2004 – 2005
LOS ANGELES COUNTY
CIVIL GRAND JURY

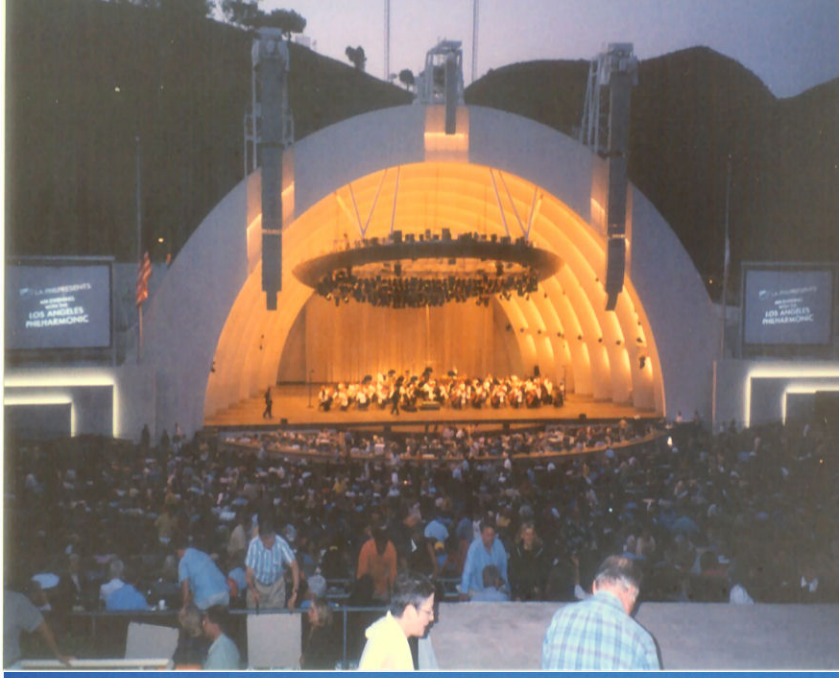
FINAL REPORT

2004-2005 Los Angeles County Civil Grand Jury Final Report

FINAL REPORT
LOS ANGELES COUNTY CIVIL GRAND JURY
2004-2005

LOS ANGELES COUNTY BOARD OF SUPERVISORS

Gloria Molina	First District
Yvonne Brathwaite Burke	Second District
Zev Yaroslavsky	Third District
Don Knabe	Fourth District
Michael D. Antonovich	Fifth District


LOS ANGELES
PHILHARMONIC

2004-2005 Los Angeles County
Civil Grand Jury
Final Report
Table of Contents

Note: the page numbering for the report resumes following the Health Authority report which is numbered separately.

Los Angeles County Civil Grand Jury
Clara Shortridge Foltz Criminal Justice Center
210 West Temple Street – 11th Floor, Room 11-306 – Los Angeles CA 90012
Telephone (213) 893-1047 – FAX (213) 229-2595

June 30, 2005

To The Citizens of Los Angeles County:

On behalf of the 2004 – 2005 Los Angeles County Civil Grand Jury, the final report of this fiscal year is submitted for your review. It was a high honor to have been selected by the Supervising Judge of the Criminal Courts, the Honorable David Wesley, as the Foreperson of this Civil Grand Jury.

Likewise, it was a very humbling experience to have presided over such a distinguished body of people as the twenty-two other grand jury colleagues that I served with. We all came from different backgrounds and experiences from the far reaches of Los Angeles County, and none of us was acquainted with each other before we commenced our journey into unchartered domains. Except for a few relatively unimportant obstacles, we were able to coalesce our respective backgrounds and experiences, and join together in the best interest of duties we were charged by Judge Wesley to perform.

If I were to offer a response as to the most common concern of this grand jury, I would have to say it was health and well being of the people of the Los Angeles County. This is evidenced by the fact that the overwhelming amount of budgeted resources was directed toward health care of the citizens. This Civil Grand Jury organized into several committees for purposes of pursuing areas of interest adopted by the group.

Although this Civil Grand Jury set its own agenda, there were numerous persons that we owe a sense of gratitude and thanks for their assistance when requested. Along with Judge David Wesley, others include Judge Terry Green and Gordon Trask, Esq., who met with us on a weekly basis. I would also like to thank the grand jury staff for their valued assistance.

Thank you for the opportunity to serve in the capacity of Foreperson of the Civil Grand Jury, and many heartfelt thanks to a great bunch of fellow Grand Jury Colleagues that gave me significant support as we journeyed toward the completion of our charge.

Sincerely,

Charles H. Parks, Foreperson
2004 – 2005 Los Angeles County
Civil Grand Jury

Front Row (left to right):
William R. Jackson, William D. Noble, William H. Korb, Akasia Minamoto, Dennis O. Brusseau, Ernest Oestreich, Geneese Simmons, Elyse Ruth,
Charles H. Parks (foreperson), Alfred Rucker, Hal D. Hichborn, David Amitai
Back Row (left to right):
Oscar J. Warren, Wayne N. Hunt, Lawrence Silk, Robert T. Dobson, Mary A. King, Clairene Almond, Jane A. Grossman, Beverly Clemence, Rita Kleinman, Richard McDonald

Not Pictured: Shirley B. Black

2004-2005 LOS ANGELES COUNTY CIVIL GRAND JURY ROSTER

OFFICERS:

Charles H. Parks	Foreperson
Hal D. Hichborn	Foreperson Pro Tem
Mary Alice King	Secretary
Geneese Simmons	Secretary Pro Tem
Elyse Ruth	Sergeant-At-Arms

CIVIL GRAND JURORS

NAME:	RESIDENCE:	OCCUPATION:
Clairene Almond	San Pedro	Community Library Manager*
David Amitai	Los Angeles	Marriage & Family Therapist*
Shirley B. Black	Lancaster	Domestic Violence Counselor*
Dennis Brusseau	Santa Monica	Transportation Coordinator*
Beverly Clemence	Whittier	H.R. Analyst*
Robert T. Dobson	Los Angeles	Director, Specialty Retail*
Jane Grossman	Los Angeles	Registered Nurse*
Hal D. Hichborn	El Segundo	Mgr, IBM*; Col., USMCR
Wayne Hunt	Palmdale	Sheriff's Dept., Civilian*
William R. Jackson	Gardena	Engineer*
Mary Alice King	Los Angeles	Educator*
William Korb	Rancho Palos Verdes	V.P., Sales & Marketing*
Rita Kleinman	Los Angeles	Social Worker*
Richard McDonald	Marina Del Rey	IT Manager*
Akasia Minamoto	Alhambra	Information Spec., U.P.S.*
William D. Noble	Los Angeles	Cable Splicing Coordinator*
Ernest Oestreich	Hollywood Hills	Div. Chief*, H. R. Consultant
Charles H. Parks	Long Beach	Police Cmdr.*, Water Comm.
Alfred B. Rucker	Compton	School Teacher*
Elyse Ruth	West Hollywood	Attorney*
Lawrence Silk	Woodland Hills	Real Estate Investor
Geneese Simmons	Los Angeles	Marketing, Universal Studios*
Oscar Warren	Gardena	Industrial Engr. Specialist*

*Retired

OATH OF OFFICE

(Penal Code § 911)

"I do solemnly swear (affirm) that I will support the Constitution of the United States and of the State of California, and all laws made pursuant to and in conformity therewith, will diligently inquire into, and true presentment make, of all public offenses against the people of this state, committed or triable within this county, of which the grand jury shall have or can obtain legal evidence. Further, I will not disclose any evidence brought before the grand jury, nor anything which I or any other grand juror may say, nor the manner in which I or any other grand juror may have voted on any matter before the grand jury. I will keep the charge that will be given to me by the court."

Administered by
Judge David Wesley
July 1, 2004

Hon. David Wesley, Judge of the Superior Court

INTRODUCTION

LOS ANGELES COUNTY CIVIL GRAND JURY

The 2004-2005 Los Angeles County Civil Grand Jury served from July 1, 2004 to June 30, 2005. The following provides a broad overview of the Civil Grand Jury, what it is and how it functions.

GRAND JURY DEFINED

California Penal Code Section 888 (as applicable to Civil Grand Juries) provides that a Grand Jury is a body of the required number of persons returned from the citizens of the county before a court of competent jurisdiction… charged and sworn to investigate or inquire into county matters of civil concern such as the needs of county officers, including the abolition or creation of offices for the purchase, lease or sale of equipment for, or changes in the method, or system of, performing the duties of the agencies subject to investigation pursuant to Section 914.1.

For Los Angeles County, based on its population, the required number of Civil Grand Jurors is 23.

HISTORY

The California grand jury system has its historical roots in the Old English grand jury system, the purpose of which was to protect citizens from the arbitrary power of the Crown. The California system continues to retain the goal of protecting residents from abuse by local government. In civil matters, the jury performs oversight functions of the city, county and other local government elements.

FUNCTIONS

The Civil Grand Jury is an independent and confidential body and may not, except for legal cause, be prevented from acting within its jurisdiction. The Civil Grand jury functions as one body, with all its matters discussed and votes taken to be kept private and confidential. It is a misdemeanor to violate the secrecy of the Civil Grand Jury proceedings

REQUIREMENTS TO BECOME A GRAND JUROR

In order to be selected as a grand juror, an individual:

- Must be a United States citizen 18 years of age or older and a resident of California and Los Angeles County for at least one year immediately prior to selection
- Must not be serving as a trial juror in any California court
- Cannot have been discharged as a Grand Juror in any California court within one year of the beginning date of service
- Cannot have been convicted of malfeasance in office or any felony or other high crime
- Cannot be serving as an elected public official.

Service as a Civil Grand Juror is for an entire year (July 1 to June 30) and is basically a full time job Monday through Friday with each jury determining its work schedule. Each grand juror is required to complete a financial disclosure form in compliance with the California Government Code. Further information is available on the Grand Jury Website – **http://grandjury.co.la.ca.us**.

ORGANIZATION

The Supervising Judge of the Criminal Division of the Los Angeles Superior Court designates the foreperson to preside over all proceedings of the Civil Grand Jury. The Supervising Judge also oversees the activities of the Civil Grand Jury and must approve the jury's Final Report before its issuance.

The members select the Civil Grand Jury officers, foreperson pro-tem, secretary and sergeant at arms. The chairs of the committees are selected by the foreperson.

A Deputy County Counsel is assigned as the legal advisor to assist the Civil Grand Jury on legal questions. In situations where the County Counsel has a conflict of interest, the Civil Grand Jury may seek advice from the State Attorney General.

METHOD

The Civil Grand Jury is divided into committees which investigate certain departments of the city or county government or special districts. Independent auditors may be employed to examine financial records and operations of government agencies.

Members of the jury visit various government facilities, meet with government officials and develop recommendations for improvement.

At the end of the Civil Grand Jury's term, a Final Report is prepared and sent to the concerned government agencies, the Presiding Judge of the Superior Court and the

County Board of Supervisors. Copies of the Final Report are distributed to other public officials, libraries and the news media. Responses to recommendations are required within ninety days.

APPOINTMENT TO THE CIVIL GRAND JURY

Any interested citizen who wishes to be considered for nomination to the Civil Grand Jury for the following fiscal year (July 1 to June 30) may obtain an application form and submit it before the deadline in November to:

Angeles County Civil Grand Jury
Clara Los Shortridge Foltz Criminal Justice Center
211 West Temple St., 11th Floor, Rm. 11-506
Los Angeles CA 90012
Telephone: (213) 893-1047

Each year prior to March 1st every Superior Court Judge may nominate two persons deemed qualified to serve as Civil Grand Jurors. Following the nominations, the selection process for grand jurors involves a random selection of prospective jury members and alternates. The Sheriff's Department performs a background check on these individuals. In a final random selection, the members of the jury are selected. A number of alternates are also selected to serve as jurors should any of those originally chosen be unable to continue to serve.

STATEMENT OF SUPPORT FOR

THE CLEAR PROGRAM

The Gang Committee of the 2004-2005 Los Angeles County Civil Grand Jury was formed to perform follow-up work to studies from prior grand juries to insure that continued progress was being made to combat gang activity within the County. Although no formal audit was done, the members of the Gang Committee should be recognized for the tremendous amount of research and investigation that they contributed to the decision that led to the statement of support on the following page. The members of the Gang Committee are as follows:

Geneese Simmons, Chairperson

Shirley B. Black
Beverly Clemence
Wayne Hunt
William R. Jackson
Mary Alice King
William Noble
Oscar Warren

"CLEAR"

COMMUNITY LAW ENFORCEMENT AND RECOVERY PROGRAM

The 2004-2005 Los Angeles Civil Grand Jury Gang Committee elected to study a unique program model, the Community Law Enforcement and Recovery Program (CLEAR). This program facilitates the recovery of communities that have been plagued by gang activity and where the life of the gang is the mainstay of the neighborhood. The CLEAR mission to aide in this recovery is "…accomplished by an infusion of coordinated resources into targeted areas of high gang crime in order to decrease gang violence and promote community recovery. This mission is accomplished through an effective collaboration among several city, county and state criminal justice agencies, and through partnerships between CLEAR's core collaborative and agencies, programs and individuals in the targeted communities".[0]

This program was designed to be a multi-level, inter-agency collaboration between law enforcement entities, the California Department of Corrections and the Los Angeles Mayor's office. An "Operations Team", "…composed of CLEAR personnel and community stakeholders…engages other law enforcement agencies and community programs to make CLEAR a truly comprehensive anti-gang initiative".[1]

The Gang Committee visited one of the six CLEAR sites (the Los Angeles Police Department's Hollenbeck Division) and was able to witness, first hand, the working relationship CLEAR utilizes among all of the participants involved in its program. According to the Hollenbeck CLEAR staff, crime in their community has been reduced by 50% since its inception. It is anticipated that CLEAR's presence in affected neighborhoods will continue to reduce gang activity in those areas.

The Gang Committee believes that the Los Angeles City Council should continue to support, and further expand the CLEAR program.

FINDING

The 2004-2005 Los Angeles County Civil Grand Jury supports the Clear Model Program of the Los Angeles Police Department Special Operations Division in their ongoing multiple efforts to reduce gang activity in the city and county of Los Angeles.

[0] The CLEAR Program Model, CLEAR Executive Committee, October 2004

RESPONSES TO THE CIVIL GRAND JURY REPORT

The California Penal Code specifies both the deadlines by which responses shall be made to grand jury final report recommendations, and the required content of those responses.

DEADLINE FOR RESPONSES

Penal Code Section 933 (c) states:

> *"No later than* 90 *days after the grand jury submits a final report on the operations of any public agency subject to its reviewing authority, the governing body* of *the public agency shall comment to the presiding judge* of *the superior court on the findings and recommendations pertaining to matters under the control of the governing body, and every elective county officer or agency head for which the grand jury has responsibility pursuant to section* 914.1 *shall comment within* 60 *days to the presiding judge of the superior court, with an information copy sent to the board of supervisors, on the findings and recommendations pertaining to matters under the control of that county officer or agency head and any agency or agencies which that officer or agency head supervises or controls. In any city and county, the mayor shall also comment on the findings and recommendations...* "

The code requires that responses from governing bodies and elected governmental officers, mayors and agency heads be made to the presiding judge. The 9O-day deadline applies to the governing body required to respond to a grand jury report (i.e. the Board of Supervisors). The 6O-day deadline applies to elected county officers or agency heads.

RESPONSE TO FINDINGS

Section 933.05 states:

> *"(a) For purposes of subdivision (b) of Section 933, as to each grand jury finding, the responding person or entity shall indicate one of the following:*
>
> *(1) The respondent agrees with the finding.*
>
> *(2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefore."*

For each grand jury recommendation, the responding person or entity shall report one of the following actions:

"(1) The recommendation has been implemented, with a summary regarding the implemented action.

(2) The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation. The recommendations require further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame from the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This time frame shall not exceed six months from the date of publication of the grand jury report

(3) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefore."

RESPOND TO

Written responses to grand jury final report recommendations should be sent to:

The Honorable William A. MacLaughlin
Presiding Judge
Los Angeles County Superior Court 111 North Hill Street Room 222
Los Angeles, California 90012

AUDIT COMMITTEE

Robert Dobson, Chairperson

Hal D. Hichborn
William R. Jackson
Rita Kleinman
William Noble
Elyse Ruth
Larry Silk

AUDIT COMMITTEE

INTRODUCTION

The Audit committee was charged with selecting the consulting or auditing organizations that the Civil Grand Jury might utilize in assisting the conduct of its investigations of the fiscal and operational performance of Los Angeles County government and other local public entities. It also monitored negotiation of contracts and the progress of contracted audits.

BACKGROUND

Under the California Penal Code ξ925, 925A, 933.1 and 933.5, the Los Angeles Civil Grand Jury 2004-2005 was empowered to investigate the fiscal and operational performance activities of public entities within Los Angeles County. The authority includes engaging outside consultants/auditors in order to assist in its investigations. Remuneration for the outside services was provided through funds allotted to the Los Angeles Civil Grand jury in the form of an annual budget granted by the Los Angeles County Board of Supervisors.

METHOD

The Audit Committee established initial candidates from firms selected using the County Auditor's list of "approved suppliers" that met the Civil Grand Jury criteria. An invitation to participate was extended to those firms. References for past work performed for previous grand juries or public entities was mandatory. The two final candidate firms were selected and reviewed by the entire Civil Grand Jury. Both candidate firms were approved.

After selection of the consultant/audit firms, the Audit Committee followed-up on progress of audits and secured proper interim reports in order to keep the Civil Grand Jury apprised of the status of the commissioned audits/studies. The Audit Committee also ascertained that vendor drafts of final reports were supplied to the Civil Grand Jury in a timely manner and that the members of the concerned committees were present at the exit interviews conducted by the auditors, prior to issuance of its final audit/study report.

SUMMARY

One major and one minor investigative audit were contracted with separate outside firms.

CITIZEN'S COMPLAINT COMMITTEE

Ernest Oestreich, Chairperson

Shirley B. Black
Wayne Hunt
William Korb
Rick McDonald
Akasia Minamoto
Alfred Rucker
Elyse Ruth

CITIZEN'S COMPLAINTS COMMITTEE

BACKGROUND

The primary function of the Civil Grand Jury is to provide unbiased, independent "watchdog" or oversight concerning the operations of county and city governments, schools and special districts. The independent Civil Grand Jury works to assure citizens that government is operating lawfully, efficiently, and in an ethical, honest manner. The jury may investigate local governmental policies and procedures and make recommendations to improve governmental operations. The Civil Grand
Jury is further charged with the investigation of individual citizen complaints In all its proceedings and investigations, the jury is sworn to maintain complete secrecy. All complaints to the Civil Grand Jury are confidential, as are all its proceedings. The Civil Grand Jury Citizen Complaint Committee's function is to review each complaint received, evaluating it for possible investigation. If appropriate, the committee then refers it to another specialized committee for further investigation.

METHOD

Receipt of all complaints or requests for investigation is acknowledged by mail. If a matter does not fall within the Civil Grand Jury's investigative authority, or the jury determines not to investigate a complaint, no action will be taken and there will be no further jury contact. The findings of any investigation can only be communicated in a formal final report published at the conclusion of the jury's term (June 30th).

The jurisdiction of the Civil Grand Jury includes the following:

- consideration of evidence of misconduct by public officials within Los Angeles County

- inquiry into the condition and management of public prisons within the county

- investigation and reports on the operations, accounts, and records of the officers, departments or functions of the county and cities including special districts created by state law.

Some complaints do not fall within the jurisdiction of the jury's responsibilities. For example, the Civil Grand jury does not have jurisdiction over judicial performance, actions of the court, or cases that are pending in the courts. Grievances of this nature must be resolved through the established judicial appeal system. The Civil Grand Jury has no jurisdiction or authority to investigate federal or state agencies.

FILING A COMPLAINT OR REQUEST FOR INVESTIGATION

Any private citizen, governmental employee or officer may ask the Civil Grand Jury to conduct an investigation. This complaint must be in writing and is treated by the jury as confidential. Requests for an investigation must include detailed evidence supporting the complaint or request for investigation. If the Grand Jury believes the evidence is valid and sufficient to support the complaint, an investigation may be held. The written complaint should cover the following points:

- Who or what agency is the complaint against?
- What is the nature of the complaint?
- What action was improper or illegal?
- When and where did the incident(s) occur?
- What were the consequences of this action?
- What action or remedies are being sought?
- Why/How? Attach relevant documents and correspondence with dates.

A citizen may wish to use the attached complaint form.

Additional Information about the Jury is also available on the Civil Grand Jury website at **http://www.lasuperiorcourt.org/jury/grandjury.htm**

2004-2005 CIVIL GRAND JURY CITIZEN'S COMPLAINTS CATEGORIES

Category	Total
No Grand Jury Jurisdiction (State, Federal & Court)	**21**
Complaint about law enforcement	**20**
Inmate complaint about court, trial, prison conditions or mistreatment	**12**
Governmental mismanagement, waste, or incompetence	**14**
Governmental malfeasance or corruption	**9**
Workplace abuse or discrimination	**7**
Non-governmental or personal disputes	**8**
Vague or incomplete complaint	**4**
TOTALS	**95**

FINDINGS

The 2004-2005 Civil Grand Jury received 95 complaints or requests for investigation. Many complaints received were not under the jurisdiction of the Civil Grand Jury, others were otherwise inappropriate for investigation. Some were vague and made no actual complaint. Other complaints were cases pending in the courts and therefore could not be reviewed by the Civil Grand Jury.

