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Appendix 1

SUMMARY POSITION DESCRIPTION
DIRECTOR OF CHILD PROTECTION,
COUNTY OF LOS ANGELES

The Challenge and the Opportunity

The governing Board of the nation's most populous county has launched a pathbreaking initiative to develop and execute a Strategic Plan which harnesses the full array of County child safety-related services to achieve measurable major improvements in child protection within a strict timeframe. This initiative reflects the Board's reaffirmation of child safety as a top priority and its determination to make the systemic changes required to address this vital need in a comprehensive, child-centered manner. The Director of Child Protection, who will report directly to the Board, will play a leading role in the success of this critical endeavor.

Serving 10.5 million residents across a land area as large as Rhode Island and Delaware combined, and supported by a total operating budget of \$26 billion, Los Angeles County is one of America's largest providers of public services, many of which are directed to the protection, health and well-being of children. These services are largely delivered through seven Departments – Children and Family Services, Health Services, Public Health, Mental Health, Public Social Services, Child Support Services, and Probation, respectively – together with a variety of law enforcement activities principally provided by the Sheriff's Department and the offices of the Public Defender, Alternate Public Defender, and District Attorney. The operating programs which bear on child safety, broadly construed, span the entire spectrum of interventions, from all aspects of health, to diverse law enforcement, abuse-related and foster care programs, to income maintenance for the disadvantaged, to housing, education and a variety of other service areas.

Taken individually, each of these operating Departments has won recognition as a national leader in many aspects of its field. However, in June 2013 repeated instances of undiscovered or ineffectively addressed child abuse/neglect and related problems caused the Board to name a Blue Ribbon Commission for Child Protection comprised of prominent private citizens. It was tasked with conducting a thorough review of child protection failures, highlighting organizational barriers to effective service delivery, and recommending feasible reforms. After extensive public hearings, stakeholder interviews and document review, the Commission produced its Final Report in April 2014. Entitled "The Road to Safety for Our Children," it may be found at www.blueribboncommissionla.com. The Commission's most fundamental findings were that a "State of Emergency exists" in this subject area, and that "The greatest obstacle to reform ... [is that] key County entities too often operate in silos, rather than as an integrated network with a shared commitment and vision."

The five-member Board of Supervisors, which is vested with all the relevant executive, legislative and quasi-judicial authorities, adopted the basic principle of the Commission's organizational recommendation that a single entity be established to develop, coordinate, update and continually advise the Board on implementation of a Strategic Plan covering the total complex of child safety programs. It did so in a manner consistent with the framework of applicable State and Federal laws governing administration of the external funding streams which support much of this work, and also within the terms of existing labor contracts.

The new entity is an Office of Child Protection headed by a Director who will be the Board's chief advisor on the integrity, effectiveness and efficiency of the overall complex of child safety-related service provision. The work of this new Director, supported by a small but very talented staff, will enable

the Board to inform its policy decisions and exercise its oversight in the light of data, analyses and qualitative evaluations of the full body of County policies, operations and resource allocations which affect the safety of children. The operating agencies will continue to bear their operational responsibilities and budgetary authority while the new Director works with their Directors in a joint, ongoing Strategic Plan development and execution monitoring forum, independently reviews and analyzes their budget proposals and resource allocation patterns, and advises the Board on all of these from the standpoint of consistency with the Strategic Plan and probable impact on the County's ability to achieve the Plan's regularly updated strategic goals. Responsibility for management of the County's overall budget process will continue to reside in the Office of the County Chief Executive Officer, but the Director of Child Protection will also advise the Board of Supervisors and CEO on resource allocation in this subject area.

The Board recognizes the practical challenges involved in making this matrixed structure work to its full potential. Both innovative thinking and readiness to collaborate in pursuit of a shared vision and mission will be required of all concerned. The Board will look to the new Director to devise and propose the specific coordinating mechanisms and procedures which he/she considers most likely to achieve the Board's purposes, and to suggest mid-course revisions as experience with them is gained. The sole measure of the success of any organizational or procedural configuration will be the extent to which the measurable outcomes set forth in the Plan as strategic goals are in fact achieved.

Responsibilities of the Appointee

Having been appointed by the Board, whose members are elected on a non-partisan basis and bear ultimate authority and accountability for County policies and operations, the Director will be its chief aide in drawing together the many specialized elements of child safety-related policies and programs as integral parts of a single, unifying County strategy which defines target outcomes, measures of success, and major timing milestones. His/her authority to play this central role will flow from the Board's deep commitment to this effort and the Director's status as its chief advisor with regard to the totality of the child protection effort.

The Director will perform the following basic functions:

- Design and manage a joint strategic planning process involving the heads of the relevant operating Departments, Agencies, and Commissions which develops for Board approval a comprehensive County Strategic Plan for child protection which articulates measurable goals and time frames and provides for regular and continuous joint monitoring and progress assessment, together with provision for mid-course corrections as lessons are learned and new problems and opportunities arise. The County Strategic Plan should take into account well-functioning as well as problematic current activities, incorporate best current practices in the field, and factor in extensive strategic planning work already completed in the form of the strategic plans of the seven Departments.
- Working with the CEO and Departments' budget staff, develop and maintain a cross-cutting Child Safety Program Budget which brings together the diverse elements of the County Budget which fund the activities included in the Strategic Plan, thereby permitting the Board to address management and resource allocation decisions with respect to each agency in light of data documenting the overall pattern of related operations and expenditures and the results achieved by each program.
- As part of the broader annual budgeting process, lead a joint review focused on agency proposals for their respective pieces of the Child Safety Budget and advise the CEO and the Board as to the

alignment of proposed allocations with the goals and implied needs of the Strategic Plan and any changes recommended to improve that alignment.

- Monitor and evaluate implementation of Board decisions and guidelines in this subject area, including those associated with the recommendations of the Blue Ribbon Commission.
- Perform independent reviews of agency staffing, management, productivity, and resource utilization in this subject area, both as parts of a systematic review cycle and in response to special problems identified by the Director and/or the Board.
- Reach out to and establish strategic partnerships with philanthropic organizations, resulting in jointly supported program improvements.
- Prepare and publish quarterly and annual status update reports on Plan implementation as demonstrated by progress on its performance indicators.
- Recruit, engage and retain a small, highly trained staff with the ability, expertise and experience necessary to support all of the Director's functions.

Additional or amended functions may be assigned by the Board as needs evolve.

Qualifications

The capacity most needed in the Director is the ability to assist the Board in carrying forward this critical initiative with result-changing effectiveness in a context where authority over day-to-day operations and budgetary authority remains in the hands of very able heads of specialized Departments. This will require the capacity to lead collaboratively, mainly through facilitation and by demonstrating the outstanding intellectual and operational qualities necessary to win and sustain the confidence of the Board. The Director's practical leverage in the County's senior ranks will flow directly from the degree to which he/she earns that confidence and that it lends enduring weight and authenticity to the Director's effort to make the Strategic Plan more than a shelved relic to which only lip service is given.

More specifically, the Director should have as many as possible of the following characteristics and capacities:

- Passionate dedication to the interests of children and families, with special interest and expertise in child safety, broadly construed.
- The vision, strategic thinking, creativity and capacity to mobilize and direct the analytic skills necessary to form and propose for Board approval sound recommendations with respect to all facets of child safety-related County policies and operations, and to respond to Board requests for assessments and analyses of all elements of relevant services, agencies, and personnel.
- The people skills, confidence, listening capacity, ego control and personal security necessary to play an effective leadership role without line authority over operating personnel, and to challenge existing agency policies and procedures without fear or favor.
- Extensive experience in executive positions in sizeable organizations operating in large urban settings. This need not be government experience, but it must include involvement in managing organizational change and familiarity with complex political environments.

- Proven excellence in budgeting and other resource allocation and financial analysis techniques, preferably including experience with multiple streams of revenue from independent external sources, showing the ability to track management of financial and other resources effectively and accountably, to allocate resources equitably among competing needs and constituencies, and to maximize the ground-level impact of expenditures.
- High energy and highly advanced communication skills, together with acute cultural sensitivities and empathy, steady calmness in crises, and deep familiarity with the issues and challenges that face large, culturally diverse urban areas.
- Rock solid personal and professional integrity and honesty in presenting facts, figures, conclusions and recommendations, as demonstrated throughout his/her career.
- A solid track record of effective management of an organization or unit, demonstrating a fine eye for superior talent coupled with the ability to assemble and motivate a strong and diverse staff and to hold its members to high standards of accountability.
- Recognized professional stature in one or, even better, more than one relevant specialty. One or more graduate degrees in a relevant field is a plus, but equivalent experience will also be considered.
- Demonstrated problem solving capacity and receptivity to promising new approaches, skill at programmatic entrepreneurship, and recognition of the enhanced impact which can often be achieved by leaving it to others to take most or all of the credit for successes.
- Willingness to locate in the Los Angeles area.

Eligibility for Appointment

The County is an Active Equal Employment Opportunity Employer and engages employees without regard to race, color, religion, creed, age, gender, marital status, or sexual orientation.

Compensation Package

The appointee will receive a base annual salary in the range of \$175-\$260,000, commensurate with qualifications and earning history, as well as an excellent program of benefits.

Timing of Appointment

Initial consideration of candidates will begin in the latter part of March 2015. The appointee will be selected as soon thereafter as possible, and will take office at the earliest feasible date.

To apply or for further information, please contact:

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Appendix 2

COUNTY OF LOS ANGELES—DEPARTMENT OF MENTAL HEALTH
SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, February 18, 2015
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90026

Board Consolidation Motion

Dr. Robin Kay: I just wanted to provide you with a little history and a little chronology and that'll take us right up to today and the work that we're going to do together. Many of you were here last time the SLT met. You contemplated and considered a number of principles at that point related and I'll come back to that in a minute. To the Board's proposed consolidation of the 3 health related departments; department of health services, department of mental health and department of public health.

But I wanted, this time, to take us back a little bit further and just give you some history and context. The department of mental health was established in 1960 as an independent department. And we functioned that way until 1972. In 1972 the board of supervisors was facing a pretty big crisis in that health department related to the operation of hospitals. At the same time the Short Doyle Act was passed and there was an infusion in California of federal dollars for mental health services.

I'm obviously giving you the Reader's Digest version of what went on. But to make a long story short the board, at that time, did what the board should do and that was to contemplate whether or not it would be prudent for the department of mental health and the department of health services to merge. At the time, 1972, they concluded that it would be a good idea, mostly because it was viewed, at the time, from the documents that we found in the archives, as a way of helping to sure up the hospital based programs in DHS.

A couple of things happened between 1972 and 1978 including the inability to access some of those funds for the DHS financial difficulties and also the erosion of mental health services at that time. In 1978 the board concluded that the merger really was not a success and they wanted to separate the 2 departments. DMH became a department again, an independent department.

Nevertheless, the question of, "What is the most efficient, economical, and best way to deliver services?" is something that the board of supervisors does and should contemplate from time to time. In 2004 - 2005 the civil grand jury asked the same question that came up again, "What's the best way for the county to deliver health related, mental health, and primary care services?" At that time the civil grand jury concluded that a merger was not really a good option because the populations served were different. The missions of the 2 departments were different. The cultures of the organizations were different.

But it's an issue that does and should come up periodically because the board should always be asking, "What's the most economical, effective, efficient, best way to serve clients?" Those of you that are from organizations know that we do this all of the time. We look at our own organizational structures and we ask ourselves, "Is the way we're organized the best way for us to support the mission of DMH, or Gateways or PACS or Share, or SAPC--", that's part of the work that we do.

It's within that context that the board, on January 13th, past a motion by Supervisor Antonovich, that approved, in concept, the consolidation of DHS, DMH, and public health. Initially, the motion read as an agency under DHS. Then the motion was amended, recognizing that agency structure might be a more appropriate structure concept, which would have, as we understand it, an agency director, and then the 3 departments, DHS, DMH, and public health, under an overarching agency; and directed the CEO to come back with a report on an analysis of the advantage and disadvantages of such a consolidation.

That takes us pretty much up to the present. You know that the following week the SLT met and this group developed, as we do, it's a tradition in SLT, we do it for budget planning, principles; we start with principles. You start with principles. We do it for budget planning which is a very inclusive and transparent process. Every big issue begins with principles. When you contemplated and approved a set of principles last month, Larry Liu from the mental health commission was here representing the commission and the following week the commission took those principles, as an example, and then made some modifications because the commission wanted to have their set of principles, very similar to what was approved by the SLT.

And so those principles were submitted to the board. I understand that the public health commission also had a set of principles, again, a different language but primarily the same concepts. Those principles, people have asked, "What are they for?" They serve as a touchstone, a way of measuring recommendations and implementation against the principles that you all and we all hold dear. I won't go through principles because a lot of that work was done last time.

One of the things that the CEO was charged with doing was getting broad feedback from many entities about the benefits and risks of a consolidated agency model. That's what Dr. Ghaly is here to do today. Some of you have participated in other stakeholder meetings. We've had quite a number of them; joint commissions, the mental health commission and the public health commission met together, the SAACs met and provided input, the hospital association has met as a stakeholder group, NAMI has met as a stakeholder group, the client coalitions have met, the underrepresented—I could go on and on.

There have been a number of stakeholder meetings. I will say that within DMH, because our staff are also stakeholders, we've had quite a number of discussions in programs. Cathy Warner is here, she has led a number of discussions within the service areas 7 and 8 programs for DMH. We've had discussions in the District Chief's meeting, in EMT, etc. I will say that the department last night provided to Dr. Ghaly a summary of the internal DMH stakeholder conversations.

We're here today to another stakeholder discussion. Dr. Ghaly will go over them and you've got a copy of the questions to be answered. It's really important that all of our voices be heard. Nobody knows the functioning of the department, in particular, MHSA, the way that you all do, and the department as a whole. So you're in a perfect position to be able to imagine what might be beneficial if an agency structure were to be established and what might be perilous if an agency structure was established.

The discussions will focus on 2 main areas: "Is there a possible enhancement to service delivery?" and "What are the administrative changes that might be made to support an agency?" So slightly different issues, we're delighted that Dr. Ghaly has joined us, delighted that you're here

to provide your input. It will become part of the final report to the board, which is coming up soon. With that I'm going to turn the microphone over to Dr. Ghaly who is currently serving, on a temporary basis, on loan from DHS to the CEO to conduct this planning process.

Dr. Ghaly's Reponse: My role here is really to listen. I will speak very briefly. I will cover the overview. But the board has asked to get broad input. That's what we're here to do. I'm here to listen to your comments. I'm happy to answer questions. If people have specific questions I will do my best to answer them. But mostly I really want to listen to you and listen to your input and your ideas, concerns, and suggestions, about what you'd like to see happen, what you're worried about, and just your thoughts on this agency motion in general.

Robin provided the background. I would add the obvious, which is that the way this came about did not create an atmosphere of trust among many different stakeholder groups, constituents, among patients, clients, customers, and different advocacy organizations. I just want, before we go any further, to openly acknowledge that. I think that people have different opinions about how the board did it, about the language that was used in the board motion, the language of the term 'consolidation', which is not one that I am using.

But we are where we are. I think the role now is to try to work, over time, to rebuilding that trust; trust in the process and trust ultimately in the outcome. So I just want to state upfront that I acknowledge and understand that. My role here is, again, to be open and listen to you. I will work to help build that trust over time.

Everyone I've spoken with, while there are very different perspectives on this topic, every single person I've spoken with at some point in the conversation says, "We all want the same thing." I do think that all of the different groups want the same thing. They want the best outcome for the residents of LA County, whether it's patients, clients, consumers, whether it's for certain programs, regulatory and policy making activities, everyone wants the best outcome. So I think it's helpful to start at the place where we do have a shared goal and shared vision. That's just to acknowledge that everyone is thinking the same thing despite the fact that there may be different opinions about what best way there is to get there.

With respect to the agency, in particular, the goal is to be able to improve services. I use the word 'services' very broadly. I won't try to keep repeating the language but when I say the word 'services' I do mean the full spectrum of what's provided within the 3 departments. Obviously, they have a different mix of services and a different mix of activities in each of the 3 departments. Public health takes on a much stronger policy making and regulatory role though each of the other 2 departments, DHS and DMH, also have some roles in policy and regulatory activities. There is a direct clinical services component. There are programmatic activities. There is population, health and preventive health activities. I do mean the full spectrum of those services.

A lot of people have said, "Well if it's not broken, don't fix it," or, "I have received wonderful services from" whichever department that might be, "so please leave it alone." As many times as I've heard that I've also heard others say, "Well it's working for these people over here but it's not working for these people over here. So what can be done to do better? I think that's ultimately what's behind this decision by the board and the discussion at the board is, "What can be done to help make sure that all of the residents in LA County have as high quality of services broadly defined as possible?"

I also want to acknowledge, obviously, that there is a lot of work of integration that is ongoing. There is a lot of good work that the DMH has done in collaboration with other county departments, including DPH and DHS, but also with other county departments, with sheriff's department, with probation, with DCF, with CCS, and with a lot of different organizations. In no way should this be a reflection of the fact that there is not good work already being done. The question is, moving forward, "What's the best way to get to the next level of what is possible?"

Some people have asked for specific examples of what the goal is or what the opportunities are under an agency model. I don't want to talk about those too much here today. I'm not here to sell you on anything. I'm not here to convince you that this is the right answer or the wrong answer. I'll share just a few thoughts about what I've heard from other individuals or some of the examples I've brought up in some of the other meetings. But I give them just as starters for discussion and would love people's reactions to those or suggestions of other opportunities that they think the agency might create.

A lot of people have talked about the ability to better coordinate care and do integrated case management and joint care management plans at the level of primary care, community mental health, substance abuse services, of the need to work on better co-location, whether it's physical or virtual co-location, of the fact that there is a lot of times, as we all know, it's the social determinants of health that are holding our patients and clients back and that by better addressing those social determinants of health, addressing issues of poverty, homelessness, unemployment, lack of living in a safe and healthy community, that those issues are ultimately what is going to improve the health and well-being of patients, regardless of which department they receive those health related services in.

There has been discussion about being able to streamline access to care, on working on IT systems, registration processes, and financial screening processes. Depending on the context where it's taken absolutely means the full spectrum of providers that are involved in LA County. It's not meant to mean just the directly operated clinics within either DMH, DHS or DPH. Obviously, each of the 3 departments has a very broad network of contracted providers who provide direct services but who also provide other activities for the departments. I think it's important to make sure that the agency maintains that broad focus on services rather than simply focusing on only the directly operated portions of the network.

There has been a lot of talk about integrating population health and community based interventions better into mental health and primary care settings; but how you could inform population health activities with what's going on in the ground in the clinical setting and how you could take those population health activities and integrate them in, work on obesity prevention, safe communities, and again, that would be done across the full spectrum of the patients and clients that are ultimately served by the county, and not, just again, those in the directly operated clinics and hospitals within DHS or within DMH.

Some people have raised on the public health side the possibility of better responding to public health threats. People have talked a lot about the recovery model. That is such a strong component and a very positive characteristic of the community mental health system. Certainly I've heard concerns that there will be a medicalization of the mental health model, that if DMH and DHS work more closely together that it will lead to the over medicalization of mental health care, that there will be increased prescribing and increased focus on that medical model. I am happy to talk about that concern if there are any. I would offer though that I've heard equally strongly that there is an opportunity rather than

to lead away of the medicalization of the physical health model and allow the recovery model to be able to be better integrated into that physical model.

I'm a primary care physician. I'm a physician in urgent care. I know very well that when patients come into a clinic oftentimes they don't need a lab test and they don't need an MRI. They don't need yet another prescription. What they need is someone that's working on their social supports, working on their broader community engagement, and on the number of factors that affect their life and health. I think there is a huge number of assets that are in the recovery model that is so strong in the DMH and there is a lot that everyone could learn from that.

I won't go on too much about the opportunities. Again, I want to hear from everybody here what they think are the opportunities and that risks. I will say on the subject of risks that I've heard several. I'll run through the list here just so people understand, I would say, very broad categories of what I've heard, I won't get into the nuances of each, but I want to be open with what I think of as the major categories that I've heard.

Those are first and foremost that Robin eluded in her introduction is that history will repeat itself. The history of the mergers, the budget cuts in the late 1990's and the early 2000's in public health, will repeat itself. Some, either assumption or expectation, that the board might be doing this for financial gain, to have cost cutting initiatives, the tendency toward crises or emergencies then toward high cost problems in the physical health system might lead ultimately to the reduction of resources that are available in either the public health system or the mental health system. I want to make very clear that, as proposed by the board, this is not a merger. I don't think the word merger is what applies to the agency description.

An agency, in organizational and in government governance, is the creation of an entity where then the 3 departments would report to that agency but maintain the full structure of those reporting departments, full budget and full appropriation of authority within the departments and maintain the department head. The board of supervisors has the full authority to be able to set the appropriation breach department. That authority, I would add, is not able to be delegated. The agency director would not have the authority to move money from one department to another.

So you couldn't say, for example, have a fiscal crisis in DHS or in one of the other departments, and move money from mental health or another department over to the department where there is a fiscal crisis. The board could do that. The board could do that today. There is nothing that would prevent the board from making that decision today if one of the departments even outside of the health sphere had a fiscal crisis. But there is nothing about the creation of an agency that would change that. Still, I think that there is a very real concern that somehow, in part because of the lack of transparency into the budget process in the county system, that there would eventually be a risk of service cuts and a risk of the budget being put at risk for critical population health and mental health services.

I've heard a lot about people being concerned that the departments would become too insular, would not have the full breadth and scope on their full mission. Public health serves all 10 million residents in LA County. Mental health, in many ways, serves the same with its prevention

activities, but also does focus on a subset of those patients and clients through direct services. DHS has some activities that affect the broad population but also focuses very specifically on the 800,000 patients that it serves through direct or contracted services.

I've heard that people are worried only the areas of overlap is where the agency would focus and that would be done at the expense of all of the other things the departments do; all of the other programs and activities, that regulatory activities and the DPH would take a hit, that community mental health to the extent that there is not overlap with the physical health system, would not be prioritized. I think there are lots of different ways that this idea has come up. It's an important one to think about. If an agency is created what is the best way to make sure that the departments do maintain their full breadth of mission? Obviously those missions are critical to ultimately improving the health and well-being of Los Angeles county residents.

I would say the third general category of risks heard is about bureaucracy, additional layers of government, concern that the agency would be a costly endeavor that money would have to be put into the agency, and then the question about where that money would come from, because certainly the board hasn't necessarily volunteered additional funds to do this. Would the funds come from the departments themselves? Would additional net county costs be put into the departments and into the agency? How many layers would be present in the agency?

I think it's a great set of questions and certainly one that should be taken into account when proposing a structure for the agency. What I've understood in discussions broadly with a number of different individuals is that the intention is to have a very lean agency structure without additional levels. There is no added budget that is being considered for the creation of an agency. The board has been very clear that they don't intend to add additional items or an additional budget to create this.

So then the question is, "How do you create a very lean agency that relies on the strengths on the individuals and departments within each department to be able to build up agency functions to the extent agency functions should even exist?" Very clearly, I think what I've heard from pretty much everybody is that people should be very slow to place anything at an agency level and to create an agency function. That would need to be done carefully with a lot of study and overtime and careful not to disrupt critical services. You can't simply move a finance department out of a department and into an agency level without disrupting billing, charge, claiming, cost reports, financial documents that are critical to departmental operations. The same can be said for a number of different administrative functions such as HR, contracting, and others.

I have heard from suggestions from certain people about what they would like to see in an agency level. I'd be happy to talk about that, but more, again, I'd like to hear that from you here. I would say that the general theme is that people might be interested in more strategic functions at an agency level, someone that's helping the department make decisions that are well aligned and coordinated to the extent that it's in the best interest of services but that it wouldn't be the full scale move of certain administrative functions to the agency level.

I spoke briefly about it and I won't talk more but I very much heard the risk of the medicalization of the mental health model. Again, I think that really is an opportunity but also a risk and a risk that would need to be very cautious to make sure that it doesn't happen.

I've heard particularly from private contractors and also from private nonprofit organizations that they're concerned about their future under an agency model. They describe having very strong relationships with certain department leadership including this department, the DMH. They talk about being worried, not so much that their services would be cut, but that their contracts would be cut or that their existing relationships with the department would change, if there was new leadership in place who didn't necessarily understand the history, understand their contributions, or have the same vision about what the shape of things would be moving forward.

I've heard concerns about cultural friction and a concern that the unique cultures and the strengths of those unique cultures within the different departments would be diluted or changed in a negative way over time as a result of the agency. I think absolutely there are tremendous strengths of each of the three departments from a cultural standpoint. I won't go into detail but I think particularly within the mental health department there is a strong culture of community engagement, stakeholder participation, focus on recovery model, focus on as the plaque says, "hope, wellness, and recovery." I think there are multiple aspects of the culture of DMH that are strong and should be preserved. The same could be said of DPH and DHS. The question is whether or not an agency would change that, whether or not there are opportunities to allow the departments to learn from what is best in the other without losing what is best in the other.

