County of Los Angeles
**CHIEF EXECUTIVE OFFICE**
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WILLIAM T FUJIOKA
Chief Executive Officer



June 29, 2009

To: Supervisor Don Knabe, Chairman
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

From: William T Fujioka
Chief Executive Officer

**DEPARTMENT OF PUBLIC HEALTH FISCAL CONDITION AND SEPARATION FROM THE DEPARTMENT OF HEALTH SERVICES (ITEM NO. 72, AGENDA OF JUNE 30, 2009)**

On June 22, 2009, during Budget Deliberations, your Board directed this Office and the Director of Public Health to report back on the Department of Public Health's (DPH) fiscal condition, including its curtailment plan for handling projected deficits, and whether there are escalating costs which are attributable to the separation of DPH from the Department of Health Services (DHS).

## Background

On May 30, 2006, your Board approved the establishment of DPH separate from DHS, and the new department became effective on July 7, 2006. The budgetary changes implementing the new department were approved by your Board on September 26, 2006, during the Supplemental Changes phase of the Fiscal Year (FY) 2006-07 budget process. The first full fiscal year's budget for DPH as a separate department appeared in the 2007-08 Proposed Budget.

Attachments I and II are prior memoranda from this Office which, in addition to providing information discussed further below regarding administrative positions and associated costs, reflect the justification provided for establishing the separate public health department:

- Potential budgetary impact of DHS' projected deficit on DPH operations;
- Varying missions and/or priorities of both DHS and DPH;
- DPH operational efficiency and neutrality by way of eliminating the layer of DHS management between DPH and your Board;
- Existing size, complexity, and scope of DPH responsibilities warranted DPH as a separate County department; and
- New and existing public health issues which warrant a separate organizational focus and direct responsibility of preventing and controlling serious threats.

Attachments I and II (memoranda dated August 12, 2008 and June 9, 2005, respectively) also reflect our assessment, based on the review during the separation analysis, that both DHS and DPH would require additional budgeted positions to meet existing administrative workload needs. Specific to positions for DPH, we indicated further that the additional costs of those positions would be recommended for absorption within the new department's available funding.

**Additional Net County Cost Impact of Establishing DPH**

Attachment I responded to your Board's request for a report on DPH administrative support positions. As noted, 21.0 position were added during the FY 2007-08 budget process to provide DPH the ability to address operational issues, primarily in human resources and contracts and grants. Of these, 18.0 were added to the DPH budget on June 18, 2007, as part of the 2007-08 Final Changes recommendations, and $0.6 million in additional net County cost (NCC) was provided to DPH.

However, since that time, the costs of all additional administrative support staff have been internally financed by DPH resulting in no additional NCC from the County General Fund. As an example, the 35.0 budgeted positions approved in FY 2008-09 were financed by DPH with indirect grant revenues and administrative overhead received as intra-fund transfers received from budget units within DPH.

Attachment III provides a comparative analysis of DPH's budgeted NCC just prior to and since the establishment of DPH as a separate department and offers a description of the basis for the NCC adjustments. Note: the significant decrease in budgeted NCC from FY 2005-06, when DPH was part of DHS, to FY 2006-07 when it was a separate Department, relates primarily to allocated overhead charges from Health Services Administration; also, the actual NCC at final closing for DPH in FY 2005-06 was $161.1 million compared to the budgeted $171.7 million.

As shown in Attachment III, the major source of NCC growth for DPH is from County General Fund offsets for the non-subvened portion of negotiated salaries and employee benefits, which have been provided beginning with the 2007-08 Proposed Budget. Of the $9.6 million net increase in NCC for DPH identified at that time, $8.6 million related to non-subvened costs for salaries and employee benefits. The balance of the net increase in NCC was a transfer of NCC from DHS to DPH related to the separation which was offset by a like reduction in NCC for DHS, for no net change across both departments.

Adjustments in NCC related to the separation continue to occur on an intermittent basis. These NCC transfers between DPH and DHS, which result in no net change or increase in NCC countywide, have been agreed to, for example, in order to complete the transfer of the information technology operation between the two departments and to finalize the transfer of NCC to DPH in order to support the costs for services that are billed by County Counsel.