Of the 95 complaints, eight complaints were recommended for further Investigation by the appropriate Civil Grand Jury committee. These included three citizen complaints against law enforcement; one inmate complaint about prison mistreatment. Some complaints against law enforcement resulted in an investigation and report by the Public Integrity-Law Enforcement Committee. One individual who complained about governmental mismanagement was invited by the entire Civil Grand Jury to discuss complaint issues. One complaint was referred to the District Attorney for further investigation.

Citizen Complaint Form

Los Angeles County Civil Grand Jury
Los Angeles Superior Court
Clara Shortridge Foltz Criminal Justice Center
210 West Temple Street
11th Floor, Room 11-506
Los Angeles, CA 90012

See Complaint Form Guidelines opposite side for complete instructions
All forms must be signed.

1. **Who:** Your Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number:

2. **What:** Subject of Complaint. Briefly state the nature of complaint and the action of what Los Angeles County department, section, agency, or official(s) that you believe was illegal or improper. Use additional sheets if necessary.

3. **When:** Date(s) of incident: _____

4. **Where:** Names and addresses of other departments, agencies, or officials involved in this complaint. Include dates and types of contact, i.e., phone, letter, personal. Use additional sheets if necessary.

5. **Why/How:** Attach pertinent documents and correspondence with dates.

6. **Signed:** **Date:**

CONTINUITY COMMITTEE

Clairene Almond, Chairperson

Dennis Brusseau
Beverly Clemence
Hal D. Hichborn
Mary Alice King
William Korb
Akasia Minamoto
Ernest Oestreich
Elyse Ruth

CONTINUITY

BACKGROUND

The 2004-2005 Civil Grand Jury Continuity Committee had a two-fold responsibility for helping the jury move forward in a timely manner. The first step was to connect the new jury to past juries by providing easy access to all past jury's reports and documented methodology. This access is an essential tool for the incoming jury's understanding of how to successfully begin their work. Secondly, the committee's responsibility was the tracking and follow up of all recommendations made by the previous jury.

The 1998-1999 Los Angeles County Grand Jury formed a Research and Follow-Up Committee whose purpose was to track and determine the ultimate disposition of its recommendations. The jury also recommended that the 1999-2000 Grand Jury, and all future juries appoint a similar committee to monitor the content and status of the previous jury's report. There are no records or evidence to indicate that, prior to that date, there was a tracking system in place to determine if recommendations were implemented. The Research and Follow-Up Committee was given the responsibility of identification and evaluation of all recommendations made to cities, agencies, or county departments by the previous Grand Jury. When the Los Angeles County Grand Jury was bifurcated into the Criminal and Civil Grand Juries, the Civil Grand Jury assumed the responsibility of recommendation follow-up. At the beginning of the 2003-2004 Civil Grand Jury's term, the name of the follow-up committee was changed to the Continuity Committee.

Webster's New World Dictionary defines continuity as: "the state or quality of being continuous; connectedness; coherence." Taking the meaning of "continuity" seriously, the 2004-2005 Los Angeles County Civil Grand Jury's Continuity Committee overhauled and reorganized Grand Jury resource documents, reference materials and files. Such an undertaking was necessary in order to create a useable library of reference tools for future Civil Grand Juries. The committee created a listing consisting of all past Civil Grand Jury final reports, L.A. County Auditor/Controller audits, L.A. City Controller audits, and Efficiency and Economy Committee Reports. This index is a user-friendly reference tool for determining if earlier Grand Juries had previously studied, or audited a particular subject or department. By locating and reading previous reports or audits, the Civil Grand Jury can determine if further investigation of certain topics is warranted. The use of this index should also identify a starting point for a new investigation and help channel the Civil Grand Jury's efforts more effectively.

Responses to recommendations, dating back five years, can be found online at www.lasupiorcourt.org/.

METHOD

According to Penal Code, Section 933(c), the Civil Grand Jury may investigate and make findings and recommendations to Los Angeles County *"governing bodies, elective officers, or agency heads"* and *"the governing body of the public agency shall comment to the presiding judge of the superior court on the findings, and recommendations pertaining to matters under the control of the governing body, and every elected county officer or agency head for which the grand jury has responsibility pursuant to Section 914.1 shall comment within 60 days to the presiding judge of the superior court".* The code specifically states that elected county officers or agency heads must respond to the presiding judge within 60 days and that governing bodies are required to respond within 90 days.

It is the responsibility of the Continuity Committee to follow up on all recommendations made to cities, county department heads, redevelopment agencies, the Board of Supervisors, etc. The process began by identifying all recommendations made by the 2003-2004 Civil Grand Jury as soon as our committee was established. We developed forms for reporting both the existence of and the quality of all responses made to those recommendations. It was necessary to communicate with several agencies concerning the implementation of their responses or the quality of the response made to a particular recommendation. It is essential that recommendations made by the jury be clear, concise, and have actual merit. It is also necessary that responses made to recommendations demonstrate an understanding of the content of the recommendation and provide a clear blueprint for implementation, or a clear reason for why it would not work. In some cases a city/agency indicated that that they agreed with a recommendation and would implement it on a particular date. In those instances, written communication with the city/agency was initiated to verify that the agreed upon changes were finalized.

SUMMARY OF RESPONSES

The 2003-2004 Civil Grand Jury studied six subjects and made fifty-five recommendations. See table A below.

Table A

Subject of Study	**Number of Recommendations**
Domestic Violence	11
Education	11
Gang Injunctions	6
Jails	7
Law Enforcement	9
Public Integrity	11
Total Number of Recommendations	**55**

Eight county agencies, two cities, and one school district submitted fifty-six responses to the 2003-2004 Civil Grand Jury's recommendations. See table B below.

Table B

Responding Governmental Agency	No. of Responses	No. of Satisfactory Responses	No. of Unsatisfactory Responses/or No Response
Chief Administrative Officer, County of L.A.	1	1	
Children & Family Services	1	1	
Community & Senior Services	11	11	
District Attorney	1	1	
L.A. County Office of Education	6	2	4
Probation Department	Detention Centers-7 Gangs-1	8	
Public Social Services	4	4	
Sheriff's Department	9	9	
City of Irwindale	7	7	
City of Lancaster	3	3	
L.A. City Unified School District	5	5	
Total Number of Responses	**56**	**52**	**4**

Please note that the total number of recommendations is 55 and the total number of responses is 56. This discrepancy exists because two collaborating county agencies reported on the same recommendation.

An example of effective cooperation between an agency and the Civil Grand Jury was the interaction of the City of Lancaster and the 2004-2005 Civil Grand Jury Continuity Committee. In their initial response to the three recommendations made by the 2003-2004 Civil Grand Jury, the City indicated that full implementation of all three Community Redevelopment Agency recommendations would not be in effect until November of 2004. A follow up letter was sent requesting documentation of their implementation of a "whistle blowing" policy. The City responded appropriately and included a copy of their newly written policy. The City of Lancaster is to be commended for it's prompt and professional handling of the recommendations made by the Civil Grand Jury.

Of the six recommendations made to the Los Angeles County Office of Education, four, specifically associated with distribution of lottery funds, were initially evaluated as inadequate (see Table B). On January 11, 2004, a follow up letter was sent to the Superintendent of Education requesting further information and explanation. Her response, dated 2/28/05, addressed our concerns and we can report that all six recommendations made to LACOE have been responded to satisfactorily.

FINDING

It is the responsibility of each successive Continuity Committee to evaluate all of the recommendations of the preceding jury prior to beginning its follow up process. This process should insure that each responding agency has fulfilled its obligation to the Civil Grand Jury and the people of Los Angeles County. If a governmental agency does not meet its obligation, the incoming Continuity Committee must keep following up with that agency until its responsibility has been satisfactorily met.

EDIT COMMITTEE

Jane A. Grossman, Chairperson

Clairene Almond
Shirley B. Black
Hal D. Hichborn
Mary Alice King
Rick McDonald
Ernest Oestreich
Alfred Rucker

EDIT COMMITTEE

BACKGROUND

The Civil Grand Jury's final report fulfills the California Penal Code Section 933 (a) requirement to provide the Presiding Judge of the Los Angeles Superior Court with a final report at the conclusion of the jury's one year term of office. This report summarizes the results of the activities, inquiries, audits and investigations conducted by the various committees of the Civil Grand Jury.

METHOD

Each committee of the Civil Grand Jury was responsible for determining its topics of concern, conducting studies, gathering pertinent data and supervising investigations within its field of interest. At least fourteen members of the entire Civil Grand Jury are required to approve any investigations recommended by the committee. The Civil Grand Jury engaged a professional auditing firm to assist a committee in a major investigation. Upon completion of investigations, written reports were submitted to the edit committee for editing and publication. The edit committee has no authority to make substantive changes, alter facts, or delete materials in a contract audit report or committee report. Suggested changes must be reviewed by the appropriate committee and The Civil Grand Jury. The Final Report was reviewed and approval by the entire Civil Grand Jury as well as County Counsel for consistency with the law. After review, the Supervising Judge of the Criminal Division of the Los Angeles Superior Court gave final approval.

The edit committee is responsible for choosing a printer, selecting layout, format, photographs, graphics, stylization, presentation, delivery and overall project management. After all approvals were made, the report was then presented to a private sector printer, which made copies for public distribution. A number of compact disks were also produced. The final report can be accessed on the Grand Jury website: **http://www.lasuperiorcourt.org/jury/grand jury.htm**

FINALITY OF REPORTS

All reports issued by the Civil Grand Jury are final. Once issued, they cannot be changed. The law does not permit minority reports or minority opinions. The Civil Grand Jury speaks with one voice through the report of its findings and recommendations. The Final Report is the only document through which the Civil Grand Jury communicates with the public.

ENVIRONMENTAL COMMITTEE

Robert Dobson, Chairperson

Clairene Almond
Charles H. Parks
Elyse Ruth

COUNTY HYBRID VEHICLE REPORT

INTRODUCTION

The current passenger car inventory of County vehicles acquired and maintained by the Internal Services Department (I.S.D.) presents an opportunity for the scheduled replacement of those vehicles, in all County departments, with hybrid vehicles. The exceptions are police, emergency or other specialty vehicles.

METHOD

After the committee interviewed I.S.D. personnel and acquired numerous reports and articles regarding how hybrid vehicles use less gasoline and emit fewer green house gases, we focused on how the County could take advantage of this improving technology. I.S.D. acquires and maintains vehicles for 33 County departments and agencies (See I.S.D Vehicle Chart). Not all County departments and agencies use I.S.D. to acquire and maintain vehicles. There is no single agency charged with the purchase and maintenance of passenger vehicles for all County departments.

FINDINGS

Hybrid vehicle technology continues to advance, with manufacturers expanding the number of models and availability of passenger cars using this technological innovation. Using these vehicles would reduce departmental gasoline costs by 20% to 40%. Gasoline averaged $2.50 a gallon, or more. As of April 1, 2005, Considerable fuel savings would be achieved by using hybrid passenger vehicles. The California Public Employees' Retirement System (CALPERS) has announced its support of the California Greenhouse Gas Emissions Standards. The use of hybrid vehicles will help the County meet these standards.

"For most people, fuel economy is the ultimate measure of a vehicle's environmental impact – the higher the miles per gallon, the greener the car. Better overall fuel economy means lower fuel costs…and less dependence on oil, with all its environmental and geopolitical implications. But fuel economy is only one part of the story. Emissions that create air pollution are another important element. One way to reduce them is through engineering…environmental friendliness is the reduction of the amount of released greenhouse gases (carbon dioxide, methane, and nitrous oxide), which have been linked to global warming…the less gasoline burned, the less greenhouse gases produced…gas-electric power combination provides much higher gas mileage – and low emissions too".[1]

[1] Westways Magazine, January/February 2005, pages 51-52

As of September 2004, the Internal Services Department maintained a fleet of 3,421 on road vehicles for 33 County departments and agencies; 768 of those vehicles are passenger cars. Of the total 3,119 gasoline burning vehicles in the entire fleet, only 3 are hybrids. (See below)

I.S.D. VEHICLE/FUEL TYPE INVENTORY

Inventory	
Owned	3,393
Leased	28
Total	3,421

Vehicle Type	
Passenger	768
SUV's	117
Vans	980
Pick-Ups	1,170
Heavy Trucks	368
Total	3,421

Fuel Type	
Gasoline	3,119
Hybrids	3
Electric	0
CNG	69
Diesel	227
Methanol/Gas	1
Propane	2
Total	3,421

The average replacement cost per gasoline vehicle ranges from $15,000 to $25,000; the average cost of a new Hybrid vehicle ranges from $20,000 to $30,000. The average annual maintenance cost per gasoline vehicle is about $1,925; the average maintenance cost of a Hybrid vehicle is approximately $2,100.

The average annual fuel cost per vehicle cannot be calculated accurately because the purchase of fuel is decentralized within I.S.D. At this time, none of the various purchase methods are interfaced with I.S.D. Automated Fleet Management Information System ("A.F.M.I.S."); therefore, I.S.D. is unable to accurately determine the amount spent on fuel for any vehicle during any particular time period. The annual fuel cost of Hybrids is estimated to be 20%-40% less than any gasoline vehicle.

In January 1995 the Board of Supervisors adopted policy 3.020. The purpose of this policy was to establish a clean air policy, which has a sunset review date of January 10, 2007, and to transition to vehicles using clean fuels (See Attachment). As of September 2004 only three hybrid vehicles have been added to the fleet that I.S.D. manages.

The County Department of Public Works "…acquired six hybrid-electric…vehicles. These cars combine gas engine with an electric motor, which dramatically improves gas mileage…and produce lower emissions than gas-only automobiles. The vehicles get almost 700 miles per tank of gas."[2]

RECOMMENDATION

- The Los Angeles County Board of Supervisors direct all County departments and agencies to replace their gasoline passenger vehicles scheduled for replacement, which are not emergency or other specialty vehicles, with hybrid vehicles beginning in fiscal year 2006-2007.

[2] Workplace Connection, September/October 2004, page 1

Los Angeles County
BOARD OF SUPERVISORS POLICY MANUAL

Policy #:	Title:	Effective Date:
3.020	Clean Fuel Program	01/10/95

PURPOSE

Establishes a clean air policy to improve air quality in the South Coast Basin through the expanded use of clean fuels in conjunction with other County-sponsored environmental programs to the extent it is financially feasible.

The goal is to transition as many vehicles to clean fuels as possible within the limits of service delivery requirements and funding capabilities.

REFERENCE

September 20, 1994 Board Order, Synopsis 9

November 30, 1994 Chief Administrative Office and Internal Services

Department memo, "Los Angeles County Clean Fuels Policy"

January 10, 1995 Board Order, Synopsis 8

POLICY

It is the policy of the County of Los Angeles to transition its motor vehicle fleet to viable clean fuels as approved by the California Air Resources Board. Transition to clean fuel will be based on the use of the vehicle, availability of fuel, and funding. The Clean Fuels Policy shall
be executed in compliance with the following guidelines.

1. Each department head shall be responsible for implementation of the Clean Fuels Policy within his/her department.

2. Whenever possible, new vehicle purchases will be clean fuel vehicles.

3. Implementation of the Clean Fuels Policy shall depend on the financial resources available to the County. Departments shall pursue funding available from a variety of sources and may work with other public/private agencies to share resources, coordinate efforts, and apply jointly for available funds.

4. Departments shall report to the Board by March 1st each year on the composition of their fleet and the number of vehicles powered by clean fuels.

RESPONSIBLE DEPARTMENT

Internal Services Department

Chief Administrative Office

DATE ISSUED/SUNSET DATE

Issue Date: January 10, 1995 **Sunset Review Date: January 10, 2004**
Review Date: February 19, 2004 **Sunset Review Date: January 10, 2007**

SEAWATER DESALINATION PROJECT

BACKGROUND

The Long Beach Water Department (LBWD) has developed a proprietary technology to convert seawater into high-quality drinking water in the most cost-effective manner. The innovative, two stage, nanofiltration method is capable of producing high quality potable water using pressures lower than typical seawater reverse osmosis membrane desalination, significantly cutting costs and making desalination a necessary component of the water resource mix creating more reliable water supplies for the future.

METHOD

The general manager of the Long Beach Water Department made an initial presentation of their method of ocean water desalination. The engineer-inventor of the process and assistant general manager of the department made a subsequent presentation prior to the Civil Grand Jury tour of the development project.

FINDINGS

Traditional desalination consists of single-stage reverse osmosis membranes requiring approximately 1,100 pounds per square inch (PSI) of pressure to desalinate water. Their process consists of two stages of nanofiltration membranes that require 525 PSI in the first stage and 250 PSI in the second stage. This method is a potentially more cost-effective source of high-quality potable water that meets or betters all state and federal regulations for safe drinking water.

The department has developed a methodical approach to desalination by leading the three-phased Long Beach Desalination Research and Development Program. Phase-1 (Pilot Phase) is a bench-scale 9,000-gallon per day (GPD) desalination unit constructed in 2001. The bench-scale unit was utilized for preliminary work on the LBWD's proprietary two-stage nanofiltration method for seawater desalination.

The project's Phase-2 consists of a 300,000 GPD Prototype Seawater Desalination Plant currently being constructed. This phase will facilitate intensive research in seawater desalination. Identifying the optimum desalination process, membrane type, energy recovery units, and permeate integration into the distribution system will result in a reduction of the cost of seawater desalination. In this phase, LBWD has partnered with the Los Angeles Department of Water and Power and the U.S. Bureau of Reclamation.

The research information acquired from the Prototype Phase will contribute to Phase-3 (Full-scale Plant) of the Long Beach Desalination Project, consisting of the design and construction of a full-scale plant capable of producing 10 million gallons per day (MGD). In preparation for Phase-3, a site selection study is currently underway to investigate potential locations for the full-scale plant. As part of this phase, the Long Beach Water Department is a project proponent in the Metropolitan Water District's Seawater Desalination Program. Metropolitan's program will implement incentive measures for water produced from a full-scale plant.

The Long Beach seawater desalination patent pending process, together with a well-planned and phased approach, presents a potentially promising cost-effective alternative to reverse osmosis for the seawater desalination industry.

HEALTH AND SOCIAL SERVICES COMMITTEE

William R. Jackson, Chairperson

Foster Care Sub-committee

David Amitai, Sub-chair
Shirley B. Black
Dennis Brusseau
Jane A. Grossman
Rita Kleinman
William Noble

Health Authority Sub-committee

Clairene Almond, Sub-chair
Dennis Brusseau
Rick McDonald
Wayne Hunt
Mary Alice King
William Noble
Ernest Oestreich

Homeless Sub-committee

Geneese Simmons, Sub-chair
Clairene Almond
Shirley B. Black
Mary Alice King
Akasia Minamoto

HEALTH AND SOCIAL SERVICES COMMITTEE

INTRODUCTION

During the early meetings of the Health and Social Services Committee it became apparent that there were many meaningful topics worthy of our attention. We discussed child welfare fraud, homelessness, healthcare, foster care, mental health, and other areas of responsibility within the Los Angeles County Department of Health Services and the Department of Mental Health.

We decided to split our committee into three subcommittees to better cover these subjects.

- Alternative governance models for the Los Angeles County Department of Health Services
- Homelessness in Los Angeles
- Foster Care

One of the areas of great interest to the citizens of Los Angeles County that we decided not to investigate is the current status and the future of Martin Luther King Jr. Hospital and Charles R. Drew Medical Center (MLK/Drew). We feel that many other agencies and media outlets are already investigating MLK/Drew and our investigation would have been a needless duplication of effort. Nonetheless, the members of the Los Angeles County Civil Grand Jury for 2004-2005 submit the following statement concerning MLK/Drew.

Martin Luther King, Jr./Charles R. Drew Medical Center

Martin Luther King, Jr./Charles R. Drew Medical Center "MLK" is a critical component of the countywide healthcare system and vital to the healthcare needs of tens of thousands of people residing in its surrounding communities. During 2004-2005, the Civil Grand Jury met with many individuals regarding MLK including members of the Board of Supervisors, representatives of the Health Services Department, MLK physicians, nurses and administrators, and many other knowledgeable individuals with expertise in healthcare delivery. The Grand Jury's health committee toured MLK, meeting with hospital and consulting staff. The 2004-2005 Los Angeles Civil Grand Jury fully supports the efforts being made to transform MLK into an outstanding hospital providing excellent medical care.