Finally, I've heard concerns that the process of planning for an agency will distract from the good work of integration which is ultimately what is needed to improve services. People are worried about long, drawn out planning phases where they go to multiple different meetings and processes where they have to think about a 1 year plan to be able to move 1 tiny unit over to another area. I think this overlaps a lot with the issue bureaucracy and a concern about administrative layers. People want to do the work that they do because they want clients and patients to get better services not because they want to sit in a room full of meetings talking about what should move on an org chart.

I put those forward as a very high level summary of concerns. I know I've gone through them very quickly and I've glossed over a lot of the nuances of them. But I wanted to be open about them.

Moving forward, just a note about the process and then we'll open it up for discussion. The board asked for a 60 day report back. That 60 days will end March 13th. The process of developing a report obviously requires a lot of stakeholder input before the report is developed. To this point I have not written anything. I started drafting an introduction this weekend but literally that's it. There is no org chart on paper. There is no written document about what this looks like. If anyone has seen anything it wasn't developed by me.

So the process of getting stakeholder input is very important and should absolutely be done before a report is written. With that said, people have an understandable desire and right to respond to a document after it's written but before it's final. So because of that the report will be released to the public, including the board, on March 13th. It will be released as a draft. Then we'll open up a 30 day comment period where I would invite and welcome any and all stakeholder input. I promise you the report will not be right the first time and it will need your thoughts, ideas, and suggestions about how to strengthen it. I would welcome that input in written form and then also in oral form. We'll have several public convening, dates, and times still to be scheduled where we would invite different stakeholders to come and share their perspectives.

At the end of 30 days we will modify the report. The written stakeholder comments that we received from the public will be included with the final version of the report as a full appendix so that people can see the full color of what was written in the report and encourage open transparency and communication. Then the report within 30 days of that will be delivered to the board as a final copy. That will be no later than May 12th. Then the board could take whatever action they would take.

Your feedback is very important. I know there are a lot of concerns. There is a lot of fear and anxiety. There may be a lot of questions. There may be confusion. Certainly, if I can help to clarify confusion I would love to do that. I will try to answer questions but mostly I am here to listen to you and listen to what you'd like to see happen, what you would not like to see happen and just have an open dialogue so thank you for letting me be here.

Comment: One of my major concerns from the law enforcement perspective is that the vast majority of the calls that we receive and manage are crisis related mental health calls along with public health issues. While we've had a very good working relationship with the DMH in developing strategies to combine our efforts to mitigate these types of calls for service and manage them we haven't received the same feedback when dealing with the psychiatric emergency departments in DHS. My concern is that there might be a trickle down or pollution of the culture of cooperation because of the perspective from the DHS side as opposed to the DMH side.

Dr. Ghaly's Response: I will not try to address every comment. I will just say that certainly your perspective is very valid to the extent that certain things have worked with DMH. I see no reason why that wouldn't be able to continue under an agency. I think the Psych ER issue is very complicated. I know it very well. There is a lot of different factors that play on both the DHS and the DMH side. But certainly the goal would be to work and to continue working very productively.

Comment: My concern is that historically the DMH or mental health issues have been looked at as secondary issues compared to the physical and the DPH and the public services at the health services department. I'm afraid that with this integration that will continue and then other 2 departments will take over rather than look more closely and give precedent to the mental health issues.

Comment: I think that it looks like there could be a lot of advantages. Everybody's integrating at the moment, blah, blah, blah. The difficulties that I see are more practical ones, for example, housing. What we've seen in housing is that when there is an agency that does any sort of housing there is stigma against mental health consumers. They allowed the mental health consumers to get evicted for erratic behavior that easily be gotten under control. What we've seen in the past is that when there is money that is supposed to be for all types of housing, including mental health, that the mental health consumers don't get the housing. That's a really big concern. It's easier to deal with somebody that I don't have stigma and discrimination against then it is to deal with somebody that I do.

The other part of that is that the recovery model may be alive and well in DMH but it is certainly not throughout DMH. We fight every day with including the recovery aspects against what Medi-Cal is willing to pay for; this idea that, all of a sudden, getting a bigger Medi-Cal contingency that we're not going to be able to keep the recovery aspects going. When we look at both health and mental health care we find out that we have a new mega study done that shows that 40% of health and mental health wellness comes from a lack of social isolation. So we really do need to be working on these issues. Yet when it comes down to it it's much easier to do Medi-Cal and to measure how many units of service

were done than to use some of the newer measurements for, "How do we get people a sense of community?" "How do we get people not to be isolated?"

I have to put in a plug for self help support groups that are totally under used, almost free, and the health people aren't using them practically at all. The mental health people still want to have a paid person in each group even though the evidence based best practice is not having paid people in those groups. I think we've got to look at how we're going to make this happen in a practical way.

Comment: From the substance use disorder perspective I just wanted to emphasize that in the context of other co morbid physical and mental health conditions we still realize that substance use disorder is a discreet, chronic, brain disease and needs to be treated as such, in the context, and that we don't let it become a subset of mental health or physical health.

Q: There was an original comment, and, again, there is certainly a concern about the atmosphere of trust and why did it happen this way. I have not heard why it did happen this way. In other words, what, all of a sudden, created this push by health services to consolidate? Where did that come from? As I said at the hearings, the public health and health committees didn't come from mental health. It didn't come from public health. It obviously came from health services.

The second part of that question is, "What has health services done over the last 4 years to improve integrated health and mental health care?"

Dr. Ghaly's Response: In my role I'm currently assigned to the CEO. I don't see that it's appropriate for me to respond on behalf of DHS. I did used to work for DHS. That is my permanent role. With that said, that's not my current role. So I would welcome you asking that question to Dr. Katz or to his staff who would be best positioned to respond to it. I say that in all fairness. It wouldn't be fair for me to only speak for DHS but then not to speak for the other 2 departments.

In terms of how this came about I'll tell you what is also in the LA Times. The memo is on the health integration website if you haven't seen it. Again, I would encourage you to ask that same question to the board and to Dr. Katz, if you would like, because those are the individuals that were involved.

There was a closed session in early January related to the selection of a director for the DPH. In that context they asked Dr. Katz to come into the meeting. I was not in the room. It's also hearsay after that. I wasn't there to listen to the actual conversation. But during the course of the conversation the board asked Dr. Katz to write a memo, which I said is on the website. The memo written was in response to that board request about creating an agency. The discussion at that time was [inaudible]. Then they met again in a follow up closed session to look at the memo and decided, again, I wasn't in the room, to put it on the board agenda.

I think the question really needs to be presented to the board though. I would encourage you to speak with them and certainly with Dr. Katz, if you would like.

Comment: We would like to see him here.

Dr. Ghaly's Response: I think that would be a great idea if you invited him.

Comment: Again, it sounded, from what I understand, maybe correct me if I'm wrong, the board asked Dr. Katz to write a memo after he suggested the idea of the integration. Is that your understanding?

Dr. Ghaly's Response: I can only say what my understanding is. Other than that I feel like the people that are involved in the actual meetings would need to speak for themselves. They asked him to come into the closed session. They asked him to write a memo. He wrote the memo in response to that request. I think having you speak for him here directly may be helpful. I don't want to impose on your meeting. It's your meeting and your decision. But I would encourage you to speak with him or the board about it.

Q: One separate thing on the process which is, overall, I said this earlier, certainly the way this came about is concerning. There is no doubt that there are certainly serious trust issues. At the same time the one thing that I said earlier that I appreciate is that the process itself of having all of the stakeholder meetings and then a preliminary report and an opportunity to comment. I think that's a good process so I want to acknowledge that, completely objectively.

The one thing that I see here on the list of key questions that I didn't understand from the mental health and public health hearing is that there is a question now about, "Other than a model of an agency director and 3 distinct reporting departments what additional models should be considered?" Was that added? Or was that always on here? I understood and heard, and maybe I misunderstood, that really the main focus of the report was going to be on this agency model and there was going to be very little discussion of these other models that would be considered.

Dr. Ghaly's Response: That's correct. The report asked for 5 things: the opportunities and benefits of the agency model, the drawbacks, the proposed structure, and the context they're referring to the agency model, the implementation steps and timeframe for achievement of what they call the consolidation, which is, again, not the word I'm using. These questions don't directly mirror what's in the board report. We've added the question about alternatives just because it's come up so much.

The report will not include a very detailed, fleshing out of what all of those various different possibilities look like but because it's come up in so many different contexts of people saying, "Well I don't want this, I would like this", or "I want to see these departments or these entities" that we felt like it was fair in the spirit of openness and transparency to put that question out there so people can offer an opinion in other venues if they want to. There will be a section of the report that, at a very high level, lists those different ideas that will come out.

Q: They'll just list them?

Dr. Ghaly's Response: Well I haven't written it yet so I can't tell you exactly what it's going to say. But it's going to list, generally speaking, the ideas that people have said.

Q: I think that my reflection of what I would say having conducted the commission hearing was, and you heard it particularly from consumers, a lot of distrust, a lack of confidence, a feeling of lack of transparency, and they still ask the questions and I don't know when they're going to get their answers about, "Why?", some of the things that Bruce voiced. You've done a great job of identifying and summarizing a lot of the input you've received but I don't see responses to it. It's just a recitation of all of these things. Even if you're going to talk about other models—you put in a question in there but you did it only for the audience and not for the sake of the sake of the report, talking about #3.

I've heard people wanting to talk about additional models, wanting to know the advantages and disadvantages of these other models as opposed to the proposed agency model. I don't hear that conversation being invited. I don't hear that, even from your statement, do you do some assessment of that? That's not there. I think it's the lack of how all of the input is going to be evaluated and considered and thoughtfully addressed in terms of how these things will be accomplished or incorporated I haven't heard. I don't hear who's going to be involved in that discussion. You're hearing from everybody but I don't know hear, from the meetings that I've attended; a back and forth to really review those things and hear from people why they think this would be a better model.

Particularly, I think DHS—you were talking about the medicalization model and maybe there could be improvements on it. Well why isn't DHS working on it? Does it need an agency, another boss, another layer to tell them to do the right thing?

Dr. Ghaly's Response: I'm not here to speak on behalf of the department. I will say that there are a lot of things that DHS is doing to move away from the medicalization model but it's not my place to try and advertise those or defend DHS. On the alternative models the question is intentionally put here because it has come up so much and people asked for an opportunity to speak on that. It is as one, very small, way of encouraging discussion on that. It will be put, despite the fact that the board didn't specifically request for consideration of alternative models or alternative structures.

But I do intend to put in, again, not a dissertation on it, but some discussion on other ideas people have raised. I think in the spirit of transparency that's part of this more full discussion. Again, it is aimed at transparency.

Your other point just about the responses, my role is to gather the input, work collaboratively with the entities that were outlined in the board motion and then the departments, as well as the department of human resources and county counsel and CEO, as named in the motion, will have a chance to edit the document before it's released, just a draft to the public, and then we'll incorporate that input. It's, in part, because people should have a chance to see how their input was put into a draft, why there is that 30 day comment period and why their written comments will be attached in full transparency to the actual final report of the document.

Q: I can understand a little bit how the agency might have an impact with health services, public health, and mental health but we have a lot of other partners that we're not talking about. We have probation, DCFS, there is housing, sheriffs, just a whole lot of partners. I don't understand the role that the agency would play in DMH's broad network of partnerships. I don't see how that's going to be helpful.

Dr. Ghaly's Response: This is another side of one of those risks that I mentioned. People have raised concerns that the agency would focus on just the areas where the 3 departments' together overlap or potentially 2 do at the expense of some of those broader partnerships or clients, patients, or programs. Certainly the other cross departmental relationships outside of the health related departments have been raised.

Q: The voice of families and consumers has to be heard so I'm going to give you a case. I'm an LCSW so I have to do it. This is an FSP client. The family came to be under extreme duress, caregiver burden. The adopted family, they had cultural bias, they were Spanish. She was indigent, Black, Puerto Rican, Spanish speaking, bilingual though.

We were engaged in legal services because she obviously was indigent. She had serious mental illness, chronic lifelong. The only place she didn't hear voices was in the Catholic Church, even with medications. She did not have substance abuse, thankfully. She did have a baby with DCFS. She had no housing. She did not qualify for GR because of her legal status. She was involved in mental health court. She was under court order for treatment. She was ordered for domestic violence classes as the perpetrator which was impossible to find. She was diabetic, obese, and insulin dependent and she wanted birth control. That's a brief summary.

The advantages of consolidation obviously would be with DHS to help me get diabetic medication for her and get her regular care for her diabetes and birth control and that did work with a lot of work. I didn't need public health at all. She didn't have substance so thankfully for that. We were involved also with DCFS court justice system and obviously the church because she showed up there a lot.

That's a case consult, where I think there are some definite advantages. The disadvantages, the only one I want to mention is that the consumer voice and the family voice is very small, even in DMH and even though we purport the recovery model I encountered, daily, people that do not understand what it feels like to have mental illness and do not understand the caregiver burden that is associated with mental illness that is serious, chronic, and lifelong.

On #3, the other model that I would like to purport is a grassroots model. Start with change at the bottom, turn the triangle upside down. Start the change at the bottom. Do case consultations and overlapping with my client and all of the other services that she needed and make it a little easier to get those health care services like birth control and those kind of things.

Lastly, I just want to address #7, the thoughts of implementation timeline. If we do turn this agency model upside down and start with a grassroots I think that time will show itself and that we won't really need a timeline.

Comment: The work that we have done in service area 2 in terms of integration, there has been some work between mental health and primary care, one of the stumbling blocks that we have found that a great deal of people in primary care don't really understand specialty mental health and feel like that they can handle those kinds of clients until they get to a crisis or suicidal client. Then they want us to take over. I think we're hopeful in this process that maybe some education can happen but we really want to protect our specialty mental health.

Q: Just echoing some of the sentiment around service integration and how that's been advantageous and also disadvantageous, particularly the DMH model as far as innovations. I think there have been successes but also challenges in that, so just really ensuring that the voice of the consumers, particularly from a mental health perspective, is definitely heard during this process.

Some comments in terms of some of the key questions for stakeholders under #4 and 5, as far as the centralized administration functions, I was wondering if you could comment, I know it's still in the preliminary stages, but we already deal with a lot of bureaucracy, as you know, just concerned about how further bureaucracy could impact delivery of services, even the basic process of billing or contract execution which could potentially delay services. I think that's always an ongoing constant issue that providers face and ultimately consumers are the ones that suffer from it.

Dr. Ghaly's Response: On your last point that's certainly something I've heard very clearly. I don't think anybody in this room wants more bureaucracy in the county. That's come through and, I think, very practically people raised issues of contracting, of procurements, supply chain issues, financing, billing, claims and making sure that an agency doesn't just create another layer of that, so that you have it in the department and you go to the agency level to do it all again. That would be a very bad outcome.

Q: I'm choosing to view this as an opportunity. One thing we do well and that I've been very hardened to be part of in this department is to participate in this body and be aligned with the recovery approach. You see before you a real partnership of people who are providing services, people who have "been there, done that", people who are caregivers, family members, consumers, and living proof of what we do works.

Before this I worked with DHS in a program that is now under DPH. The office of aids programs has gone through some changes. It was very informative to me. It was very inspiring to me be part of that, of what was really recovery based and very activist oriented approach to being involved in services. It's my hope that there will be some synergy and that what we do here will inform the other agencies and that is being taken into account, of course. We are all here at the behest of being in an advisory capacity to MHSA. So we will persist.

That leads me to a question. What other advisory bodies and entities have been consulted? We are a loud a rangy bunch here. I know you spoke to us last week about, as part of UREP, about our concerns for our underserved and underrepresented communities. But I'm just wondering what other, because I don't know everything that goes on in the county, entities or commissions, like the American Indian Commission, for instance.

We're a small community, the American Indian population, so we touch all parts of the system and we do it as best as we can. But we're somewhat disenfranchised and I know there are all sorts of underserved that have advisory bodies and commissions. To what end have they been contacted to weigh in and provide input? That includes the Gay and Lesbian community and the deaf and hard of hearing communities.

Dr. Ghaly's Response: I have some copies. There is a list of groups that we are proactively reaching out to that we've met with. Sometimes they're grouped together for a chance for multiple different groups to come together at the same time. Per their request, sometimes groups want an individual meeting. This group was developed with the feedback of the 3 department heads. We asked them to send to the CEO a list

of the stakeholder groups that they wanted the CEO to engage with. Also, some other groups have self-identified just by calling me or by, there is a place on the county CEO website, where you can ask to be included in the stakeholder process.

I'd be happy to accommodate any group that wanted to weigh in on this. So if some of the suggestions that you made in American Indian Commission or others, if they want to have a chance to engage you can either point them to existing mediums that are set up if they want to go or if they want to have a separate meeting I'm happy to do that. The website is a great place to do that. There is a place, I think its "Contact Us" where they can put in their request.

Q: What Mark referred to, for those in the SLT that weren't aware, we had a meeting with the cultural competency committee and UREP communities with Dr. Ghaly to give our testimony and feedback. Some of the issues that came up, I'll just summarize our concerns, that this kind of consolidation would result in higher percentages of disparity and also the issue of cultural competency of course is as important to all of us.

The API's presented and Dr. Hatanaka presented some research of the literature in terms of this kind of consolidation. I want to put in that we think it's important that the report have some references that show researched literature on this type of merger because he seemed to feel, from his research, that the success rate is pretty low.

I know that there are a number of work groups, about 17, going on now amongst the 3 major departments. I'd like to know how the information from those work groups will be incorporated into the report. My understanding is that a lot of it is a very detailed, administrative work that actually is "How to implement a consolidation" rather than discussion whether or not a consolidation is possible.

Dr. Ghaly's Response: There are 17 work groups. The stakeholder is someone—they have involvement from each of the 3 departments; the individuals that are involved in those groups were identified by the department leadership. There is a facilitator not from the department who is helping to guide people through the discussion. The discussion is about the 5 questions that the board asked for the response on opportunities, drawbacks, proposed structure, implementation steps and timeline.

The feedback from those groups, the facilitators are typing it up making sure that the group gets a chance to weigh in on it for accuracy. It will then be sent to me and incorporated into the document. Then, absolutely, that's again the purpose of that 30 day comment period to make sure that there weren't omissions, errors, or inappropriate statements made, that there can be opportunity to correct those.

Q: Does this Dr. Katz going to have anything to do this report?

Dr. Ghaly's Response: Dr. Katz is the head of the DHS. Each of the 3 heads of the departments will have a chance to read and edit the document before it is released to the public, Dr. Katz as well as Dr. Southard and Cindy Harding. When it's released to the public there will be broad stakeholder input and then again before the final document is completed the department heads, the 3 department heads including Dr.

Katz as well as the others, and then also county counsel in department of human resources and the CEO also will again review and edit the document before it's final.

Q: I just want to know what his role is [Dr. Katz].

Dr. Ghaly's Response: His role is the same as each of the other 2 department heads.

Q: I'm not going to repeat what we gave you because I felt it was well done by all of those involved in the cultural competency committee and all of the UREP groups but I'm going to reaffirm the issue of disparity and cultural competency. We clearly made it clear that cultural competency is not just a linguistic effectiveness, it's also about understanding the people and doing the right things and letting them have a say.

I'm going to reiterate, for the group, that this is just one body that this department has created a process that allows people to give input to changes and things that they are going to do before they do it. They've been very gracious in doing that. They don't do everything we want them to do but at least they're kind enough to hear it and we see that they do incorporate some of the things that we're suggesting, that they're capable of doing within the structure of their organization. I hope that in this reorganization whether it be at the top, in the middle, or at the bottom, that there is a process that continues to allow this voice to be heard and things to happen.

This department has done an outstanding job of going out and testing different models because I didn't hear about that in your comments. We need to take into account what they've learned, how they're doing it, and what all the contributors are saying about what we can do better. The third thing that I'm not hearing and that really concerns me is, "What kind of service model this entity is going to create?", especially at the crossroads and the points and services that a client needs crosses these intersections in the quadrant of services from health, mental health, and public health and even substance abuse, how that inner case management will work, what that will look like and the shared case documentation will look like? I'm not hearing about the practicality on the ground as to what that will look like. I'm very concerned that we're talking here but not talking about what the people will see.

Dr. Ghaly's Response: Certainly a lot of that work will happen over time, which is the work of the departments, agency, and the integration work. In a 60 day report back there is no feasibility. It wouldn't be realistic nor appropriate to try and outline how services are being fundamentally changed. That's not the purpose of the report.

Comment: As a county employee I'm going to remain agnostic about this whole proposal but I have been involved with the Katie A lawsuit for many years on the department's side. I do have concerns about this proposed change and our county's ability to meet the mental health needs of the children we serve. Some 85% of the children we serve in our department are screening positive for mental health needs. Under the Katie A settlement agreement we are approaching those families with the teaming approach that does require all professionals to sit down the family together to effect positive change to the extent that the models under which services in public health currently operate I just hope that we can figure out a way to continue moving toward our exit strategy on the Katie A lawsuit.

Q: What is that lawsuit?

A: It was a settlement agreement that was crafted in 2002 and finalized in 2003 in which Los Angeles County and the named defendants were children services, public health, I'm sorry, health services and probation agreed to make a reattempt to close MacLaren Children's Center, MacLaren Hall, improve mental health services to children, to have better stability in placement for kids, prevent kids from moving from placement to placement, deliver intensive home based services to families and therapeutic foster care, in a nutshell.

Q: Who were the plaintiffs?

A: The plaintiffs were a group of children at MacLaren Children's Center who are represented by a couple of law firms, Western Center for Poverty and Law, being principle.

Dr. Ghaly's response: I would say, in general, if the work of the department is great and if there is no benefit from greater collaboration or involvement by others it should just be left alone. I think everyone would agree that the agency shouldn't have any scope or desire to touch things that are working perfectly well.

Comment: I would like to reiterate that clients/consumers be a part of the stakeholders and a part of the decision making for this agency and that we not be left out. Also, I'd like to say again that everyone from top to the bottom needs to be trained, taking this on, about mental health. There is a lot of stigma around the board. This needs to be raised. Those are the 2 things I would like to point out.

Comment: The American Federation of state, county, and municipal employees is not yet taken a stance, yes or no on this, because we're interested to hear and give input. One of the things that you know already is that the people in this room and a lot more have worked long and hard over the last several years to improve and expand mental health services in Los Angeles County. Everything's a work in progress.

I think probably what a lot of us fear is that mental health become a stepchild to another department and sort of undermine all of the work that we've done. Even now in some of our integrated programs or co-located programs there are still struggles when we're working with other partners. Oftentimes mental health does still get steam rolled by those partners. It's our house. Well it really isn't anybody else's house. It's the county's house and the mental health mission needs to be carried forward no matter what the walls look like.

We have problems with our probation side. There are significant problems in the DMH, DHS collaboration programs. They are kind of a mess. We would just like to see that if this process goes forward as an agency that mental health be protected in that way and keep its strength and not be subsumed.

The second issue though, I know that this is more about service than money, or that's what's being said, but there could be an opportunity for efficiencies, and I see it, not necessarily in direct services but in what supports direct services, which is like the human resources piece. Each department now has its own human resources. Some, frankly, are done better than others, more professionally, more efficiently, just a lot

better. So perhaps we could look at, if we do go toward this integration, combining human resources and taking the best practices from who is doing it best and get rid of all of the junk.

Q: I still haven't heard what the advantage to the DMH there is in this process, how it will positively impact the DMH. Until I hear that it's kind of going in one ear and out the other.

The fact that #3 is only on here as a key question, and I very much appreciate that you added it as a key question, is pretty compelling and pretty important. I think that should be the question that we're addressing and discussing.

You talked about the fundamental changes and services aren't addressed aren't what we're talking about. I can't imagine how we're doing this before we look at what the fundamental changes and services for our consumers, clients and patients would be. That just doesn't make sense to me.

Dr. Ghaly's Response: We are looking at the services. But it's not at the level of actually planning. I think the example given was, "What is the new model for integrated case management?" Actually defining that new model is not the work that's being done in the 60 day report, but it's not that services aren't being looked at.

Response: I understand that. But until we can have a sense of what those models would look like it's difficult to support or not support this. I really appreciated your comment that the agency shouldn't touch what is working.

I know this isn't exact fit. I know it's not exactly the same thing. But I watched and am watching the CCI process, the Coordinated Care Initiative unfold and have been involved in many stakeholder groups from the last 1115 waiver on to that. One of my experiences has been that the DMH, I cannot even describe the amount of work and the complexity of the spreadsheets that they had to develop to try and make it work.

Then we watch and we watch the fact that the consumers are not interested in this. They're opting out of this. I just think that's something that should be looked at, what's working and what's not working in something we just tried.