Aside from these NCC adjustments, other changes in DPH budgeted NCC result from increases and/or decreases in State Realignment Vehicle License Fees (VLF) revenue, the provision of discretionary, time-limited funding from either your Board or this Office, and the one-time carryover of unspent funds from prior years to support the completion of specific programs and/or projects.

Over recent years, DPH has received several time-limited, discretionary allocations from your Board and this Office. Examples of these allocations include funding for: illegal vendor enforcement activities; methamphetamine treatment and prevention; STD case finding and social marketing services; and a tobacco cessation project. While these allocations for the implementation of specific programs and projects result in increases to DPH's budgeted NCC, these funds are time-limited and will eventually be removed from DPH's budget, resulting in a decrease to DPH's budgeted NCC.

**DPH Fiscal Condition**

As discussed during Budget Deliberations, the current unidentified curtailments placeholder in the DPH 2009-10 Final Changes budget results from projected shortfalls in Realignment VLF and Realignment Sales Tax revenues and the additional curtailment required of County Departments in order to help address the County's projected decrease in locally generated revenues.

As reported in Attachment II, as a General Fund department, DPH is subject to all requirements placed upon other General Fund departments. As a result, DPH has experienced a total of approximately $6.6 million in NCC reductions related to the countywide curtailments in FYs 2008-09 and 2009-10. They have also been required to

absorb budgeted reductions in Realignment revenues, as have both DHS and the Department of Mental Health (DMH), both of which also receive Realignment revenues.

It should be noted, however, that without the additional NCC provided by your Board to address the non-subvened costs of salaries and employee benefits increases, DPH would otherwise have been required to absorb those costs within their new department beginning in FY 2007-08, as they and DHS were required to do in prior fiscal years. This would likely have resulted in curtailments within DPH.

In order to address the projected FY 2009-10 deficit, DPH has developed an initial draft curtailment plan that addresses DPH's share of the countywide curtailment, as well as DPH's share of the decrease in Realignment VLF and Realignment Sales Tax revenues. DPH's initial proposed curtailment plan identifies over $9.0 million in possible curtailments and the potential elimination of more than 100 budgeted positions across various programs and divisions within DPH. Implementation of the initial plan would result in the elimination and/or curtailment of several public health programs and services.

Following further review of the initial curtailment plan, DPH anticipates providing the proposed curtailment plan to your Board in early August 2009.

If you have any questions please contact me, or your staff may contact Richard F. Martinez at (213) 974-1758.

WTF:SRH:SAS
MLM:RFM:bjs

Attachments

c: Executive Officer, Board of Supervisors
County Counsel
Director and Health Officer, Department of Public Health

062909_HMHS_MBS_DPH Budget Report

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Attachment I

WILLIAM T FUJIOKA
Chief Executive Officer



August 12, 2008

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

From: William T Fujioka
Chief Executive Officer

**REPORT ON PUBLIC HEALTH ADMINISTRATIVE SUPPORT POSITIONS AS REQUESTED AT THE JUNE 16, 2008 BUDGET DELIBERATIONS**

On June 16, 2008, during the Budget Deliberations discussion, your Board directed this Office to report back on the Department of Public Health's (DPH) administrative support positions that are being converted from "N" items to "A" items and the policy of why items that are being converted are using net County cost (NCC).

This is to advise your Board that all 35.0 positions that were added to DPH's budget during Budget Deliberations were new items, and no conversion of "N" to "A" items occurred. In addition, NCC was not provided to DPH to support the costs associated with these items; they are 100 percent funded with long-term State grant funding and administrative overhead received as intra-fund transfers. The attached fact sheet provides additional information regarding these items as well as, program requirements, and additional administrative staffing changes that were approved during 2007-08.

If you have any questions please contact me, or your staff may contact Richard F. Martinez at (213) 974-1758.