During 2004 and 2005, MLK has experienced serious problems and challenges. The Grand Jury commends the Board of Supervisors and the Department of Health Services for their commitment to do whatever necessary to resolve these complex and urgent problems. A new MLK Advisory Board, composed of health care experts, has been implemented to oversee the medical center's transformation. A private consulting company, Navigant, has been contracted to turn around the medical center and has developed an action plan based upon a thorough and intensive evaluation. All of the above parties want MLK to succeed and achieve its unfulfilled potential of excellence. The Board of Supervisors has devoted many hours and significant financial resources to achieve this goal.

A key ingredient in MLK's transformation is in attracting and recruiting outstanding physicians, nurses and administrators, to assume leadership and clinical positions. Outstanding leaders should attract an outstanding staff of interns, residents, physicians, and nurses, which should produce an outstanding medical center.

Therefore, the 2004-2005 Los Angeles Civil Grand Jury recommends to the Board of Supervisors and MLK Advisory Board:

1. To continue to give MLK's leaders the authority, support, and resources, necessary to meet all challenges in transforming MLK into providing the highest level of health care delivery.

2. To continue to conduct an extensive nationwide search and do whatever necessary to recruit leaders of stature and excellence to lead MLK into the 21st century.

DCFS AND AGENCY BOARD OF DIRECTORS

BACKGROUND

The Los Angeles County Department of Children and Family Services (DCFS) contracts with nearly 400 private agencies to care for more than 30,000 children and families. Services include out-of-home-care (e.g., foster care and group homes) and preventive and educational services (e.g., family reunification). All contracted agencies must be non-profit organizations meeting California Corporations code Sections 5210-5215 and 5220-5227. These regulatory codes specify the requirements and responsibilities of the Board of Directors of non-profit organizations. Contracts with DCFS must be signed by the president of the board of directors or the board's designee. Officers and members of the board may be held legally accountable for agency operations.

METHOD

The Foster Care sub-committee met representatives of DCFS and the Ombudsman of Los Angeles County Department of the Auditor-Controller (who monitors contracts). Jurors also conducted Internet reviews of the boards of directors of fifteen agencies contracted with DCFS.

FINDINGS

State Code Sections 5210-5227 of California Corporations Code specify the role, responsibility and composition of the board of directors:

- Corporate power is held by or under the direction of the board.
- Boards must have at least two officers/members: president, secretary, and chief financial officer; the secretary and CFO may be the same officer.
- Agency bylaws determine the qualifications of board members.
- No more than 49% of a board may be employed by the agency or be family or relatives of employees.

Contracting agencies submit names of board members, bylaws and articles of incorporation when contracting with DCFS and update material at contract renewals, annually but sometimes every three years. Board officers and directors sign statements for DCFS acknowledging their service on the board.

DCFS contract personnel review documents: list of the board of directors, articles of incorporation and bylaws for timeliness and completeness.

No DCFS policy exists regarding board size, composition, qualifications, or meeting frequency. The primary focus of DCFS is to determine whether the board approved signing the DCFS-agency contract.

Contract review audits are conducted annually by the Ombudsman of the Department of the Auditor-Controller. Contract compliance audits do not review the board of directors other than minutes authorizing the signing of the contract.

Community Care Licensing, a state agency, reviews, approves, regulates, and investigates agency licensing compliance and does not review board matters.

The Office of the California Secretary of State, while approving non-profit organizations in California, does not review non-profit agency boards.

An Internet review determined that boards varied considerably in size from 4 to 15 members. They varied considerably in the number of employees serving on boards, with some agencies having no employees on boards while others have a considerable number of employees serving on the boards.

No county or state agency reviews board compliance to code other than noted above and DCFS has no policy nor standard regarding the composition, size, qualifications, or frequency of board meetings.

DISCUSSION

The purpose of a Board of Directors is to oversee the functioning of an agency, provide various types and levels of expertise to the agency (e.g., administrative, fiscal), safeguard the safety and security of children, meet state and county laws, regulations and contracts, and ensure appropriate and qualitative care and service. Usually, the board authorizes the executive director to assume these responsibilities and report to the board. However, the board holds ultimate responsibility and accountability for the functioning of the organization. The California Corporations Code specifies the *minimal size* of a board (which may have as few as two) but does not specify how often a board meets or establish member qualifications. DCFS has no policy regarding this and neither the county or the state reviews meetings, standards for membership or composition.

Since boards hold ultimate authority and accountability, board decisions greatly impact the lives of tens of thousands of children. To provide the most ethical and effective leadership to the agency they direct to care for the children entrusted to them by DCFS, it is important that DCFS develop standards that agencies must meet to serve DCFS children.

RECOMMENDATION

To safeguard children's safety and security and achieve the highest level of professional care and agency oversight, the following is recommended for implementation of new or renewed agency contracts:

The Department of Children and Family Services develop standards for private agency board of directors concerning the number and qualifications of board members and frequency of meetings. These recommended standards to be used to develop new and revised service agreements.

PSYCHOTROPIC MEDICATION AND OUT-OF-HOME-CARE

BACKGROUND

The County of Los Angeles has approximately 30,000 children and adolescents in “Out-of-Home Care.” Children and adolescents removed from families due to abuse and/or neglect are placed under the jurisdiction and protection of the Los Angeles County Department of Children and Family Services (DCFS). The majority of these children are in licensed foster homes or homes certified by private licensed foster family agencies, group homes, residential treatment facilities and shelters. Many adolescents who have broken laws are in youth camps administered by the Los Angeles County Probation Department.

Approximately 6,000 children and adolescents take daily psychotropic medications for the treatment of serious psychological, emotional, and behavioral dysfunctions. Many medications are anti-depressants to treat depression, a common diagnosis in children and adolescents who have been traumatized. Prescribed psychotropic medications are in a class of drugs known as SSRI’s (selective serotonin reuptake inhibitors), a newer generation of drugs proven to be very effective in treatment of child and adolescent depression. These drugs include Celexa, Prozac, Luvox, Paxil, and Zoloft. Most remain in off-label status for use with children.

During 2004, new evidence of the potential harmful effects of SSRI's on children and adolescents surfaced and the Food and Drug Administration (FDA) now requires a "black box" warning.[1] These warnings are due to studies and evidence questioning the risk-benefit of SSRI's for treatment of child and adolescent depression. In the past year, information from previously unpublished studies has shown the drugs' risk to be greater than previously assumed. The "black box" for all antidepressants warns of increased risk of suicidal thoughts and behavior in children and adolescents. In 2004, the FDA ordered a warning label on SSRI's and related antidepressants that all children and adolescents be "monitored closely for worsening depression or the emergence of suicidality.”

[1] FDA Public Health Advisory, Suicidality in Children and Adolescents Being Treated With Antidepressant Medications, 10/15/04

METHOD

Members of the Foster Care sub-committee reviewed medical literature and recent FDA press releases concerning the risk factors of SSRI drugs when used with children and adolescents. The Medical Director of DCFS was invited to speak before the Foster Care sub-committee and presented an overview of the number of children currently taking medication, the types of medications prescribed, and the process of gaining court approval for the administration of medication. Members of the Foster Care subcommittee visited Mental Health Services at Los Angeles County Superior Court, Juvenile Division. Staff of Mental Health Services detailed the review and approval process of psychiatric medication for children and adolescents, together with a discussion of the review process, the number of authorizations reviewed, qualifications of prescribing physicians, qualifications of reviewers, and recent FDA warnings.

FINDINGS

The Los Angeles County Superior Court, Juvenile Division, must approve whenever a child or adolescent under the jurisdiction of the court is administered psychotropic medication of any kind. *Psychotropic Medication Authorization Forms* completed by a physician are reviewed by Mental Health Services (of the Los Angeles County Department of Mental Health) and they recommend to the Juvenile Court whether to approve the prescribed medication as detailed on the forms. This office reviews approximately 10,000 authorization forms annually; reviews are conducted by a staff that includes a psychiatrist, pediatrician, and pharmacist. The review evaluates the appropriateness of the type and dosage of medication for the diagnosis and age of the child or adolescent. Approximately 300 physicians in Los Angeles County complete most authorization forms with approximately 80 physicians providing 80% of the care. The majority of the physicians submitting authorization forms are psychiatrists (adult and child) and pediatricians, although physicians in other fields such as family practice complete authorization forms. It is not a requirement that physicians have completed a residency training in a specific specialty. It is not known how many physicians prescribing psychotropic medication to children and adolescents have specialty training or are Board Certified or Board Eligible in their respective fields. It is asked on the authorization form to check a box as to the field of medicine the physician practices, but no verification of certification, or specialization is required. Physicians in California, registered with the Drug Enforcement Agency, can prescribe any medication without regard to specialized training or certification.

Following FDA warnings about SSRI's, it remains unclear the exact relationship of SSRI's children and adolescent suicide. There exists some disagreement among physicians as to the extent of the risk factors, it is clear that physicians must be cognizant of a possible linkage and a serious adverse relationship. Physicians prescribing SSRI's must remain up-to-date as to the FDA's concerns and recommendations.

Physicians prescribing SSRI's must be well trained and competent to make appropriate clinical decisions and each must possess the expertise to accurately diagnose child and

adolescent psychiatric disorders and to determine the most effective medication and dosage to prescribe. This is a very specialized area of medicine and generally not part of medical residency training in any field other than psychiatry (with child and adolescent psychiatry being a full-time two-year training program after completion of adult psychiatry training). The 10,000 reviews conducted annually by Mental Health Services advising Juvenile Court can only be effective if the prescribing physician accurately evaluates and diagnoses children and adolescents. In most instances the reviewer does not see the child nor does he/she generally review the entire medical chart. Children and adolescents do not select their physicians and it is of the utmost importance that as advocates for the welfare of every child and adolescent served, every physician prescribing medication with potential life threatening side effects be highly skilled and have the expertise, competency and knowledge to provide such care.

RECOMMENDATION

Mental Health Services establish qualifications (e.g., training, certification) that physicians must meet to prescribe psychotropic medications to children under the court's jurisdiction, including documented verification of established qualifications.

Health & Social Services Committee

Health Authority Sub-committee

BACKGROUND

At the inception of the Health & Social Services Committee, several sub-committees were formed under its umbrella. The "Rancho Los Amigos" committee was one of them. It began because a few committee members had an interest in the fate of that nationally recognized hospital with its long history of service to the people of Los Angeles County. As we researched the tribulations of that institution, which was scheduled for closure by the Board of Supervisors, we discovered that the entire health delivery system in Los Angeles County also had severe problems. We kept coming across the idea of a "health authority" for Los Angeles County. Many task forces and committees, formed at the request of the Board of Supervisors, had studied the statutory requirements of a change in its delivery system as well as its monetary challenges. All of them recommended a different form of governance for the Department of Health Services. In September of 2004, after three months of research and study, our sub-committee decided to investigate the feasibility of forming a new form of governance for the entire DHS system instead of concentrating solely on Rancho Los Amigos. Subsequent media coverage of systemic problems at Martin Luther King Jr. Hospital reinforced our decision to study a new form of governance for the entire Department of Health Services.

METHOD

Using all forms of research available to us; internet searching, procurement of existing county documents, interviewing medical personnel, hospital site visits, etc., we formed a clear idea that a "health authority" would provide the best chance of saving our County's health care system. We asked for, and received, jury approval to study the feasibility of creating a separate Health Authority form of governance for DHS.

At the completion of our study, we again asked for, and received, jury approval to hire an auditing firm for the purpose of studying the feasibility of creating a separate public entity existing independently of local government, governed by a separate board of trustees with some involvement of local government. We charged the Harvey Rose Auditing firm with:

- Profiling the strengths and weaknesses of the current state of Los Angeles County's public hospital and health care system.

- Evaluating the extent to which the limitations of local, state, and federal government control applies to Los Angeles County's hospital and health care system.

- Study other health jurisdictions for comparable examples of the health authority form of governance.

- Determining whether conversion to an alternative form of governance would provide the greatest opportunity to resolve problems facing the County's hospital and health care system.

- Provide a blueprint and timetable for implementation.

The audit report from the Harvey Rose Accountancy firm begins on the next page.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Harvey M. Rose Accountancy Corporation was retained by the FY 2004-05 Los Angeles County Civil Grand Jury to conduct an ***Analysis of Implementing a Health Authority for the Los Angeles County Hospital and Health System***. The purpose of the analysis was to identify specific steps that the County needs to take to create a separate legal entity to govern personal health services now governed by the Board of Supervisors and provided by the Department of Health Services and, to some extent, the Department of Mental Health.

A summary of the findings, recommendations and costs and benefits of the recommendations contained in this audit report are as follows. The recommendations are numbered according to their respective sections in this report.

1. HEALTH AUTHORITY COMPONENTS AND ROLE

Summary of Findings:

- A number of proposals to create a Los Angeles County health authority have been made over at least the past ten years. However, the health services components included in each proposal have differed greatly and have been vaguely defined.

- Until recently, these proposals have not fully addressed whether responsibilities related to mandated public health or mental health services should be retained by the County or absorbed by the health authority. Further, these proposals have not answered critical questions related to the complex responsibilities for providing indigent medical care services defined by California Welfare and Institutions Code Section 17000, case law and policy of the Board of Supervisors.

- Before considering the complex governance, operational, funding and legal questions associated with the creation of an independent health authority, the Board of Supervisors, with input from the Department of Health Services (DHS) and the healthcare community, should clearly define the health authority's mission and functional components. A preferred model would: transfer authority and responsibility for all personal health services now provided by DHS including hospitals, ambulatory care centers, comprehensive health centers and personal health clinics, to the health authority; charge the health authority with the responsibility for providing specified levels of healthcare services to the uninsured and indigent; and, establish emergency and acute psychiatric care services at levels negotiated with the Department of Mental

Health. Public Health services, Emergency Medical Services and other broad regulatory or coordination functions should be retained by the County. The Department of Mental Health should remain an independent County department that is separate from the health authority.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors, with input from DHS and the County's healthcare community:

1.1 Develop a clearly defined mission for the new health authority that is focused on the delivery of safety net physical health services for the uninsured and indigent populations within Los Angeles County.

1.2 Clearly define the minimum level of service to be provided by the health authority, based on Welfare and Institutions Code §17000 and case law.

1.3 Develop a structure that retains the County's responsibility for providing public health, mental health, drug and alcohol, emergency medical, managed care and juvenile court health services.

The Board of Supervisors should:

1.4 Retain the Department of Mental Health as a distinct County department not under the jurisdiction of the new health authority.

1.5 Establish Public Health as a distinct County department not under the jurisdiction of the new health authority.

1.6 Consider placing the Emergency Medical Services function under the authority of the Public Health Officer.

1.7 Consider placing Managed Care under the authority of the Public Health Officer, and expanding its role to include the monitoring of health services provided by the health authority under its contract with the Board of Supervisors.

1.8 Consider placing the Alcohol and Drug Program Administration function under the Department of Mental Health and creating a Behavioral Health Department.

1.9 Retain responsibility for health services functions provided to juveniles who are in County institutions (Juvenile Court Services), but contract with the health authority or another provider to provide such services.

1.10 Direct the Chief Administrative Officer, with assistance from DHS, to determine the most appropriate allocation of DHS Health Services

Administration personnel and resources as part of a health authority transition plan.

COSTS AND BENEFITS

There would be no direct cost to implement these recommendations. However, staff time would be required to provide the analyses that will be necessary for the Board of Supervisors to make informed decisions.

The health authority would be given a clear and focused mission, which would increase its chances of operational success. Regulatory, disease management, countywide coordination and health education functions would be retained by the County. By retaining the managed care function and expanding its current role, the County would be better equipped to monitor the services and costs of the health authority.

By retaining the mental health and alcohol and drug program administration functions, the behavioral health services will receive more focused attention and prominence in the organization. This is appropriate since both programs serve a broader population than just the uninsured and indigent residents of the County, and are more closely aligned with non-health services functions such as criminal justice.

By retaining responsibility for medical services provided to juveniles that are housed in County institutions, the Board of Supervisors will be better able to ensure appropriate levels and quality of care. The Board could choose to contract with the health authority to provide these services, as a supplementary service that would exceed the Authority's statutory mandate.

2. HEALTH AUTHORITY GOVERNANCE STRUCTURE

Summary of Findings:

- The Board of Supervisors has been criticized for its lack of health care expertise and difficulty balancing its other priorities against the hospital and healthcare system needs of the County. In addition, the Board's approach to governance has reportedly created a risk adverse environment that suppresses management innovation.

- A review of its activity in recent years concerning the County's hospital and health system reveals that the Board of Supervisors devotes limited time to the complex and multi-faceted $3.5 billion department due to its many other responsibilities. Board actions in key operational areas were found to often be reactive and lacking follow-up, resulting in recurrences of some of the same problems. Creating a Health Authority Board of Directors focused solely on the County's hospital and health system and

statutorily composed of members with healthcare, finance and other business backgrounds would allow for a more pro-active, strategic, problem solving approach to governance of the new organization.

- It is important that this governing board not be insulated from consumers. Currently, patients of the County healthcare system have a limited ability to exercise consumer choice and instead utilize the political process for providing input to the Board of Supervisors. The governing structure should therefore be designed in a manner that provides avenues for consumer input into the process.

- Because of its unique role, the Health Authority Board of Directors should self-appoint its members after nomination by a combination of the Board of Directors, itself, and external groups, with all nominations subject to confirmation by the Board of Supervisors. By incorporating the best attributes of a business model with one designed to protect consumer interests, the Health Authority Board of Directors will be better able to exercise healthcare system oversight. Consumer interests could be protected by designating some board seats for consumer appointments and establishing a network of regional Healthcare Consumer Advisory Committees.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors, with input from DHS and healthcare professionals:

2.1 Develop recommendations for enabling legislation that specifies membership on the Health Authority Board of Directors. At a minimum, the Board of Directors should include nine members, as follows:

- Five hospital and health care professional slots, as follows:
  - A member with a background in hospital administration to be nominated by the Health Authority Board of Directors;
  - A member with a background in ambulatory care/clinic administration to be nominated by the Health Authority Board of Directors;
  - A member with a background in finance and/or administration to be nominated by the Health Authority Board of Directors;
  - A member with a background in human resources and/or labor relations to be nominated by the Health Authority Board of Directors;
  - A member with a background in risk and/or asset management to be nominated by the Health Authority Board of Directors;
- Two physician members to be nominated by the Medical Director or voted on by physician staff;
- Two healthcare consumer members to be nominated by the consortium of Healthcare Consumer Advisory Commissions

established in each of the County's major service areas (See Recommendation 2.4).

2.2 Develop recommendations for enabling legislation that requires the Board of Supervisors to appoint a Task Force comprised of DHS representatives and other health care professionals, practitioners and consumer representatives to develop a slate of nominees for appointment to the Health Authority Board of Directors, consistent with the composition outlined in Recommendation 2.1.

2.3 Develop recommendations for enabling legislation that requires the creation of Healthcare Consumer Advisory Commissions in each of the County's regional service areas or networks with one role being nominations to the two consumer representative positions on the Health Authority Board of Directors.

2.4 Develop recommendations for enabling legislation that establishes an ongoing nomination and appointment process for the Health Authority Board of Directors, where: (a) nominations are made by the Board of Directors for the five hospital and health care professional slots, by DHS' medical school affiliates for the two physician members, and by the recommended Healthcare Consumer Advisory Commissions for the two consumer representatives; and, (b) all nominations are confirmed by the Board of Supervisors.

COSTS AND BENEFITS

There would be no direct costs to implement these recommendations, although staff time will be required to provide analytical support to the Board of Supervisors.

The benefits of implementing these recommendations would be that the Health Authority Board would include members who possess appropriate hospital and health care system management, finance and other business expertise, as well as members who represent consumer interests. By segregating ongoing member appointment responsibilities between consumer groups, medical school affiliates and the Health Authority Board of Directors, a less politicized and more balanced organization should be in place, better reflecting the diverse interests of the community.

3. HEALTH AUTHORITY FINANCE AND PERFORMANCE REQUIREMENTS

Summary of Findings:

- Only 34.2 percent of the Department of Health Services $2.4 billion hospital and ambulatory care net operating budget is funded from direct patient revenues. The remaining 65.8 percent, or $1.6 billion, is funded from intergovernmental transfers from the federal and State governments, designated tax revenues, grants and subsidies received from the County. The substantial portion of income received from the federal, State and County governments are received by DHS to fund health services for the County's medically indigent and uninsured population.

- The creation of a health authority will not relieve the County of the significant financial responsibility it bears for the care of the medically indigent and will not alone resolve the fiscal problems facing DHS. While net operating costs could be lowered by implementing service efficiencies and initiatives to maximize revenues, it is likely that a significant operating deficit will continue unless the County redefines service responsibilities presently included in California Welfare and Institutions Code § 17000, case law and policy of the Board of Supervisors. Even with such a redefinition, challenges to the County's ability to fund medically indigent service demand will likely continue as the federal and State governments attempt to reduce their costs through Medicaid reform.

- To provide financial stability to the health authority, adequate financial provisions must be incorporated in the operating agreement with the County. A coordinated care approach, using standard rates for each covered patient or episodic treatment category, that can be adjusted each year based on changes in patient population and service profile, is recommended. The rate should incorporate planned cost reductions from efficiency improvements and redefined services, and cost enhancements for investments in areas such as information technology.