Q: Will, hypothetically, these 3 entities have direct access to the board of supervisors as opposed to having to go through the head of 3 agencies?

Dr. Ghaly's Response: I see no reason why communication with the board would change. Right now the department heads don't report to the board directly, none of the 3 do. Until a month ago they reported to the deputy CEO of the county who then reported to the CEO of the county who then reports to the board. Certainly, despite that structure the department heads have a very robust set of relationships and communication with the board. I don't see that the agency structure would change that. Even within the departments themselves I know of many examples where there are certain units that have very strong independent relationship with the board apart of the department heads' involvement. So don't think that that relationship with the board is dependent on that structure.

Response: Maybe it can even be improved.

Dr. Ghaly's Response: That would be great.

Q: The issue of co-occurring disorders and co morbid conditions, I'm just wondering at a pragmatic level if you could just tell us what do you see from what you're hearing would make it better for a client/consumer who suffers from both mental illness, physical illness and substance abuse, how this combined agency could make a difference in terms of their care pragmatically?

Dr. Ghaly's Response: I would love to hear from people in the room about what they would like to see happen. A lot of what I've heard is about steps for how you get in the door. I know from a lot of providers who have spoken; clinical staff and nurses who have spoken, they talk about how challenging it can be. It's very hard to figure out how to connect people to resources and services for whatever is the scope for things that they need.

There are a lot of reasons why that's hard. I don't want to pretend that it's one problem only. It's many different problems. It's referral systems, IT systems, registration processes, protocol, policies about who gets care and who doesn't get care, sometimes it's financing streams, this patient qualifies for 'this' so they get 'this' services and you try to link it all up.

It's very complicated so there could be a lot of work done to try to improve that front door access. I think there is a lot of work that can be done to help reduce health disparities and try to make sure that the benefits are felt broadly across population. There are a lot of populations who don't; some patients and clients and consumers get excellent service no doubt, there are many examples of people who have come forward and said, "I get great service." But I bet all of us know, in this room, certain segments of the population, whether it's ethnic groups, specific places where individuals where individuals live, incarcerated individuals, foster kids, medically challenged and frail elderly, there are a lot of patients that don't necessarily get good services and where there are disparities there are opportunities there.

Actually at the site of care those models, whether it's case management, collocation, there is a lot literature written about this, [inaudible] did their recent report, there are many documents put out there about, "What's the spectrum of services of integration at the point of care?" People wrote them and they are out there. Certainly, we could do a lot better than the models that we have put in place which I agree have a long way to go.

Comment: If the goal is to improve care certainly I hope that we maintain that goal while we go through these changes. We've talked a lot about cultural competency and the importance of that. But I also want to look at it as a broad base, that we really need cultural competency between the 3 agencies that we need to understand each other's cultures. I think that's some one of the fear, that some individuals are probably expressing in this room, that DMH has worked very hard in trying to establish a culture where it's all inclusive and to really look at the broad base in how mental health has affected many different individuals at many different levels of services. I hope at some point that's not lost.

The other thing that I think we need to look at is really, "What does integration mean?" I haven't really seen much of a definition thrown out there. We talked initially about consolidation. Now we want to throw out that term because that means doing away with something or bringing people together. Now we're looking at integration. So, like some of my colleagues in this room have been expressing, I'm sort of stuck on question #3 as one of the key questions about, "What kind of model are we really talking about?"

I just want to share anecdotally one of the roles, and I've introduced myself oftentimes as a SAAC co-chair for the city of Long Beach, department of human health and services or commonly known as the health department, and I had the great opportunity back in 2008 to be hired as their first mental health coordinator into a public health arena such as that. I can tell you, first hand, that even though that I was working within a very welcoming environment the understanding of cultures in terms of mental health and physical health, particularly in the public mental health arena, we did have some challenges in that aspect.

I think it's very important that when we talk about cultural competency that we really have not only an understanding of each other's culture but flexibility within each department's cultures to try and come together to meet the client's need, that's really what we're talking about here, the client's need and what it is. Being in mental health for over 30 years I saw the client take a back seat in the treatment for many years and now I see them into the driver seat more often. I just don't want to see that lost for whatever direction that we go.

Comment: However we move forward it's my hope as a manager, a psychologist, and more importantly as a veteran myself that we continue the forward momentum and focus and innovation that we've demonstrated here in the past 5 years, that this department has concerned itself with the mental health needs of our veterans who, regardless of VA eligibility or discharge status, it's my hope that we continue that. It's led to unique partnerships with the VA. Through our work and some of our pilot projects it's also led to national change in them approaching or accepting housing first. It's my hope that we don't lose that focus.

Comment: One of the reasons that we are so worried about what's happened it's really important that we learn from the history. We definitely don't want history to be repeated. We want to learn from it. History and the different organizational developments that have happened throughout the times have shown us that more bureaucracy has always ends up hurting the people. [inaudible] makes their services go down, the access to them is a lot worse, the delay of services becomes worse, access, the bureaucracy makes things more convoluted and makes it a lot more difficult for the culturally diverse populations, especially the underserved, un served, and the inappropriately served to be even worse and to be not only not be considered but actually kind of disappear.

In the contrary, what we need to do is to make sure that they are in the forefront. If the board's goal is to make sure that we better serve our community the way that we can better serve our community is to decrease bureaucracy, not to increase it. An overarching umbrella agency would only increase more administrative costs. I know that it hasn't been discussed yet but somewhere, somehow that is going to have to be addressed and the more administrative costs, the more bureaucracy, the less money and the less resources and energy will be geared toward the people that need it the most.

In our cultural competency committee we support integration but integration is much more than just 3 departments. Integration really must include the stakeholders, the grassroots communities, and our faith based organizations that are in the forefront, our nonprofit organizations and collaborators. We need to make sure that we bring the services to the neighborhoods rather than take them away.

In terms of centralizing, one of your questions is, "Should we centralize any services or any functions?" What we need to do is not centralize, not take away the services and the programs into a much hierarchal and much more difficult place to access but actually bring it down to the neighborhood level. There really is no need for an overarching or umbrella agency. We need to come together in the neighborhood situation and make sure that everybody, all of the stakeholders, all of the departments that are being needed in those neighborhoods, [inaudible] all of us work together at that point, not bring or add to the difficulties of doing that.

Q: Since I represent parents of children I want to say first and foremost that I'm the first one to say that I don't represent the exact ideas of all parents but that is my concern too. When you're coming out asking for stakeholder input and you exactly don't know what the integration or whatever it's going to be is going to have how do parents comment on that? How do people who don't understand bureaucracy comment on something they don't know?

After it happens then they're going to say, "Well how come this is happening? Why is my child being moved from here to here? Why is my child being done this and this? That's my concern. We're going to change things and parents, and I know a lot of other people, caregivers, have a hard time accessing services as it is. Now if this changes, and I know they're saying there are not going to be any changes, but I can't say there are not going to be any changes. I don't see it that way. Parents are going to be lost with their children, foster parents, caregivers, whoever, because they're not going to understand the bureaucracy of what's going on.

Comment: NAMI families have spent decades developing a relationship with the department of mental health. Dr. Southard has been very open to listening to our feedback and our concerns as well as everyone in the department all the way down to the line staff. That is a necessity for families of NAMI. When we're dealing with something that is so much stigma that we have to fight every day we need our staff to be responsive and adding an additional layer will make it that much more difficult and add that much more stress to the family burden.

Comment: I'm here representing 27,000 employees. For us we're in every facet that is in the county as far as public health, mental health and health services, also in the jails, department of probation, etc. We're working very closely with all of the contractors and all of the partners out there.

Our concern is obviously this year is a bargaining year. We expect that we would continue to bargain in good faith. We also are at work diligently in many facets in different labor management groups and different process with all of the different departments. We're hoping that would continue and that, in fact, that from the bottom up that our employees could actually be released on county time to come work within the different groups out there to show and actually brainstorm what things are working and what isn't working, and also from a lot of the consumers that we serve.

We know that our obviously our employees are going to be impacted as we are trying to deliver the services. Ultimately, we're definitely concerned that all of the hard work that has been done in here and all of the hard work that we've all been working toward could be stifled in this particular process of agency integration or what we want to call it. Our concern is that all of a sudden there will be a magical hiring freeze when we've always been trying to get more staff hired so we can actually serve the public.

Q: In your summary you say that the strategic priorities of each department should align with the key goals and strategies established by the agency. If there is disagreement there what is going to be the mechanism for ensuring stakeholder input in terms of resolving those differences?

Our executive director also wants to comment that he agrees that oftentimes mental health does take a back seat. The probably that you're ultimately trying to solve here isn't going to be solved by making the system bigger.

Q: I want to raise an issue that I didn't see addressed in the various Katz memos and the other related documentation nor have I heard much said about it today. We all know from both anecdotal and an empirical basis that there is a director correlation between the size of a health provider and the percentage of the clients they serve or are purported to serve that fall through the cracks.

If you want to visualize that you can look on one end of the spectrum and see a private practice provider and on the other end we keep reading lately what's going on with the Veterans Affairs hospital healthcare system. This fact would seem to inform that we would be moving toward further disaggregation rather than the kind of aggregation that you're talking about. I just want to lay that out there and hear your thoughts.

Dr. Ghaly's Response: I think it's a good question. The question is always, "How can services, broadly defined, be improved?" I think the right model certainly depends on a lot of different factors. There are people that think it should be small units, that there shouldn't be a DHS or a DMH or a DPH; that those entities should be split up, that more should be done by private providers. I think there are pros and cons of all of those different models. I think the important piece is what you mentioned; to make sure that the system is set up that for those who would otherwise fall through the cracks and to be attentive to that.

Q: I'm going to ask you to involve with a public dialogue with me because this is my fourth interaction with you. I've watched you listen. I've watched your words change. I'm truly hoping that by the time we get to our seventh interaction which is when science says we can be friends that our relationship will have trust.

But I've got to talk about an elephant in the room for me. I believe I am hearing you say that you specifically are on loan from DHS to the CEO's office. I believe in another conversation that I heard that was for 6 months. So I'm assuming you go back to work for DHS at the end of this, or who knows what happens.

But I'm also hearing you say that your job is to write the report on the agency and I am making that with large florescent signs with 'Agency'. I'm also trained as an executive coach. One of the things you said is that good work being done. The question is, "What is the best way to get to the next level?" If that was the key question for everything that is going to go on you can't leave the task that you've been given and answer that question, can you?

Dr. Ghaly's Response: Well I'm not sure that I understand your specific question but just on the facts that you've opened; yes, my permanent role and my item within the county is within DHS' item. I was reassigned by Sachi Hami, the current interim CEO of the county from DHS to the CEO where I currently report to Sachi. The reassignment took place, I believe, it was on January 20th, plus or minus a day or two, somewhere in there. It may have been a couple of days prior to that.

There was no timeline given for my reassignment. I've heard people say 6 months. I haven't been told 6 months. I don't know how long I'll be there. I think how long I'll be there to a large extent depends on what the board chooses to do in May and then what people feel like, particularly the board, are the next steps for that.

I do anticipate that I would return to the DHS after my reassignment to the CEO's office ends. But that is not my decision. That is Sachi's decision.

Response: From the point of view of the conversation that I'm hearing in this room of the concern that we have with an additional layer of bureaucracy and the concern with the individual, who, at some point in their life faces a challenge and needs the support structure in order to rebuild their lives are you the person that can carry our message back or do we need to ask someone else to listen?

Dr. Ghaly's Response: Carry your message back to whom, to the board?

Response: Mm hmm.

Dr. Ghaly's Response: My role is to write a response to the board that answers the questions that the board asks for a response on; and that is the opportunities, the drawbacks, the structure, the implementations, steps, and the timeframe. I will do my best in all transparency to incorporate input into that response. The comments in the report will be focused on those 5 issues with the added note that because there is so much interest in other topics I do plan, like with the alternative agency models, to at least point out that there were other points raised that are outside the scope of what the board requests a response on.

However, that is not the sole voice that goes to the board on this issue. I would encourage people to the extent that they don't like the agency, like the agency, want to see something else, to speak to their elected representatives or their staff, the deputies, about those thoughts. In no way do I see my role as being the funnel or the tunnel where all input must go through me.

My job, my reassignment, is to respond to the directive of the board. They have said that they approve the agency in concept, that's their words, not mine, and to write a report about it.

Response: I appreciate that and I think there is hope for our relationship.

Comment: You have actively been involved in a stakeholder process. I really want to underscore how we have a group have focused on, for example, identifying service gaps that exist among our vulnerable populations. So you are embedded in this and have been observing this process and I'm glad that you're here.

You mentioned in your opening remarks about social determinants of health. I had the honor of representing our UREP Latino committee and I discussed how the circumstances under which people are born, grow up, live, work, and age as well as the systems put in place to deal with these illnesses. We also know that these are shaped by economics, social policies and politics. I truly believe that's something that's going on as we speak as well as issues of trust that are continuing to emerge and pink elephants in the room, for example.

One of my worries is that when we talk about these social determinants that zip codes will continue to determine how long you live with this consolidation. Folks have already mentioned that a grassroots, bottom up approach to address these root causes of the disparities and inequities that exist within our vulnerable populations is paramount. So called social justice approach is really imperative and that's something you are hearing as we go through these stakeholder processes.

Another concern is that the agency or a medical model has no history of having a grassroots approach, in my opinion. Truly, a top down, into what our clients and consumer residents need will guide our work.

Comment: I was the first co-chair of the DMH clergy advisory committee. I currently serve on the executive board of what has been renamed, I say this because sometimes I sense there is not really good communication between all of the various entities within DMH, of late we were asked and we agreed to change our name. Clergy Advisory Committee became the Faith Based Advocacy Council. The difference between advising and advocating is not semantics.

That we adopted that approach I think reflects the fact that we became more and more cognizant to the fact that the faith community has a unique voice. We're not here to rubber stamp, even though our organization serves under the auspices of DMH, we as faith based providers who are frequently, statistically, the first place that people turn when they're in trouble, are not just some kind of a quaint icing on the cake in extracurricular activity but have a unique and indispensable role to play in every aspect of mental health, not just when mental health needs buy in so that we can swing open the gates of our community to interject projects, proposals and programs which we had no say in creating whatsoever and to somehow mistake the coming to us for a 10 minute pilgrimage to hear what we have to say for 10 minutes, to then leave us completely and totally out of the loop, except when you need us to open up our congregations to your projects.

So the mission statement that we have, "Integrating spirituality into mental health for hope, wellness, and recovery" and that means true integration, not the icing on the cake but there when the cake gets baked, part of the ingredients. Carol Myers, she made a pilgrimage to us, and our faith based advisory committee, she sat there for the better part of an hour and my sense of it was that as far as a faith based community is concerned, and this whole project, as well as health neighborhoods, we're done. Everything will be done without us. We will not have a voice at the table. Adrian Hemet who works for the community relations group, I didn't know this, in one statement there was a list of stakeholders that included educational, political, and labor, no mention of the faith community at all. But I guarantee that when you're ready to come back your present whatever we [inaudible] you will expect that we will open up our communities to you because you came to us for one hour.

I'm saying it's too little, too late. We've heard, Helena mentioned about this woman who only didn't hear voices when she was in the Catholic Church. Is the Catholic Church represented in this process? Do we have an ongoing place at the table? Adrian suggested that the initial proposal be amended, that the faith based community be mentioned by name and just not as a picture on a diagram, which it is with the health neighborhoods because increasingly we're recognizing that there is a great expectation that we will be there for you when it comes time for you to interject predominantly clinical programs on our communities which we're not sure truly reflect our values.

Dr. Ghaly's Response: I welcome your comments. Obviously, I think your comments speak to a broad issue that I won't try to solve in this context. But I would say that I would be happy to engage more with the faith based community. I would love to do that. The stakeholder list was developed by the department heads and then by those organizations who self-identified. I'm very open to including--

Response: Are we on that list?

Dr. Ghaly's Response: I can give you the list because there are different groups--

Response: You mentioned that there are 17 working groups.

Dr. Ghaly's Response: Those are the interdepartmental groups. I'll give you a copy of the list and let you see it.

Response: Are we on it?

Dr. Ghaly's Response: What's the name of your group?

Response: Faith Based Community.

Dr. Ghaly's Response: "DMH Faith Based Advocacy Council."

Response: That's my group but I'm really representing a larger voice here which is the general-

Dr. Ghaly's Response: I understand. There still needs to be the people, the group, and some forum to do that. I'm happy to be open in figuring that out. I don't want to shut down those lines of communication. I fully support the involvement of faith based community. In the vision statement we did incorporate in faith based community because I think that inclusion was very important.

Q: I'm still listening for, "What is the benefit of this happening?" Please get it across to the board of supervisors, "Before you do something like that again you do what we're doing now." Before you even decide you're going to consolidate you should have been out here. Make sure to reiterate what I said do the board of supervisors. Before they take on another thing like they what they [inaudible] were going to pass do the study out there first. Find out what the people think.

Q: My concern is record. I think the issue is, again, voices. I'm a commissioner with the commission for children and families. Often, health services has really looked to private partners such as Mattel's children's hospital, Miller's children's hospital, Los Angeles children's hospital, rather than dealing with issues within health services itself.

There is one ray of light at county and that's someone who's a maverick, who really doesn't follow protocol, and that's Dr. Astrid Heger. She's really developed some innovative program. Probably administration cringes but she's managed to get all of her programs funded privately.

I think talking about children, trauma is so important to realize. Kaiser hospital had the eight study on adults. It showed that adverse childhood experiences do matter later in life. I think this is the thing, here what children need.

Q: I'm head of the Los Angeles Greater Agency on Deafness and I'm an advocate for them. I want to provide some feedback. We have so many deaf and hard of hearing clients that are coming in and lining up for services. Oftentimes, their continued services, they have to come in again and again asking for these services. It's sad because before we had "signing health" and it shut down. It was an AOR.

Now what's left is one direct service, services for the mental health. There is just one agency right now and it's in Santa Monica. LA is huge and not all of the deaf people can go over there to get the services from that one place. Anyway, what we're proposing that integration I hope--what happens is when all of the departments provide services for the deaf and hearing the communication is under one problem. But there is oftentimes one interpreter. Mental health really needs skilled interpreters. They put them in these facilities and they send them home and they're still not healed and recovered. The providers don't have the cultural competency to deal with the deaf clients that they're supposed to be serving.

With this collaboration, integration, when you put these deaf people in these services and there is no cultural competency, there is no language, there is no efficiency working with these deaf clients that need the mental health. They need this continued therapy. They need to go through these models but the percentage is so low because there is no communication and no cultural competency. We have a few

organizations in the city that are working and I hope that we can see that they all be able to be involved to help this to become successful. We all need to be involved in this.

Comment: There was a discussion about the department heads reporting to the board. I understood you said the agency structure wouldn't change that, not reporting directly, but whatever their current relationship is to the board and that their relationship with the board wouldn't be dependent on the structure. In considering other models I'm thinking that maybe the most important thing that still is not clear to me is, "What

does the agency model look like?" I know you don't want to say and dictate what the structure is but that structure is critical to what we're analyzing here. Is it a structure where the 3 department heads report to an agency director and they can't say anything before they go the agency director?

One of the comments I made in front of the commission is what I saw was distributed at the cluster meeting was that the understanding that the agency model had the 3 department heads overseen by the director of health services. If that's a model that's very precise and very clear. To me that does not mean autonomy. That does not mean independence. It means that the director of the agency is the one that speaks on behalf of all the agency and not the independent department heads. So I'd really like to know, again from your perspective, what the agency model looks like. Is the purpose to coordinate or honestly is it to dictate in terms of what goes on in the health department? Are all 3 department heads co-equal or are they all really overseen by the director of health services?

A related question is a rhetorical question. Maybe you can't answer this. Would Dr. Katz support an agency model if he wasn't the head of the agency?

Dr. Ghaly's Response: In terms of the agency model my understanding from the board, and certainly when people talk about an agency and the government, not the business world, but in the government context it does imply a direct reporting relationship. I don't know of any examples of an agency where that agency is not directly supervising whatever is under the agency. Certainly, that's my understanding of what the board intends through use of that word 'agency', that's what they're talking about. Yes, it is a direct reporting relationship.

The purpose of the agency is in terms of setting a strategic direction, vision, promoting alignment, coordination, and communication. Is it to dictate? I realize that's partly rhetorical. No high quality agency director takes an approach of dictating. But obviously it depends on who's in the position, ultimately, what their style is and their manner of interacting is.

I would say that with respect to the board, and I do really believe that the relationship with the board is largely dependent on the board, on their level of interest in the topics, on their level of relationships with the individuals and those relationships can be very strong despite the fact that there is not a direct reporting relationship to the board which doesn't exist now and wouldn't exist with an agency. I don't see any reason why necessarily that agency creation would change that.

If the board of supervisors or the deputy, we can't control what they do. So I think it's a good question to ask them what their intent is. Certainly the creation of an agency itself doesn't change that. Your last question I realize is rhetorical. I'll let you present that question directly to Dr. Katz.

In the documents that I shared at the health cluster meeting there was nothing in there that the agency director would be the director of health services. There is nothing in the board motion that says the agency director would be the director of health services. Ultimately, that's the board choice, about who they appoint to be the agency director. That's their decision. They could select Dr. Katz, they could select somebody else. But there has been no formal comment on that.

Response: Is it possible that the agency director would also be one of the department heads?

Dr. Ghaly's Response: I would say yes, particularly as a means of not adding administrative cost and not adding bureaucracy. My understanding is that yes that's a model the board is interested in.

Response: So to the extent that the director of health services was the agency director then the directors of public health and health would report directly to the director of health services.

Dr. Ghaly's Response: In your example, if that's the case, it would report to the agency director when that case has 2 roles. If he kept the role of the head of department of health services and then if he was the agency director he would hold 2 roles in that model if that's what happened. Ultimately, that's the board's decision.

Public Comments

Comment: I wanted to thank the members of the SLT for so eloquently expressing our concerns about this proposed consolidation. My experience is that when a structural change like this is proposed it comes usually from a place where people aren't satisfied with the current structure. At least there is an implication with that.

I was resonating with a lot of the concerns that people were expressing. I think a lot of that is because if you take that for granted and say that there is an implication there that things are not working or that they could work better we're sort of left without an understanding or a statement or a concern about what could be working better. We have no sort of statement on the part of the board about why this consolidation is taking place. So we're left with our fears and anxieties about what it might be.

Most of us have spent decades forming relationships. I have a long relationship with the DMH. I've only known you for 5 days. So it's difficult in the context of not having a structure to react against. Several people sort of brought this up. So if we could hear from the board, and I think that should come from the board rather than from the DHS about, "What's the reason behind this?" What would they like to see come out of this? What's the added value? Do we get something that's really specific that would allow us to sort of say, "We can react against that." We might actually find some really good things that we could really go forward with.

Dr. Ghaly's Response: I agree. I think a lot of people would like to hear that from the board and certainly have the right to speak with the board and ask the questions that they want answers to.

Comment: [inaudible] had been working honesty and trustworthy [inaudible] see how things are working out between individuals, that's my gift since I was 8 years old, to see what's said and what's not being said. I'd like to send this message to the board, "I don't know," 80% of what's being asked, that's the response I heard in so many different words.

I have a bad day today. I don't like people to waste my time because when a leg is swollen like this it's connected up to your heart. My heart can pop any time. I live in fear with life and death, day by day. Can the board handle those? I'm just a few. Can the board handle those kind of clients and not waste their time in getting the help that they really need? Or do I have to keep going around in circles to try and figure out where our mom over here in her chair struggled to get out of bed and get here as early as she can to be able to come here and be able to hear the words, "I don't know." 80% of the response is, "I don't know."

I'm figuring out that my 11,720 hours and I know when somebody is hiding something from me, a skill that I live with 24 hours a day for 2 years, I'm skilled with that. When somebody takes my information and uses it. We're giving them suggestions for the new agency. I figured it out. We're doing the work for them on what works, what doesn't work. Maybe we could try this. Maybe we could try that. Do you really have an agency set up? Now, say the words, "I don't know."

Dr. Ghaly's Response: I understand what you're saying. I think all of us are in the same position together, working to collect all of the opinions, collect all of the input, put that to the board and ultimately the board will make a decision. I would encourage everyone to go forward and ask their questions. If they don't know the answers, if they don't know why the board is doing this or they don't know what this means to let those voices be heard to the elected officials.

Q: I'm here today for my staff who is the UREP co-chair for the API community. The bottom line is that if we're going to proceed with this we need more time to receive more input and feedback from our communities and stakeholders. They are so under-represented and under-served.

I'm going to share a story. I've been in the field forever. I still cannot understand why this happening and what are the advantages and disadvantages this change would have for our service recipients and communities? I usually help our consumers and families to have meetings and so on. I don't know how to respond to their questions, I just don't.

