board, when failure to address such concerns and needs may be detrimental to the optimal provision of services in LAC.
6. The Board should consider the following qualification criteria when appointing the Agency Director: extensive experience and knowledge in the three service areas; demonstrated commitment to public health and mental health; visionary leadership; extensive administrative talents and programmatic expertise; and a successful track record of managing large, complex health systems.
7. The Health Officer function should remain within DPH and have a direct line of reporting to the Board. This would ensure that should a Health Officer Order, or other action to protect the public's health, be required, the Health Officer would maintain his/her authority to take action to in a timely manner to protect the public's health.

Christina Ghaly, M.D.

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*Operationalizing the Agency*

8. The agency should utilize evidence based best practices and ensure that specialized prevention and treatment services provided to vulnerable populations (e.g. SUD populations, transition aged youth, children with special medical needs) are preserved.
9. Develop and publish a specific work plan outlining goals, objectives, performance measures and timelines to meet the stated Integrated Health Agency Vision (i.e. reduced duplication; improved departmental alignment; increased efficiency; and enhanced service delivery) and are demonstrably beneficial to all three departments.
10. The agency should capitalize on the substantial expertise in each department and develop a concrete process to ensure cross pollination between the departments for increased coordination, improved referral networks, enhanced workforce competence and better overall capacity to effectively meet the needs of LAC residents.
11. Establish a special expert advisory committee to report to the Board on how well public health functions are faring in a changed structure and make recommendations, as necessary, for improvements. The Board should be composed of local and national experts in public health and be chaired by the CEO of the California Endowment.

I appreciate the opportunity to synthesize stakeholder input on the proposed Health Agency and welcome the opportunity to assist with implementation of the above recommendations. Please let me know if you have any questions or need more information.

CAH:sc

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