- To ensure that a desired level of service quality and cost-effectiveness is achieved, the operating agreement should include specific performance and financial goals for the health authority and measurements to use for periodic reports to the Health Authority Board of Directors and the County on actual accomplishments.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors:

3.1 Clearly and effectively define a patient benefits package and the population for whom the health authority will provide services, within the context of State law, case law and local priorities, to be included in the operating agreement between the County and the new health authority.

3.2 Direct the CAO to work with the Department of Health Services representatives to establish a funding mechanism that will reasonably finance the health authority's operations. At a minimum, the health authority should retain all patient revenues and other resources that result directly from the services that it provides, as well as dedicated tax revenues and maintenance of effort guarantees for sufficient County General Fund subsidies to finance its operations.

3.3 Direct the CAO to work with County Counsel and the Department of Health Services representatives on the development of an operating agreement for services that provides revenue and cost-based incentives for (a) the County to provide sufficient resources to the health authority using a coordinated care standard rate per patient or episodic treatment approach, and (b) the health authority to use those resources effectively, as demonstrated by reductions in cost per patient over several years.

3.4 Direct the CAO to work with Department of Health Services representatives to establish baseline costs based on current operations, and to determine the planned timing of cost reductions and efficiency improvements and needed investments in areas such as information technology so that the standard rates used in the agreement between the health authority and County can be adjusted each year, in accordance with this plan.

3.5 Direct the CAO to work with the Department of Health Services to develop (a) hospital and health care system financial and performance goals and measurements, for inclusion in the operating agreement between the County and the health authority; and, (b) systems to measure actual financial and service quality performance of the health authority, including cost measures, patient outcome and satisfaction measures and improvements in efficiency. These goals and measurements should be regularly reported to managers, the Health Authority Board of Directors and the County Board of Supervisors, supplemented by periodic analysis of results by an independent party.

COSTS AND BENEFITS

There will be initial costs to implement the service quality and performance monitoring system, primarily in County staff time. However, we did not estimate that cost within the scope of this study.

The health authority will be provided with greater assurance that sufficient funding will be provided by the County for designated levels of service. The County will have greater assurance that it will receive high quality, low cost services for the indigent and uninsured population that the health authority will be serving.

4. HUMAN RESOURCES

Summary of Findings:

- The Department's hospitals had a 12.7 percent position vacancy rate for the first five months of FY 2004-05, with even higher rates for key classifications such as nurses and technicians and specialists. These vacancy rates, measured in full-time equivalents, are one indication of potential human resource management problems in areas such as recruiting, hiring and/or compensation. A review of the Department's and County human resources processes and systems indicates that all of these areas are affecting the Department's ability to hire and retain staff. A fiscal impact of this situation is the use of Registry personnel to fill vacant positions. For Staff Nurses, the Department will spend an estimated $9 million in FY 2004-05 for Registry positions compared to the cost of in-house County employees.

- Adherence to County civil service rules means that the Department's recruitment and hiring processes are lengthy and time consuming. Review and approval of job bulletins, selection criteria, position information, and classifications can delay the hiring process.

- To address some of these concerns, DHS has begun to reengineer its human resources function. Many responsibilities have been centralized within the Department. The DHS Director has sought and received increased authority for making compensation and hiring decisions; and, much of the hiring process has been automated with the development of an in-house system available to program managers. Despite these achievements, the process is still governed by County civil service requirements and many DHS managers continue to

assert that the Department's human resources system is ineffective and cumbersome.

- With the creation of a health authority, many of these inefficiencies could be eliminated. Current restrictions placed upon DHS by the County Charter, Civil Service Rules, and employee bargaining agreements could be lifted; compensation levels could be strategically set by the health authority board within the context of the health authority's singular mission and budget; the recruitment and hiring process could be streamlined and made more efficient; and, the rules associated with employee disciplinary actions could be reconsidered.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors:

4.1 Direct the CAO and DHS to collaborate on development of a human resource plan for transition to the health authority, with detailed recommendations regarding timelines and alternatives for addressing the various labor and collective bargaining issues identified in this report.

4.2 Direct the CAO to expedite negotiations with employee bargaining groups to implement the proposed Flexible Staffing Pilot Program, in an effort to immediately reduce outside Registry costs.

4.3 Direct staff to include goals for key human resources measures in the operating agreement between the County and the health authority, including reducing turnover and vacancy rates, improving hiring cycle time and achieving compensation parity with the hospital and health care market, with the results reported annually to the Board of Supervisors.

The Department of Health Services should:

4.4 Continue efforts to improve the internal human resources organization, process, resources and tools for effectively administering human resources processes prior to the date of transition to the health authority

4.5 Conduct an analysis of the existing classification and compensation system and identify specific changes needed under the new health authority.

4.6 Develop a proposed expedited hiring system for implementation under the health authority.

COSTS AND BENEFITS

There would be unspecified costs to implement an effective human resources function within the Department of Health Services.

The human resource process within DHS should continue to improve until the health authority is created. The new health authority would be provided with critical information regarding labor and collective bargaining agreements, needed changes to civil service processes and other critical human resource concerns. The net result should be faster and more flexible hiring processes, fewer vacancies and turnover and reduced costs from decreased use of Registry personnel.

5. HEALTH SERVICES PROCUREMENT

Summary of Findings:

- In FY 2004-05, the Department of Health Services procured goods and services worth up to $1.7 billion. Procurement occurred in a structure featuring formal rules codified in State law, the County charter, County ordinance and Board of Supervisors policies, emphasizing maximum opportunity for vendors to bid to provide goods and services, and focusing on competition as the primary way to achieve the lowest prices.

- Department staff criticized the rigidity of this process, complaining that the plethora of rules slows down the procurement process unnecessarily, and does not achieve substantially better prices than could be achieved for lower dollar value items by more informal processes that permit informal negotiations with vendors. In addition to these interview comments, a review of a limited number of service contracts negotiated by the DHS Contracts and Grants unit revealed instances where technical violations of procurement rules led to contract protests, and significant delays in the award of contracts. DHS staff estimates that approximately 80 percent of all service contracts issued are subject to protest over the award and related delays.

- Because the rigid procurement system that currently exists is defined in State law, the County charter, County ordinance and Board of Supervisors policies, establishment of a health authority would provide the opportunity to eliminate some of those strictures, establishing a more flexible procurement system, while still providing some centralized control of procurement to prevent abuses.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors:

5.1 Direct DHS staff to develop recommendations for enabling legislation that exempts a new system of health care governance from the requirements for a County purchasing agent in State law, and from the procurement requirements of the Los Angeles County Code and Board of Supervisors policies.

The Department of Health Services should:

5.2 Develop procurement procedures to be implemented under the health authority that eliminates a rigid focus on formal bidding processes and that emphasize maximum vendor access in favor of a more flexible system that focuses on getting goods and services quickly, at reasonable prices.

5.3 Develop procurement policies for the health authority to increase the value of goods and services that individual health care facilities can purchase on their own with less formal bidding requirements based on an analysis of current purchasing amounts and financial risk so that formalized bidding is used only when there will be substantial benefits or price advantages resulting from the additional time and administrative requirements.

5.4 Design a consolidated procurement structure to be established under the health authority that includes a centralized procurement office overseeing all components of the system, including the Contracts & Grants Division, that would process bids above the newly established threshold for formal bidding, provide organization-wide oversight and monitoring of compliance with the Health Authority's new regulations to ensure that procurement abuses are not occurring, and would be headed by a purchasing manager established at the same management level as a health system director of nursing, or director of clinical care.

5.5 Develop a system for ensuring and reporting to management and the Health Authority Board of Directors that competitive bidding is used when appropriate and advantageous to the organization and that procurement abuses are not occurring.

5.6 Determine the number of positions that should be transferred from the Internal Services Department to the new health authority for the new centralized procurement function, recognizing that fewer formal bids will be required in the new system and that more items will be standardized and purchased through a Group Purchasing Organization.

5.7 Determine the number of positions that will be needed for the Contracts and Grants Division under a new more streamlined contracting procedure.

COSTS AND BENEFITS

There would be no costs to implement these recommendations. A new system of procurement, based on a new system of health care governance, would be more flexible, allowing the health care system to get the items needed for patient care more quickly, at reasonable prices, by eliminating rigid bureaucratic rules and processes. Benefits would include reduced cycle time for procurement and reduced administrative costs as fewer staff would be needed to process purchases without all of the procurement rules and regulations and processes with which DHS must now comply. There should be some cost reductions from a reduced need for the current ISD staff that processes DHS purchase orders since fewer procurements would be subject to formal bidding procedures and in the Contracts and Grants division since the service contract procedure would be streamlined.

6. INFORMATION TECHNOLOGY

Summary of Findings:

- The Department of Health Services' past approach to information technology has been decentralized, with each hospital and department developing its own systems and protocols. As a result, it is not possible to track patient records across the Department as there are no common patient identifiers and no common methods for recording patient transactions.

- The Department has recently developed a system for centrally collecting and standardizing some patient data from each cluster after it is entered into each independent system, allowing for better management monitoring of patient outcomes and quality of care across the system, and has been used to develop some new clinical protocols. Further integration of the Department's information systems is a key component to managing the Department as a single system, consistent with the Department's strategic plan.

- The Department completed a business automation plan in 2005 that sets its strategic information technology objectives and goals and assesses strengths and weaknesses of the current information technology resources. The key weaknesses identified are the level, mix, compensation, and skills and abilities of the Department's information technology staff. As

one indication of staffing limitations, vacancies in the Department's information technology classifications averaged approximately 14 percent in FY 2003-04, and were even higher for core classifications such as Systems Analysts and supervisors.

- Under a health authority, the new organization would be free of County constraints on classifications, compensation and hiring processes. The organization could redesign or establish new classifications more appropriate to its needs and adjust compensation accordingly. At the same time, the organization should establish a stronger management function centrally by converting the current Chief, Information Systems in Health Services Administration to a chief information officer, responsible for overall information technology development and maintenance for the entire organization.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors direct the Department of Health Services to:

6.1 Expand the current business automation plan into a five year strategic information technology plan for the health authority linked to the priorities and principles of the 2002 DHS strategic plan and detailing current hardware, software and utilization throughout the Department, future priorities, proposed projects, costs and benefits of projects, funding sources and project selection criteria.

6.2 Determine the unit cost for the highest priority, most cost-effective information technology projects to include in the payment rate that the health authority will receive from the County.

6.3 Design and implement a skills assessment process for current information technology staff and compare results to skills needed as detailed in the five year strategic information technology plan.

6.4 Begin preparation of new or redesigned job specifications for information technology positions for the health authority, including creation of a chief information officer classification.

6.5 Conduct or obtain existing information technology salary survey data to determine market rate compensation levels for new or redesigned classifications.

6.6 Prepare a formal plan, including an implementation schedule, for restructuring the information technology function under the health authority with a centralized chief information officer responsible for overall

direction and priority setting for the function and overseeing centralized and decentralized staff, with the latter responsible for day to day operations at hospitals and other facilities.

6.7 Participate in the funding for a fully integrated, comprehensive information technology system for the health authority, that will be able to provide cross-system data on patient care and costs that will be necessary to monitor health authority performance.

COSTS AND BENEFITS

The primary cost of implementing these recommendations will be staff time. One-time direct costs could be incurred if an appropriate salary survey cannot be obtained and needs to be commissioned to assess current salaries for information technology positions. Benefits of the recommendations would include preparation of a plan to guide future information technology investments under the health authority, consistent with the 2002 strategic plan, a more consistent approach to information technology across the organization, an improved information technology staffing plan that will enable the organization to achieve its goals and improved information to assess performance and patient outcomes.

7. COUNTY SUPPORT SERVICES

Summary of Findings:

- The FY 2004-05 Countywide Cost Allocation Plan (CCAP), allocates nearly $1.4 billion in County costs to departments for services that are provided centrally, such as payroll, accounting, building maintenance, facility rent and use, utilities, insurance, legal and other general support activities. DHS was charged approximately $203.9 million for these services in the current year plan. Approximately $185.6 million was direct charged and the balance was allocated to the Department using a variety of allocation methods.

- A separate health authority would not be required to use County support services, but would likely continue to use many of them at little or no cost savings. In addition, many of the costs presently charged to DHS such as rent, facility use and utilities would still be incurred even if the services are no longer provided by the County. In some instances the combined cost for both the health authority and the County could increase because the County would be unable to sufficiently lower its costs to offset losses in income from the health authority.

- Nonetheless, some County overhead costs charged for support services provided to DHS could be eliminated, by providing the

services in-house or through less costly contractors. Costs for some external County oversight and control services that would no longer be required under a separate health authority could also be eliminated.

- Conservatively estimating reductions in overhead costs for some County support services, savings could amount to an estimated $10.8 million per year. However, this is a relatively small amount of savings when compared with the projected cumulative DHS operating deficit of over $1.3 billion.

- After an initial transition period, the health authority should be given the option to (a) continue to purchase services from the County, (b) purchase services from contractors, or (c) provide services in-house. Each alternative should be fully analyzed for the potential to produce savings for the health authority and the County, but should primarily be chosen based on business considerations for the health authority.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors direct the Chief Administrative Officer to:

7.1 Conduct a thorough analysis of current County costs to support DHS services. The analysis should include:

- A comprehensive accounting of costs, such as rental expenses, utility charges, judgments and damages, insurance and security services, that would likely offer little opportunity for health authority savings;
- An analysis of services, such as legal and information systems, where some limited health authority savings could be achieved; and,
- An analysis of services, such as auditing, accounting, budgeting, financial management and employee relations, where more substantial savings may be possible.

7.2 Conduct a thorough analysis of County cost impacts that might result from possible health authority decisions to discontinue the use of County services and possible offsets under the health authority.

7.3 Estimate the net countywide cost or savings (i.e., the combined finances of the County and the health authority) that might be achieved with the creation of a health authority, considering fixed support services costs that the County might still incur even if the health authority no longer uses the support service.

7.4 Work with the Department of Health Services to identify and report back support service overhead costs that could be eliminated by DHS providing

the services in-house or contracting to a lower cost contractor for services now provided by County departments, and, to identify other cost reductions that would be achieved for external verification and monitoring of DHS operations that would no longer be needed under a separate health authority and is now performed by departments such as County Human Resources, the Chief Administrative Office and the Auditor-Controller.

The Board of Supervisors, with input from the County Counsel, the Department of Health Services and other County departments, should:

7.5 Develop legislative provisions that ensure the most cost effective partnership between the County and the health authority. At a minimum, these provisions should require that:

- The health authority be required to purchase support services from the County during a transition period lasting no less than two years; and,
- The health authority be required to give a one year notice when it intends to discontinue the use of County support services.

COSTS AND BENEFITS

There would be no direct cost to implement the recommendations, although staff would be required to conduct the recommended analyses and report to the Board.

Taxpayer interests would be protected, while providing the health authority with the eventual autonomy that would be required to operate in an efficient and effective manner. The County would be provided sufficient notice to plan for transition when the health authority determines that County services are no longer required. While further analysis is recommended for more precise quantification, annual savings to be realized by the health authority for reduced overhead costs for support services and reduced oversight and monitoring by external County departments could amount to as much as $10.8 million per year.

8. TRANSFER OF COUNTY ASSETS AND LIABILITIES TO THE HEALTH AUTHORITY

Summary of Findings:

- The County has invested significant resources in facilities and equipment used by DHS to provide hospital and health services. Many of these facilities are in need of significant rehabilitation or replacement. For example, the County is presently involved in a major construction effort to replace the LAC+USC Medical Center, which will cost an estimated $820.6 million. As a result,

complex legal and financial decisions need to be made as part of creation of a health authority regarding asset ownership, responsibilities for debt repayment and the ongoing maintenance and improvement of the County's infrastructure.

- The County has significant long-term unfunded liabilities for employee retirement obligations and prior workers compensation, general liability and medical malpractice self-insurance program claims against DHS. These obligations amounted to nearly $920 million as of June 30, 2004, and do not include unfunded liabilities for retiree health care benefit costs which are in the billions of dollars.

- Since these unfunded liabilities are the result of policies and decisions made by the County over the years, they should be retained as an ongoing County expense, not an expense of the new health authority, until they are fully paid. In fact, some of the County's self-insurance policies reflect exemptions from State Controller insurance guidelines to ensure federal grant reimbursement to local agencies and therefore would probably not be allowable for new health authority. As a result, the health authority will most likely have to fully fund the insurance liabilities that it incurs starting the day of its inception. The operating agreement between the County and the health authority should be structured and external approvals obtained to ensure that all existing and future liabilities are fully funded and that the County can effectively leverage federal and State funding. Unless the County can successfully obtain such external approvals, there is a risk that the substantial unfunded liability that exists at the time of separation would become a General Fund cost and would not be considered eligible for reimbursement from federal and State grants.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors direct the Chief Administrative Officer, the Auditor-Controller and County Counsel to collaborate to:

8.1 Develop strategies and recommendations for either (a) transferring ownership of health and hospital facilities to the health authority; or, (b) retaining ownership of all health and hospital facilities, but defining rights and obligations regarding facility use, rehabilitation, maintenance, expansion and replacement.

8.2 Determine federal and State requirements regarding the funding of retirement and insurance liabilities under the health authority that must be

complied with for the County to be able to leverage all available federal and State funding for the health authority.

8.3 Seek authority from the federal and State governments to permit the County's unfunded liability to be partially financed by federal and State grants made to the health authority.

8.4 Develop estimates and report back on the financial implications to the County of (a) fully funding the LACERA pension plan, (b) repaying pension obligation borrowings, (c) establishing appropriate post-retirement health care benefit reserves, and (d) fully funding the unfunded liabilities for the County's self insurance programs. This analysis should assume that the County would be required to proportionately fund its share of all current and future pension and insurance costs through its operating agreement with the health authority.

8.5 Include a reduction in hospital and health system insurance costs, including general liability, medical malpractice and workers compensation, as a goal in the operating agreement with the new health authority, to be measured and regularly reported back to the Health Authority Board of Directors and the Board of Supervisors.

The Department of Health Services should:

8.6 Determine the costs and impacts of alternatives to the current post-retirement health benefits that could be established under a new health authority.

8.7 Establish systems and reporting mechanisms to be established under the new health authority that would track and report insurance costs, including liability, medical malpractice, and workers compensation.

COSTS AND BENEFITS

Although there are no direct costs associated with the implementation of these recommendations, staff time will be required to perform the analysis and report on the results to the Board of Supervisors.

The County Board of Supervisors would have a clear understanding of the significant financial consequences related to the formation of a health authority. Health authority representatives would have a more comprehensive understanding of the financial obligations that should be retained by the County and assumed by the new entity.

9. HEALTH AUTHORITY LEGISLATION AND TRANSITION PROCESS

Summary of Findings:

- The Department of Health Services, the Chief Administrative Office and County Counsel will all be very involved in the analysis and preparations for implementation of a health authority to govern Los Angeles County's hospital and health care system. To formalize and facilitate these efforts, the Board of Supervisors should appoint a health transition team comprised of representatives of those departments, health care professionals from within and external to the County system and consumer representatives. The main task of the transition team should be preparation of a health authority implementation plan. This approach, used in other jurisdictions, would bring cross-departmental cooperation, accountability and continuity to the process.

- The transition team's tasks should also include development of draft State legislation needed to authorize creation of the health authority. The legislation authorizing creation of a health authority in Alameda County should be used as a model, with some modifications specific to the needs and principles of a health authority in Los Angeles County. The Alameda County implementation plan could also be used as a model, though it was prepared after the enabling State legislation was adopted, so should be expanded for Los Angeles County to include tasks that the County should perform to prepare for drafting the legislation.

RECOMMENDATIONS

Based on the above findings, it is recommended that the Board of Supervisors:

9.1 Appoint a health authority transition team comprised of representatives of the Department of Health Services, County Counsel, the Chief Administrative Office, health care professionals from within and external to the County system, consumer representatives and other County representatives as needed, responsible for preparation of a detailed transition plan needed for implementation of a separate health authority in Los Angeles County.

9.2 Direct the transition team to identify the areas where outside counsel or other expertise will be needed to assist with certain implementation issues and report back to the Board of Supervisors with the estimated costs and timelines for procuring such services.

9.3 Assign responsibility and due dates for each implementation plan task and classify each as one of the following: 1) issues to be resolved prior to drafting of enabling legislation; 2) issues to be resolved prior to drafting of necessary County Code and Charter amendments; 3) issues to be resolved prior to transfer of authority to the health authority; and, 4) issues to be resolved after transfer of authority to the health authority.

9.4 As part of the implementation plan, direct the transition team to prepare draft State legislation to enable creation of a health authority in Los Angeles County, including each of the components outlined in Exhibit 9.1 of this report.