WTF:SRH:SAS
MLM:RFM:yb

Attachment

c: Executive Officer, Board of Supervisors
County Counsel
Director and Health Officer, Department of Public Health

DPH Admin Positions_mbs

# PUBLIC HEALTH STAFFING CHANGES
# FACT SHEET

## BACKGROUND

DPH separated from the Department of Health Services (DHS) July 7, 2006; a general analysis in a report, dated June 9, 2005, noted the following primary reasons for establishing DPH as a separate department:

- Potential budgetary impact of DHS' projected deficit on DPH operations;
- Varying missions and/or priorities of both DHS and DPH;
- DPH operational efficiency and neutrality by way of eliminating the layer of DHS management between DPH and your Board;
- Existing size, complexity, and scope of DPH responsibilities warranted DPH as a separate County department; and
- New and existing public health climate (i.e. threats to the public's health) warrants an experienced public health leader to take direct responsibility of preventing and controlling serious threats

Subsequent reports recognized that the public health mission within the County had grown significantly over the last several years in the following areas: 1) increased attention for protection from emerging infections; 2) bioterrorism and other communicable and food-borne disease outbreaks; 3) toxic exposure and preventable injury; and 4) prevention of chronic diseases such as heart disease, cancer, and diabetes.

Prior to and at the time of the separation the following observations were also noted: 1) need to assess both DHS and DPH, December 13, 2005 letter to your Board, as the infrastructure was not adequately staffed to meet existing workload needs; 2) departmental efforts/initiatives would need to be prioritized; and 3) DPH would conduct an in-depth analysis of their administrative operation and staffing needs, as well as the maximization of available financial opportunities (i.e., indirect grant revenue).

The following staffing changes have taken place since the separation of the departments:

*FY 2007-08*
- Support - 21.0 Positions; and
- Information Technology - 18.0 Positions.

*FY 2008-09*
- Administrative - 35.0 Positions; and
- Deficit Mitigation/Curtailment - (27.0) Positions.

## SUPPORT

A total of 21.0 positions were added during FY 2007-08 resulting in a gross appropriation increase of $0.9 million, but only $0.6 million in net County cost was necessary. These positions were added to provide DPH the ability to address several operational issues; primarily in the human resources area as well as the contracts and grants section (Attachment A).

## INFORMATION TECHNOLOGY

In addition to the noted support items, during FY 2007-08, a total of 18.0 positions, related services and supplies, and associated NCC, was transferred from DHS to complete the information technology piece of the separation between the two departments (Attachment B).

## ADMINISTRATIVE POSITIONS

DPH's FY 2008-09 Final Changes Budget includes the addition of 35.0 budgeted positions to address several critical, yet under-resourced operations primarily in Materials Management, Finance, and Human Resources sections (Attachment C).

The fiscal impact related to the 35.0 positions represents a gross appropriation increase/cost of $1.8 million which is 100 percent offset by State grant funding and administrative overhead, received as intra-fund transfers. Monies for these positions will be received in the form of indirect revenues budgeted under various grants.

## DEFICIT MITIGATION/CURTAILMENT

As outlined in the FY 2008-09 Proposed Budget and in DPH's May 6, 2008, Board memorandum, DPH was facing a structural budget gap. Contributing to the operational short-fall was DPH's $2.4 million share of a curtailment to address the County's projected funding deficit. At the time of the FY 2008-09 Proposed Budget, the $2.4 million reduction was set as a placeholder reduction in services and supplies with a commitment from DPH to return in Final Changes with a plan to address this issue.

DPH's curtailment plan implements operational savings and efficiencies resulting in the elimination of 27.0 positions at a salaries and employee benefits savings of approximately $2.7 million. Although the department ensured that services would be protected, the curtailment will minimize DPH's ability to address future increases in the fluctuation of workload. A description of the 27.0 budgeted positions that were eliminated through DPH's deficit mitigation/curtailment plan is provided in Attachment D.

## SUMMARY

- The additional 35.0 positions will ensure DPH's administrative infrastructure will have the requisite staffing levels to meet departmental workload needs and that intra-County requests for support and information are met in an efficient and effective manner.

- The elimination of the 27.0 positions does not result in any service reductions and ensures that the department's projected funding deficit is adequately addressed.