I want to thank the department because just a few years ago when we were really trying to help develop our consumer leaders and family advocates they were so intimidated and nonassertive. After a few times of attending meetings they didn't want to attend the meeting unless I offered to go with them. One time they refused go. I said, "I'll drive, let's go." We're in the van and I didn't see anybody in the back of the van. I said, "How come you guys are not here?" We had to take out the chairs out of the van. They never complain. They sat in the back of the van without chairs. That's how far we have come now. Our consumers spoke last week but it still is a long way to go. Give us more time. Thank you.

Q: I'm going to speak on behalf of the constituent base because at the last meeting we were together Miss Stephens made it very clear that our bodies cannot heal our minds. We are at a place now where there is so much decision. When you come to us with "I don't know" it's hurtful.

We need Dr. Katz to come in. If he is that important that he cannot come and meet with us face to face and present his position on why this must go forward I've seen the logos created now for the integration when you're still stating that, "We need the communities' input" what's going to happen? If it's not an actual structure, if this has been approved on basis of what was just said this is very alarming because as individuals just made testimony their lives, our lives are involved in this.

We do not like covert procedures, backroom deals, that's been referred to as, 'hoodwinked.' What is this? We really want concrete information. We'd like to know who the origin is? What's the genesis of this? Why is it important in this time, 2015, when we're going into 2020 where a lot of these issues should resolve?

Right now the constituency is hurting. If service providers, stakeholders, and administrators can't give you a clear picture do you really understand what we're going through? So we really need clear answers on what's happening, not the possibilities as what's to happen. We want concrete information.

Why is this happening right now? It seems like the constituents is not really their main focus. Right now during the integration process it seems more than the integration, more than consolidation. This is something that you do in the middle of the night. Could you please we have complete information on what the origin, what the genesis, and this has been asked from you prior to this. It's really weighed on the constituents.

Dr. Ghaly's Response: I'm happy to answer any other questions that there are on the subject. I've told you my knowledge of it. There is the LA Times article. There is the memo from Dr. Katz that's on the website. If there are specific questions I'd be more than happy to answer those. I stated earlier that if this group or any other group would like to extend an option for Dr. Katz to come and address questions I'm pretty sure he would accept that opportunity. But to my knowledge there hasn't been an offer.

Q: The concern that I have is that the doctors that are in the field and the local offices and hospitals don't know about behavioral health. We're trying to tie behavioral and physical health together. Necessary information needs to get out to the local doctors about this. That to me is very concerning. This is not just LA County. This is going on nationwide.

Dr. Ghaly's Response: I appreciate the opportunity to be here. I can be here for a few minutes if people want to come up and ask other questions. If there are other suggestions, questions, and comments I'd be happy to take those. Certainly I can understand the frustration, the desire for answers about some of the background, the desire to know what's in the board's mind, why did they vote the way they voted, how they came out, and I just want to say that I can absolutely appreciate those concerns and understand that. I will do my best to make sure that I will share any knowledge that I have that directly answers those questions. But I think a lot of those questions absolutely I would encourage people to speak with the board.

Appendix 3



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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. *Cynthia A. Harding*
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.

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February 17, 2015

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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.

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 13th 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 in a timely manner to protect the public's health.

Christina Ghaly, M.D.

February 17, 2015

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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

c: Supervisor Michael D. Antonovich, Mayor
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Shiela Kuehl
Supervisor Don Knabe
Sachi A. Hamai, Interim Chief Executive Officer
Mitchell H. Katz, M.D., Director, Health Services
Marvin J. Southard, D.S.W., Director, Mental Health
Public Health Executive Staff

Appendix 4



DMH LED SERVICE INTEGRATION INITIATIVES

Initiative	Description	No. of Programs	Established	Health	Partner(s) Substance Abuse	Housing
Integration of Services Through Co-Location						
Mental Health Co-Location in Primary Care Facilities						
DMH-DHS Collaboration Programs	DMH staff are stationed within DHS Comprehensive Health Centers, Multiservice Ambulatory Care Clinics, and health clinics to provide early intervention mental health services for patients with mild to moderate mental health symptoms who are referred by DHS primary care providers. Patients requiring services beyond what can be provided in a primary care setting are linked to appropriate services by DMH staff.	10 (7 Full-time/ 3 Part-time)	2011	✓		
Primary Care/Substance Abuse Co-Location in Mental Health Facilities						
Behavioral Health Home Model <ul style="list-style-type: none"> • JWCH in DMH Rio Hondo Mental Health Center • Tarzana Treatment Centers in DMH San Fernando Mental Health Center 	Co-location of primary physical health care services within an outpatient mental health clinic for clients who have an established relationship with the clinic, who may not have a health care provider, and/or have barriers to accessing health care in the community. Health care provider conducts routine medical examinations, treatment, chronic disease management activities, laboratory diagnostics, follow-up, dispensing of medications to treat ailments, and referrals to specialty care. Flu shots, vaccinations, testing for specific illnesses, HIV testing, reproductive health services, including family planning services, are also offered. On-site medical team and mental health teams confer on shared patients/clients to ensure coordination of care.	2	In Process	✓		
Co-location of DPH SAPC Providers in DMH UCCs	Mental Health Urgent Care Centers (UCC) offer assessment, initial treatment and linkage to ongoing services for individuals with co-occurring	4	2006		✓	



DMH LED SERVICE INTEGRATION INITIATIVES

Initiative	Description	No. of Programs	Established	Health	Partner(s) Substance Abuse	Housing
	disorders. Because the substance use disorder issues are most often as critical as the mental health concerns, DMH has involved SAPC providers who deliver integrated services with mental health providers at all sites.					
<i>Integrated Care for Homeless Individuals</i>						
Integrated Mobile Health Teams	Multi-disciplinary staff provide mental health, physical health and substance abuse services working as one team, under one point of supervision, operate under one set of administrative and operational policies and procedures and use an integrated medical record/chart. Housing providers are included; focal population homeless individuals.	5	2012	✓	✓	✓
Project 50	A demonstration program that began in 2008 to identify, engage, house and provide integrated health, mental health and substance abuse services to the 50 most vulnerable, long-term chronically homeless adults living on the streets of Skid Row. Due to its success, Project 50 now serves almost 75 of the most vulnerable, chronically homeless adults and has been replicated to create nine distinct programs with six service providers serving close to 1,000 individuals, including replications for veterans, women and their children, and a pre-sentencing diversion program to serve homeless individuals in need of co-occurring treatment who are identified and referred by the MHCLP from the Van Nuys and San Fernando Courts.	9	2008	✓	✓	✓



DMH LED SERVICE INTEGRATION INITIATIVES

Initiative	Description	No. of Programs	Established	Health	Partner(s) Substance Abuse	Housing
Inter-Agency Collaborations for Treatment Integration						
Health Neighborhoods	The Health Neighborhood Initiative brings together health, mental health, substance abuse treatment providers, and public health providers who deliver direct services to establish and enhance collaborative relationships and promote the integration of whole-person care, consistent with the County Strategic Plan. Seven pilot neighborhoods are under development. While the initial emphasis is on individual health and wellness and is focused at the provider level, the pilots will expand to include a variety of social service and other community-based organizations that are essential in supporting whole-person care and population health.	7	2014-15	✓	✓	
Integrated Clinic Model	Improves access to quality, culturally-competent services for individuals with physical health, mental health and co-occurring substance use diagnoses by integrating care within both mental health and primary care provider sites.	6	2012	✓	✓	✓
DMH GENESIS – DHS LAC+USC VIP	GENESIS field-based clinical staff join DHS Violence Intervention Program (VIP) staff weekly to provide mental health services to older adults who are victims of crime or abuse, suffer from trauma, depression and/or serious mental illness and also have multiple health problems. GENESIS staff review referrals, case-conference, and consult in the development of coordinated treatment plans to provide psychiatric evaluation and intervention on-site or follow up at the client’s home for ongoing psychiatric services, case management, linkage and support.	1	2007	✓		



DMH LED SERVICE INTEGRATION INITIATIVES

Initiative	Description	No. of Programs	Established	Health	Partner(s) Substance Abuse	Housing
IMD Step-down Partnerships	Partners with housing and health programs to provide supportive on-site mental health services for persons being discharged from Institutions for Mental Diseases (IMD), acute psychiatric inpatient units or intensive residential facilities, or those at risk of being placed in a higher level of care.	4	2009	✓		✓
Integrated Service Management Model	Promotes collaboration and community-based partnerships to integrate health, mental health and substance abuse services together with other needed non-traditional care to support the recovery of consumers.	14	2012	✓	✓	✓
Integrated School Health Centers	The Integrated School Health Centers (ISHCs) provide both health and mental health services to students, family members and community members, from children to older adults, in areas with a high percentage of medically underserved residents. Mental health clients benefit from “warm hand-off” referrals to the medical services, and vice-versa, providing the most efficient, accessible access to these resources. Consumers may self-refer or be referred by school personnel or the ISHC’s community partners.	16	2013	✓		

Appendix 5



County of Los Angeles
CHIEF ADMINISTRATIVE OFFICE

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(213) 974-1101
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Attachment II

DAVID E. JANSSEN
Chief Administrative Officer

June 9, 2005

To: Supervisor Gloria Molina, Chair
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

From: David E. Janssen
Chief Administrative Officer

Board of Supervisors
GLORIA MOLINA
First District

YVONNE B. BURKE
Second District

ZEV YAROSLAVSKY
Third District

DON KNABE
Fourth District

MICHAEL D. ANTONOVICH
Fifth District

REPORT ON PUBLIC HEALTH AS A SEPARATE DEPARTMENT

On April 19, 2005, your Board requested a report from my office with a general analysis of the advisability and implications, including fiscal, of separating Public Health from the Personal Health service components of the Department of Health Services (DHS) and creating separate departments for hospitals, health centers and emergency medical services.

The attached report was developed with the assistance of DHS, Department of Human Resources (DHR), and County Counsel staff and included a review of available historical documents, including past County budgets.

Combined Department of Health Services

DHS was established as a single Department in 1972 by combining the Departments of Health, Hospitals and Veterinarian to provide for a unification of all health services and a more comprehensive health services delivery system.

Despite the separate missions of Personal Health and Public Health services, both share the goal of improving the health of County residents. A unified system attempts to ensure the integration of those efforts where the service delivery systems may overlap, and a major benefit of maintaining Personal Health and Public Health in one Department is the integration of prevention activities into the delivery of personal health care services.

In addition, the current structure of a single Department has allowed DHS to move towards consolidation of administrative services, such as human resources, finances and contracts and grants, in an effort to achieve cost-efficiencies. Public Health operations are also supported by DHS for facilities management, capital projects and for certain maintenance and renovation services. Further, with respect to personnel actions, DHS is able to run centralized examinations which can be used to fill positions at any of the various DHS programs, whether in Public Health programs or at the hospitals, simplifying the process for DHS employees seeking promotional opportunities or job changes across the range of health services programs.

Public Health As a Separate Department

The rationale for creating a separate Public Health Department stems from five primary concerns. First, there are concerns regarding the budgetary impact of the projected deficit from the Personal Health Care Services (hospitals and clinics) on Public Health Services operations. Creating a separate Public Health Department budget is not expected to eliminate the potential that service reductions may also be needed in Public Health Services as a result of funding shortfalls. However, Public Health would then be in a similar position to other County General Fund departments when reductions are considered. Creating a separate Department also could potentially mitigate the negative impact on Public Health programs from staffing reductions in Personal Health Care programs.

Second, Public Health and Personal Health have different missions. Public Health's mission is to protect and improve the health of all 10 million Los Angeles County residents, while Personal Health's mission is to provide medical care for the medically indigent. This difference, and the fact that Public Health accounts for approximately 19 percent of the DHS budget, complicates discussions of DHS priorities and increases the risk that the Public Health mission will not receive sufficient attention, despite growing threats of epidemics, bioterrorism and burdens of chronic disease in our County.

Third, a separate Public Health Department would eliminate the layer of DHS management between the Public Health programs and your Board, allowing the Public Health Director to come directly to your Board regarding the financing needs of Public Health in the face of public health threats or projected service reductions. A separate Public Health Department would then allow the DHS Director to focus attention on critical indigent healthcare issues and long-term funding problems.

Each Supervisor
June 9, 2005
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Fourth, there appears to be justification for creating a separate Public Health Department given the growth in size and complexity of the various Public Health programs. The combined Public Health programs have a very wide scope of responsibility, ranging from regulatory functions to more than 30 separate programs to protect health, prevent disease and promote improved health in the population. Public Health is larger than many other County Departments and operates in many ways as a distinct and separate unit of DHS.

Finally, the serious new threats to the health of all residents require an experienced public health physician leader to act as the County's Public Health Officer, to help prevent and control serious threats. Currently, that authority, although delegated to the Director of Public Health, rests with the Director of Health Services, where an incumbent may not be a physician and may not possess a public health background.

Creating a separate Public Health Department budget would not be difficult to do since the four proposed programs, Public Health Services (PHS), Office of AIDS Programs and Policy (OAPP), Alcohol and Drug Programs Administration (ADPA) and Children's Medical Services (CMS), are currently separate budget units which could be rolled up into a separate Public Health Department budget, rather than the larger DHS budget.

However, the County funds provided to DHS to meet statutory maintenance of effort (MOE) requirements, as well as Board-approved discretionary County funds above that amount, are used for both Personal Health and Public Health Services. Therefore, given the MOE requirements, we would need to continue to track as an aggregate the total amount of County funding for both Personal Health and Public Health programs, whether Public Health remains as part of DHS or is split off as a separate Department.

Should the decision be made to proceed with creating a separate Public Health Department, my staff would also work with DHS staff on a program by program review of the Public Health programs to ensure the appropriateness of transferring each to the newly created Department.

Since there are operational arguments for maintaining Public Health and Personal Health Care in one Department in order to continue to integrate prevention activities into the personal health care system, strong agreement between the two Departments would need to be put in place if a separate Public Health Department is established.

Each Supervisor
June 9, 2005
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In addition, we would need to conduct a further analysis on the staffing needed for centralized administrative functions of the separate Department. We anticipate that this change could require a net increase in budgeted positions, although the number and potential cost would depend upon the share of existing finance, human resources, and administration positions which would be transferred to the new Department. It is possible that such costs would not be significant and any additional costs would be recommended for absorption within the new Department's available funding.

Based on our review, the proposal to create a separate Public Health Department appears to offer some benefits; however, there are also benefits which support maintaining these programs as a single Department. Since this proposal would reverse an earlier decision by your Board to create a unified County health care system, it would again be a policy matter for your Board.

If you have questions or need additional information, please contact me or your staff may contact Sheila Shima, of my staff, at (213) 974-1160.

DEJ:DIL
SAS:bjs

Attachment

c: Executive Officer, Board of Supervisors
County Counsel
Auditor-Controller
Director of Health Services
Director of Personnel

REPORT ON PUBLIC HEALTH AS A SEPARATE DEPARTMENT

Historical Background

The Los Angeles County Board of Supervisors (Board) established the Department of Health Services (DHS) in 1972 by combining the Departments of Health (included Public Health), Hospitals and Veterinarian to provide for a unification of all health services, including mental health services and a more comprehensive health services delivery system. The following provides a brief summary of some major organizational changes affecting DHS, specific to Public Health.

In 1975, a DHS organizational structure was created which consisted of five distinct regions, each headed by a Regional Director with responsibility for all hospital and health care activities, including Public Health services, within that region. The Department of Mental Health was established as a separate County Department in 1978.

In 1980, the organizational structure was changed to consolidate all of the hospitals, except LAC+USC Medical Center, under one Deputy Director, leaving in place the Regional Directors, with responsibility primarily for ambulatory care and Public Health programs. In the following year, 1981, the five regions were eliminated in order to strengthen Public Health functions and reduce operational costs, and program responsibilities were assigned to Deputy Directors for Public Health, which included the health centers, and for Ambulatory Care, which included the comprehensive health centers.

In 1993, DHS reorganized its health centers and comprehensive health centers, establishing the framework of the current system with health centers and comprehensive health centers assigned to areas aligned with the County hospitals. Ten health centers remained as part of Public Health Services.

Issues to Consider in Maintaining Public Health Programs as part of DHS With Personal Health

The rationale for maintaining the current organizational structure is that, notwithstanding their separate missions, both Public Health and Personal Health Care share the goal of improving the health of County residents through the services they provide. A unified system attempts to ensure the integration of those efforts where their service delivery systems may overlap.

Integration of Prevention in Health Care

A major benefit of maintaining Public Health and Personal Health Care in one department is the integration of prevention activities into the delivery of personal health care services. This integration has been one of the initiatives of the Director of Health Services over the past two years and has resulted, for example, in increased numbers of flu shots and pneumococcal vaccine provided preventively to inpatients in County hospitals. Personal Health, Public/Private Partners, and Public Health have co-located primary care and public health sexually transmitted diseases (STD) and tuberculosis (TB) clinics at several health centers. In addition, activities related to Bioterrorism Preparedness have required a close working relationship between Public Health and the Emergency Medical Services (EMS) Agency in Health Services Administration. While these efforts can continue even with a separate Public Health Department, having a single Director over both Public Health and Personal Health Services can provide an advantage in ensuring collaboration and cooperation when apparent conflicts may arise.

Consolidated Administrative Services

As part of the System Redesign Scenario III reductions in DHS, Public Health finance, human resources and administrative services were consolidated with Health Services Administration (HSA) to achieve administrative cost savings. Even if Public Health is allocated back its share of HSA staff in finance, human resources, contracts and grants, and other administration, additional resources would likely be needed to support a separate department, although these costs may not be significant. Further analysis would be needed to determine the level of additional staffing that might be needed. The two departments could explore areas in which consolidated activities could continue, if cost-effective.

Further, with respect to personnel actions, DHS is currently able to run centralized examinations which can be used to fill positions at any of the various DHS programs, whether in Public Health programs or at the hospitals, simplifying the process for DHS employees to seek promotional opportunities or job changes across the range of health services programs. While this could still be done with Public Health as a separate Department, as with other County Departments, there would be an added administrative procedure to follow.

Issues to Consider with a Separate Public Health Department

DHS indicates that there are several reasons which support creating a separate Public Health Department, as discussed further below, particularly if a decision is made to establish a Health Authority.

The current proposal for a separate Public Health Department from DHS includes the separate budgets of Public Health Services (PHS), Office of AIDS Programs and Policy (OAPP), Alcohol and Drug Programs Administration (ADPA), and Children's Medical Services, which are currently part of the larger "roll-up" that comprise the total DHS

budget. A separate Public Health Department could easily be established with a "roll-up" of the four budget units. From a programmatic perspective, a decision to proceed with creating a separate Public Health Department would also require a program by program review of the Public Health programs within each budget unit to ensure the appropriateness of transferring each to the newly created Department.

Consideration should also be given to including the Antelope Valley Rehabilitation Center (AVRC) in the separate Public Health Department. Previously a separate budget unit, AVRC became a part of the Antelope Valley Cluster in 1994-95. The services provided by AVRC, i.e., long-term residential substance abuse treatment services, differ from the acute inpatient care and the personal health services provided by the County hospitals and health centers/comprehensive health centers, but are similar to the treatment services purchased by ADPA under contracts with community-based organizations.

If a Health Authority were to be established, further discussion would be needed regarding the appropriate placement of other DHS programs, such as the Office of Managed Care (OMC)/Community Health Plan (CHP), and Juvenile Court Health Services, as well as two programs currently part of Health Services Administration (HSA), Ambulatory Care Services and Emergency Medical Services. A change in organization for these units is not currently recommended by DHS as part of the creation of the Public Health Department.

Different Core Missions for Public Health and Personal Health Services in DHS

The mission of Los Angeles County Public Health is to protect health, prevent disease, and promote health and well-being. Public Health activities are population-based and prevention-focused, seeking to assure a basic level of health protection for all 10 million County residents. Public Health protects County residents from the basic health threats such as emerging infections (e.g. pandemic influenza, SARS), bioterrorism, other communicable and food-borne disease outbreaks, toxic exposures and preventable injury, as well as working to prevent chronic diseases such as heart disease, cancer, and diabetes.

The DHS Personal Health Care mission is to provide or assure health care for the medically indigent. This safety net function is available for County residents who find themselves without any other access to affordable care. Some safety net services, such as trauma care and disaster-related emergency care, are supported by government funds for the expressed purpose of protecting all County residents during crisis.

Under the current organizational structure, ultimate responsibility for all DHS recommendations, including those related to Public Health Programs belongs to the Director of Health Services. However, in practice, the distinct roles can often be seen in the lead role played by the Director of Public Health and Health Officer on Public Health issues of interest to the Board of Supervisors and the community at large, such as Bioterrorism Preparedness and disease prevention and control, including cases such as Methicillin-Resistant *Staphylococcus aureus* (MRSA) and West Nile Virus.

Given both the growth in size and complexity of Public Health Programs and the myriad critical issues facing the Personal Health Care system, the responsibility of administering both major parts of the public healthcare system presents tremendous challenges to DHS senior managers. Therefore, DHS indicates that consolidating Public Health Programs into a separate Department would allow the Director of Health Services and senior leadership in DHS to devote their time and attention to the pressing patient care and operational issues in its hospitals and comprehensive care centers.

Legal Responsibility for Public Health Emergency

One consequence of having Public Health within DHS is that the responsibilities of the Health Officer are assigned by County ordinance to the DHS Director, and are delegated, at his or her discretion. While the Health Officer responsibilities are currently delegated to the Public Health Director, DHS indicates that the roles of the two Directors in public health emergencies can be confusing and unclear. It is essential that the responsibility for a public health emergency be clearly assigned to a Health Officer with broad knowledge and experience in public health and epidemiology and in the management of public health emergencies. Having a separate Public Health Department with its Director designated, under County ordinances, as the Health Officer would provide clear responsibility and accountability for management of a public health emergency.

Growth in Public Health Responsibilities and Scope of Responsibility

In the aftermath of September 11, 2001 and with the growth of global infectious disease threats, public health protection has grown as a critical priority responsibility. PHS has primary responsibility for early detection and control of all bioterrorism, as well as detection of chemical and radiological terrorism. In addition, PHS has the responsibility to prevent, detect and control serious old and new infectious diseases such as Severe Acute Respiratory Syndrome (SARS), pandemic flu, and the Ebola Virus.

The combined Public Health programs have a very wide scope of responsibility, including significant regulatory functions, such as licensing all 36,000 retail food establishments and all hospitals (except DHS and federal) and nursing homes. Further, it operates more than 30 separate programs to protect health, prevent disease and promote improved health in all segments of the population. These include alcohol and drug prevention and treatment programs, HIV/AIDS prevention and treatment programs, a variety of programs to improve maternal and child health, women's health, lead

poisoning prevention, prevention and control of toxic exposures, assessment of health of the overall county population and major ethnic/ racial groups, services for children with special health care needs, smoking prevention and control, prevention of injuries and of chronic illnesses, bi-national border health, tuberculosis control, control of sexually transmitted diseases, detection and control of acute communicable diseases, bioterrorism prevention and response, public health laboratory functions, including both biologics and chemical health threats, veterinary public health, public health nursing, dental health, radiological health and others.

Public Health Is Large Enough To Run Efficiently as a Separate Department

Combining the budgets and staff of PHS, OAPP, ADPA and CMS would establish a total budget of over \$650 million annually, based on the 2005-06 Proposed Budget, and almost 4,000 budgeted positions, which would in the aggregate be larger than many existing County departments.

The consolidation of these four units as a separate Department would require establishing centralized administrative units for finance and budget, contract development and monitoring, personnel, materials management, facilities management and other areas. Some current positions could be proposed for transfer from centralized DHS operations or consolidated to the extent these activities are already performed by PHS, OAPP, ADPA or CMS staff. For example, ADPA and particularly OAPP operate fairly independently in developing, bidding and negotiating contracts, and it may be possible to centralize existing staff to minimize the need for additional positions.

However, it is anticipated that implementing this change will require additional budgeted positions. While the overall number of new positions and associated costs would have to be determined based on further review, it is possible that such costs would not necessarily be significant. Additional costs would be recommended for absorption within the new Department's available funding.

Public Health staff indicate that one of the difficulties they face, as a relatively small part of the largest County Department, is sharing priority for human resources assignments and other support services with County hospitals in an almost constant state of crisis with respect to the delivery of Personal Health services. As a separate Department, with adequate staff, the Public Health programs would set their own priorities and assure that key personnel actions and contracts development and monitoring occur in a timely manner.