9.5 Determine a sponsor in the State legislature to introduce the proposed legislation.

COSTS AND BENEFITS

The primary costs of implementing these recommendations will be County staff time for participation on the transition team. The use of outside counsel and possibly other experts needed to assist in this effort will result in direct County costs of an amount that cannot be determined at this time. The benefits of implementing these recommendations will include a process for transition to a new health authority that is well planned and executed, with all key areas addressed and decided on based on thorough analyses of all key issues. This will assist the health authority smoothly begin it operations and start achieving its mission as soon as possible: the cost-effective provision of high quality health care services to the indigent and medically needy.

INTRODUCTION

The Harvey M. Rose Accountancy Corporation is pleased to present this *Analysis of Implementing a Health Authority for the Los Angeles County Hospital and Health System*. This study was conducted in accordance with the Harvey M. Rose Accountancy Corporation task plan submitted and approved by the FY 2004-05 Los Angeles County Civil Grand Jury in December 2004.

PROJECT PURPOSE AND SCOPE

The purpose of this analysis as defined by the FY 2004-05 Los Angeles County Civil Grand Jury, is to determine the necessary steps for Los Angeles County to take to create an independent health authority. This Health Authority would provide a governance entity through which hospital and health services currently provided by the Los Angeles County Department of Health Services and other County departments could be provided more efficiently and effectively. Whereas other County analyses and studies have considered whether or not a health authority should be created, this audit commences with the premise that the question to answer is not whether to create a Health Authority, but rather how best to create a Health Authority

After reviewing the current state of the Departments of Health Services and Mental Health and various alternatives available, the FY 2004-05 Los Angeles County Civil Grand Jury concluded that creation of a separate health authority is the recommended course of action for Los Angeles County. Creation of a singular purpose health authority governing board comprised of individuals with training and expertise in hospital and health care operations would provide the opportunity to realize improvements in the areas that have been affecting the County's hospital and health system for years: operational efficiency; quality of care; and, fiscal stability. The Grand Jury defines a health authority as, "a separate public entity existing independently of local government and governed by a separate board, often with involvement of local government." One such model that the Grand Jury reviewed was Denver Health, the primary safety net health system that provides medical services to uninsured, Medicaid and insured patients in the City and County of Denver.

The scope of the study included all components of the Los Angeles County Department of Health Services (DHS), the Department of Mental Health (DMH), the Board of Supervisors as the governing body over the County's hospital and health system and other County departments that provide support services to DHS and DMH, particularly County Human Resources, the Internal Services Department, the Auditor-Controller and the Chief Administrative Office. The focus of the study was the County's hospital and health system but the components of that system were not defined at the outset of the study. Instead, the recommended components of County government to be placed under the governance of a separate health authority were defined as part of this analysis, as discussed in Section 1 of this report.

PROJECT METHODS

The *Analysis of Implementing a Health Authority for the Los Angeles County Hospital and Health System* was conducted in accordance with *Government Auditing Standards, 2003 Revision* by the Comptroller General of the United States, United States General Accounting Office[1]. This publication provides guidance to auditors who perform audits and financial analyses of governmental entities. The standards provide an "overall framework for ensuring that auditors have the competence, integrity, objectivity and independence in planning, conducting and reporting on their work."

Methods used to complete the study included interviews with all key managers and staff at DHS and DMH and directors or representatives of the Chief Administrative Office, the County Department of Human Resources, the Internal Services Department, the Auditor-Controller, the Los Angeles County Employees' Retirement Association (LACERA) and external stakeholders. Previous studies on alternative governance structures for the hospital and health system in Los Angeles County and elsewhere were reviewed and other jurisdictions that have established health authorities or alternative governance structures were reviewed and contacted for interviews in some cases. Budget, staffing and workload data were collected from DHS and DMH to assess the current state of both departments and for analyses of how governance by a health authority might affect operations. Key business processes were mapped and analyzed to determine if they could be streamlined under a health authority. Sample cases were reviewed from DHS' hiring records and procurement and contracts records. The current and planned state of information technology at DHS was reviewed and analyzed. Focus groups were conducted with managers from the County's hospitals and comprehensive health centers.

Board of Supervisors' agendas, transcripts and media coverage were reviewed from the 1990s through the present. The County's cost allocation plan as it pertains to DHS was reviewed in detail with Auditor-Controller staff. Retirement, insurance and County asset records were reviewed and analyzed to determine the impact in these areas from conversion to a health authority.

PROFILE OF THE LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

Los Angeles County, covering 4,061 square miles, had a recorded population of 9,871,506 persons in 2003, representing 28 percent of all Californians. This population is greater than all but eight of the 50 states in the United States according to Census Bureau data. In 2000, the Census Bureau documented that 14.4 percent of families and 17.9 percent of individuals living in Los Angeles County had incomes below the poverty level. The Los Angeles County Department of Health Services has the responsibility and obligation under California Welfare & Institutions Code to provide some level of health care to the

[1] Now the Government Accountability Office.

indigent and the County of Los Angeles has chosen to provide health services to the uninsured and under-insured. The following description of the Los Angeles County Department of Health Services is posted on the County's website[2]:

> The Los Angeles County Department of Health Services (DHS) is the second largest public health system in the nation providing direct patient care and public health services for its 10 million county residents. DHS is the major source of medical care for the more than 2 million residents without health insurance and provides the vast majority of all uncompensated medical care in the county. DHS has an annual budget of more than $3 billion, employs more than 22,000 individuals and is governed by the Los Angeles County Board of Supervisors.

In its 2003-04 Annual Report, the Department of Health Services described itself as follows:

> The Department operates the nation's second largest public health system, with five hospitals, one multi-service ambulatory care center, six comprehensive health centers, a network of more than 100 public and private primary care clinics, and 11 public health centers. The department is responsible for providing a full range of health services, such as communicable disease control and treatment; preventive and investigative public health functions, including the prevention of infectious diseases; trauma and emergency medical care; primary, specialty, and hospital inpatient services; training of health care professionals; environmental management programs, such as restaurant inspections; substance abuse and treatment; HIV/AIDS prevention and treatment services; and enforcement of all state and county laws related to public health.

The County hospital and health system and Department of Mental Health, with budgeted staff exceeding 24,000 positions, constitute a complex, organization and combined set of programs and divisions. The Department of Health Services expects to provide approximately 600,000 inpatient bed days during FY 2004-05 and to provide approximately 3.5 million ambulatory care visits across the medical, mental health, alcohol and drug and public health service programs. Patients and clients accessing services across the system may or may not recognize the various providers they encounter as members of a single system; and integration of the various programs is challenging, given the enormity of the services alone. The Los Angeles County Charter, Section 22, establishes that the Director of Hospitals as the authority under the Board of Supervisors to supervise the County's hospitals as well as other health institutions and activities, as indicated by ordinance or law. The organizational chart of the County of Los Angeles reflects a structure where the Board of Supervisors, as established by ordinance, appoints the Director of Hospitals, currently referred to as the Director of Health Services.

[2] http://lapublichealth.org/phcommon/public/unitinfo/unitdirview.cfm?unitid=68&alphalist=all

Fiscal Year 2004-05 Final Approved Budget

Table I.1 depicts the Fiscal Year 2004-05 Final Approved Budget of the Los Angeles County Department of Health Services at the broadest level possible, based on a budget summary schedule provided by the Department. The primary categories include budgeted expenditures, budgeted revenue, the subsidy required from the County General Fund and other sources to continue to operate, and total funded positions.

Table I.1
Fiscal Year 2004-05 Final Approved Budget
Los Angeles County Department of Health Services
($ in millions)

	Hospitals	Comprehensive/ Commty. Health Centers	General Fund	Other	Total
Expenditures	$2,204	$205	$1,018	$45	$3,472
Revenues	1,501	110	794	6	2,410
Subsidy [1]	704	95	225	39	1,063
Positions	16,660	1,694	5,897	86	24,337

Source: DHS Finance Department

[1] Subsidy is defined as the required General Fund contribution to maintain operations in a fiscal year.

The budgeted subsidy of the Los Angeles County Department of Health Services has grown 39 percent since FY 2001-02, when it equaled $763,744,000. This increase and the projected additional subsidy necessary when the federal waiver expires, represent what many consider to be a pending crisis in Los Angeles County.

Hospitals

The Hospitals budget of the Department of Health Services includes five hospital sites and one ambulatory care center that constitutes 61 percent of the entire DHS budget, an amount equal to $2.204 billion in FY 2004-05. The DHS Hospital sites range significantly in size and the scope of services provided, ranging from a Rehabilitation Center to a large County/University hospital. Ultimately, the responsibility to maintain these hospitals rests with the Board of Supervisors, which acts as the governing body of the entire Health System. In addition to the hospitals within the Los Angeles County Department of Health Services, there is an extensive network of over 100 private and not-for-profit hospitals across Los Angeles County according to the California Office of Statewide Health Planning & Development.

Table I.2
Fiscal Year 2004-05 Budgeted Financial Data

LA DHS Hospital Locations

	LAC+USC	Harbor/ UCLA	MLK Jr./ Drew	Rancho Los Amigos	Olive View	High Desert	Total
Budgeted Expenditures (in millions)	$925	$409	$359	$186	$269	$57	$2,204
Budgeted Subsidy (in millions)	$323	$96	$107	$68	$72	$38	$704
Subsidy as Percentage of Total Budget	35.0%	23.4%	29.7%	36.7%	26.7%	66.9%	31.9%
Budgeted Positions	7,071	3,092	2,887	1,393	1,830	388	16,660
Expected Average Daily Census	745	332	204	191	171	-	1,643
Expected Ambulatory Care Visits	498,689	273,637	167,861	54,294	180,368	61,100	1,235,949

Source: DHS Finance Department

Comprehensive and Community Health Centers

The Los Angeles County Department of Health Services provides ambulatory health care through its regional clinics, operated by both DHS and private and not-for-profit agencies. There are over 100 clinic locations according to the DHS web site where clients can access primary care health services. A major focus of the Department has been to increase clinic visits and better integrate the clinic, specialty and inpatient systems within the County.

Table I.3
Comprehensive and Community Health Centers by Region
Fiscal Year 2004-05 Budgeted Financial and Expected Utilization Data by Region
($ in millions)

	Northeast	Coastal	Southwest	San Fernando Valley	Antelope Valley	Total
Budgeted Expenditures	$98	$25	$32	$33	$17	$205
Budgeted Subsidy	$48	$11	$10	$15	$10	$95
Subsidy as Percentage of Total Budget	49.2%	45.5%	31.5%	46.3%	60.3%	46.4%
Budgeted Positions	759	182	342	288	123	1,694
Expected Ambulatory Care Visits	397,417	108,867	145,475	125,084	52,868	829,711

Source: DHS Finance Department

General Fund Units

In addition to the hospital and ambulatory care services of the Department of Health Services, General Fund departments provide various public health, managed care and substance abuse services. The Department of Mental Health is not included in the DHS budget and constitutes an independent budget unit. Table I.4 displays the Final Approved FY 2004-05 Budget information for the programmatic DHS General Fund Departments.

Table I.4
Fiscal Year 2004-05 Budgeted Financial Data for DHS General Fund Departments

	Budgeted Expenditures (in millions)	Budgeted Subsidy (in millions)	Subsidy % Total Budget	Budgeted Positions
AIDS Services	$87	$16	18.3%	238
Alcohol & Drug	$151	$4	2.5%	210
Children's Medical	$86	$25	28.5%	953
Public Health	$299	$125	41.7%	2,675
Health Svs. Admin.	$261	$50	19.2%	1,440
Office of Managed Care	$128	$(0)	-0.1%	191
Juvenile Court Services	$6	$6	98.6%	190
Total	$1,018	$225	22.1%	5,897

Source: DHS Finance Department

Department of Mental Health

The Department of Mental Health (DMH) in Los Angeles is a separate General Fund Department that is not organizationally located within DHS. DMH acts as a "purchaser" of inpatient mental health services from private and community hospitals, including four DHS hospitals.

Table I.5
Department of Mental Health Budget Information
Approved Fiscal Year 2004-05 Budget from County Approved Budget Document
($ in thousands)

	FY 2002-03 Actual	FY 2003-04 Actual	FY 2004-05 Final Approved
Adjusted Expenditures*	$977,014,628	$985,299,937	$1,013,876,000
Revenue	861,422,020	851,337,225	907,984,000
County Contribution	115,592,608	133,962,712	105,892,000
Positions	2,801.0	2,856.6	2,861.6

* Includes Intrafund transfers

Source: County of Los Angeles Final Approved Budget (lacounty.info/budget.html)

Proposition 63, which went into effect on January 1, 2005 will provide additional financial resources to the Department of Mental Health. Portions of allocated Prop 63 funds may ultimately support innovative and necessary mental health programs and services in other County Departments, including Alcohol and Drugs, Probation, DHS inpatient units and correctional medical care.

ALTERNATIVE GOVERNANCE OF PUBLIC HOSPITAL AND HEALTH SYSTEMS ELSEWHERE

In a 2002 survey by the National Association of Public Hospitals and Health Systems, only 40 percent of respondents reported that they were operated directly by their local or state government. The survey report states that local government control,

> "… offers little flexibility and often imposes civil service requirements, procurement rules and sunshine laws. These requirements provide health systems little autonomy, affecting their ability to plan strategically and to react proactively in competitive situations."

In California and across the United States, alternative governance structures have been established in an effort to sustain the provision of healthcare services to indigent, uninsured and underinsured persons. While a thorough comparison of other jurisdictions with Los Angeles County was not part of the scope of this

study, the report includes references and comparisons to other jurisdictions with health authorities or alternative governance structures when relevant and appropriate. A primary difference between the obligations of the various entities may be the specific definition of indigence in each state and the statutory obligation of the local jurisdiction to provide a defined level of health care to such individuals.

Denver Health

Since 1997, an independent Board of Directors that is separate from the City and County government, has governed Denver Health. Prior to 1997, the Denver Health system was part of Denver's City and County government organization. The Board of Directors is comprised of nine members appointed by the Mayor of Denver and includes physicians and health professionals. The Board's responsibilities include financial management; education and quality assurance; and personnel and compensation matters. Denver Health offers a managed care approach to health care through its integrated system of hospitals, community health centers, school-based clinics, substance abuse and mental health services, and advice line and public health services. The reported benefits of such a large integrated system is that a managed care approach can be used; primary and specialty care access can be coordinated so that patients receive the most appropriate level of service in the least costly environment. At Denver Health, for example, many patients reportedly receive primary care at less costly community health centers rather than hospital emergency rooms. And because the system is integrated, community health center costs can be subsidized by hospital revenue.

Alameda County Medical Center

The Alameda Alliance for Health was created under the enabling legislation adopted by the State to create MediCal managed care programs in California counties. Because Alameda County was creating a Health Authority at the time, special legislation was adopted and included in California Welfare and Institutions Code § 14087.35 that merges the enabling legislation to establish a Health Authority and the authority to create the County's MediCal Managed Care Plan. The composition of the 11 member Board that governs the Health Authority is laid out in the W&I Code, and includes a member from the Alameda County Medical Center (ACMC). ACMC includes hospital and ambulatory care centers; services to indigent and MediCal clients are augmented by Highland Hospital, a facility managed by the Health Authority.

New York City Health and Hospitals Corporation

The following description of the New York City Health and Hospitals Corporation (HHC) is drawn from the City's website:

> The New York City Health and Hospitals Corporation (HHC) was created by legislation in 1970 as a public benefit corporation, governed by a Board of Directors, to oversee the City's public health care system in all five boroughs. The Corporation consists of 11 acute care hospitals, 6 Diagnostic and Treatment Centers, 4 long-term care facilities, a certified home health care agency, and more than 100 community health clinics, including Communicare Centers and Child Health Clinics. Through its wholly owned subsidiary, MetroPlus, HHC operates a Health Plan which enrolls members in Medicaid, Child Health Plus and Family Health Plus. HHC facilities treat nearly one-fifth of all general hospital discharges and more than one third of emergency room and hospital based clinic visits in New York City. Source: http://www.nyc.org/html/hhc/html/about/faq.shtml

According to a presentation by the former CEO and President of the NYC HHC to the Robert Wood Johnson Clinical Scholars Program in November 2004, the system had made significant gains in both the application of technology in the healthcare environment and in delivering preventive care to the system's population. However, a more recent press release indicates that the FY 2005-06 budget as proposed by the Governor's office could result in a loss of over $300 million, and require reductions in services and benefits.

In New York City, a separate Department of Health and Mental Hygiene includes traditional Public Health functions such as disease control, environmental health and epidemiology. The mission of this Department is to "Protect and promote the health of all New Yorkers," and it is therefore similar to the Los Angeles County Public Health Department in its statutory focus on all residents rather than those who are under or uninsured. The Department of Mental Hygiene manages the provision of mental health and chemical dependency services, as well as services to developmentally disabled persons. (Source: New York City Health and Hospitals Corporation Website)

Hennepin County, Minnesota

Beginning in June of 2004, Hennepin County began a process to investigate and ultimately create a public-benefit corporation to govern public healthcare services in the County. To date, the Governance Committee has reported back to the County Board, and on January 14, 2004 the Board approved a resolution to seek legislative authority of the creation of the new entity and the eventual transfer of the hospital and its employees on January 1, 2006. HF1827 has been introduced and as of April 13, 2005 was under consideration by a Committee in

the Minnesota State Legislature. According to a House Bill Summary, HF1827 would, in part, create the "Hennepin Healthcare System (HHS) as a public corporation and subsidiary of Hennepin County to take over the operation and management of Hennepin County Medical Center. The county has two county commissioners on the corporation's board and reserves powers over the corporation related to its mission, budget, ability to incur debt, governance and care for the indigent".[3]

Maricopa County, Arizona

In July 2003 the Governor of Arizona signed House Bill 2530 that allowed Maricopa County to create a voter-approved district to operate its county healthcare system. The legislation describes the governance of the district and its obligation to provide healthcare services within a three-mile radius of the previous hospital for at least ten years. A fact sheet on the legislation from the Arizona State Legislative website provides the basis for the County and the Legislature creating the Special Healthcare District:

> The Task Force concluded that MIHS (Maricopa Integrated Health System) is facing a financial crisis due to the uncompensated care incurred, pressures on county expenditure limits, loss of income from the shift to competitive bidding for long-term are contracts, loss of federal and state disproportionate share hospital (DSH) program funds and lack of capital improvement funding.[4]

In November 2004 the County of Maricopa and the Maricopa County Special Health Care District executed an amended Intergovernmental Agreement detailing the responsibilities of each party, the details of the phased transfer of Medical Staff, assets and liabilities from the County to the District.

[3] http://ww3.house.leg.state.mn.us/hrd/bs/84/HF2187.html
[4] Fact Sheet for H.B. 2530/S.B. 1359, www.azleg.state.az.us

PREVIOUS STUDIES OF ALTERNATIVE GOVERNANCE STRUCTURE FOR LOS ANGELES COUNTY'S HOSPITAL AND HEALTH SYSTEM

Four key prior studies concerning alternative governance structures for the Los Angels County hospital and health system were reviewed: 1) a 1995 study by Burt Margolin, the Crisis Manager for the Los Angeles County Health Crisis Center; 2) a 2001 study by the Los Angeles County Chief Administrator's Office; 3) a 2002 study by the Ad Hoc Hearing Body on Governance; and 4) a 2003 study by the University of Southern California Keck School of Medicine School of Policy, Planning & Development. The following summarizes the findings from each of these studies.

The 1995 Burt Margolin Study

On August 1, 1995, in response to a request from the Board of Supervisors, Mr. Burt Margolin, Crisis Manager for the Los Angeles County Health Crisis Center, submitted recommendations to the Board of Supervisors regarding the governance of the Department of Health Services. In this report, Mr. Margolin proposed establishing a semi-autonomous Health Authority to oversee the Department of Health Services. In determining which governance system would be best, Mr. Margolin reviewed the experience of other jurisdictions. He found a wide range of governance models have been employed which vary considerably in the degree of independence from an elected body, breadth of decision-making powers, and involvement in the day-to-day management of operations.

Exhibit I.1
Alternative Hospital and Health System Governance Structures

AUTONOMOUS GOVERNANCE STRUCTURES		SEMI-AUTONOMOUS GOVERNANCE STRUCTURES	
Public Benefit Corporation	Health Authorities	Semi-Autonomous Health boards or commissions	Advisory Governance Structures
• New York Health and Hospitals Corporation • Hawaii	• Dallas • Louisiana Health Authority • Denver Health & Hospital Authority	• San Francisco Health Commission • Sonoma County • Monterey County	• San Luis Obispo County • Ventura County

Mr. Margolin concluded that simply transferring one of these existing models to the County would not be the best course of action. Instead, he recommended a semi-autonomous health authority designed specifically for the needs of Los Angeles County. Although the independent health authority was suggested by many involved in the governance discussion, Mr. Margolin did not recommend

the completely autonomous health authority because he believed the changes needed were so far reaching that the Board of Supervisors needed to retain a role in the ultimate ratification of the restructuring. Also, Mr. Margolin believed a fully autonomous health authority would require a County charter amendment or specific State Legislation which would focus scarce resources on changing the process rather than on health care policy and finance issues which he found to be more important.