ATTACHMENT A

**DEPARTMENT OF PUBLIC HEALTH**
**SUPPORT POSITIONS - SUMMARY**
**FY 2007-08**

| Division | Item Classification | Number of Positions |
|---|---|---|
| Finance | Accounting Officer II | 1.0 |
| Contracts and Grants | Assistant Staff Analyst, Health | 1.0 |
| | Staff Analyst, Health | 2.0 |
| | Senior Staff Analyst, Health | 1.0 |
| | Student Worker | 2.0 |
| Contract Monitoring | Financial Specialist IV | 1.0 |
| | Senior Secretary II | 1.0 |
| Materials Management | Senior Typist Clerk | 1.0 |
| | Intermediate Typist Clerk | 1.0 |
| Human Resources | Personnel Officer II | 1.0 |
| | Head Departmental Personnel Tech | 1.0 |
| | Departmental Personnel Technician | 1.0 |
| | Departmental Personnel Assistant | 2.0 |
| | Payroll Clerk I | 2.0 |
| | Intermediate Typist Clerk | 2.0 |
| Materials Management | Warehouse Worker II | 1.0 |
| | **GRAND TOTAL** | **21.0** |

ATTACHMENT B

**DEPARTMENT OF PUBLIC HEALTH**
**INFORMATION TECHNOLOGY POSITIONS - SUMMARY**
**FY 2007-08**

| Item Number | Item Classification | Number of Positions |
|---|---|---|
| 4593A | Staff Analyst, Health | 1.0 |
| 2591A | Information Systems Analyst II | 7.0 |
| 2590A | Information Systems Analyst I | 2.0 |
| 2611A | Departmental Information Security Officer I | 1.0 |
| 2573A | Information Systems Manager I | 1.0 |
| 2593A | Senior Information Systems Analyst | 3.0 |
| 2525A | Senior Application Developer | 1.0 |
| 5477A-2 | Physician Specialist, MD | 1.0 |
| 2612A | Departmental Information Security Officer II | 1.0 |
| | **GRAND TOTAL** | **18.0** |

ATTACHMENT C

**DEPARTMENT OF PUBLIC HEALTH**
**ADMINISTRATIVE POSITIONS - SUMMARY**
**FY 2008-09**

| Division and Item Classification | | Number of Positions |
|---|---|---|
| **Contract Monitoring** | | |
| 0749A | Financial Specialist III | 2.0 |
| 4619A | Head Contract Program Auditor | 1.0 |
| **Facilities Management** | | |
| 1138A | Intermediated Clerk | 1.0 |
| 6774A | Custodian | 2.0 |
| **Finance** | | |
| 2101A | Senior Secretary II | 1.0 |
| 4593A | Staff Analyst, Health | 1.0 |
| 0648A | Accountant III | 1.0 |
| 0666N | Senior Accounting Systems Technician | 1.0 |
| 0672N | Health Care Financial Analyst | 2.0 |
| **Controller's Division** | | |
| 2095A | Secretary II | 1.0 |
| 0668A | Principal Accounting Systems Technician | 1.0 |
| **Human Resources** | | |
| 1848A | Departmental Personnel Technician | 3.0 |
| 1842A | Departmental Personnel Assistant | 2.0 |
| **Materials Management** | | |
| 1004A | Administrative Services Manager III | 1.0 |
| 1002A | Administrative Services Manager I | 1.0 |
| 0907A | Staff Assistant I | 1.0 |
| 2373A | Supply Officer I | 1.0 |
| 2334A | Procurement Assistant I | 3.0 |
| 2331A | Warehouse Worker I | 2.0 |
| 2100A | Senior Secretary I | 1.0 |
| 1140A | Senior Clerk | 1.0 |
| 1138A | Intermediate Clerk | 2.0 |
| **Risk Management** | | |
| 3033A | Safety Assistant | 1.0 |
| 3037A | Safety Officer I | 1.0 |
| 4593A | Staff Analyst, Health | 1.0 |
| **GRAND TOTAL** | | **35.0** |