Public Health Responsibilities Should Not be Transferred to a Health Authority

DHS indicates that, if a decision is made to establish a Health Authority to operate indigent health services in the County, inclusion of Public Health in the Health Authority would not make sense from either a financial or legal basis. This is part of the reason why other large urban jurisdictions have separate governmental structures that separate the administration of personal health care services and public health services:

City/County	Public Health Responsibility	Safety Net Responsibility
New York	New York City Health Department handles public health services.	Hospital and Health Corporation is a municipal hospital system that also includes diagnostic/treatment centers.
Chicago	Chicago Department of Public Health is responsible for public health, primary care, and mental health services.	Cook County is responsible for hospital-based services.
Houston	Houston Health Department is handles public health services.	Public hospitals are under the jurisdiction of the Harris County Hospital District.
Miami-Dade	Miami-Dade County Health Department is responsible for public health services.	Miami-Dade County established the Public Health Trust as an independent governing body for the county's public hospital, primary care centers, and long-term care centers.

Financial Considerations

From the budget and organizational perspectives, as indicated earlier, it would not be difficult to create a separate Public Health Department with a budget "roll up" of the PHS, OAPP, ADPA, and CMS budgets. These budgets are currently separate operating units among those included in the larger "roll-up" DHS budget. Further, these programs already report organizationally within DHS to the Director of Public Health and Health Officer, who in turn reports to the DHS Director. A current organizational chart for Public Health is attached.

County funds are provided to DHS to meet statutory maintenance of effort (MOE) requirements, and funds above that amount are provided at the discretion of the Board. County funds provided to the Public Health departments, even if they were established as a separate Department, would be applied to the amount needed to meet the statutory MOE.

Given the fact that almost 70 percent of the overall DHS budget is associated with County hospitals and health centers/comprehensive health centers, most of the \$1.5 billion deficit projected in the March 2005 Health Department Budget Committee of the Whole report is related to revenue and cost issues in the Personal Health Care system. However, the General Fund DHS units, including the Public Health programs, have experienced NCC growth as well.

DHS has been able to obtain time-limited or one-time revenues over the past 10 years, primarily under the 1115 Waiver, in order to sustain the County's healthcare system. There has also been a growth in County funding associated with increases in the Realignment Vehicle License Fee (VLF) equivalent amount, as well as NCC increases related to 1115 Waiver commitments, the availability of Tobacco Settlement funds and voter passage of Measure B Special Tax revenues. This increase in revenues has benefited both the Personal Health Care and Public Health programs, as costs have grown for both. However, for both the Enterprise Fund and the General Fund budgets, costs continue to grow faster than available revenues.

Potential Financial Impact on Public Health

While concerns have been expressed regarding the potential for curtailments in PHS related to funding shortfalls in the hospitals and health centers/comprehensive health centers, the potential need for curtailments would still exist for the separate Public Health Department because of their own funding shortfalls.

Since the majority of the net County cost (NCC) requirements for OAPP, ADPA, and CMS are associated with maintenance-of-effort (MOE) or share-of-cost/"match" requirements to continue receiving State and/or federal revenues, NCC cuts for those programs are generally not included in the DHS curtailment proposals. A reduction in NCC for those programs would trigger a potential loss of revenue, requiring even deeper cuts.

However, it appears that most of the NCC in the PHS budget is not required to draw down the State and federal revenues which have been awarded for specific program activities, such as Bioterrorism Preparedness and other disease control and prevention activities. A majority of the NCC is associated with meeting State mandates for various programs and continuation of Board-approved Public Health Initiatives. While preservation of a strong basic Public Health capacity in epidemiology, health assessment, and communicable disease prevention and control is critical and consistent with the Board's past support of Public Health initiatives, it is appropriate that the increasing costs within PHS should also be reviewed as part of the DHS deficit reduction scenarios. Establishing a separate Public Health Department would allow the Public Health Director to present proposals directly to the Board instead of through the DHS Director.

Impact of Staffing Reductions from Curtailments

A secondary problem for Public Health is that, as part of DHS, cascading from positions eliminated in curtailments to services in the hospitals and health centers/comprehensive health centers may result in persons without public health training displacing trained and experienced public health staff. While it may be possible, under Civil Service guidelines, to seek exceptions from the order of layoffs for some Public Health physicians and nurses, for example, establishing a separate Public Health Department could help mitigate the unintended negative impact on other experienced Public Health staff.

Financial Accountability Will be Enhanced

DHS indicates a separate Department of Public Health would increase the visibility of Public Health services and help residents understand the important benefits every resident derives from public funds spent on these services. In addition, a separate department may increase the County's ability to obtain outside discretionary and program-related funding. A smaller, more focused County department may be more attractive to grant funders because it can be more responsive and accountable, and has a history of financial responsibility. Development of a separate Public Health Department would eliminate the role of DHS management for a very large range of programs, activities and issues which already directly interface with each Board office. The DHS Director could then focus attention on critical indigent health care issues and long-term funding problems.

Implementing the Change to a Separate Public Health Department

County Code Changes

Implementation will require several County ordinance changes, including: Title 2, Administration, to designate the new department; Title 5, Personnel; and Title 11, Health and Safety. In the Health and Safety Code, the specific references to the Director of Health Services as the County Health Officer would have to be amended. References to the Director throughout this Title would be reviewed and revised as needed to separate and clarify the functions.

Budget, Finance, Human Resources and Administration

Creation of a "roll-up" budget for a separate Public Health Department will be relatively straight-forward, since the affected Public Health programs are currently established as four separate budgets within the overall DHS budget. These four budgets, which are already distinct budget units, would remain distinct but would be considered under a separate "roll-up" as the Public Health Department. Budgetary control would remain at the current levels.

As indicated above, centralized administrative units would have to be created, including reassigning staff involved in earlier DHS administrative consolidations of Finance, Human Resources and administrative support units. Public Health staff indicate, for example, that a separate section of central DHS Finance handles most Public Health finance, accounting, and budget work and the other budget units have their own finance staff. While such discussions will need to occur regarding current staffing resources which may be transferred to the new Public Health Department centralized administrative unit, it is anticipated that additional budgeted positions will be required.

Since the positions and NCC of these finance and administrative units are included in the HSA budget, a share of that budget would need to be moved into Public Health. However, DHS would retain a pro-rata share of the budget for administration and finance, which should not significantly increase overall NCC due to the division. A portion of the cost of these administrative units is reimbursed to the County through the indirect cost rate charged to Public Health program grants.

Facilities

Public Health operates clinics and has field staff based at 15 health center or satellite sites, including five at which PPPs provide services and two at which Personal Health provides services. It is anticipated that these co-locations would continue to operate as they currently do. In addition, Public Health has program staff located in various County-owned and leased buildings. Public Health relies on DHS for facilities management, capital projects and for certain maintenance and renovation services. Arrangements between the new departments would need to be negotiated to preserve facility support services.

Information Services

Public Health has its own Information Systems unit, which coordinates with the DHS Information Services Bureau. Public Health is currently reviewing the feasibility of switching its clinic information system to the same one used by DHS hospitals, in order to integrate systems for all clinical care. If this review recommends this option, DHS indicates it can be accomplished, regardless of whether the Public Health programs are created as a separate department. A separate department would have responsibility for the computer network. Staffing could come from a division of existing DHS staff and/or through contracting.

Health Assessment, Epidemiology, and Data Warehouse

Public Health's Health Assessment and Epidemiology unit produces data which is used by public and private hospitals, community agencies and others for planning, grant applications and policy work. This includes vital records, disease reports and data from the L.A. Health Survey. Public Health would continue to share data and work with all users of these data.

Coordinate with Emergency Medical Services

Public Health's work on Bioterrorism Preparedness requires a close working relationship with the DHS Emergency Medical Services (EMS) Agency. Although EMS has a different primary mission, the working relationship has been a close one, and Public Health staff do not anticipate a change in this relationship.

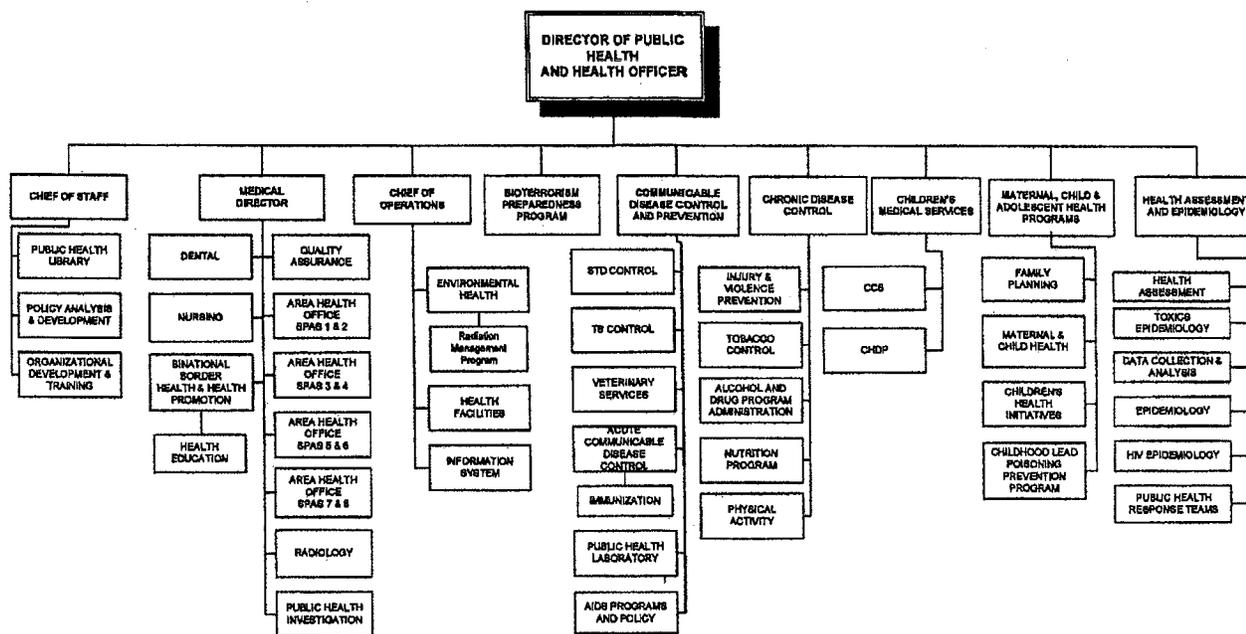
Services of Other County Departments

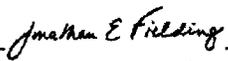
The Public Health staff already work directly with other County departments, such as County Counsel, Chief Administrative Office and the Internal Services Department, and costs are already included in the Public Health budgets. While specific discussions would have to take place, Public Health staff do not anticipate significant changes in these areas.

Implementation Timeframe

If further instructed by the Board to proceed with creating a separate Public Health Department, the Chief Administrative Office would facilitate discussions between the affected departments to implement these changes during 2005-06. The budget format and organizational changes for the new Department would be reflected in the 2006-07 Proposed County Budget. Activities would include working with the Director of Personnel to make conforming changes to the staffing ordinance and with County Counsel to prepare an ordinance to amend the County code to establish the Department and clarify the duties of the Health Officer.

Department of Health Services Public Health

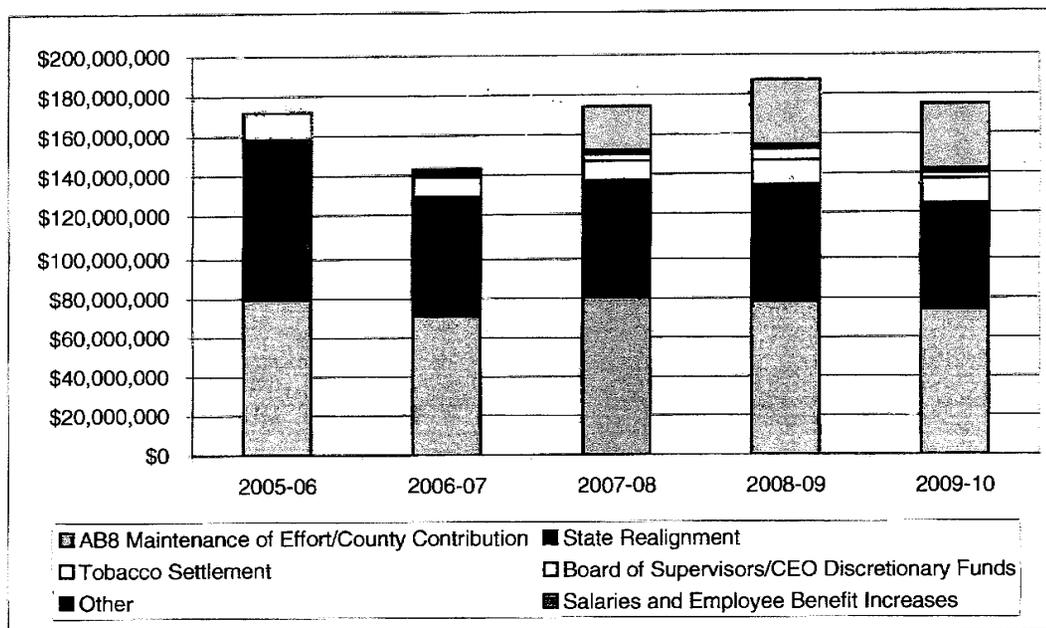



 Director of Public Health and Health Officer
 April 15, 2004

**Department of Public Health
Net County Cost Comparative Analysis**

NCC Categories	2005-06	2006-07	2007-08	2008-09	2009-10
Salaries and Employee Benefit Increases	\$0	\$0	\$21,830,000	\$32,487,000	\$32,359,000
Other	\$0	\$3,176,000	\$2,100,000	\$2,216,000	\$2,293,000
Board of Supervisors/CEO Discretionary Funds	\$0	\$1,030,000	\$3,350,000	\$5,536,000	\$2,915,000
Tobacco Settlement	\$13,540,000	\$9,846,000	\$9,846,000	\$12,446,000	\$12,446,000
State Realignment	\$78,873,000	\$58,328,000	\$56,420,000	\$56,257,000	\$50,592,000
AB8 Maintenance of Effort/County Contribution	\$79,320,000	\$70,760,000	\$80,353,000	\$78,002,000	\$73,859,000
TOTAL	\$171,733,000	\$143,140,000	\$173,899,000	\$186,944,000	\$174,464,000

* NCC transfers between DPH and DHS and NCC reductions resulting from countywide curtailments are reflected in the AB8 MOE/County Contribution amount.



Appendix 6



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August 22, 2014

TO: Each Supervisor

FROM: Jonathan E. Fielding, M.D., M.P.H. *J. Fielding MD*
Director and Health Officer,
on behalf of the entire Public Health Staff

SUBJECT: **HEALTH AND DISEASE IN LOS ANGELES COUNTY: THE IMPACT AND ACCOMPLISHMENTS OF THE DEPARTMENT OF PUBLIC HEALTH OVER THE PAST 16 YEARS**

The County of Los Angeles Department of Public Health (DPH) aims to protect health, prevent disease, and promote the health and well-being of all persons in Los Angeles County (LAC). Nearly 4,000 skilled and specialized professionals conduct core public health functions that protect residents from public health threats, support healthy lifestyles, and reduce health disparities affecting vulnerable populations. The Department is prepared to respond immediately to County-wide or more localized natural or man-made disasters. With 39 programs, 14 health centers and a state-of-the-art public health lab, DPH provides population health services for the diverse residents who live, work, play, and learn in the County.¹

This document summarizes the accomplishments of the Department during the 16 year period of my tenure. Most of these accomplishments are the result of successful collaborations with Board offices, other County Departments, local, state and federal government agencies, and many public and private organizations. Progress in fulfilling our mission significantly accelerated after your Board approved Public Health as a separate County department in 2006.

Encouraging Trends in Reduced Disease Burdens and Improved Health Behaviors

DPH and partners have changed the trajectory of major health and disease trends for the better in our County. Life expectancy at birth increased by more than three and a half years, to 81.5 yearsⁱⁱ largely attributable to a 25% decline in overall death rates.ⁱⁱⁱ The top three leading causes of death showed a major decline: 37% for coronary heart disease, 35% for stroke, and a 22% decrease from lung cancer.^{iv} Infant mortality declined 26% between the three year averages of 2000-2002 compared to 2010-2012.^v

Significant improvements have also occurred in specific health behaviors and health risks for chronic diseases due to effective promotion of healthier lifestyles, better screening and clinical preventive services, and the passage of healthy public policies. For example:

- LAC has one of the lowest rates of smoking among large U.S. metropolitan areas.^{vi} Overall, 13.1% of adults reported smoking in 2011. This marked the first time the number of adult smokers in the County fell below one million since the LAC Health Survey was initiated in 1997. Since 1999, there has been a 72.4% decline in adult smokers and 62.7% decline in teen smokers.^{viiiii}
- The percentage of adults who reported consuming five or more servings of vegetables and fruits a day increased from 11.6% in 1999 to 16.2% in 2011^{ixx};
- The percent of adults who reported sufficient aerobic activity to meet national guidelines increased 29% from 2002 to 2011^{xixii}; and
- A 70% reduction in sedentary behavior was reported from 2002 to 2011.^{xiiiixiv}

Internal Structural and Programmatic Improvements

The following are a few key accomplishments by DPH in fulfillment of its mission to protect and improve the health of all LAC residents over the past 16 years:

- *Restructuring of the LAC Public Health System:* In response to a critical report issued in 1997 by the University of California, Los Angeles (UCLA) School of Public Health, entitled “The Breslow Report”, your Board adopted a plan to revitalize and empower DPH to fully embrace its public health responsibilities and better coordinate services. 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 to public health functions. The restructure allowed community-specific leadership through eight Area Health Offices (AHOs) intended to increase accountability and responsiveness to the public; created a Public Health Communications Office to centrally coordinate external and internal communication; enhanced partnerships with private healthcare providers, managed care organizations and community-based agencies to facilitate broader public reach; and developed systems to collect health data and track performance measures to evaluate efficacy.

- *Los Angeles County Health Survey (LACHS)*: DPH has innovated in conducting a periodic survey on the health care, health care utilization, health behaviors, health status, and knowledge and perceptions of health-related issues among LAC residents. Survey results are used to understand and track trends over time and to ground policy and program planning on real-life, local data. The survey data report was first published in 1997. A user-friendly data query system is available online and facilitates direct access to key indicator data at the County and Service Planning Area (SPA) levels alike. The seventh edition is planned for release in 2015.
- *Nurse-Family Partnership Program*: This nurse home visitation program is multidisciplinary and evidence-based. It provides intensive direct one-on-one services to low-income, first-time mothers and their children. The intervention is clinically proven to improve prenatal health, reduce childhood injuries, abuse and neglect, and increase maternal employment. The Los Angeles-based program was initially piloted at California Hospital and Medical Center, and expanded Countywide in February 2000. Since 2000, the program has served 9,173 of the highest high-risk pregnant youth and women in LAC. Results are very positive:
 - Among mothers:
 - 27% and 36% reductions in maternal smoking and alcohol use, respectively;
 - 52% decrease in fear of partner violence; and
 - 33% increase in workforce participation.
 - Among children:
 - Lower rates of premature babies and low birth weights even compared to the Nurse-Family Partnership national average; and
 - Increased rates of breastfeeding.
- *Restaurant Letter Grading Program*: Establishing the Board approved restaurant letter grading program in 1998 improved hygiene and food safety in local restaurants. It gives consumers information on the most recent inspection results regarding the cleanliness and safe food-handling procedures in place at specific food retailers. In a published scientific study, implementation of the program reduced hospitalization for severe food borne illness by 13% in LAC within the first year following implementation. The LAC grading program has been nationally and internationally replicated.^{xv} In 2010, DPH expanded the program to mobile food facilities to ensure health and safety standards across all dining experiences. DPH proactively partnered with Yelp, the popular online business ratings and review site, which now incorporates DPH letter grades on business listings for LAC restaurants.
- *First 5 LA Partnership*: First 5 LA, the County child-advocacy organization that funds health, safety and early education programs for children ages 0-5, has granted DPH more than \$93 million dollars since 1999 to support projects, such as the LAC Health Survey and the Los Angeles Mommy and Baby (LAMB) data project. First 5 funding has also supported direct services such as Substance Abuse Services for High Risk Caregivers, enrollment for

young children and their families into health plans, and a project to reduce overweight and obesity among preschool children (Choose Health LA Obesity Project).

- *Nutrition Policies:* Numerous school, workplace and community policies and practices were adopted to encourage healthier food and beverage consumption. DPH worked closely with the Los Angeles Unified School District to adopt policies that improved the nutritional quality of food served in cafeterias, and eliminated junk food and sugar-sweetened beverages from vending machines and lunch lines. This partnership affected 740,000 students and accelerated school nutrition conversations throughout California, paving the way for State legislation in 2003 and 2005 mandating the removal of sugar-sweetened beverages from schools. DPH also played pivotal roles in obtaining the first State legislation in the U.S. to require menu nutritional labeling in restaurants with 20 or more locations. The Department led the charge to revise the County vending machine policy to limit allowable sodium content for pre-packed snacks and calorie levels for beverages. DPH also worked with DHS on the expansion of healthy food and beverage options offered at County hospital cafeterias and vending machines.
- *Tobacco Prevention and Control Policies:* DPH tobacco prevention and control efforts have provided actionable information on the benefits of smoke-free beaches to your Board, and helped cities across the County pass over 120 local tobacco control policies in the last decade. Major accomplishments include the implementation of smoke-free outdoor dining in the City of Los Angeles in 2011, and the adoption and implementation of a smoke-free multi-unit housing policy in partnership with the Los Angeles County Housing Authority in 2014.

Quality and Productivity Commission: The LAC Quality and Productivity Commission manages the Productivity Investment Fund, which nurtures innovative programs that improve the efficacy and operations of the County. From 2006 to 2014, the Commission has awarded DPH more than \$1.2 million dollars in grants to support innovative solutions for public health advancement. Additionally, the Commission has recognized DPH with 21 awards or honors in the past five years, including two prestigious Gold Eagle Awards for Countywide Response to H1N1 Influenza (2009) and the E-contract Management Encounter Billing System (2013). Ten DPH projects have been honored with designation as "Best and Shared Practices."

- *Opiate Overdose Prevention:* To reduce cases of fatal opiate overdose, DPH advocated for successful state legislation (SB 767) to limit the civil and criminal liability for prescribing and distributing Naloxone, a safe opiate antagonist, for all parties involved in pilot programs operating in seven counties. These programs trained clients on how to prevent narcotics overdose and allowed for the distribution of Naloxone to trained individuals to reverse the effects of an opiate overdose. The 13-month LAC pilot program trained 369 clients in

overdose prevention, distributed 818 doses of Naloxone to program participants, and documented 39 lives saved by successful overdose reversals.^{xvi}

- *Emergency Response:* Following the September 11, 2001 attacks, DPH embraced and expanded its roles and responsibilities as a public safety and emergency response agency. A new division of Emergency Preparedness and Response was created. DPH has cultivated the capacity through its on-staff experts, real-time surveillance systems, and a highly equipped Public Health Laboratory to rapidly identify and respond to biological, chemical and radiological terrorism, as well as natural threats to health and public safety. DPH established the national model for public health agencies to effectively serve as a valued ally in counterterrorism efforts through its unique and strategic partnership with the Federal Bureau of Investigation. DPH provides daily staffing support for the Joint Regional Intelligence Center, a cooperative interagency partnership that aims to centralize federal, state, and local response activities related to suspected terrorist threats. These relationships have been effective and vital to maintaining public safety.

In 2009, the Department demonstrated its readiness with an unprecedented response to the H1N1 influenza pandemic. During the response, more than 230,000 doses of H1N1 vaccine were directly administered by DPH staff through mass vaccination clinics, community outreach events and existing public health centers. Another four million doses were dispensed to 3,500 local private health care providers for privately-insured patients. DPH, working with many partner agencies, has provided extensive training to its entire workforce, and has participated in 29 major disaster exercises since 2004. In addition, the Department has responded to several major incidents since H1N1, including the Fukushima Daiichi Nuclear Power Plant Radiation Incident in 2011. These exercises and incidents have increased our preparedness to respond to serious health threats, both natural and man-made, using the incident command structure.

- *Strategic Partnerships to Improve the Physical Environment:* Efforts to address the underlying causes of health disparities have led to new partnerships and initiatives related to the built environment and other factors that influence health outcomes. These collaborative opportunities have led to effective Public Health programming and health-supporting policies. For example:
 - A current initiative to prevent prescription abuse for opiates and other drugs of abuse working with the Los Angeles Medical Association, Kaiser Permanente, and emergency room doctors;
 - Direct assistance by the Chronic Disease and Injury Prevention Division to cities and organizations as they design and implement walkable and bike-able neighborhoods;

- Financial support of the highly successful summertime program, Parks After Dark, implemented with the LAC Parks and Recreation Department at six locations. Since its implementation in 2010, Parks After Dark has:
 - Shown a 32% reduction in serious and vital crimes reported in communities surrounding its six sites compared to an 18% increase in other similar communities;
 - Increased participation in physical activity; and
 - Enhanced residents' perceptions of neighborhood safety and community-level social cohesion.^{xvii}
- DPH led the Healthy Design Workgroup to implement healthy design in the County's unincorporated areas. This Board-mandated workgroup was launched after the Board's adoption of the Healthy Design Ordinance, which changed existing zoning and subdivision regulations to legally establish community gardens and farmers markets throughout the County and created more specific requirements for bicycle parking and sidewalk design.