Under Mr. Margolin's proposed semi-autonomous health authority structure the health authority would have responsibility for developing and presenting major policy and implementation recommendations for the Department of Health Services. These recommendations would be submitted to the Board of Supervisors who would ratify them by a simple yes or no vote.

The board, under Mr. Margolin's proposal, would be made up of seven individuals who are recognized experts in the health field and possess experience in areas such as public policy, business, finance, and labor. These members would serve on a voluntary basis. The chair and vice-chair of the authority would be selected by the authority's membership.

Mr. Margolin proposed that the semi-autonomous health authority would meet with the Director of Health Services, at a minimum, biweekly to receive budget and policy recommendations. The Director would continue to report to the Board of Supervisors on the day-to-day operation and management of the Department. The health authority would have delegated authority by the Board of Supervisors for approval of contracts up to a set amount, without subsequent ratification by the Board.

Mr. Margolin's report recommended several initial items upon which the authority would focus, such as analysis of the DHS budget, development of mechanisms to respond to changes in health care financing, and access to funding strategies to meet future health service needs.

The 2001 Los Angeles County Chief Administrative Office Study

On August 29, 2001, Mr. David E. Janssen, Chief Administrative Officer (CAO), submitted an analysis of various governance models for the County's hospital and health system to the Board of Supervisors.

In this analysis, the CAO considered four possible governance structures: the health commission; health authority; private non-profit public-benefit corporation; and health care district. Under any of these models, the report points out that the ultimate responsibility of meeting the Welfare and Institution Code Section 17000 obligation would remain with the County.

The analysis considered the following criteria for evaluating the alternative structures: (a) span of control and degree of separation from County rules and policies, (b) ability to meet the county's obligation to care for the indigent, (c)

impact on organizational flexibility, both personnel and contracting/procurement, (d) revenue and budget implications, (e) relationship of the entity to the County government, (f) application of special laws affecting public entities, and (g) interaction with the Medicaid 1115 Waiver.

The CAO concluded that the benefit of implementing one of these alternative governance models would be an increase in the flexibility related to contracting, procurement, and personnel activities. Elsewhere, he reported that these alternative models have increased the ability of the systems to establish specific job classifications and compensation levels that improve their ability to hire and retain medical personnel. Alameda County Medical Center, Denver Health and Hospitals, and New York Health and Hospitals Corporation all noted their governance structure have improved their ability to recruit and retain physicians and other clinical personnel. The level of administrative autonomy of any of these governance models is dependent upon the breadth of authority that is vested in the entity by the Board or the enabling legislation upon its creation, according to the CAO.

Financially, the CAO reported that the results of these governance models were more mixed. For Alameda County Medical Center, separation from the County led to a declining investment, both fiscally and politically, in the medical center and its activities. Under a health authority there has been a decreased share of County revenues received. While the New York Health and Hospitals Corporation was financially stable at the time of the analysis, it expected within the following two years to be in a deficit situation, which it attributed, in part, to the fact that the indigent population it served was growing, while the subsidy from the City of New York had remained flat.

The CAO reported that an indirect benefit that may be derived from establishing a new governance model could be increased responsiveness from federal or State officials who may view the change as an indication that the County is seriously addressing the structural issues that have led to the need for repeated infusions of federal dollars. However, given the size of DHS' structural deficit, the report concluded that it is unlikely that an administrative change such as this would solve the Department's budgetary problems.

A key issue for consideration under any of the models, according to the report, was the ability to secure public financing for low-income and indigent patients. With the possible exception of the County's Medicaid 1115 Waiver, the same funding mechanisms presently used to finance DHS would continue to be the primary funding sources. An "1115 Waiver" refers to section 1115 of the federal Social Security Act, which allows the Secretary of Health and Human Services to waive any provision of Medicaid law for direct patient care and demonstration projects that provide program improvement or innovations. Los Angeles County applied for and received two five year 1115 Waivers since 1995 to pay for various aspects of restructuring of the Los Angeles County health system.

The CAO also concluded that because of the sheer size of Los Angeles County it was unreasonable to assume that any of the new governance structures could be implemented either quickly or successfully. The CAO stated that the implementation, including significant planning, could be three to five years.

Since the County would retain legal responsibility to assure that the obligations of W&I Section 17000 to provide medical care to eligible residents is met, there would still be challenges regarding the definition of who is entitled to services under Section 17000 and what services are provided, as well as whether the contracting entity is fulfilling these obligations, according to the CAO.

Under its Memorandum of Understanding with unions, the County must notify the unions of the transfer of operation to another entity. The CAO noted that if the transition to a new entity, such as a health authority, resulted in the elimination of jobs or a significant reassignment of functions, the County would be required to make an intensive effort to reassign or transfer the affected employees to other positions for which they qualify, or train them for new positions in order to retain their services.

The County should consider the costs related to the legal, administrative and personnel costs of transitioning to another governance structure, the CAO stated. During the transition in Alameda County, the health authority's first independent action was to secure their own legal counsel to protect its interest during the contract negotiations with the county; the cost was approximately $500,000. The legal and administrative costs could be significantly higher for LA County since they have six hospitals instead of one and the health system is more complex.

Upon transfer to a health authority, the CAO reported, employees would no longer be part of the County civil service though they could opt to return back to the County. The CAO noted that based on the results of Alameda, of the 24,000 budgeted position in DHS, approximately 400 employees would opt back into the county civil service system, if the 1.7 percent remains true for DHS. However, if there is a greater number of employees opting to continue their civil service status and to the extent they are not able to be absorbed back in the system, the County could face potential layoffs and union involvement in the transition, according to the CAO.

Based on their experience, the Alameda County Health Authority believes there are cost savings by purchasing services elsewhere or by providing the services in-house. They estimate overhead represents approximately 25 percent of the total cost to purchase services from other county departments. The analysis points out that if the governance structure that is established determines to purchase services from providers other than the County departments, the County will need to address the impact to these departments regarding the loss of revenue from DHS.

The 2002 Ad Hoc Hearing Body on Governance Study

On September 4, 2001, the Los Angeles County Board of Supervisors received a report from the CAO that outlined a series of options related to the governance of public health care delivery systems. One of these options was the Health Authority. In response, the Board of Supervisors established an Ad Hoc Hearing Body on Governance, to hold a public hearing and evaluate options for governance. The Ad Hoc Hearing Body was instructed to evaluate the creation of a separate Department of Hospitals, within the current governance structure, which would oversee the provision of both inpatient and outpatient health care services. The Ad Hoc Hearing Body was also expected to identify whether a Health Authority could create a mechanism to charge a fee for certain services for which the County does not presently charge. A major consideration in the evaluation of the several options was whether access to patient care services would be limited by a change in governance to a model such as a Health Authority.

The Ad Hoc Hearing Body on Governance broke into three Task Forces to consider the legal, fiscal, and administrative issues pertaining to the selection of a new form of governance. Several conversations were also held with Denver Health Authority and Alameda County Health Medical Center. Public testimony was heard by individuals and organizations that interact with the Department of health Services.

Both Denver Health Authority and Alameda County Medical Center agreed that the greatest benefit realized from the new governance structure was increased autonomy with regard to personnel, contracting, and procurement. A strong relationship with the city, both fiscally and operationally, was a strength for Denver while the lack of this relationship had created challenges for Alameda.

The study notes that the task force determined that DHS' fiscal problems were secondary to the issues of flexibility, autonomy, and accountability and should be addressed at the time of the transfer of authority to a new entity.

Key legal factors pertaining to a Health Authority were identified. As an entity separate from the County, a Health Authority would not be subject to Beilenson requirements, reducing public involvement significantly according to this report. Since state statute establishes a Health Authority it could be written to include whatever its authors' desire. A Health Authority would have access to the same funding sources that presently exist but would set its own budget apart from the County budget, according to the study. The report stated that the Health Authority would not be subject to civil service or County contracting or procurement rules and would be required to obtain licenses for non-hospital clinics, which are currently exempt. Because of State corporate practice of medicine laws, the reports stated that the Health Authority would be prohibited from directly employing physicians. The County would still have the legal mandate to provide and/or pay for health care services to the indigents.

According to the study, those in support of the Health Authority noted that the reform and redesign should include the consideration of the 2.5 million of uninsured in Los Angeles County. With decreased funding for DHS, starting with passage of Proposition 13, the report stated that new governance should be able to increase funding available. The study points out that DHS has assumed the role of provider of emergency and trauma services, which has allowed the private hospitals to survive. Changes to the County based care must also consider the impact it will have on the private care system.

The Ad Hoc Hearing Body recommended that the Board of Supervisors not make any change to governance of the hospital and health system at the time, but should first attempt to make improvements recommended by a previous Blue Ribbon Commission. If these changes were not accomplished within 12 months, the Ad Hoc Hearing Body recommended that the Board of Supervisors explore the desirability and feasibility of establishing a health authority to govern the Department of Health Services.

The 2003 University of Southern California Keck School of Medicine Study

This study revisited the issue of alternative governance by describing its potential for stabilizing the health care system in Los Angeles County, and understanding stakeholder views about the relevance, potential benefits and obstacles to accomplishing system reform and stabilization.

Over the past 20 years, the study reported that DHS has been through major cutbacks, threats of closures and public health emergencies. The crisis of 1995 nearly shut down the system and the federal government responded with nearly $1 billion in federal aid-commonly through the first of two five year Medicaid Waivers. The study notes that with the expectation of the expiration of the second and final waiver in 2005, the County will face new crises and discussions about the benefits of new governance.

The authors of the study recommend a new governance to help stabilize the county health care system, improve efficiency and attract new revenue. A governance change, they say, will entail substantial transition costs and so must provide substantial long-term benefits for the County's mission to serve the indigent population of Los Angeles and protect and improve the health of the public.

Key stakeholder interviews conducted by the authors revealed several concerns about new or alternative governance. Opponents argued that new governance would not solve the underlying structural problems facing the health care system, which include insufficient revenue and high numbers of uninsured. Also, new governance was not needed to address existing administrative problems. Moreover, governance change could not achieve the desired integrated planning or enhanced role for consumers and it might not be effective. Finally, others argued that governance change would create new problems for the system. Some say it could diminish the county's commitment to maintain indigent

services as mandated by State law and merely add a new layer of bureaucracy, reduce revenues, destabilize the private system by increasing competitive pressure on private hospitals for 3rd party reimbursement, and eventually lead to privatization and a loss of jobs.

Supporters indicated that new governance would lead to more efficient and effective decision making by removing the politics from decision-making, by promoting system-wide planning and program integration, by defining target populations, and by providing new opportunities for community input. Many also felt that new governance could help make the health care system more competitive within the existing health care market, thus enhancing revenues. Finally, supporters argued that new governance would enable the BOS to focus more attention on broad public health issues, such as reducing the number of uninsured and protecting and promoting health, and less on day-to-day administrative issues.

The authors propose an independent Authority created by the State Legislature in cooperation with the County of Los Angeles to operate personal health services, primarily hospitals and ambulatory care centers. This model would separate the administrative oversight of personal health services from policy development and most core public health services. The delivery of health services, including mental health, would fall under the new Authority. Core public health activities, including environmental health would remain as a direct county function. The provision of clinical preventative services such as communicable disease treatment, and family planning would fall under the Authority. The Board of Supervisors would assure health care to the poor through a contract with the Authority.

1. HEALTH AUTHORITY COMPONENTS AND ROLE

- **A number of proposals to create a Los Angeles County health authority have been made over at least the past ten years. However, the health services components included in each proposal have differed greatly and have been vaguely defined.**

- **Until recently, these proposals have not fully addressed whether responsibilities related to mandated public health or mental health services should be retained by the County or absorbed by the health authority. Further, these proposals have not answered critical questions related to the complex responsibilities for providing indigent medical care services defined by California Welfare and Institutions Code Section 17000, case law and policy of the Board of Supervisors.**

- **Before considering the complex governance, operational, funding and legal questions associated with the creation of an independent health authority, the Board of Supervisors, with input from the Department of Health Services (DHS) and the healthcare community, should clearly define the health authority's mission and functional components. A preferred model would: transfer authority and responsibility for all personal health services now provided by DHS including hospitals, ambulatory care centers, comprehensive health centers and personal health clinics, to the health authority; charge the health authority with the responsibility for providing specified levels of healthcare services to the uninsured and indigent; and, establish emergency and acute psychiatric care services at levels negotiated with the Department of Mental Health. Public Health services, Emergency Medical Services and other broad regulatory or coordination functions should be retained by the County. The Department of Mental Health should remain an independent County department that is separate from the health authority.**

Since at least 1995, the Los Angeles County Board of Supervisors has received recommendations to modify the governance structure of the health services delivery system within the County. Plagued with the ongoing financial crises experienced by the Department of Health Services (DHS), the various experts

commenting on the system have made recommendations focusing primarily on the need to establish a health authority that would govern hospital and clinic services provided to the County's uninsured and indigent population. Common to all proposals has been the perception that the creation of a health authority would provide opportunities for improving governance, create administrative flexibility for functions such as human resources administration and procurement, and make the services more cost effective. However, there has been little analysis or discussion in the previous recommendations regarding the health authority's mission or of the DHS and non-DHS components of the County's health care delivery system that should be transferred to the proposed authority or retained by the County.

In 2001, representatives from the University of California at Los Angeles (UCLA) School of Public Health, the Los Angeles County Medical Association (LACMA) and the University of Southern California (USC) School of Medicine formulated recommendations that would charge a health authority with the responsibility to provide "hospital services, ambulatory medical services, emergency medical services, and *perhaps* school clinics, mental health and *possibly* correctional health" (emphasis added).[1]

Following those recommendations, in May 2003, the University of Southern California conducted *An Analysis of Alternative Governance for the Los Angeles County Department of Health Services,*[2] which went further than any of the earlier studies and made specific recommendations regarding the components of an independent health authority. That report described "the key components of the new Authority," as follows:

- "The Board of Supervisors ensures California Welfare and Institutions Code Section 17000 obligations and other mandated services through a contract to the Authority.
- The new Authority would govern the delivery of mental health, and drug and alcohol services.
- Core public health services remains separate and directly under the control of the Board of Supervisors.
- All funding for safety net will fall under the Authority, including DSH dollars."

Therefore, under this 2003 proposal, the health authority would be given responsibility for providing physical health services to the indigent and uninsured

[1] An ad hoc task force, composed of Dr. Lester Breslow, UCLA School of Public Health, Dr. Brian Johnson, Los Angeles County Medical Association, and Dr. Robert Tranquada, USC School of Medicine, *Health Authority for the County of Los Angeles - A Summary,* submitted in response to a Board of Supervisors request for the Chief Administrative Officer to study Health Authority governance options, July 2001

[2] Division of Community Health, Department of Family Medicine, USC Keck School of Medicine and the USC School of Policy Planning and Development, *An Analysis of Alternative Governance for the Los Angeles County Department of Health Services,* A Report to the John Randolph Haynes and Dora Haynes Foundation, May 2003

population under contract with the County (broadly referred to as "safety net services"), mental health services, and alcohol and drug treatment services. The County would retain responsibility for providing "core" Public Health services.

The rationale for leaving the core Public Health functions with the County was described by the USC team, as follows:

> "Several respondents felt that new governance would enable the DHS to focus more on its core public health responsibilities. Many felt that all services currently under DHS (including public health) would fall under the new Authority, while others felt that keeping public health separate from the Authority made administrative and legal sense. By preserving core public health as a county function, and shifting the delivery system under new governance, the County can better focus attention on disease prevention, environmental health and broad health assurance functions."

Although recommended, the report did not provide a rationale for transferring mental health or alcohol and drug treatment services to the new Authority. In addition, there was no recommendation or discussion regarding the responsibility for the placement of correctional health or juvenile court services within the new health services structure.

CURRENT ORGANIZATION OF HEALTH RELATED FUNCTIONS IN LA COUNTY

The current organization of health related functions in the County of Los Angeles is steeped in the history of the County and decisions that were made many years ago by previous boards of supervisors. The current Department of Health Services provides a wide range of services, but is focused primarily on safety net medical services that are provided through a combination of its five hospitals, one ambulatory care center, six comprehensive health centers and clinics, and through various contracts with private providers that serve uninsured and indigent patients whose care would otherwise be the direct responsibility of the County.

While most of the Department is directed toward this mission, a review of the DHS organization suggests that there are several functions that do not fully align with the safety net patient care emphasis of the rest of the Department. These include:

- Public Health (4,062 positions) - charged with a variety of functions that are designed to monitor, assess and report on the broader public health concerns of the Los Angeles County community; regulate health safety and the spread of communicable disease; coordinate health services that are provided by both public and private organizations within the County; and, educate the public concerning certain health risks. In addition, Public Health has been charged by the Board of Supervisors with overseeing direct patient care provided by contract through the Alcohol and Drug Program Administration section (ADPA).

- Emergency Medical Services (181 positions) - charged with coordinating emergency medical services that are provided by disparate agencies throughout the County, including fire departments, private ambulance companies, and public and private hospitals.

- Managed Care (136 positions) - charged with a managed care insurance function for a segment of the MediCal patient population and certain other select groups, that is akin to the managed care insurance function performed by Health Maintenance Organizations (HMOs) in the private sector.

- Juvenile Court Services (190 positions) - charged with providing medical services to juveniles who are housed in County juvenile institutions, such as the juvenile halls.

In total, these activities have been allocated 4,569 of the 24,303 DHS positions in FY 2004-05, or 18.9 percent of the Department's total workforce. In the same year, total expenditures for these services exceeded $470 million of the Department's $3.5 billion operating budget, or approximately 12.4 percent.

In addition to the DHS health services described above, the County provides mental health services through an organizationally independent department. The separate Department of Mental Health (DMH) is established in County ordinance and the Director reports to the Board of Supervisors. DMH provides care for patients exhibiting symptoms of mental illness either directly – with its own staff – or through community based contractors. In addition, the Department of Mental Health is the fiscal intermediary that pays MediCal to private sector mental health treatment providers on a fee for service basis.

The following discussion evaluates factors related to the need to clearly define the mission for a new health authority, and analyzes organizational and service complexities that should be considered when the County moves forward with the creation of the health authority.

HEALTH AUTHORITY MISSION

The Department of Health Services is a complex organization that provides a wide array of services to Los Angeles County. One approach for organizing the health authority would be to simply transfer all of DHS and other health related functions (such as the Department of Mental Health) to the new entity. As an alternative, and to maximize the effectiveness of the new health authority, the County should consider taking advantage of this unique opportunity and restructure its existing approach to health care delivery. As part of this restructuring, the County may wish to retain and/or reorganize certain health related functions, while transferring others to the health authority.

Our experience suggests that public sector organizations are most successful when they adhere to the following organizational principles:

- The mission is clearly defined for the public, policy makers and employees.

- Services are focused on a narrow client base which shares common interests.

- The organization is charged with fulfilling complementary mandates and is not required to implement policies that might conflict with one another.

Our analysis suggests that the current organization of DHS does not conform to these principles. Despite its broader mission, the current DHS organization is largely structured to provide safety net medical services to the uninsured and indigent population within the County. Based on interviews conducted for this study, it is clear that most of the organization views this emphasis as its primary mission. Further, the major financial concerns of the Department currently focus on the funding difficulties related to these safety net services.

However, it is also clear that the emphasis on this overriding mission may result in unintended consequences for other parts of the Department. This became clear after interviews and a review of documents, which generated several examples of the organizational consequences arising from the operations of a department that has a broad and varied service delivery structure. The following discussion provide some of these examples.

- Representatives from Public Health and the Mental Health Department spoke of their concerns that service integration within a health authority, which is primarily focused on providing hospital and clinic services to the uninsured and indigent populations, and would be organizationally distant from the County, might diminish the standing of the public health and mental health functions within the organization. Because the direction of the organization may become disproportionately influenced by the overriding safety net health care mission, these individuals expressed added concern that diminished standing could result in losses in funding that otherwise might not occur.

- Several organizations within DHS serve a broad client base with different interests and concerns than the larger DHS organization. For example, a September 2003 report from the Emergency Medical Services (EMS) Agency Director responded to concerns expressed by the EMS Commission that "the EMS Agency's organizational status as part of the Department of Health Services creates potential bias with respect to decisions affecting public and private system constituents." This report was requested when DHS changed its patient transfer policies in a manner perceived by some to adversely impact private sector providers. The EMS Agency, which is charged with coordinating emergency medicine across both the public and private health care systems, was charged with implementing this change.

- An organization such as Public Health is required to fulfill mandates that can be inconsistent with the primary service emphasis of the rest of DHS. As discussed previously and described more fully below, the County's Health Officer is charged with a variety of regulatory, communicable disease control and prevention, and health education functions that are directed toward the general population of the County and not just the uninsured and indigent

populations that receive care at DHS hospitals and clinics. Some services are functionally very distant from the rest of DHS (e.g., restaurant inspections) while others are more closely aligned (e.g., maternal and child health), but few are consistent with the safety net service emphasis that drives most policy and budget decisions at DHS.