ATTACHMENT D

# DEPARTMENT OF PUBLIC HEALTH
## DEFICIT MITIGATION/CURTAILMENT POSITIONS - SUMMARY
## FY 2008-09

| | | Item Classification | Number of Positions |
|---|---|---|---|
| **Defunded Positions** | N | Information Systems Analyst II | (1.0) |
| | N | Research Analyst II, Behavior Science | (1.0) |
| | N | Registered Nurse II | (1.0) |
| | N | Assistant Staff Analyst, Health Services | (1.0) |
| | N | Health Program Coordinator | (1.0) |
| | N | Clinical Microbiologist I | (1.0) |
| | N | Environmental Health Specialist IV | (1.0) |
| | N | Health Educator | (1.0) |
| | N | Public Health Microbiologist I | (1.0) |
| | N | Program Manager II | (1.0) |
| | N | Health Education Assistant | (1.0) |
| **Efficiency Items** | A | Chief Physician I, MD | (1.0) |
| | A | Chief Physician I, MD | (1.0) |
| | A | Chief Physician I, MD | (1.0) |
| | A | Chief Physician I, MD | (1.0) |
| | A | Animal Sanitation Inspector | (1.0) |
| | A | Public Health Microbiology Supervisor I | (1.0) |
| | A | Laboratory Assistant | (1.0) |
| | A | Intermediate Typist-Clerk | (1.0) |
| | A | Staff Assistant II | (1.0) |
| | J | Clinic Physician, MD (Per Session) | (2.0) |
| | A | Senior Typist-Clerk | (1.0) |
| | A | Intermediate Typist-Clerk | (1.0) |
| | A | Intermediate Typist-Clerk | (1.0) |
| | A | Epidemiology Analyst | (1.0) |
| | A | Staff Analyst, Health | (1.0) |
| | | | |
| | | **GRAND TOTAL** | **(27.0)** |

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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

**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.

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.

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

**Attachment**

# 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 Heath 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.

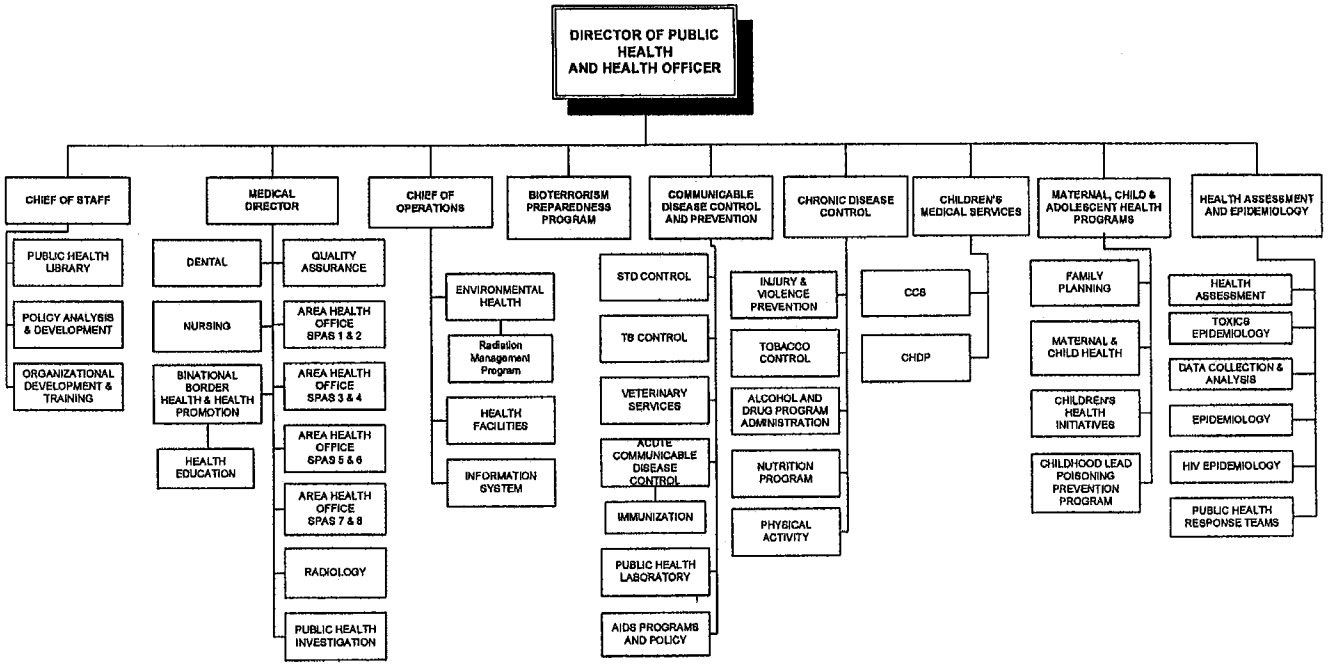
Services of Other County Departments

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 Heath 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*




Jonathan E Fielding

Director of Public Health and Health Officer
April 15, 2004

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

**Attachment III**

| 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.