The Department has helped ensure that health is a key consideration in planning decisions. Notable developments in this direction include support of a comprehensive chapter on health and wellness in the City of Los Angeles General Plan, as well as similar health elements in the general plans of several other cities within the County.

- *Infant Mortality:* In 2001 the infant mortality rate among African Americans in LAC was disproportionately high, with exceptionally high rates reported in Antelope Valley.^{xviii} In response, DPH helped form a local collaborative to promote healthy births in Antelope Valley and implemented targeted improvement recommendations based on data collected by DPH and other community stakeholders. Some of those recommendations led to the Black Infant Health Program, Safe Sleep Campaign, and the Partnership to Eliminate Racial and Ethnic Disparities in Infant Mortality. As a result of these, and many more efforts, infant mortality rates for African Americans in Antelope Valley area decreased from 28.4 to 8.2 deaths per 1,000 live births between 2001 and 2011.^{xix}
- *Baby-Friendly Hospitals:* DPH initiated "Baby-Friendly" hospital designations at LAC+USC, Harbor-UCLA and ValleyCare Olive View-UCLA medical centers, in collaboration with DHS. The "Baby-Friendly" designation is awarded to birthing facilities that successfully implement evidence-based practices shown to increase breastfeeding initiation and duration. Designation was granted for all three county-run hospitals between 2011 and 2012. Additionally, DPH collaborated with LAC and the City of Los Angeles' human resource departments to develop policies that support employees who choose to breast-feed and expand employee access to lactation rooms. Now over 18,500 employees throughout County departments and the City of Los Angeles have access to worksite lactation accommodation policies that support mothers who continue to breastfeed after

returning to work. Breastfeeding reduces infants' risks for a variety of diseases and conditions, such as childhood overweight and obesity, type 1 and 2 diabetes and some types of cancers. Research has also shown a decreased risk of breast and ovarian cancer among women who have breastfed.

- *HIV Testing and Treatment:* The Department's Division of HIV and STD Programs (DHSP) has successfully implemented program improvements to reduce HIV transmission in LAC and meet benchmarks set by the 2010 National HIV/AIDS Strategy. The division's revamped HIV testing program significantly increased the number of individuals being tested. The Division also introduced medical care coordination (MCC), a new service that integrates medical and psychosocial support services to improve health outcomes for patients in HIV care. Program innovations resulted in:
 - 43% increase in testing volume;
 - 63% increase in identifying newly diagnosed HIV+ individuals;
 - Nearly 49% increase in linking HIV+ individuals to care; and
 - Four-fold increase in suppressed HIV viral load among HIV+ patients who received MCC.

DPH also changed the way payments are made for the HIV testing and medical outpatient care contractors, from cost reimbursement to performance-based and fee-for-service. This has increased accountability to ensure more efficient and effective use of public funds.

- *Lead Paint Litigation Award:* In 2013, LAC and seven other counties and three cities in California, prevailed in a lawsuit against companies that manufactured and sold paint containing lead. The trial court verdict awarded LAC \$632.5 million dollars, of the \$1.5 billion dollar judgment, to pay for inspections and lead abatement inside affected homes. Lead-based paint and lead contaminated dust are the most hazardous sources of lead exposure for children in the U.S. and are linked to learning disabilities and other health problems.^{xx}
- *EnvisionConnect:* In 2013, the DPH Environmental Health Division transitioned from traditional paper inspection reports to EnvisionConnect, an electronic inspection and data management system that uses portable electronic laptops/tablets to enter information in the field. This much improved system is now used for routine inspection of nearly 122,000 retail food facilities and residential housing annually, and in response to public complaints ranging from unsanitary housing conditions to unsafe restaurant practices. This innovation has created a paperless environment that streamlines workflow by eliminating double data entry and consolidated the collection and analysis of data from multiple decentralized areas into one central system to improve data quality.

- *Affordable Care Act (ACA) Implementation:* DPH facilitated the early adoption of Medi-Cal expansion through successful enrollment of eligible participants. For example, DHSP took the lead in managing the early adoption of Medi-Cal expansion through the migration of eligible HIV-positive individuals from the Ryan White program to ensure continuity of quality care for this medically vulnerable population. The Maternal, Child and Adolescent Health Program assured that children and families received appropriate healthcare insurance coverage through direct and contracted outreach and enrollment services. DPH is upgrading its internal systems to comply with the federal mandate for electronic medical records (EMR). This includes the development of a new on-line public health lab interface that allows providers to order tests electronically and receive the results directly in their EMR system.
- *Healthy Pets, Health Families Initiative:* DPH launched the 2020 Healthy Pets, Healthy Families initiative to improve both animal and human health through the relationship between pets and their owners. The Countywide initiative focuses on several key areas, including spaying and neutering, bite prevention, vaccine-preventable diseases, pet obesity, secondhand smoke, disaster preparedness, and zoonotic disease and parasite infection prevention.
- *Vaccine Preventable Disease Prevention:* DPH has successfully managed the control of measles and other outbreaks of vaccine preventable diseases (VPDs), reducing the burden of all VPDs, such as Pertussis (Whooping Cough). Strategies have included immunization skills training for providers across the County to enhance communication about vaccine safety and policy work to combat parental resistance to immunizations stemming from persistent misinformation regarding their safety.

An Independent Department (2006 to present)

Your 2006 vote to establish a separate DPH was a signal contribution to improving health and safety in LAC. Its mission, to protect and improve the health of all LAC residents, is distinct among County departments. Independence allowed the Department to advocate for and allocate its own administrative and fiscal resources. This flexibility has been essential in our prioritizing disease prevention and control efforts, diversifying and establishing effective partnerships and evolving into a more prepared and responsive agency when public health emergencies arise. No longer eclipsed by DHS complexity and competing priorities, DPH has focused public resources on mitigating the biggest disease burdens in our population and reducing the yawning disparities in health that undermine quality of life and economic productivity for many. Our increased flexibility contributed to development of an appropriately diverse and highly-skilled workforce.

Outlined below are major successes largely facilitated by the creation of and advocacy by a stand-alone department.

- *Chronic Disease and Injury Prevention Division:* In 2001, the Chronic Disease and Injury Prevention Division had been dismantled due to budget crises and shifts in DHS priorities. As its own entity, DPH was able to re-prioritize chronic disease and injury prevention as a core responsibility and restored the Division in 2006. This provided the foundation to tackle significant health problems affecting millions of County residents, and helped us successfully seek competitive federal funding for major initiatives. Since its reinstatement, the Chronic Disease and Injury Prevention Division has grown from a \$6 million dollar to \$40 million dollar operating budget and consistently delivers innovative programming and policy guidance of state and national significance. These issues will remain among the major DPH priorities moving forward given that chronic disease accounts for 80% of premature death and disability and 75% of the nation's healthcare spending.^{xxi,xxii}
- *Public Health Lab:* The Public Health Lab relocated to a new state-of-the-art facility in Downey in 2007. Since then, the lab has made significant improvements, including an expanded menu of testing services and the capacity to rapidly detect agents with potential for bioterrorism in environmental samples and clinical specimens. The lab also is part of a department wide surveillance system for the detection of influenza and other respiratory viruses, food borne pathogens, and other organisms that can cause public health emergencies. The lab currently processes more than 300,000 specimens annually.^{xxiii}
- *Public Health Center:* In 2011, DPH expanded the availability of much needed public health services in South Los Angeles through the Martin Luther King, Jr. Center for Public Health, the first public health center in LAC to open in 35 years. In addition to providing clinical services related to tuberculosis, sexually transmitted diseases, and immunizations for uninsured individuals and those with tenuous healthcare, the facility has become a central asset to the surrounding communities. This welcoming facility has dedicated staff that provides technical assistance and education on a variety of public health issues and it offers meeting space for community groups to foster social cohesion.
- *Creative Public Awareness and Social Marketing Campaigns:* DPH has tackled important issues with creative public awareness and social marketing campaigns designed to encourage residents to prioritize important public health issues. Examples include:
 - *Break Up:* A lesbian, gay, bisexual, transgender (LGBT)-targeted smoking cessation campaign that employed social media channels to effect awareness and behavior change in a traditionally hard-to-reach, commercial-savvy population;
 - *LA Condom:* A campaign to encourage the practice of safer sex by using condoms through the design and distribution of an LA-branded condom. Condom designs were selected from community member submissions, and LAC businesses and community based organizations distributed the condoms for free. The campaign has distributed approximately 2.5 million LA-branded and other condoms to date.

- *Community Disaster Resilience Project*: A DPH-led collaborative that promotes community resilience in the face of public health emergencies, such as pandemics and natural or man-made disasters. Project partners include RAND Corporation, UCLA Center for Health Services and Society, Loma Linda University, the Emergency Network of Los Angeles (ENLA), the U.S. Geological Survey and community partners. This project encourages communities to plan together and know the assets and needs of those who live and work in specific communities.
- *Choose Health LA*: A multimedia DPH initiative to prevent and control chronic disease in LAC. The campaign works with community partners to develop innovative strategies to reduce youth access to tobacco products and exposure to secondhand smoke; improve nutrition and opportunities for physical activity; and increase access to high quality, clinical preventive services. This includes Choose Health LA Restaurants, a partnership with restaurant operators to promote healthier meal choices among customers through smaller portion size options and healthier children's meals. Currently, 16 brands representing nearly 700 locations participate in the program.
- *Consumer Protection*: DPH successfully influenced the Federal Drug Administration (FDA) to take regulatory action against aggressive, direct-to-consumer marketing of the Lap-Band, citing major concerns about misleading and imbalanced information. The Department has since expanded its scope to include other consumer protection activities. DPH has formed a Health Care Consumer Protection Program charged with empowering consumers to make informed choices regarding medical devices and pharmaceuticals.
- *Toxic Threat Strike Team*: DPH ensures the environmental protection of communities with its prominent role on the Board-approved Los Angeles County Toxic Threat Strike Team, a high-level, interdisciplinary team of regulatory and technical experts to evaluate and help abate the impact of industrial pollution on surrounding neighborhoods.
- *Quality Assurance and Improvement*: The Department contributed to scientific knowledge and the dissemination of cutting-edge public health practices through numerous publications in well-respected journals and presentations at national conferences. This allowed DPH to participate in a larger dialogue and to emerge as a professional leader with national recognition. Over the past 18 months alone, DPH has published more than 100 articles on a range of diverse topics including infectious diseases, reproductive and sexual health, nutrition, obesity, emergency preparedness, substance abuse, public health policy and public health infrastructure.
- *The Public Health Report Card*: DPH developed the Public Health Report Card as a unique approach to measure and improve internal processes that affect the quality of services delivered by its programs. The Report Card tracks a variety of cross-cutting measures that assess the quality of DPH infrastructure. Seven objective areas are measured including:

program planning, stakeholder engagement, partnership and collaboration, emergency preparedness, policy development, scientific advancement, and staff training. As a result of this tracking system, improvements have been observed in many areas including the number of programs that use population-based data to guide planning and monitoring activities, and the percentage of staff who participate in emergency preparedness exercises.

- *Evidence-based Practices:* DPH moved to align programming with evidence-based strategies to ensure a rigorous and scientific approach to public health practice. The role of Chief Science Officer (CSO) was institutionalized in 2009. The CSO strengthens the Department's science base by overseeing health assessment, data collection, and analysis. The CSO consults on new strategies and assist DPH leaders in integrating guidance from the U.S. Task Force on Community Preventive Services which recommends effective public health interventions.
- *Sharing Best Practices:* The publication of "Public Health Practice: What Works" in 2013 showcased the wide range of LAC DPH responsibilities, innovative programs and continuing challenges. Published by Oxford University Press, with over 70 DPH authors, it is the first volume to compile the activities of a local health department for the purpose of sharing lessons learned with a broad public health audience, including public and private partners, students, academics, business leaders and policy makers. The collection of case studies increased the visibility of public health practices in LAC and made an important contribution to an evolving anthology of public health knowledge.
- *Fund Development:* DPH has financially sustained its programs in large part due to the repeated success in securing competitive grants over the past five years. For example:
 - All but one grant application submitted by DHSP since 2006 has been funded and only 18% of the Division's operating budget is funded by net county dollars; and
 - The Emergency Preparedness and Response Program receives over 10 million dollars of federal funding annually.
- *Administrative Services:* DPH has implemented multiple systems to improve the efficiency of administrative processes. This includes the implementation of the eCAPS Approver Improvement Process and an improved On-Line Requisition approval process, which reduced payment voucher approval time by 56% and increased productivity by an estimated 22%.

Future Opportunities and Challenges

DPH must remain accountable as new health threats, natural and man-made disasters, toxic exposures, and preventable illness and injury challenge LAC's infrastructure and the health of its residents. It is, therefore, critical that DPH continue to have autonomous authority to strengthen its capacity and thrive in a rapidly changing environment. This means adapting to shifts in public health

paradigms, a newly reformed healthcare system and a growing diversity of health information channels. Persistent budgetary pressures on public health funding will necessitate new and flexible approaches. It will also be imperative for the Department to focus on policy-level interventions and address the underlying social and physical determinants of health and significant health disparities among groups in LAC. With the implementation of the Affordable Care Act, future public health initiatives will need to guide and assure appropriate delivery and receipt of effective, high-quality medical services delivered by all health plans and providers. The Department will need to cultivate new strategic partnerships, particularly with organizations that have different missions and those outside our traditional partnering sectors. DPH will be expected to assess and address the preventable local disease burden and health equity challenges, and to work on improving health across every stage of life, with special attention to early childhood and the elderly population. Foreseeable challenges and opportunities include:

- *Perceptions of Public Health:* Public health is aspirational. Goals are long-range and achieved through incremental successes in an environment that often unrealistically expects rapid results. Certain divisions within DPH may face competition from for-profit and other external entities that promise to do the job better, faster, and cheaper. It is, therefore, critical to set and measure our performance expectations and to evaluate both health impact and economic efficiency.
- *Health Disparities:* Life expectancy and mortality rates among LAC residents vary significantly based on socioeconomic status and race/ethnicity. For example, people in wealthy neighborhoods live an average of 12 years longer than those in impoverished neighborhoods, while Asian/Pacific Islanders live an average of 10 years longer than blacks.^{xxiv,xxv} And the rates of many leading causes of death remain highest among blacks.^{xxvi} Progress in reducing these health disparities will require engaging multiple sectors to address the root causes that contribute to disproportionate high mortality rates among different communities, including poverty, lack of safe and affordable housing, lack of educational and job opportunities, poor access to health care, and limited access to healthy affordable foods and safe places to recreate.
- *Social and physical determinants of health:* Health status is largely determined by social and physical determinants, such as formal education, employment, income, family and social support, community safety and the physical environment. Targeting these underlying causes has the potential to effect widespread and sustainable changes that promote better health, and reduce ill health and disability among all individuals. However, the fundamental challenge of convincing people that their health is primarily determined by social (including economic) and physical environments persists. DPH needs to extend and strengthen the brand to promote public understanding of its essential role in ameliorating poor social and physical conditions in the tradition of early public health practices. This also includes capitalizing on, and further enhancing, community resilience.

- *Health in All Policies:* With a renewed interest in social and physical determinants of health as nexuses of change, public health will need to capitalize on its role to inform public policies that can have positive health effects across a range of service and infrastructure sectors. It will be critical to continue this momentum and engage multiple public and private partners to apply a health lens to their policies, practices and programs to identify win-win opportunities. This collaboration is essential. Society can only develop healthy environments through the collective efforts of public health with urban planning, mental health, economic development, public works, parks and recreation, fire, law enforcement, and transportation departments.
- *Healthcare Reform:* Affordable Care Act has greatly expanded the number of people eligible for no- to low-cost health insurance plans, but certain populations will continue to have limited access to coverage (e.g., undocumented individuals). Given this shifting healthcare landscape, DPH will need to:
 - Develop mechanisms for financial reimbursement to recoup appropriate costs from insurance companies for preventive and other care services provided to insured individuals;
 - Ensure continued service provision to those ineligible for health insurance and public programs; and
 - Assist clients in navigating their health insurance eligibility, enrollment, and benefits.

Communication: The internet, social media and cell phones have revolutionized the ways in which people, organizations, businesses and governments interact and disseminate information. These technologies have the potential to engage and educate a wider network of constituents on many public health issues. To be an effective communicator on the wide range of issues where residents need objective public health information, the Department will need to substantially expand distribution channels and the level and timeliness of their content. However, commercially-motivated influences have access to these same communication channels to promote ineffective—and in some cases, very harmful—products and services. Health misinformation also proliferates unchecked through a range of savvy, for-profit marketing strategies or through well-intentioned, yet ill informed, individuals. DPH needs to broaden its work in consumer protection to counter these influences.

- *Public Health Department Accreditation:* DPH is preparing to obtain accreditation through the relatively new Public Health Accreditation Board. The process to obtain accreditation helps advance the quality and performance of DPH and stimulates greater accountability and transparency. It will confer independent validation that DPH is effectively performing all of the services essential to protecting the public and promoting good health for all.
- *Climate Change:* Shifts in weather patterns will likely increase heat-related illnesses, spread vector-borne diseases, such as West Nile, reduce air quality, with resultant increase in

respiratory illness, and stress already strained municipal systems, such as water and power. Public and other health systems need to prepare for these negative impacts related to climate change. Of particular concern is its impact on finite water resources. Reduced supply and increased demand gravely threatens the food supply, energy production, and availability of water for consumption and recreation. Investment must be made in conservation and other strategies for water reuse and resource management. In response, DPH has developed the "Five Point Plan to Reduce the Health Impacts of Climate Change" to proactively address climate change in Los Angeles County. The plan includes:

- Raising awareness and educating the public on the impact of climate change;
 - Promoting policies that reduce contribution to climate change;
 - Providing guidance to other agencies around related issues;
 - Building the Department's capacity to address climate change; and
 - Adopting best practices that reduce greenhouse gas emissions within DPH facilities.^{xxvii}
- *Globalization:* With international transport becoming easier and less expensive, more people are traveling to once remote areas of the world, fueling the potential spread of non-native diseases and increasing the possibility of pandemic infections, such as Ebola, SARS, and influenza variants with high mortality rates. DPH must support common-sense practices to mitigate exposure and contain imported infections; advise the public necessary precautions when traveling (e.g., vaccinations and prophylaxis, when needed); and disseminate accurate health information that allows elected officials and individuals to make informed decisions.
 - *Aging population:* The number of people aged 65 and older has dramatically grown due to the aging "baby boomer" cohort.^{xxviii} Over the next 20 years, LAC will experience a four-fold increase in the number of older adults. This portends a shift in disease burden and public health priorities that will include more age-related health concerns, such as Alzheimer's disease, cancer, diabetes, and other chronic illnesses which can all lead to disabilities and poor quality of life. Public health plays a vital role in shaping programs, practices, and policies that prevent or delay the onset of these age-related conditions and address issues that currently affect aging residents and their families. This will include participating in large multi-sector collaborative efforts to address the health of aging populations (such as the recently formed Los Angeles Alliance for Community Health and Aging); supporting service provider networks that aid the elderly; providing technical assistance through the collection and dissemination of health data and evidence-based practices to decision-makers to those in social work, medicine, and emergency response; and advocating for programmatic policies or systems change that support the care of older individuals and assist caregivers of aging family members.

Substance Use: Drug overdose is the fourth leading cause of premature death in Los Angeles, and misuse of illicit and prescription drugs are responsible for both deleterious health effects

and public health safety concerns.^{xxix} Healthcare reform has mandated substance use disorder services as an essential health benefit, thereby increasing access to many more individuals. This means a strong infrastructure with the capacity to support expanded service delivery must be in place. At the same time, many County residents remain uninsured and dependent on DPH to provide substance use disorder services as part of the County's health care safety net. To address these conditions, DPH must increase its collaboration with the Departments of Health Services, Mental Health and Public Social Services, County criminal justice agencies, and the two County health plans, to coordinate an effective County-wide approach to health care that addresses physical health and behavioral health service needs of low-income persons, both insured and uninsured, including those incarcerated in the County jail and those returning from state prison. Some of the initiatives already in place include services specifically targeting chronically homeless individuals, prison re-entry populations, transition age youth (TAY), and high utilizers of the emergency department due to mental health and substance use disorder conditions by linking to community services. DPH and its County partners are aggressively working to maximize the opportunities offered by the federal Affordable Care Act and the State health care reform.

DPH has weathered the volatile economic environment of the past several years and continues to flourish with a clear vision, mission and purpose. Sustaining forward momentum will largely depend on DPH's ability to retain autonomy and continue to be innovative, science-driven, accountable and demonstrably effective in addressing significant population health issues. With the support of your Board, DPH will continue to be a national leader in sound public health policies, programs and practices. I have every confidence that the existing cadre of experienced, mission-driven public health professionals at DPH will pursue their charge with vigor and rise to the public health challenges of the 21st century.

If you have any questions or need additional information, please let me know.

JEF:hn

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors

ⁱ U.S. Census 2013 estimate

ⁱⁱ Los Angeles County Department of Public Health, *DPH Annual Report 2012-13*, July 2014.

ⁱⁱⁱ 1998-2010 Linked Death Files, Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology.

^{iv} Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology. Mortality in Los Angeles County 2010: Leading causes of death and premature death with trends for 2001-2010. October 2013.

^v 2001-2010 Linked Death Files, Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology.

^{vi} Los Angeles County Department of Public Health. Adult Smoking on the Decline, but Disparities Remain. *L.A. Health*, November 2012.

^{vii} Los Angeles County Department of Health Services, Public Health. Key Indicators of Public Health by Service Planning Area 1999/2000, April 2002; Los Angeles County Department of Public Health. Key Indicators of Health by Service Planning Area, March 2013.

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^x Los Angeles County Department of Health Services, Public Health. Smoking Prevalence and Efforts to Quit Smoking Among Los Angeles County Adults. *L.A. Health*, April 2001; and Los Angeles County Department of Public Health. Adult Smoking on the Decline, but Disparities Remain. *L.A. Health*, November 2012.

^{xi} Los Angeles County Department of Health Services, Public Health. Key Indicators of Public Health by Service Planning Area 1999/2000, April 2002; Los Angeles County Department of Public Health. Key Indicators of Health by Service Planning Area, March 2013.

^{xii} Los Angeles County Department of Health Services, Public Health. Smoking Prevalence and Efforts to Quit Smoking Among Los Angeles County Adults. *L.A. Health*, April 2001; and Los Angeles County Department of Public Health. Adult Smoking on the Decline, but Disparities Remain. *L.A. Health*, November 2012.

^{xiii} Los Angeles County Department of Health Services, Public Health. Key Indicators of Public Health by Service Planning Area 1999/2000, April 2002; Los Angeles County Department of Public Health. Key Indicators of Health by Service Planning Area, March 2013.

^{xiv} Los Angeles County Department of Health Services, Public Health. Smoking Prevalence and Efforts to Quit Smoking Among Los Angeles County Adults. *L.A. Health*, April 2001; and Los Angeles County Department of Public Health. Adult Smoking on the Decline, but Disparities Remain. *L.A. Health*, November 2012.

^{xv} Fielding, MD, J.E., Teutsch, S.M., and Caldwell, S.N. (ed). 2013. *Public Health Practice: What Works*. New York, NY: Oxford University Press.

^{xvi} Fielding, MD, J.E., Teutsch, S.M., and Caldwell, S.N. (ed). 2013. *Public Health Practice: What Works*. New York, NY: Oxford University Press.

^{xvii} Fischer K, Welsing A, Aragon L, Simon P. Parks After Dark: Preventing Violence while Promoting Healthy Active Living. Los Angeles County Department of Public Health. June 2014.

^{xviii} Los Angeles County Department of Health Services Public Health, *Key indicators of health by Service Planning Area, 2002-2003*, <http://publichealth.lacounty.gov/wwwfiles/ph/hae/ha/keyhealth.pdf>

^{xix} California Department of Public Health, Center for Health Statistics, OHIR Vital Statistics Section, 2001 and 2011.

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^{xxi} OHAE, 2000.

^{xxii} CDC, Chronic Diseases: The Power to Prevent, The Call to Control: At A Glance 2009, <http://www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm>

^{xxiii} Los Angeles County Department of Public Health, *DPH Annual Report 2012-13*, July 2014.

^{xxiv} Health Atlas for the City of Los Angeles, June 2013

^{xxv} Los Angeles County Department of Public Health, L.A. HealthDataNow!, <https://dqs.publichealth.lacounty.gov>, last accessed on July 26, 2014.

^{xxvi} Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, *Mortality in Los Angeles County 2010: Leading causes of death and premature death with trends for 2001-2010*, October 2013.