As the County considers the formation of a health authority, these types of considerations should be made and addressed within the context of the health authority mission. While there may be benefits from organizational consolidation of disparate services, we believe these are outweighed by the concerns discussed above. By more narrowly defining the health authority as an organization that is primarily focused on providing safety net health services to the County's uninsured and indigent population, the chances for organizational success are strengthened. Further, the impediments resulting from being part of the County have a more detrimental impact on the personal health service functions than they do on the other County functions that have been considered for placement into a health authority.

Welfare and Institutions Code §17000

As discussed in Section 3 of this report, the County's responsibilities related to Welfare and Institutions Code §17000 should be clearly defined in relation to the mission of the health authority. Welfare and Institutions Code §17000 states:

> "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

Section 17000.5 allows boards of supervisors to "adopt a standard of aid, including the value of in-kind aid which includes, but is not limited to the monthly actuarial value of up to forty dollars ($40) per month of medical care." However, Section 17000.51 clarifies that Section 17000.5 "was not intended, and shall not be construed, to do any of the following:

1. Satisfy, in whole or in part, the duty of a county or a city and county to provide health care services to indigent and dependent poor persons under Section 17000.

2. Permit a county or a city and county to cease providing health care services to indigent and dependent poor persons under Section 17000.

3. Affect the eligibility of indigent and dependent poor persons for health care services under Section 17000."

As a result, eligibility for healthcare services has been defined by Los Angeles County as including "General Relief recipients and individuals aged 18 to 64 with income between 100 and 200 percent of the Federal Poverty Level (FPL)."[3]

[3] January 29, 2002, *Department of Health Services Strategic and Operational Action Plan*

Other sections of the law and various court decisions have further complicated this definition. Patients and advocacy groups have previously sued counties in California when attempts have been made to reduce benefits, curtail services or significantly redefine the health care delivery systems, using legal challenges rooted in California statute and federal Medicaid regulations. A recent example occurred when Los Angeles County was challenged in federal court after announcing its intentions to close Rancho Los Amigos Rehabilitation Hospital and reduce the number of beds at the LAC+USC Medical Center.[4]

In its 2002 Strategic Plan, DHS attempted to define the population which the County is legally responsible to serve under the definition previously discussed, and for whom it actually provides services. The Plan stated that, "The legally-mandated population is estimated to be some 700,000 residents of the County. In Fiscal Year 1999-2000, DHS (including the PPP network) provided services to 140,000, or 20 percent of this mandated population. These services included 637,000 outpatient and emergency room visits and 68,000 inpatient days."

It is difficult to measure the proportion of this population that receives services from other community providers or receives no care at all. However, in its Strategic Plan, the Department recognized that in order to reduce the County's costs, the scope of safety net services and service delivery strategies would need to be redefined. According to the Department, opportunities for reducing costs would involve a range of alternatives that would (a) utilize managed care principles for the "legally-mandated" population, (b) discontinue or discourage service for the non-mandated population (e.g., non-County residents), and (c) redefine the scope of services that would be provided by DHS, based on decisions regarding service emphasis. Under each of the scenarios that were presented, the Department anticipated that there could be legal challenges.

Within the scope of this study, we have not evaluated the accuracy of the Department's legally-mandated population projections or made recommendations regarding the scope or level of services that should be provided by a health authority. However, the legislative mandate for the health authority should be designed to include (a) a minimum level of service requirements that meets the minimum service mandate, and (b) sufficient flexibility to permit the County to purchase additional services if determined appropriate by the Board of Supervisors.

ORGANIZATIONAL COMPONENTS OF A HEALTH AUTHORITY

Consistent with the criteria discussed previously in this finding, the health authority should include the following components as the core infrastructure required to provide services to the County's indigent and uninsured population:

---

[4] Harris v. Board of Supervisors, Los Angeles County, Federal Court of Appeals, Ninth Circuit No. 03-56028, and Rodde v. the California State Department of Health Services and County of Los Angeles, United States District Court for the Central District of California, No. 03-55765.

- DHS' five hospitals
- High Desert multi-service ambulatory care center
- Six comprehensive health centers
- Clinics (non public health)
- Public Private Partners (PPPs)

This configuration would appropriately focus the organization's mission, narrow the client base and minimize possible conflicts between the organization's mandates. In accordance with this basic organizational approach, it would therefore be appropriate to disassemble DHS and retain certain DHS functions within the County. The following discussion provides a framework for structuring both County health and health authority functions.

Public Health

As discussed previously, Public Health is a division of the Department of Health Services. As a division of DHS, the Public Health Director reports to the DHS Director for purposes of the budget and administrative management of the Public Health Division. However, the position of Public Health Officer, which is dually held by the Public Health Director, is established in State statute. In this role, the Public Health Officer has independent responsibilities and authorities for certain regulatory, disease control, disease prevention and health education functions.[5]

Most of the functions assigned to the Public Health Officer are defined by these statutes and are typically found in public health departments in California. Very few of the statutes relate directly to the provision of safety net hospital and ambulatory care services to the uninsured and indigent population within the County. Some of the more prominent organizational functions of Public Health that follow this statutory framework are described below.

- Service Planning Area Health Offices - The Public Health Department has established eight Service Planning Areas (SPAs) that operate out of four Area Health Offices. The staff from the Area Health Offices are responsible for planning public health and clinical services according to the health needs of local communities. Such activities may include the coordination of services through DHS clinics, private providers and other community groups.
- Environmental Health - Primarily a regulatory function, this section provides consumer protection, food and housing health safety inspections and

[5] Health and Safety Code §101000 and §101460 require counties and cities to appoint health officers. Section 101460 further permits cities to make "other arrangements" for counties to exercise health officer powers and duties within the cities. Other sections of the Health and Safety Code define the specific powers and duties of public health officers related to the enforcement of statutes, regulations, ordinances and orders issued by local governing boards or councils, or the State Department of Health Services.

environmental protection services (e.g., water, sewer, pollution control, ocean water monitoring, waste management, etc.).

- Disease Control and Emergency Response - This section provides services related to the monitoring and control of sexually transmitted diseases (excluding AIDS, which is in a separate section) and acute communicable diseases. The section also provides the public health investigation and laboratory functions of the office.

- Maternal Child and Adolescent Health (MCAH) - This section facilitates the healthcare needs of pregnant and parenting women, infants, children, adolescents, and families living in the County. While many of the MCAH programs assist low income women to access quality prenatal and post-partum care and support, through the work of the Children's Health Initiatives Unit, the division also conducts policy and planning for children's health issues, and serves as a liaison to other DHS offices and external organizations working on matters concerning children's health.

- Health Assessment and Epidemiology - This section performs community health assessment functions and houses the public health response teams. In addition, the section is responsible for public health data collection and analysis, and performs toxic material and HIV epidemiology functions. It also houses the County's tobacco control program and injury and violence prevention functions.

Alcohol and Drug Program Administration

The Alcohol and Drug Program Administration (ADPA), that has been assigned to Public Health by the Board of Supervisors, could be retained by Public Health or assigned elsewhere without affecting the health officer mandates found in California statute.

The ADPA states that it has the "primary responsibility for administering the County's alcohol and drug programs . . . to reduce community and individual problems related to alcohol and drug use." Through ADPA, the County reportedly contracts with "over 300 community-based organizations to provide an array of alcohol and drug prevention, intervention, treatment and recovery services throughout the County of Los Angeles. These services include: alcohol and drug prevention, residential and outpatient treatment, alcohol and drug detoxification, perinatal day care habilitative (sic), community prevention and recovery programs, methadone maintenance, homeless day care, in-custody drug treatment, alcohol and drug free living centers, driving under the influence programs, and drug diversion programs."[6]

Data available for FY 2002-03 indicates that the major portion of services are provided to alcohol and drug program clients who are (a) involved in the criminal

[6] http://www.lapublichealth.org , Alcohol and Drug Programs Organizational Description, 3/21/2005

justice system, or (b) are receiving General Assistance or participating in the CalWORKS program. The following table distributes these clients according to major referring program.[7]

As demonstrated with data contained in Table 1.1, over 70% of ADPA program participants are accessing the programs in response to requirements of the criminal justice and welfare systems within the County. While some of these clients may also be utilizing hospital and clinic services provided by DHS, there is no demonstrated linkage between the services.

Two conclusions can be drawn from the analysis of Public Health functions and their relationship to the formation of a health authority within the County. First, as suggested in the 2003 USC report on health services governance, the core public health functions should be retained by the County because it more universally serves the general public, and provides all of the regulatory, disease control, disease prevention, and health education functions described in this report. Second, the County should retain responsibility for the ADPA program, which has been placed within Public Health by policy of the Board of Supervisors, since this program primarily serves persons involved in the criminal justice system and welfare departments of the County. This program could remain a part of Public Health, be established as a separate department or be merged with the Department of Mental Health, as discussed below.

[7] *Annual review of Participants in Alcohol and Drug Programs Contracted by the Alcohol and Drug Program Administration 2002-03 Fiscal Year,* ADPA Research and Evaluation Planning Division

Table 1.1

Alcohol and Drug Program Administration
Client Participation for FY 2002-03

	Program Participants	Percent Participants	Program Admissions	Percent Admissions
Criminal Justice				
Drug Court	1,283	5.8%	1,381	5.4%
Female Offenders	87	0.4%	92	0.4%
Prison Parolee Network	591	2.7%	676	2.6%
Proposition 36 (a)	8,703	39.2%	10,397	40.4%
TOTAL CRIMINAL JUSTICE	10,664	48.0%	12,546	48.8%
Welfare				
General Relief	3,435	15.5%	3,597	14.0%
CalWORKS	1,608	7.2%	1,785	6.9%
TOTAL WELFARE	5,043	22.7%	5,382	20.9%
Perinatal and Adolescent				
Perinatal	1,364	6.1%	1,452	5.6%
Adolescent	2,141	9.6%	2,251	8.8%
TOTAL PERINATAL & ADOLESCENT	3,505	15.8%	3,703	14.4%
Narcotic Treatment				
Methadone and LAAM	2,996	13.5%	4,082	15.9%
TOTAL NARCOTIC TREATMENT	2,996	13.5%	4,082	15.9%
GRAND TOTAL ADPA PROGRAMS	22,208	100.0%	25,713	100.0%

(a) Substance Abuse and Crime Prevention Act.

Emergency Medical Services

The Emergency Medical Services Agency within DHS is charged with planning, implementing, monitoring and evaluating the local EMS system within the County of Los Angeles. To accomplish these responsibilities, EMS is appropriated more than $36.7 million each year to:

- Establish policies and procedures for EMS operations;
- Develop an emergency medical services system plan;
- Designate EMS base hospitals and specialty care centers;
- Develop guidelines, standards and protocol for the triage, pre-hospital treatment and transfer of emergency patients;
- Authorize and implement a pre-hospital advanced life support program;
- Certify and accredit pre-hospital medical care personnel; and,
- Approve EMS personnel training programs.

In addition, the EMS Agency manages the countywide EMS geographic information system and communications system, directly provides paramedic training for EMS operators, establishes and maintains provider contracts for exclusive operating rights within designated service areas, and provides other countywide EMS support services.

This functional structure is designed to ensure that the emergency medical response system within the County is comprehensive and competently provided. The EMS Agency must therefore work with a wide range of providers, including fire departments, private ambulance companies, and public and private hospitals.

The EMS Agency reports to an Emergency Medical Services Commission established by County ordinance. The Commission is charged with duties and responsibilities defined in the California Health and Safety Code §1750, et seq., directs elements of the EMS Agency's operations and serves in an advisory capacity to the Board of Supervisors.

As with Public Health, the EMS Agency provides services that address broader needs than the proposed narrower mission of a health authority, which would be charged with providing health services to the uninsured and indigent population within the County. Because its major purpose is to coordinate and standardize EMS services provided by a variety of public and private sector organizations, it should have this broader perspective. Accordingly, we believe that the EMS Agency should remain with the County. When considering the organizational placement of the EMS Agency, the County may wish to consider the benefits of placing the function under Public Health to ensure that appropriate medical authorities are retained. However, such a placement is not essential for EMS program success.

Managed Care

The DHS Office of Managed Care (OMC) is responsible for managing the State Knox-Keene licensed Community Health Plan (CHP), which is a federally qualified Health Maintenance Organization (HMO) designed to provide low or no cost health care services for clients who receive benefits through California's MediCal Managed Care Program and Healthy Families Program. OMC also provides coverage for in-home support service workers and a small number of Los Angeles County temporary employees.

According to OMC, the CHP health plan provides coverage for approximately 159,544 clients who receive primary care from both DHS network providers and non-DHS network providers. The table below provides data on the distribution of clients by program and primary care provider category. As shown, approximately 68,000 clients receive primary care from non-DHS network providers (approximately 42% of all clients). The remainder receive services from DHS or one of its private partner providers.

Table 1.2

Office of Managed Care Client Profile
December 2004

Program	DHS Providers	Non-DHS Providers	Total OMC Clients
MediCal Managed Care	48,565	67,680	116,245
Healthy Families	25,288	-	25,288
IHSS Workers	18,000	-	18,000
Temporary Employees	11	-	11
Total OMC Clients	91,864	67,680	159,544

Under this program, the OMC receives payment from the State or the County based on the number of clients – or "lives" – for whom services are provided. OMC staff is then charged with reviewing patient service utilization and managing payments to the various healthcare providers who serve those clients, including DHS. The OMC goal is to ensure that payments for services do not exceed the revenues that are received. According to OMC representatives, DHS benefits from this program because it receives payment for services from an insured source.

While OMC provides services to individuals who use the DHS system, a substantial portion of the services are obtained from other providers. As shown in the table, at least 42% of primary care services are obtained by clients from non-DHS providers. OMC representatives cited a number of concerns that have caused this phenomenon and which impact OMC effectiveness:

- Prior to budget reductions, DHS had substantially more services it could offer to OMC clients. With the budget reductions, DHS services become less attractive for clients who have provider choice.

- OMC does not have the information systems or analytic capability to assess provider cost effectiveness.

- As a primary healthcare provider for OMC clients, DHS impacts OMC's ability to control costs. OMC representatives believe that the DHS cost accounting system is not appropriately designed for insurance cost reporting and that the inability of the Department to produce itemized charges has been problematic from a managed care perspective.

- As a County function, the OMC is subject to all County civil service rules and budget policies. In the past, the external requirements imposed by the County have made it difficult to hire staff or respond to changes in membership and healthcare activity.

It is clear that the OMC manages a patient population that includes more than just DHS clients. On this basis alone, it would be more appropriate for the County to retain direct management of the function in order to more directly influence the healthcare cost factors for the managed care population assigned to the County. However, the role of OMC could also be expanded with the creation of a health authority.

In other sections of this report, we discuss the need for the County to establish a performance based evaluation function to ensure that the new health authority is providing services in a cost effective manner. We also discuss the need for the County to establish a reimbursement mechanism with the health authority that is designed to control costs, yet respond to the dynamics of the healthcare environment and service demands. One mechanism to accomplish these objectives is to reimburse the health authority on a capitated or standard rate basis (i.e., reimbursing the health authority a fixed amount per client or diagnosis category, rather than on a fee for service basis). Establishing healthcare contracts with providers, assessing provider cost effectiveness and influencing care management are primary functions of an HMO. Accordingly, the Office of Managed Care could be used to oversee these processes for the County to ensure cost-effective performance by the health authority.

Juvenile Court Health Services

Juvenile Court Health Services (JCHS) is administered by DHS as part of the LAC+USC Healthcare Network. It is assigned approximately 190 employees who provide ambulatory care services at seventeen juvenile probation facilities. Services include basic pediatric medical care, nursing, dental, pharmacy, laboratory, radiology, medical records management and health education. These services are critical components that support the County's general custodial responsibilities for these juveniles, as defined in California Welfare and Institutions Code. Health services are regulated by the California Code of Regulations, Title 15. The health programs at each of the County's seventeen juvenile facilities are accredited by the National Commission on the Accreditation of Healthcare (NCAH).

This structure differs from that which exists in the Sheriff's Department for adults. The Sheriff independently operates a Medical Services Bureau, in association with a physician's group, to provide services to adult inmates in the County's jails. Under this alternative structure, the Sheriff possesses organizational responsibility for the healthcare function. The physician group supports this function and is licensed accordingly within the State of California.

Because medical services within the juvenile facilities support the County's general custodial care responsibilities defined in State statute, management of the service should be retained by the County to ensure strong accountability. The organization of medical services within the Sheriff's Department is a model which could ultimately be adopted for juvenile facilities within the County, or the

Board of Supervisors could contract with the health authority or a private provider for the services.

MENTAL HEALTH DEPARTMENT

As discussed previously, the Department of Mental Health is presently an independent department with a Director who reports to the Board of Supervisors. Based on our review of data available from the Department, and information gleaned from interviews and other sources, we believe that DMH should remain with the County in its current status as an independent department. Service delivery methods, the client base and the funding structure for mental health services differ significantly from the safety net physical health services provided by DHS for the County's uninsured and indigent populations.

Data from FY 2002-03 indicate that approximately 87.6% of the clients who receive mental health services that are funded by DMH, receive such services from non-DHS providers. However, clients who receive services from DHS tend to require some of the most cost intensive treatment. These include emergency psychiatric services, acute psychiatric inpatient services and a small amount of outpatient clinic services.

According to DMH, approximately 60 percent of all DMH treatment services are provided by community care contractors. These services are provided at private hospital emergency rooms; with a small number of acute psychiatric inpatient beds within private hospitals; at Skilled Nursing Facilities (SNF); Institutes for Mental Disease (IMD); crisis residential facilities; board and care facilities; and, community clinics.

Mental Health Department officials interviewed for this study estimated that probably 90 percent of Department of Mental Health patients never see a County hospital. However, the officials stated that the remaining 10 percent – which include the most acutely ill mental health patients – have been found to disproportionately use DHS physical health services because of the high degree of co-occurring physical illnesses (e.g., diabetes) that are associated with mental disease and the medications that are used for treatment.

Although DHS provides care for only a small portion of DMH clients, the medical treatment and hospitalization costs for that small population are reportedly high. Table 1.3 shows the results of a sample taken by DMH, which demonstrates the level of co-occurring physical health and mental health diagnoses for "high utilizer" patients who use both of the systems.[8]

---

[8] For purposes of the study, a "high utilizer" was identified as a patient with six or more mental health treatment visits or one or more hospitalizations. All patients in the sample were receiving services from both DMH and DHS. Co-occurring illness was listed by primary diagnosis for both services. For example, a patient might have a primary DMH diagnosis of major depression and a primary DHS diagnosis of hypertension. Although that person might also be receiving treatment for substance abuse, such treatment would not be listed in the table data.

Table 1.3

Co-Occurring Mental Health, Physical Health and Substance Abuse Diagnoses in the DMH High Utilizer Population FY 2002-03

Health Diagnosis	Mental Health Diagnosis: Bipolar Disease	Schizo-phrenia	Major Depression	Psychosis	Others	Total
Hypertension	49	71	245	2	24	391
COPD*	28	32	77	-	19	156
Diabetes	33	58	166	2	19	278
Others	460	586	1,354	14	465	2,879
Subtotal	570	747	1,842	18	527	3,704
Substance	333	520	612	6	265	1,736
Total	903	1,267	2,454	24	792	5,440
Sample Size	5,440	5,440	5,440	5,440	5,440	5,440
% w/Health	10.5%	13.7%	33.9%	0.3%	9.7%	68.1%
% w/Substance	6.1%	9.6%	11.3%	0.1%	4.9%	31.9%
% w/Both	16.6%	23.3%	45.1%	0.4%	14.6%	100.0%

Source: Department of Mental Health Study

As shown in the table, 68.1% of this subgroup of DMH clients also had primary physical health diagnoses that were being treated by the Department of Health Services. The remaining 31.9% also had primary substance abuse treatment diagnoses and were receiving services funded by ADPA. In total, DMH estimated that nearly $300 million in services were being provided to the "high utilizer" patient population in FY 2002-03.

Although only 31.9% of "high utilizer" DMH patients were also identified as having a primary substance abuse diagnoses, this percentage may not fully describe the degree to which mental health clients require substance abuse treatment. Although we were not provided data to support his assertion, the Mental Health Director has suggested that "probably 60 percent to 80 percent of *all* mental health clients also exhibit some form of drug or alcohol dependency."[9] Like the "high utilizer" population, many of these "dual diagnosed" patients receive services from both DMH and from contractors funded by the Alcohol and Drug Program Administration section of the DHS Public Health Division.

[9] This assertion has been challenged by DHS, who believe that the percentage of patients with co-occurring mental health and substance abuse diagnoses may range closer to 5% to 10% of the total DMH population.

There has been much controversy within the mental health and substance abuse communities regarding the relationships between the two populations of clients. During interviews we were advised that substance abuse clients generally do not want to be "stigmatized" by being associated with mental illness. On the other hand, mental health clients and their families see mental illness as a disease which encompasses much more than the substance abuse issues that are presented by the patients. Despite these perceptions, government agencies have been moving toward combined "behavioral health" organizations in recent years in an attempt to merge the two closely related services.