^{xxvii} County of Los Angeles Department of Public Health. *Your Health and Climate Change in Los Angeles County*, 2014.

^{xxviii} Myers, D. and Pitkin, J. *The Generational Future of Los Angeles: Projections to 2030 and Comparisons to Recent Decades*. USC Price, Sol Price Schools of Public Policy, March 2013.

^{xxix} Fielding, MD, J.E., Teutsch, S.M., and Caldwell, S.N. (ed). 2013. *Public Health Practice: What Works*. New York, NY: Oxford University Press.

Appendix 7

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DRAFT

COMMISSIONERS

Jean G. Champommier, Ph.D., Chairperson*
Crystal D. Crawford, J.D., Vice-Chair*
Waleed W. Shindy M.D., M.P.H.**
Michelle Anne Bholat, M.D., M.P.H. *
Patrick Dowling, M.D., M.P.H.*

DEPARTMENT OF PUBLIC HEALTH REPRESENTATIVE

Dr. Jeffrey Gunzenhauser, Interim Medical Director***

Evelina Villa, Interim Public Health Commission Staff*
Public Health Commission

PUBLIC HEALTH COMMISSION ADVISOR

Cynthia Harding, Interim Director*
Carrie Brumfield, Chief of Staff*

Present **Excused *Absent*

<u>TOPIC</u>	<u>DISCUSSION/FINDINGS</u>	<u>RECOMMENDATION/ACTION/ FOLLOW-UP</u>
I. Call to Order/ Approval of Minutes	<ul style="list-style-type: none"> ○ The meeting was called to order at 10:07 AM at the Central Public Health Center. ○ Introduction of Commissioners and guests <ul style="list-style-type: none"> ○ Unable to approve minutes at this time. 	Information only.
II. Proposed Health Agency Report	<p>Director of Health Care Integration, Dr. Christina Ghaly, to discuss the Draft Report to the Board of Supervisors</p> <ul style="list-style-type: none"> ○ The draft report was released to the public on March 30, 2015 and there will be a 45 day comment period (May 15th - the last comment day). ○ There was not an executive summary provided for the first draft, but there will be one for the final report in June. ○ One of the primary goals of the health agency model, per the Board, is to improve and enhance services. <ul style="list-style-type: none"> ○ Cuts/layoffs/budget cuts/decline in services is not the intention ○ Within the agency structure, each department maintains its own separate structure and budget. <ul style="list-style-type: none"> ○ Within this structure, only the Board has the authority to change 	

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	<p style="text-align: center;">a department's budget/cut/increase money for departments</p> <ul style="list-style-type: none">○ The structure is intentionally designed to mitigate risks to create a lean organization that will not require new administrative positions (which could lead to increased bureaucracy).○ The Recommendations in the draft report are designed to make sure that things are reviewed thoughtfully. ○ Commission Chair Champommier opened up the discussion for comments. The Chair invited Dr. Katz, Director of Health Services, to speak about the draft report. ○ Dr. Katz stated he is excited about the opportunity to integrate. He stated that he believes there is tremendous opportunity when smart individuals and synergistic trainings and orientations are put together. ○ Dr. Katz used example of Olive View (DHS), to highlight one of the inefficiencies across departments. Although Olive View has the most advanced tuberculosis capabilities, (negative pressure rooms, great capability of taking care of people with TB), he discussed how doctors working in Olive View (and other County hospitals) often have difficulty finding the TB record/history of a patient. ○ Dr. Katz stated that as someone who has worked at the interface between public health and health services, there is nothing antagonistic about the two. He indicated that it is true that they are not overlapping things. He stated that both DPH and DHS are both focused on health, and there are a variety of different tools that can deliver health.<ul style="list-style-type: none">○ Health services, population health, regulation, social marketing (i.e.: tobacco campaigns)- these goals of all of these are the same: the goal is health. ○ Dr. Katz discussed the historical public health model. Ten years ago, the model indicated that the public health department needed to be separate—the firewall model. The thought was to put firewalls around public health to prevent the possibility that money from PH would be	
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	<p>taken to fill hospital deficits. At the time, he stated, this was the right decision. Now, public health tools help to make a meaningful difference around social determinants.</p> <ul style="list-style-type: none">○ He stated that DPH and DHS should use their joint abilities together to make meaningful strides.○ He stated that within PH, there is substance abuse, which he believes is a health service. He stated that the clients with mental health/substance abuse problems, who are often homeless, are the most difficult patients.○ He stated that the current system requires these clients to enter three different doors, with three separate registrations, separate rules, and eligibility. He asked how that makes sense.○ He stated that the only way to get over the joint-eligibility/joint-medical records, is to integrate.○ He stated that this is only one small component of what public health does, and he believes that it can be improved.○ In discussing social determinants, Dr. Katz indicated that Kaiser data is not helpful. He asked which data is helpful in determining where PH should go in Los Angeles?<ul style="list-style-type: none">○ He indicated that DHS takes care of 600,000 people, the lowest income people in LA County; and thus, the target audience of most of public health's promotion surrounding social determinants.○ He indicated that there is tremendous opportunity to shape this.○ He stated that there are a variety of ways for health services, public health, and mental health to work together. He stated that the agency model is meant as a best compromise. He stated that the idea to return to a previous single department is not on the table. He indicated that the suggestion is an agency model—a single strategy, single entry door, a way of maximizing joint efforts of bringing health to Los Angeles.○ He stated that he thinks this is an exciting mission and hopes the three departments can work together. <p>Commissioner Dowling introduced himself</p>	
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PHC Chair opened up for comments from the Commissioners

- Commissioner Bholat thanked Dr. Katz for the overview. She mentioned that Dr. Katz's point about what was done a decade ago, creating the PH department, was an important point. She mentioned that nationally, public health does not get enough funds and public health does not get its fair share. She indicated that there are regulatory things that are very different in the medical model. She stated that DPH is a very broad-reaching department and that there are a lot of overlapping opportunities.
- Commissioner Bholat also stated that substance abuse, mental health, and homelessness, are all issues that every hospital faces—from Cedars Sinai, to UCLA. These issues are not getting smaller. She stated that the challenge will be on the mental health side because even within one unified system, it is nearly impossible to get mental health records.
- In regards to the proposed health agency model, Commissioner Bholat indicated that it would be a good idea to demonstrate real outcomes first, before plunging into the agency model. She suggested beginning with a pilot. She also stated that even within one agency, it is hard to get everything right.
- Commissioner Bholat stated that she believes in the work of all three departments and wants to focus on ways in which the Public Health Commission can be helpful during this time.
- Commissioner Dowling stated that he shares Dr. Katz's vision and complimented Dr. Ghaly on the well written and referenced draft report. He noted that he was unsure if the DHS mentioned in the report is the same organization he is familiar. He also stated that DHS is a very complex organization, and is not nimble.
- Commissioner Dowling stated that in practicing medicine, doctors are now seeing more people with more social problems—social determinants. He stated that the only way to address addiction and the mentally ill is with a model like the potential health agency.
- Commissioner Dowling expressed his concern about the fear of an

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	<p>agency being dismantled.</p> <ul style="list-style-type: none">○ Commissioner Dowling stated that the ideas and concepts brought forth in the draft report represent the direction that he believes healthcare needs to go. He questioned whether or not it should be done at once or instead, set up station projects. He suggested perhaps individuals apply for grants inside DHS to set up projects and see who might be able to master this and show how it could work.○ Commissioner Dowling expressed his thoughts regarding the need for more than one model and discussed the idea of demonstration; perhaps first figure out what works and identify what has the potential to work.○ Commissioner Dowling stated that he believes that there always needs to be a public health structure in place, and that it needs to be assured that it does not get dismantled.○ Commissioner Dowling stated that the more the departments integrate the better chance of solving healthcare needs of low income populations. He stated that he is overall supportive of questioning the strategy and the time interval to adopt the agency model. ○ Commission Vice Chair Crawford thanked Dr. Ghaly for the hard work put forth in the report. She stated she could sense the passion and vision in terms of the proposal. ○ Commission Vice Chair Crawford stated that looking at the different models proposed on page 46 (of the draft report) from a community organizer background, looking at the importance of collaboration between the departments and sharing of information, she identified potential structural/HR/recruitment challenges. She stated that when an agency structure is created, there will be someone in place that the Department heads will be reporting to, as opposed to giving them the autonomy report directly to the Board of Supervisors.○ Commission Vice Chair Crawford also stated that an important HR issue remains as the new DPH director position is vacant.○ Commission Vice Chair Crawford stated that it is important to look at personnel issues—particularly when it comes to the department head	
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	<p>reporting to the Board instead of an agency head. She mentioned that the DPH department head is going to be impacted by this structure and may impact the type of person who may be interested in the job.</p> <ul style="list-style-type: none">○ Commission Vice Chair Crawford also stated that the collaboration piece, to work smart and not reinvent the wheel, is an important issue. She stated that she is not convinced that an agency structure is the best way to go. She did state that she is willing to be convinced of it.○ Commission Vice Chair Crawford discussed her concerns regarding downsides to the model, in terms of DPH's current condition, with an interim director in place. She stated she feels that it is important for the leaders of the other departments to be accountable for collaborating, but need to retain their autonomy without reporting to an agency head. She indicated that she understands the idea that each department head would still have the autonomy, but in practice, the message that is sent (from a structural perspective), is something very different than the BOS model.○ Commission Vice Chair Crawford expressed that she considers it her duty as a PH Commissioner, to consider the public health best interest for all people in the County. She stated that taken into account her duty as a PH Commissioner, she would not recommend the new agency structure, and is not convinced of it.○ Dr. Ghaly asked Commission Vice Chair Crawford if the recruitment challenges she mentioned solely relate to the DPH director position?○ Commission Vice Chair Crawford indicated that her concern is primarily with the DPH top management—the new Dr. Fielding. She indicated that it would be a downside to a professional at the level of the DPH director to come into an agency structure, as opposed to a departmental structure, where they would have autonomy and report to the Board, but would be required to work with the DHS and DMH directors to figure out structural ways to make some of these changes happen. She suggested perhaps through demonstration projects.○ Dr. Ghaly asked about reporting to the Board. She stated that department heads do not report to the Board now, they report to Deputy	
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	<p>CEO's.</p> <ul style="list-style-type: none">○ Commission Vice Chair Crawford stated that in terms of presenting to the Board, department heads do have the opportunity to do so. She also mentioned the importance of the perception of the department head being recognized as the department director—the person in charge. Also, from a public perception—it is perceived that the Board of Supervisor's holds department directors accountable for their department.○ Commission Chair Champommier expressed his concern with the new bureaucracy. He stated that he read through the report and it was not convincing to him that the agency model is the way to go. He suggested taking two or three issues/priorities, and form a task force to work on the issues.○ He stated that DPH and DMH leadership is cooperative in working together, particularly at the community level. He expressed his concern that the enthusiasm and creativity exemplified by DPH and DMH in reaching out to the community will be lost. He stressed the fact that the current model works. He stated that he is not certain where DHS fits in the model in terms of where the control will be. He asked where the control will be and if it will be shared.○ Commission Chair Champommier stated that he supports the idea of taking three to four priorities and have the agency define and collaborate this way, rather than set up a large bureaucracy. He asked if it would be feasible for the three departments to focus on integrating while simultaneously continuing to do their job. He stated that building a new bureaucracy will double the workload of the departments as well as hinder the creativity that currently exists within DPH and DMH.○ Commission Chair Champommier expressed his concern regarding the report being filled with various assumptions. He stated that the report is not a clear road map to integration and stated that he is skeptical of how it will play out in practice. He expressed his concern about the gravity of the potential integration. He also stated that integration poses great risks, in terms of focusing on an agency structure that could be	
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alternatively accomplished by looking at specific issues (such as housing or substance abuse) and combine the resources together. He stated that risking the successes of the two departments (DPH/DMH) deeply concerns him. He stated that from his experience with DPH/DMH, the department's leadership are not opposed to collaboration, working together, to solve problems jointly.

- Commission Chair Champommier stated a potential problem of the agency structure is that if the structure does not work, it would most likely take longer to dismantle it than putting it together. He stated that the risk at hand is too great.
- Commission Chair Champommier stated that the best option, moving forward with the agency model, would be to facilitate a pilot project and further explore ways for the departments to integrate. He also stated that there would not be any resistance from DPH or DMH leadership to do this.
- Commission Chair Champommier stated that it may be useful to look at what DCFS is doing as far as having someone put in place to explore opportunities for integration and for monitoring integration efforts. He stated that he would forward his specific concerns about the report to Dr. Ghaly.
- Dr. Katz responded to Commission Char Champommier's comments and indicated that he understands the concerns.
- Dr. Katz stated that the three departments each reported to the same person for the past four and a half years, as long as he has been serving LAC.
- Dr. Katz stated that the Board is clear about its policy role, which favors integration. He indicated that the Board understands that it cannot run the-day-to-day operations. It has to run under the Brown Act. He indicated that the Supervisors are the "boss" when in public. Other than that, he indicated, they are smart, involved people, but, they cannot tell departments what to do.

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- Dr. Katz stated that the challenge is determining how to create leadership. He asked that when integration is mentioned, who is responsible for doing it. He indicated that what he sees in the existing structure (the department structure), he does not believe the DPH/DHS/DMH director can approach the interim CEO to ask for help leading the three departments as equals. He stated that the interim CEO is running a huge department, then the idea is that there is going to be less support in the CEO's office. Dr. Katz indicated that there is no way for the things to happen unless there is some structure for making decisions and making sure things are moving forward.
- Commission Chair Champommier responded to Dr. Katz, asking why he (Dr. Katz), Ms. Harding (DPH interim director), and Mr. Southard (DMH director) have yet to get together and come up with a way to accomplish this? He also indicated that Ms. Harding and Mr. Southard were the last to hear about the move towards integration. Commission Chair Champommier asked if these actions inspire trust—both at the community level and the bureaucratic level.
- Dr. Katz responded that it cannot simultaneously be said that it is important for departments to report to the Board, and then be upset that the Board can talk to the departments. He indicated that you have to choose which of those sides you want to be on.
- Commission Chair Champommier responded to Dr. Katz that there should not be sides. He asked Dr. Katz that when he spoke with the Board and developed this idea, why did he not involve the other two department heads [DMH/DPH]. He asked Dr. Katz if he was at the Board meeting, why did he not suggest to the Supervisors, about having the other department heads present. Commission Chair Champommier indicated that this bothers him. He indicated that when there is good leadership (as with DPH and DMH), why not work together to collaborate in developing what should [have] been presented to the

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	<p>Board. Commission Chair Champommier suggested utilizing collaboration--a top-down model. He stated that if collaboration is the goal, then to include collaboration in the decision making process, and reach out to the other departments to jointly present something. He indicated that from his experience working with DPH and DMH; both departments are extremely collaborative and receptive to working together.</p> <ul style="list-style-type: none">○ Commission Chair Champommier indicated that reorganizational coordination and collaboration is what is missing from the draft report. He also indicated that sending the draft report out to stakeholders is difficult, because of the inability to understand the detailed language. He stated that the language will hinder stakeholders from going through the report.○ Commission Chair Champommier indicated that it is important to watch what people do and the actions taken, not so much as to what is said or in a report. He also stated that the actions taken so far indicate that the other two departments (DPH/DMH) are junior partners. He indicated that he respects the analysis conducted, but the draft report does not include a sufficient analysis of the history of why the consolidated department did not work. He stated that one of the primary issues is that this whole process has not been a joint effort. He mentioned how DPH/DMH's top management is not going to speak up. He stated that they are aware of the top-down model and there are various things that they feel reluctant to speak up and do not want to "rock the boat".○ Commission Chair Champommier's overall concern is that the actions that have been taken have no sense of collaboration.○ Dr. Katz responded to Commissioner Champommier's comments, indicating that perhaps Commissioner Champommier is personalizing the consolidation efforts being about him (Katz).○ Dr. Katz indicated that it is not his responsibility to tell the Board how to conduct its business.	
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- Commission Chair Champommier indicated that he is not conveying that.
- Dr. Katz indicated that Commission Chair Champommier is angry about it and is associating Dr. Katz as not being collaborative and is insinuating that it was his responsibility (Katz) to tell the Board to do things in a different way.
- Commission Chair Champommier asked Dr. Katz if he was responsible for implementing the health agency.
- Dr. Katz indicated that at the moment, he is not responsible. He stated that the motion came from the Board, not from him. Additionally, the Board did not indicate in their motion how the agency would be run. He stated that if the Board chose to talk to him, which they did, and did not chose to talk to the other departments, it cannot be his fault. Dr. Katz stated that he does not tell the Board who to talk to. The Board, per his political experience, can talk to people as they chose-- which is why they are elected. They make their own decisions. Department heads do not tell the Board what to do.
- Commission Chair Champommier responded that his suggestion would be to have the other two leaders (DPH and DMH) sit down right away and analyze the mandate and discuss.
- Chair Champommier asked Dr. Katz if the mandate was assigned to him. Dr Katz indicated no, he has not been assigned anything different than Ms. Harding or Mr. Southard.
- Dr. Katz indicated that he has had great discussions with Ms. Harding and Mr. Southard. He also stated that not everyone agrees on all points, but all of the discussions are positive.

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| | <ul style="list-style-type: none">○ Commission Chair Champommier indicated that the two departments (DPH/DMH) do not feel that they are included as participants in designing alternatives to the structure, due to the fact that the process is still in the planning stage and has yet to reach the final stage.○ Dr. Katz stated that it is not his job, nor can he mandate the Board, to determine the structure. He indicated that the Board set out the structure, but did not finalize it. Instead, the Board has indicated that they support a health agency. He stated that the health agency--this radical thing that is being discussed—is less radical than any other county. He stated that every other county in California has either an agency model or a completely consolidated model. He also stated that in 13 years in San Francisco, no one ever suggested that public health or mental health would be better served as a separate department.○ Dr. Katz indicated that he understands the history of the separation of the departments in 2006, and the past cannot be changed. He also stated that the reason for moving forward or not moving forward, should not be because of the history and because the previous model was inefficient, which he stated he is not denying.○ Dr. Katz mentioned the CA Health Waiver--20 billion dollars about Whole Person Care and questioned if the best way to deliver Whole Person Care is through three departments that report to a CEO.○ Commission Chair Champommier indicated that the proposed health agency would be a very big change. Dr. Katz indicated that he feels that it is not a big change. He stated the change would be something to the effect of: one day three department heads report to CEO and then the next day, they would report to the agency director. Dr. Katz also stated that the day after the agency is implemented, there would not be a noticeable difference.○ Commission Chair Champommier indicated that if the transition were to | |
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be as Dr. Katz mentioned, then there would be no complaints. He also mentioned that if both departments (DPH/DMH) were to maintain their creativity and ability to continue to perform their mission, then there would be not be an issue.

- Dr. Katz asked how could it be proved that nothing bad will happen if the agency structure is being worked against from moving forward. He stated that assuming the agency model will move forward, one possibility is that the Board will say that there is too much negative feedback and chose not to move forward. Dr. Katz stated that he did not think this was the best option, but it would be fine. Dr. Katz stated that the three department heads (DPH/DMH/DHS) are already amicable towards each other.
- Dr. Katz discussed the proposed second option, which could be that the agency structure is approved and moves forward. Per the recommendation of the CEO, an agency director would not be hired. Instead, one of the three department heads would be hired. Dr. Katz stated that the CEO may opt to hire him due to the fact that he is the only one of the three department directors that has experience running three different groups (health services, public health, and mental health) together. Dr. Katz stated that if this scenario were to occur, there would not be much change. The new DPH director, and Mr. Southard, would report to the agency director. The only difference between this and what has historically been is that there would then be a responsibility to work together. He stated that is it has not been that way under the CEO because there is not enough bandwidth.
- Dr. Katz stated that the employees working in the CEO's office have not been individuals who understand the three different health areas (DPH/DHS/DMH). The Interim CEO is not a mental health or public health person. In trying to figure out how to implement Pre-exposure prophylaxis (PrEP), a current controversial issue, Dr. Katz asked if the Interim CEO is to decide how to implement PrEP; who is to decide?

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- Ms. Harding indicated that PrEP is being implemented without the Interim CEO. It is moving forward regardless. Ms. Harding indicated that PrEP is not a good example.
- Dr. Ghaly stated that there is a theme across integration. She stated that there has not been rapid enough progress across the board when it comes to integrating services. There are areas where there are successful pilots where there are projects that have been taken on, but have not translated to a comprehensive system of care or comprehensive thought of being able to see all of the pilots across.
- Ms. Harding indicated that the draft report does a good job of identifying opportunities for integration, but the directors of DPH, DHS, and DMH could sit down and discuss how to make the opportunities happen, which does not require an agency model. She indicated that the three department directors (DPH/DMH/DHS) have not had the opportunity to sit down and talk about collaboration, which is something that could be easily facilitated. She indicated that DPH would love to do more collaboration between the other departments.
- Dr. Katz stated that he has no problem with sitting down and identifying additional collaboration areas. However, he asked Ms. Harding if she likely has not chosen DPH to have matrix supervision.
- Ms. Harding indicated no.
- Dr. Katz stated that matrix supervision is hard. He stated that generally, the desire is to have structure that can implement the vision, and that is easier with an agency. Dr. Katz stated that he does not know any way around it. He stated that electronic medical records and the possibility of having a single eligibility doctor cannot occur without an agency. He stated that he agrees that any single thing can be done without an agency, but that does not mean it is the most successful way.

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- Dr. Katz stated that he has tried to stay out of public health issues because he does not want to step on anyone's toes. He stated that he has his views and experience but he states that he was not hired to be the public health director. He stated that Dr. Fielding was not interested in his opinions, which was okay with him. He stated that he does not want to tell public health what to do, since he does not have a public health role, it would be inappropriate. He stated that if there was one agency, then it would make sense to figure out a joint plan. Dr. Katz stated that he is not sure how this would efficiently be done in the absence of an agency.
- Ms. Harding stated that she wanted to share feedback about the draft report which she received from the community with the Public Health Commissioners. She indicated that many have stated that the report is dense and hard to share with community members. Ms. Harding indicated that she would suggest creating a condensed version, perhaps two to five pages that can be shared at the upcoming stakeholder meetings, which would make it easier for people to read and understand.
- Dr. Ghaly stated that she understands and believes it to be a valid point. She indicated that it is difficult to select specific points for a condensed version because then it appears that the rest of the information is not as important because it was not included in the condensed version; she expressed the dilemma of not wanting to compromise the integrity of certain points over others.
- Dr. Ghaly indicated that for the public convening's, which will be posted on the priorities.lacounty.gov website, there will be registration, which will be emailed out to attendees. She also indicated that during the meetings, there will be a presentation with slides that will summarize the document. She also stated that when the consolidated version is available, she will ensure it is distributed for feedback.

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- Ms. Harding indicated that she would appreciate it and that she received calls from frustrated individuals, who cannot read through the report, and who are trying to share it with community stakeholders.
- Dr. Ghaly indicated she understands that it is complex and that the report was drafted for the Board, but of course, community input on it is desired.
- Vice Chair Crawford stated that the perception that is conveyed to the community is that they [the community] are being intentionally excluded due to not including an executive summary with the draft report. She recommended that perhaps at the community meetings, Dr. Ghaly explain the reason why there is not an executive summary included with the report and indicate that it was not intentionally written so densely so that it could not be understood. Vice Chair Crawford also indicated that she understands the concept of not wanting to compromise the integrity of the work, but to community members, it may be perceived as trying to hide information.
- Dr. Katz posed a question for the Commissioners to think about. He stated that in many discussions, “departments” are discussed and— the autonomy of the departments, the integrity of the departments, etc. He stated that he does not care about the three department structures. Instead, he stated, he views it as: health, community, and patients. He indicated that he views how departments are created as arbitrary figures, because there always has to be a structure. He stated that something nice about the agency structure is that it takes all of aspects of the three departments, puts the people together, and places everything under an umbrella. He stated that once the umbrella is created, task them with projects and then assess what mental health, health services, and public health each have to offer to the project. He stated that the challenge is that the three department concept does not best serve the community.

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- Commission Chair Champommier stated that the three departments, he believes, share a lot. He also stated that he agrees-- the structures are arbitrary; structure is only to get things done and is not something that is owned. He also indicated that his concern is with the outcome; the client. He stated that he is familiar with the good services that are currently being provided and is concerned that the agency model will be able to achieve the same success. He also stated that he is concerned with the idea of more bureaucracy, which can inhibit creativity of the department heads and their staff.

- Vice Chair Commissioner Crawford stated that she believes it is not about the structure—it is about the people working to accomplish the goal. She indicated that if the structure is going to change, then it needs to be clear that it is absolutely necessary to cause change. She also indicated that the outcome needs to be proven that it will be remarkably different. She stated that from a cost benefit perspective—the cost of change and the toll that takes on people— has to be clear that the benefit will be significant. She also indicated that it is not clear that the change/upheaval in changing the structure is going to have a benefit, particularly for the director positions. From a human capital and relational point of view, she noted, is extremely important, because it is about the people.

- Dr. Katz stated that these are hard issues. He indicated that he has a different view from Commissioner Crawford regarding the department head. He stated that a search was done by an excellent firm [for the DPH director] and the search did not succeed. He stated that the deterrent is how challenging it is with Board searches and it goes to the fact that the Board can only make decisions by votes, in public, and that it can be a lengthy process. He stated for example, when he [Dr. Katz] wants to hire a candidate, he lines up a terrific candidate first, and then he will open the job up for all others to apply, and if someone more terrific than the initial candidate in mind applies, then that person is

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	<p>hired. He stated that the Board cannot do this. He indicated that the Board did not want to hire someone who was not great, nor should they.</p> <ul style="list-style-type: none">○ Dr. Katz stated that he believes he could help whoever is in the DPH director position, to be successful. He stated that LA County is a challenging and unusual County, in the sense of almost all of the other ones near its size, have an elected mayor or elected CEO. The structure here in LA County is different—the structure is under five smart, committed people; LA County is challenging place.○ Dr. Katz stated that one thing he has demonstrated is the ability to co-lect the five board members around the set of initiatives that have helped change DHS. He stated that he would like to be in a position that would support and guarantee whoever is in the position [DPH director] five votes and help make him or her a success. Dr. Katz stated that the evidence shows that he [Dr. Katz] is not a micromanager. He stated that he intends to grow people and desire to find the best people and encourage them.○ Dr. Katz indicated that he likes working with Ms. Harding. He stated he has learned things from her and he hopes she has learned some things from him.○ Dr. Katz stated that he views the chance that the DPH director will succeed even greater the agency model does happen. He stated that he [Dr. Katz] would have the opportunity to mentor the new DPH director, and Dr. Katz would be in an easier position [in the agency model].○ Dr. Katz stated that the Board would still have a say in who the DPH director will be. Again, he indicated that when he hires someone, he finds someone great, then he opens up a search, and if a greater candidate comes along, than he hires that candidate. If not, then he hires the initial candidate. He indicated, that what he would do in the situation is, he would write to the Board and ask if they would like to meet the person whom he has selected. He indicated that usually, if there is an issue that engages one or two Supervisors, they do want to	
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	<p>meet the candidate.</p> <ul style="list-style-type: none">○ Dr. Katz stated that he can help find someone great for the DPH director position and that he can help that person be a success. He stated this is what he likes to do. He stated that one of the challenges is that in a discussion like this, in many settings, it makes it seem like he [Katz] is trying to garner power or grow an empire. He stated he has no interest in doing that; he stated that from his point of view, it is not about that. He stated that he has nothing to gain and that he cares deeply about health and wants the efforts of all departments (DPH/DHS/DMH) to deliver the best health. He also stated that he does see inefficiencies in how the departments currently operate, which are not the fault of anyone. He stated that things could be better and he would like to be part of it and if the agency moves forward, great, and if it does not, DHS still has a long way to go, and has a lot of progress to make. He stated that there are people directing the progress, which is going to happen and it cannot happen any faster. He stated that it is possible in LA to bring major change; there is a lot of great stuff that can happen.○ Commissioner Dowling indicated that he was not trying to be critical of DHS, but instead, he meant to state that he has seen more progress (in many areas) in the past four years than the last 25 years. He stated that one of the Commission's reservations is identifying what is the best way to get from A to B. He asked if it has to be a leap or are there smaller steps that can be taken.○ Dr. Katz asked if the change would really be considered to be a leap. He indicated that there are various scenarios: 1) The Board will say no, in which things will stay the same, 2) Agency will be created- if an agency, is created, they would not take the CEO's advice, creating more bureaucracy, which they are not showing interest in doing, given the fact that all of the Deputy CEO's were sent back into departments. The Board is not interested in more administrative, high level. So, they would have to choose an agency director.	
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- Dr. Katz stated that it would be likely that the Board would select him [Katz] to be the agency director, but the Board has not stated that. Assuming they did select him, day one of the agency would entail meeting with DPH's interim director and health officer and Mental Health's department head/chief deputy and Dr. Ghaly to figure out the next steps. Dr. Katz said that this could happen without agency integration; however, it can be challenging because he does not want to tell Ms. Harding what to do, etc. if the departments remain separate. He stated that there are operational things that need to be decided: which system will be followed, and determine who does what, etc.
- Dr. Katz indicated that the idea of the Deputy CEO's of integrating the efforts of the departments failed.
- Commissioner Bholat thanked Dr. Katz and indicated that the meeting has been a wonderful discussion and a lot has been learned. She then asked Dr. Katz if he were named agency director, would the position open for DHS?
- Dr. Katz indicated that he would fulfill both positions. He stated that if a department view is taken, that is a bad thing. He indicated that if a view of serving and helping the community view is taken, the departments are arbitrary. He stated that DHS is a flat organization. He stated that it is the hospital leader's job to run the hospital and Dr. Katz's job is to add value. The same with juvenile correction health, etc. Dr. Katz stated the same concept would be true for the agency director.
- Dr. Katz stated that the job of the health agency director's job is to add value by working with others and work with the Board to ensure there are five votes, sufficient funding to make the project happen.
- Dr. Katz stated that this type of issue is one where individuals say that there are not equals. If it is a thing of equals, then the DHS director needs to be replaced. But, if the DHS director is replaced, then more bureaucracy is being created.

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- Commissioner Bholat indicated that she understands and wanted clarification. Additionally, she indicated that she understands the arbitrariness of directors. She then discussed some historical DPH background. DPH, circa 1999-2000, was a department of categorical approach. She stated that it took a lot of people working collaboratively to move towards a more comprehensive approach. She stated that being on the PHC over the years, she has seen major change in the way DPH operated. She stated that over the last five years, the organization (DPH) has changed.
- Commissioner Bholat stated that one of the concerns that has been raised for DPH is an amount of arrogance that is detected, in the way in which DPH relies on researchers, universities, etc. She indicated that she believes that directors are only good as the people who are representing them. Additionally, she stated, there are times where the directors do not see what is happening; this remains one of her concerns. She indicated that she is not suggesting that the agency model is not a good way to go. She stated that when there is a transition like what is being proposed, there has to be some analysis of staff that each department has in place (DPH/DHS/DMH) because they may not be in the best interest of the department heads moving forward. She stated that having people understand the community it is very crucial; communities can be hostile. People who will be representing the department heads should not only be those who have research fellowship. She indicated that this needs to be looked at critically. She stated that both DPH and DHS's department heads are excellent and each have made significant strides within their respective departments.
- Commissioner Bholat indicated that the Venn diagram should be looked at to see where the overlapping of the department is likely to occur. She also stated the importance of demonstrating success and to give some time because the community will most likely have pushback. She indicated that it does not mean not to move forward with demonstrating

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	<p>one thing can be done as a combined agency.</p> <ul style="list-style-type: none">○ Dr. Katz indicated that it is hard for people to simultaneously work against the agency model and to come up with the most successful way to make it happen. He stated that one of the reasons that Board needs to either determine if it is going to happen or it is not, is because there are a group of people who want it to happen and a group who do not want it to happen. He stated that if it moves forward, the group of people who do not want it to happen will do their best to make it successful.○ Dr. Katz stated that there are a group of people within DPH, who the agency model to move forward. He stated that there is a group of clinical staff who see much more of the positives. Dr. Katz indicated that the people who do not want the agency model to not move forward, for whatever reason, are working against it; as they should; this is a democracy. Dr. Katz stated that once a decision is made—either it happens or it does not happen—and if it does happen, the people who are fighting it, he believes, will stop fighting it. He indicated that part of why they are fighting the agency model is because they do not think it is right. He stated that once the ultimate decision is made, they will get on board. He stated that people who work for public service departments—like DPH, DMH, DHS—are generally the best employees: they come for the right reasons and they will work to make it happen; they will make it a success. Dr. Katz stated that this is why he is not enthusiastic about pilots that do not involve a decision, because he does not believe the best work will be done. He indicated that he would like the Board to either approve or deny the decision. He stated that he believes that if the agency model does move forward, the resistance will fade. He indicated that after it is approved, then it will be assessed if the model works or does not. He stated that there will be reports to the Board, recommended quarterly and the department heads will advise the Board directly to advise if the model is working or is not. Additionally, he stated that if the model does not work, given that it is just an agency and not merged departments, it should not take much to undo it and return to	
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having the three department heads report to the CEO.

- Dr. Katz indicated that when the ten DCEO's were eliminated, nothing happened. They simply went away, the reporting structure changed.
- Dr. Katz stated that if the agency model is decided upon by the Board, then would be the right time for the two or three issues to demonstrate success. He stated that then, after a year, the Board can assess whether or not to continue with the agency model or rethink the model.
- Dr. Katz indicated that budgets and staff make it difficult to create and undo things. He indicated that if the budget and the staff are not combined, it will not be hard to undo.

- Commissioner Dowling asked Dr. Katz for clarity regarding his opinion regarding approving the agency model first and then moving forward with the pilots.
- Dr. Katz stated yes, he believes the agency structure should be approved before moving forward with any pilots. He stated that if the Board choses something in the middle, then those people who do not want the agency model to happen (he indicated that people should advocate for what they believe is right), are not going to be the ones to make the agency a success because they do not believe it should happen. He indicated that this is why he feels a clear decision needs to be made to either move forward with the agency model or not.

- Dr. Katz indicated that he hopes the Public Health Commission will be deeply involved in shaping the agency model into a success. He reminded the Commissioners that if the agency model is not a success after 15-18 months, it can be ended.

- Commissioner Crawford stated that Dr. Katz is highly regarded in LA County. She indicated that it would be helpful to the community (and the Board) to know that regardless of how the agency model decision is made, Dr. Katz is still on LA County's team. She indicated that she has

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	<p>been told by community members that if the agency structure is not approved, LA County may lose Dr. Katz.</p> <ul style="list-style-type: none">○ Dr. Katz indicated that he is committed to Los Angeles County○ Commissioner Crawford suggested to Dr. Katz that he make that clear to community members. She indicated that she personally believed that Dr. Katz was committed to LA County, but suggested that it would be helpful to communicate that to the community in order to halt any speculation (within the community) regarding Dr. Katz leaving LA County if the proposed agency is not approved.○ Dr. Katz stated that the information shared was good advice. He also stated that he has not given up on the idea that the Public Health Commission does not want to support the agency model. He stated that he feels that the PHC is an important Commission and that the Commission could help shape a very exciting future. He indicated that no one can change the past history and that the model has worked elsewhere and could work in LA County. He also stated that a lot of positives have already come forward from this meeting/discussion.○ Commission Chair Champommier asked in terms of the agency, how would the staffing look?○ Dr. Katz stated that day one of the health agency model would entail himself, Cindy, Dr. Gunzenhauser, Robyn, Marv, and probably one of his deputies, most likely Dr. Ghaly, who has been most involved. He stated that all of them would meet and decide what the work plan would be for the next period of time, they would make some suggestions, and then have the work plan be reviewed by the PHC, Mental Health Commission, Hospital Commission, and the Board regarding will get done during a specified timeframe. He stated that decisions would also be made together regarding which projects would be short and long term.	
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- Dr. Katz stated that mental health, substance abuse, housing issues would be high on the work plan list. He also stated that decisions needed to be made about the clinics and assess where DPH and DHS have space for additional clinicians, with the idea that a better job could be done if mixing occurred. He gave the example of MLK- both DPH and DHS have centers. However, in other places, DPH has a center and DHS does not and vice versa. He stated that better geographic proximity would be accomplished by having DPH and DHS staff mix in locations where the other has space.
- Ms. Harding indicated that both departments have already started doing this. Additionally, Ms. Harding stated that DPH would commit to continue to doing this, regardless of what happens because DPH believes it is very important. Ms. Harding stated that DPH and DHS were already exploring these options, regardless of the agency. She also indicated that DPH wants to continue this collaboration and stated that is it exciting to hear Dr. Katz speak about it, because collaboration is what DPH desires. Ms. Harding indicated that the facilities issue remains a large area for improvement and collaboration because DPH has aging facilities that do not meet the needs for public health. She stated that DPH desires to build new centers and would desire to give the old ones to DHS. She indicated the old facilities are not set up for the new public health, which is community based and works actively with community partners, working on policy, etc. She indicated that it is very exciting to hear about collaboration, but she wanted to make it clear that collaboration with DHS (and DMH) is already occurring and is not a new idea.
- Dr. Katz indicated that collaboration is not new but he stated that the agency is the most efficient way to achieve it. He indicated the desire to have pediatricians where there are childhood immunization clinics, as well as other areas that DPH/DHS would overlap.
- Commissioner Bholat stated that the health agency model has potential

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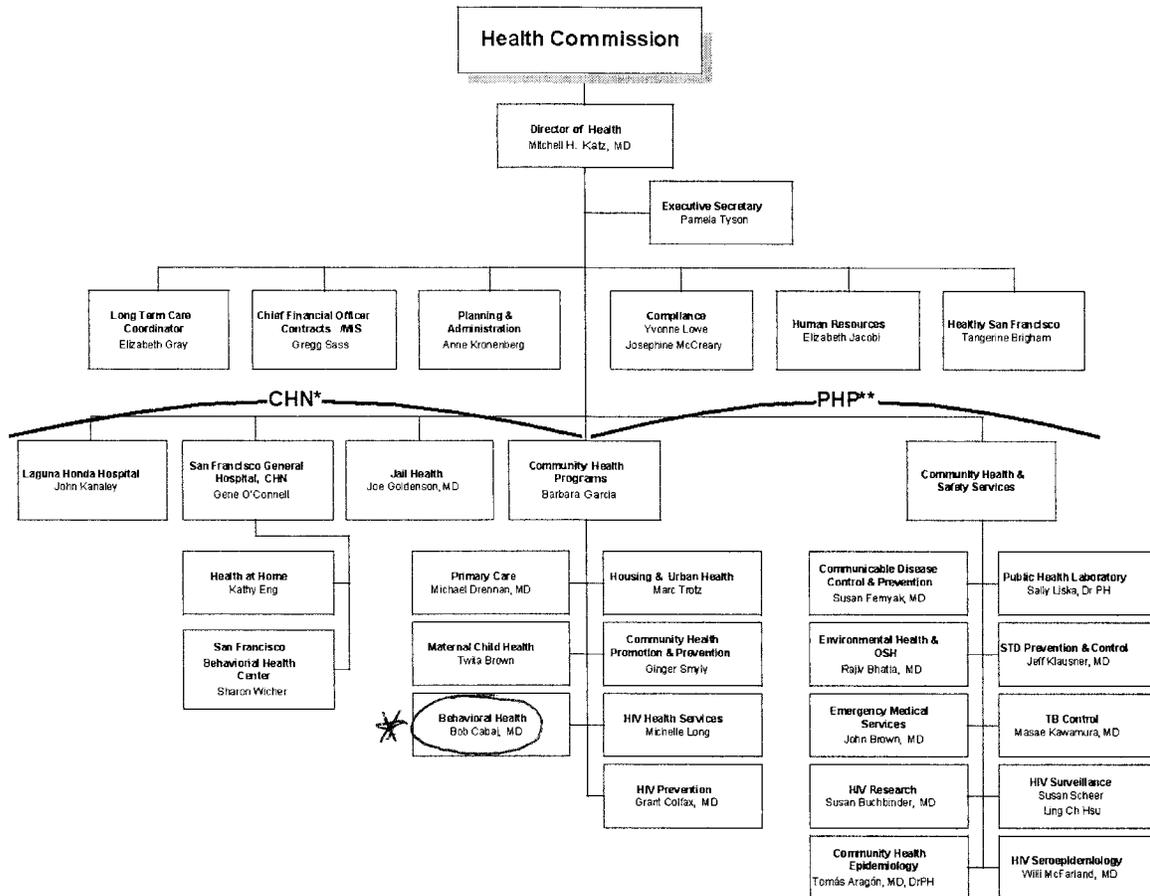
	<p>although there remains a level of distrust. She thanked Dr. Katz for a great discussion.</p> <ul style="list-style-type: none"> ○ Dr. Katz asked the Public Health Commissioners to be the people who make the agency model succeed. ○ Commission Champommier thanked Dr. Katz for the discussion. 	
<p>III. Public Health Report</p>	<p>Carrie Brumfield, Chief of Staff, provided the PH report</p> <p>Ms. Brumfield shared a memo from the Auditor Controller, indicating that the Public Health Commission’s Sunset Review has been extended another four years.</p> <p>Ms. Brumfield discussed the Health Facilities Inspection Division update. She indicated that Ms. Harding has been attending meetings in Sacramento and is in the midst of negotiations with the State. Ms. Brumfield indicated that Ms. Harding will be returning to Sacramento and will have more information regarding next steps when she returns.</p> <p>Ms. Brumfield discussed DPH’s accreditation submission and indicated that DPH is in the process of submitting all necessary documents.</p>	
<p>IV. Draft Report Next Steps</p>	<p>Commissioner Bholat asked if any member of the Commission has had any chance to work with the Hospital Commission. She stated that the Hospital Commission is missing from the table. She referenced Dr. Katz’s comments about the clinicians wanting the agency model to move forward for different reasons.</p>	

COUNTY OF LOS ANGELES
PUBLIC HEALTH COMMISSION MEETING
APRIL 9, 2015
MINUTES

	<p><i>MOTION: Commissioner Bholat entertained a motion to meet with Hospital Commission to discuss broad based population health community needs assessment and the proposed integration</i></p>	<p><i>Commissioner Bholat entertained a motion and the motion was moved by Commissioner Dowling.</i></p> <p>Evelina Villa, PHC staff, will look into making contact with the Hospital Commission staff.</p>
<p>V. New Business & Unfinished Business</p>	<p>The Rotation of Officers was rescheduled until the May 14, 2015 Public Health Commission meeting.</p> <p>PHC Logo/Website: The Commission voted on graphic #1 to be utilized as the official PHC logo</p>	<p><i>Three Commissioners (Commission Chair Champommier, Commissioner Bholat and Commissioner Dowling) unanimously voted for logo #1.</i></p>
<p>VI. Adjournment</p>	<p style="text-align: center;"><i>MOTION TO ADJOURN THE MEETING</i></p> <p style="text-align: center;">Meeting adjourned at 12:04 PM.</p>	<p><i>Motion made by Commissioner Dowling, seconded by Commissioner Bholat.</i></p>

Appendix 8

FROM: "Performance and Efficiency Review: Department of Public Health
 Controller's Office Analysis 2005-2008" City and County of S.F.
 June 20, 2008



*CHN = Community Health Network, the integrated health service delivery system of the Health Department

**PHP = Population Health and Prevention

The Department of Public Health runs the following major programs:

San Francisco General Hospital Medical Center

San Francisco General Hospital provides comprehensive emergency, urgent, primary, and specialty care to 98,244 adults and children annually. General Hospital is a leader in its field and is the only Level 1 Trauma Center for 1.5 million residents of San Francisco and northern San Mateo County. San Francisco General Hospital is also the only acute inpatient and rehabilitation hospital for psychiatric patients in the City and provides 24 hour psychiatric emergency care.

Laguna Honda Hospital and Rehabilitation Center

Laguna Honda Hospital and Rehabilitation Center is the largest skilled nursing facility in the country, with approximately 1,030 disabled or chronically ill adult San Franciscans as residents (daily average in fiscal year 2006-2007). Laguna Honda Hospital provides a full range of skilled nursing services to those with wounds, head trauma, stroke, spinal cord injuries, orthopedic injuries, AIDS, and dementia. The Hospital provides respite and hospice care, outpatient services through the Adult Day Health Care Center, as well as neighborhood nutrition services.

Appendix 9

IX. ITEMS CONTINUED FROM PREVIOUS MEETINGS FOR FURTHER DISCUSSION AND ACTION BY THE BOARD

A-9.

Recommendation as submitted by Supervisors Antonovich and Ridley-Thomas: Direct the County Counsel to prepare an ordinance that repeals the interim administrative system of governance adopted by the Board on March 27, 2007, thereby reverting back to the original governance structure, whereby the County's administrative system would be governed by the Chief Administrative Officer as articulated in Chapter 2 of the County Code; and revise the job description for the Chief Administrative Officer to comport with the updated governance structure, as requested by Supervisor Antonovich at the meeting of September 23, 2014. (A-9)

This item was taken up with Item No. 15.

Nicole Parson, Dr. Genevieve Clavreul, Herman Herman and Wayne Spindler addressed the Board.

Sachi A. Hamai, Interim Chief Executive Officer, responded to questions posed by the Board.

By Common Consent, there being no objection, this item was approved.

Ayes: 5 - Supervisor Solis, Supervisor Ridley-Thomas, Supervisor Kuehl, Supervisor Knabe and Supervisor Antonovich

Attachments: Video
Audio

15.

Recommendation as submitted by Supervisors Antonovich and Kuehl: Instruct County Counsel to prepare an ordinance to repeal the 2007 interim governance ordinance; and instruct the Interim Chief Executive Officer (CEO) to prepare a report within 60 days with recommendations to amend the County Governance structure that formalizes the recent changes to the system of governance and CEO organization, including the elimination of five Deputy CEO positions and recommend additional changes as necessary that help create a governance system that facilitates increased communication and collaboration necessary to confront complex County issues, streamlines governance and eliminates unnecessary layers of management and allows the Board to concentrate on establishing policy and ensuring effective service delivery. (15-0861)

Attachments: Motion by Supervisors Antonovich and Kuehl

16.

Recommendation as submitted by Supervisor Antonovich: Waive parking fees up to \$1,800 for approximately 90 vehicles at the Music Center Garage, excluding the cost of liability insurance, for participants attending the American Red Cross Appreciation Reception honoring County employees and the public who have donated blood, to be held March 12, 2015. (15-0855)

Attachments: Motion by Supervisor Antonovich

17.

Recommendation as submitted by Supervisor Antonovich: Waive the \$20 per vehicle parking fee at the Music Center Garage, excluding the cost of liability insurance, for participants of the 45th Annual Blue Ribbon Children's Festival in the Dorothy Chandler Pavilion, to be held April 7 through 9, 2015. (15-0792)

Attachments: Motion by Supervisor Antonovich

MOTION BY MAYOR MICHAEL D. ANTONOVICH
AND SUPERVISOR SHEILA KUEHL

February 24, 2015

COUNTY GOVERNANCE STRUCTURE

Over the last decade, members of the Board of Supervisors have periodically explored ways to improve the County's form of governance to meet the increasing complexity of issues facing local governments, such as child welfare and safety, prison realignment, sex trafficking, and implementation of the Affordable Care Act.

On March 27, 2007, the Board of Supervisors adopted an ordinance establishing an interim governance structure for the County. The purpose of the interim ordinance was to determine whether a strong, centralized administrative approach via the creation of a "Chief Executive Officer" (CEO) would allow greater service integration, focus on outcomes for County customers, and allow the Board to increase its focus on policy. The interim governance structure provided an opportunity to examine, on a time-limited basis, whether it would truly facilitate operational improvements that were not feasible through the existing Chief Administrative Office (CAO) structure.

The interim governance structure organized County government into 5 key areas: public safety, children and family well-being, community and municipal services, health and mental health, and operations. These areas, known commonly as "clusters" were designed to facilitate cross departmental collaboration and service integration to achieve better service outcomes.

MOTION

SOLIS	_____
RIDLEY-THOMAS	_____
KUEHL	_____
KNABE	_____
ANTONOVICH	_____

Recent changes in County leadership and the CEO management structure, including the reassignment of Deputy CEOs, represent an improvement over the 2007 structure by removing an unnecessary layer of management. Moreover, an unintended consequence of the interim governance was an increased distance between departments and the Board of Supervisors thereby reducing accountability.

The Board of Supervisors has an opportunity to formally update the County governance structure and provide stability in County government in a manner that retains departmental collaboration and interdepartmental communication, but reduces bureaucracy. Additional measures that enhance communication, collaboration, and eliminate bureaucracy should also be explored, and formally adopted by the Board of Supervisors.

WE, THEREFORE, MOVE that the Board of Supervisors:

1. Direct County Counsel to prepare an ordinance to repeal the 2007 interim governance ordinance.
2. Direct the Interim Chief Executive Officer (CEO) to prepare a report within 60 days with recommendations to amend the County Governance structure that formalizes the recent changes to the system of governance and CEO organization including the elimination of the five deputy CEOs, and recommend additional changes as necessary that help create a governance system that:
 - a. Facilitates increased communication and collaboration necessary to confront complex County issues.
 - b. Streamlines governance and eliminates unnecessary layers of management.
 - c. Allows the Board of Supervisors to concentrate on establishing policy and ensuring effective service delivery.

#

MDA:lg

s:\motions\County Governance Structure