As the Board of Supervisors considers the County's healthcare organization after the creation of a health authority, it should examine the possibility of moving the Department of Mental Health and Alcohol and Drug Administration Program into a combined Behavioral Health Agency structure. This structure would provide opportunities to enhance interaction between the two services.

SUMMARY OF ORGANIZATIONAL ALIGNMENT FACTORS

Based on the analysis previously presented, DHS' hospitals, comprehensive health centers and other ambulatory care clinics should be transferred to the health authority. The responsibility for all other functions reviewed as part of this study should be retained by the County, including managed care, core public health, emergency medical services, juvenile court services, alcohol and drug treatment and mental health treatment services. The County should also look for opportunities to better align those healthcare related services that it retains, as discussed in this report.

Table 1.4

Organization Planning Matrix for Aligning Health Related Functions in Los Angeles County

	Primary Mission			Client Base			Preferred Alignment	
Program	Public Health	Physical Health	Behavioral Health	General County	Uninsured/ Indigent	Other	County	Health Authority
Hospitals		X			X			X
Ambulatory Care		X			X			X
Managed Care		X				X	X	
Core Public Health	X			X			X	
Emergency Medical Services		X		X			X	
Juvenile Court Services		X				X	X	
Alcohol & Drug Treatment			X			X	X	
Mental Health Treatment			X			X	X	

By aligning services in this manner, the health authority would be given a clear and focused mission, which would increase its chances of operational success. Regulatory, disease management, countywide coordination and health education functions would be retained by the County. By retaining the managed care function and expanding the current role to include health authority monitoring functions, the County would be better equipped to monitor the services and costs of the health authority.

By retaining the mental health and alcohol and drug program administration functions, behavioral health services will receive more focused attention and prominence in the organization. This is appropriate since both programs serve a broader population than just the uninsured and indigent residents of the County, and are more closely aligned with non-health services functions such as criminal justice and welfare.

By retaining responsibility for medical services provided to juveniles that are housed in County institutions, the Board of Supervisors will be better able to ensure appropriate levels and quality of care. The Board could choose to contract with the health authority to provide these services, as a supplementary service that would exceed the authority's statutory mandate.

Currently, the staff assigned to health services administration functions within DHS are shared by the programs some of which would be separated from the County when the health authority is created. As a result, decisions will need to be made regarding the allocation of administrative personnel and other resources between the health authority and the DHS divisions that remain as part of the County organization. The Board of Supervisors should direct the Chief Administrative Officer, with assistance from DHS, to determine the most appropriate allocation of personnel and resources as part of a health authority transition plan.

CONCLUSIONS

Several proposals to create a Los Angeles County health authority have been made over the past ten to fifteen years. However, the health services components included in each proposal have differed greatly and have been vaguely defined.

Previous proposals have not fully addressed whether responsibilities related to mandated Public Health or Mental Health services should be retained by the County or absorbed by the health authority. Further, these proposals have not consistently answered critical questions related to the complex responsibilities for providing indigent medical care services defined by California Welfare and Institutions Code Section 17000, case law and policy of the Board of Supervisors.

Before considering the complex governance, operational, funding or legal questions associated with the creation of an independent health authority, the Board of Supervisors, with input from DHS and the County's healthcare community, should clearly define the health authority's mission and functional components. A preferred model would transfer authority and responsibility for all physical health services to the health authority; would charge the health authority with the responsibility to provide specified levels of healthcare services to the uninsured and indigent; and, establish emergency and acute psychiatric care services in hard to serve areas of the County. Public Health services, Emergency Medical Services and other broad regulatory or coordination functions, should be

retained by the County. The Department of Mental Health should remain an independent County department that is separate from the health authority.

RECOMMENDATIONS

The Board of Supervisors, with input from DHS and the County's healthcare community, should:

1.1 Develop a clearly defined mission for the new health authority that is focused on the delivery of safety net physical health services for the uninsured and indigent populations within Los Angeles County.

1.2 Clearly define the minimum level of service to be provided by the health authority, based on Welfare and Institutions Code §17000 and case law.

1.3 Develop a structure that retains the County's responsibility for providing public health, mental health, drug and alcohol, emergency medical, managed care and juvenile court health services.

The Board of Supervisors should:

1.4 Retain the Department of Mental Health as a distinct County department not under the jurisdiction of the new health authority.

1.5 Establish Public Health as a distinct County department not under the jurisdiction of the new health authority.

1.6 Consider placing the Emergency Medical Services function under the authority of the Public Health Officer.

1.7 Consider placing Managed Care under the authority of the Public Health Officer, and expanding its role to include the monitoring of health services provided by the health authority under its contract with the Board of Supervisors.

1.8 Consider placing the Alcohol and Drug Program Administration function under the Department of Mental Health and creating a Behavioral Health Department.

1.9 Retain responsibility for health services functions provided to juveniles who are in County institutions (Juvenile Court Services), but contract with the health authority or another provider to provide such services.

1.10 Direct the Chief Administrative Officer, with assistance from DHS, to determine the most appropriate allocation of DHS Health Services Administration personnel and resources as part of a health authority transition plan.

COSTS AND BENEFITS

There would be no direct cost to implement these recommendations. However, staff time would be required to provide the analyses that will be necessary for the Board of Supervisors to make informed decisions.

The health authority would be given a clear and focused mission, which would increase its chances of operational success. Regulatory, disease management, countywide coordination and health education functions would be retained by the County. By retaining the managed care function and expanding its current role, the County would be better equipped to monitor the services and costs of the health authority.

By retaining the mental health and alcohol and drug program administration functions, the behavioral health services will receive more focused attention and prominence in the organization. This is appropriate since both programs serve a broader population than just the uninsured and indigent residents of the County, and are more closely aligned with non-health services functions such as criminal justice.

By retaining responsibility for medical services provided to juveniles that are housed in County institutions, the Board of Supervisors will be better able to ensure appropriate levels and quality of care. The Board could choose to contract with the health authority to provide these services, as a supplementary service that would exceed the Authority's statutory mandate.

2. HEALTH AUTHORITY GOVERNANCE STRUCTURE

- **The Board of Supervisors has been criticized for its lack of health care expertise and difficulty balancing its other priorities against the hospital and healthcare system needs of the County. In addition, the Board's approach to governance has reportedly created a risk adverse environment that suppresses management innovation.**

- **A review of its activity in recent years concerning the County's hospital and health system reveals that the Board of Supervisors devotes limited time to the complex and multi-faceted $3.5 billion department due to its many other responsibilities. Board actions in key operational areas were found to often be reactive and lacking follow-up, resulting in recurrences of some of the same problems. Creating a Health Authority Board of Directors focused solely on the County's hospital and health system and statutorily composed of members with healthcare, finance and other business backgrounds would allow for a more pro-active, strategic, problem solving approach to governance of the new organization.**

- **It is important that this governing board not be insulated from consumers. Currently, patients of the County healthcare system have a limited ability to exercise consumer choice and instead utilize the political process for providing input to the Board of Supervisors. The governing structure should therefore be designed in a manner that provides avenues for consumer input into the process.**

- **Because of its unique role, the Health Authority Board of Directors should self-appoint its members after nomination by a combination of the Board of Directors, itself, and external groups, with all nominations subject to confirmation by the Board of Supervisors. By incorporating the best attributes of a business model with one designed to protect consumer interests, the Health Authority Board of Directors will be better able to exercise healthcare system oversight. Consumer interests could be protected by designating some board seats for consumer appointments and establishing a network of regional Healthcare Consumer Advisory Committees.**

Throughout this study, various individuals interviewed expressed a strong belief that the governing board for the Health Authority should be modeled after private sector boards of directors, to include individuals with expertise in the areas of health system management, finance and other business disciplines necessary to oversee a large public sector health organization. This theme has been put forward periodically since at least 1995, interspersed with alternative recommendations that would create a politically appointed governing body

without any requirements for member expertise. Some of the more significant proposals are described below.

- In December 1995, the Health Crisis Manager appointed by the Board of Supervisors recommended that "the Board create a semi-autonomous health authority with . . . (a board) membership composed entirely of health experts." Specifically, it was recommended that the board be "made up of seven individuals who are recognized experts in health policy issues, reflected by their professional backgrounds. The authority as a whole should have health expertise and experiences in such arenas as medicine, public health, finance, business, public policy, and labor." [1] Had it been created in 1995, this board would have been advisory to the Board of Supervisors.

- In 2001, a group representing the UCLA School of Public Health, the Los Angeles County Medical Association and the USC School of Medicine "began working for the adoption of a new governance structure for health care and public health in the County of Los Angeles."[2] This group recommended an eleven member board that was comprised of political appointees with no requirements regarding professional expertise. The Board would have included:

    - Five members selected by the Los Angeles County Board of Supervisors;
    - One member selected by the Governor of California;
    - One member selected by the Speaker of the California State Assembly;
    - One member selected by the President of the California State Senate;
    - One member selected by the Chancellor of UCLA;
    - One member selected by the President of USC; and,
    - One member elected by the professional staff of the authority.

- In May 2003, a team from the University of Southern California also made recommendations for the formation of a Health Authority, and suggested that the membership of the governing board be similar to the one proposed by the Health Crisis Manager in 1995. However, different than the 1995 proposal, the Health Authority that was proposed in 2003 would be "an independent authority created by the State Legislature in cooperation with the County of Los Angeles to operate personal health services, primarily hospitals and ambulatory care centers." According to the USC team, "the members of the new Authority would be composed of individuals who have expertise and professional experience in health care policy, clinical operations, finance, medicine, and labor."[3]

---

[1] Burt Margolin, Health Crisis Manager, *Governance of the Department of Health Services,* memorandum to the Board of Supervisors, December 12, 1995,

[2] Dr. Lester Breslow, UCLA School of Public Health, Dr. Brian Johnson, Los Angeles County Medical Association, and Dr. Robert Tranquada, USC School of Medicine, *Health Authority for the County of Los Angeles - A Summary,* submitted in response to a Board of Supervisors request for the Chief Administrative Officer to study Health Authority governance options, July 2001

[3] Division of Community Health, Department of Family Medicine, USC Keck School of Medicine and the USC School of Policy Planning and Development, *An Analysis of Alternative Governance for the Los Angeles County Department of Health Services,* A Report to the John Randolph

- On January 31, 2005, Assembly Member Mervyn Dymally submitted proposed Assembly Bill No. 201 to create a Los Angeles County Health Authority.[4] The original language of the proposed bill read, "The governing board shall consist of 13 members and shall include the following members who shall be appointed by ordinance or resolution of the board:
  - Five members who shall be designated by the Los Angeles Board of Supervisors.
  - Three members who shall be nominated by the Governor.
  - One member who shall be nominated by the Speaker of the Assembly.
  - One member who shall be nominated by the Senate Committee on Rules.
  - One member who shall be nominated by the Governor from the University of California.
  - One member who shall be nominated by the Governor from the University of Southern California
  - One member who shall be nominated by the Governor from the Charles R. Drew University of Medicine and Science.
  - One member who shall be appointed by the Health Authority from the Los Angeles County community."[5]

  Like the 2001 recommendations made to the Board of Supervisors by UCLA, USC and LACMA evaluators, the proposed bill did not contain language that would ensure board member expertise in the areas of health care system management, finance or other business disciplines.

The recommendations for the Health Authority board composition have clearly differed over the years. In the 1995 and 2003 examples, it was recommended that the board be composed solely of health system and business professionals. In the 2001 and 2005 examples, it was recommended that the board members be appointed by a broad spectrum of elected representatives, with no requirements for member expertise in health system or business professions.

The individuals interviewed for this study who also advocated for a professional Health Authority board of directors appear to have formulated their opinions based on perceptions of the Board of Supervisors and the manner with which it conducts business in the County. These individuals voiced concerns that a politically appointed or elected board may adopt many of the attributes of the Board of Supervisors that they find most undesirable. In fact, some stated that the Health Authority would likely fail if the County's political framework was merely replicated in the new board, and many individuals noted that the Health Authority board will need to be insulated from stakeholder groups if it is to be successful.

Haynes and Dora Haynes Foundation, May 2003

[4] Since this bill was initially introduced, it has been substantially modified by the author and no longer addresses matters concerned with the formation of a health authority in Los Angeles County. A concurrent bill (AB 166 - Ridley-Thomas) would grant the Board of Supervisors with the authority to specify the size, qualifications, terms of office and removal process for the health authority board.

[5] Detailed membership equals 14, which is inconsistent with the text which states that the "governing board shall consist of 13 members."

ASSESSMENT OF BOARD OF SUPERVISORS HEALTHCARE RELATED ACTIVITIES

Individuals who were interviewed for this study and previous studies on this topic consistently raised the following concerns regarding governance of the County's hospital and health system by the Board of Supervisors.

- The Board of Supervisors does not possess expertise in the field of health care and, therefore, is ill equipped to make many of the more complex decisions that are required.

- The Board of Supervisors is responsible for the entire County and must balance resources that are allocated for health care against competing demands from the criminal justice system, social services system and general government. The time they can devote to the hospital and health system is also limited.

- Individual members of the Board of Supervisors must balance the health care needs of the County against the healthcare needs expressed by stakeholders within their respective districts. Often these interests conflict and the resulting decisions can adversely impact overall healthcare system cost effectiveness.

- Individual members of the Board of Supervisors periodically intervene in DHS operations in response to constituent contacts or complaints.

- Individual members of the Board of Supervisors often react harshly to department initiatives or reports in both private and public meetings, creating a risk adverse environment where innovation is avoided by DHS managers.

- The complexities of the County system and the requirements imposed by the Board of Supervisors do not permit true leadership to develop in the departments.

Despite these criticisms, individuals who work most closely with the Board stated that the board members and their staffs rely heavily on Department management to oversee DHS operations and often allow managers significant flexibility on key decisions.

Historical Record of Board Activities

As part of this study, we attempted to determine the extent to which the perceptions of the individuals that we interviewed might be substantiated by a review of the Board of Supervisors actions related to health care. This included a review of newspaper coverage of the County health care system over that time, Board meeting minutes and transcripts, and staff reports provided to the Board.

First, a review of five Board meeting agendas for dates selected randomly in 2004 confirmed that the Board has many responsibilities beyond overseeing the

County health care system. For the five meeting dates, February 24, May 11, August 17, October 26 and November 3, the Board considered 41 health-related items, including items related to the Department of Health Services and to the Department of Mental Health. This compared to a total of 298 items it considered regarding all departments and topics during the five meetings. Based on the number of items reviewed, health care accounted for 13.8 percent of the total workload considered during the five meetings.

Furthermore, only 11 of the health related 41 items decided upon by the Board during the five meetings, or 26.8 percent, received any discussion. The other 30 were handled as consent items without discussion. The 11 health-related items that received some discussion accounted for about 13.1 percent of the 84 items overall in the five meetings that received some discussion. These statistics indicate that the Board of Supervisors, because of its responsibility for all of County government, is far from able to devote its full time and attention to the complex and multi-faceted County health care system.

To further assess the Board's record of involvement in managing the County health care system, we prepared case studies on the Board's handling of three specific issue areas that have arisen since at least 1992. A summary of the findings of the case studies follows:

Case Study: Medical Malpractice Issues

On at least five occasions dating back to 1992, when the news media reported that Los Angeles County was paying millions of dollars to settle medical malpractice claims without formal approval by the Board or other public officials, the Board of Supervisors criticized the Department of Health Services for not doing enough to prevent medical errors leading to malpractice claims from occurring, or for not taking specific steps to try and reduce the volume of such errors.

Its most aggressive steps were in January 1999, when the Board created a Risk Management Inspector General position to try and reduce liability costs generally in the County, and added to the Los Angeles County Code a new protocol of steps the Department of Health Services should take to prevent malpractice suits. The protocol's requirements included preparing corrective action plans whenever a malpractice claim was forwarded to the Board for approval, creating a position in the Department to hold staff accountable for negative medical outcomes, providing more detailed procedures to assess risk management issues in the Department and maintaining a quality improvement program, including prompt reporting and investigation of incidents of liability.

Our review of documents related to malpractice settlements approved by the Board of Supervisors showed that in periods after each of the Board's criticisms regarding this issue, medical errors continued to be made at all of the County's acute care hospitals, requiring millions of dollars in payments to settle lawsuits, including payments of more than $1 million in many individual cases. While a recent report by the Chief Administrative Office noted that medical malpractice losses in the Department had fallen from $20.27 million in FY 2001-02 to $13 million in FY 2003-04, the Board has recently been struggling with repeated reports of medical errors causing deaths at King-Drew Medical Center.

While medical malpractice costs are not likely to be entirely eliminated, the continuing nature of this problem indicates that the Board's responses to it have been insufficiently aggressive to reduce the problem, or that the Board has not done enough to follow-up its orders to ensure that corrective measures are taken, and that those measures reduce the problem.

Case Study: Physician Productivity and Responsiveness

Since at least 1995, the County has investigated or discovered instances where physicians at its hospitals did not meet standards for work productivity and responsiveness, and has taken steps to try to correct the problems. Attention to this issue dates back to at least 1995, when Department of Health Services and Auditor-Controller auditors investigated doctors paid for full-time County work who were working excessively at non-County jobs, sometimes during County work hours. Moonlighting arose as an issue again in 1997, when it was discovered that a gunshot patient had died at King-Drew Medical Center because no vascular surgeon was on duty, even though one was required, and that a County-paid surgeon who was called to respond did not do so, because he was treating private patients at another hospital at the time. Further investigation related to the 1997 incident revealed that moonlighting problems were still widespread in all hospitals, despite the investigation that had occurred in 1995-96.

As recently as 2003, the Auditor-Controller reported that the whereabouts of 11.3 percent of physicians scheduled at LAC+USC Medical Center by the University of Southern California medical school could not be determined. Furthermore, in 2004 news media reported that an orthopedic surgeon at King-Drew Medical Center was fired because he had referred hospital

patients to his private practice, and had falsified time cards. Earlier this year, Navigant Consulting, the firm hired to help run King-Drew, reported that anesthesiologists were not being routinely paged in Code Blue situations, in which hospital staff were attempting to revive a patient in cardiac arrest, which Navigant said was not procedurally proper.

The Board of Supervisors' inability to correct this problem again indicates that the measures it took were not aggressive enough to solve a problem, or there was insufficient follow-up to ensure they were followed and the problem was corrected.

This issue also reveals the constraints the Board faces under the current governance structure, particularly in relation to personnel matters. For example, during reporting of the 1995 investigation of moonlighting physicians, it was reported that an attempt in 1993 to require physicians to sign in and out of the King-Drew emergency room was rescinded, because doctors appealed the order to the County Civil Service Commission who determined they were exempt from such requirements. Similarly, attempts to fire the vascular surgeon believed to be at fault in the 1997 gunshot cases were abandoned, and the surgeon allowed to resign, rather than face a lengthy appeal of the firing through the civil service system. According to media reports, this decision prevented the County from reporting the physician to the Medical Board of California or other oversight organizations. The constraints of the current form of governance of the County health care system in relation to personnel are further discussed in Section 4 of this report.

Case Study: DHS' 2002 Strategic Plan

In January 2002, the Department of Health Services presented the Board of Supervisors with its *Strategic and Operational Plan*, a document outlining options for the County to continue to provide health care to the indigent despite limited financial resources. In a series of decisions from January 2002 to January 2003, the Board agreed to:

- Close 16 health clinics of various types.
- Adopt a series of administrative and clinical efficiencies and consolidations.
- Close Rancho Los Amigos National Rehabilitation Center.

- Reduce the operating size of LAC+USC Medical Center by 100 beds.
- Convert High Desert Hospital in Lancaster to an ambulatory care center.
- Adopt a policy prohibiting uninsured patients who were not Los Angeles County residents from receiving non-emergency care, and developing more stringent policies to prevent transfers of uninsured patients to the County system, including both non-emergency patients, and emergency patients where transfer was attempted in situations where the County had no room available to accept new patients.

The Board took these steps amidst widespread opposition from health care advocates, advocates for the poor, representatives of the County's private health care providers and County employee groups. The closure of Rancho Los Amigos, and the reduction of beds at LAC+USC, were ultimately blocked by lawsuits filed in federal court by a number of these opposing groups.

While in 2002 Board members acknowledged that they had no choice but to proceed with these cuts, several Board members also acknowledged the steps they were taking should have been taken years before, when the Board instead accepted federal bailout money in an unsuccessful attempt to reduce County health care cuts by shifting the County's emphasis from hospital-based care to outpatient care.

It should be noted that the *Strategic Plan,* a detailed and comprehensive plan addressing the Department's mission, strengths and weaknesses and future resources, was prepared by the Department on its own volition, not at the request of the Board of Supervisors. It is the type of document that a governing board of the $2.4 billion hospital and health system should have developed or requested years prior and periodically updated to have a set of principles guiding the Department's operations and resource allocations.

Each of these three case studies reveals a similar pattern of behavior by the Board of Supervisors. Particular episodes of the problem would be publicly revealed, usually through news media coverage. The Board would then react to the particular episode, ordering the Department of Health Services to take some action that would supposedly prevent further episodes of the problem. However, these actions were not successful, as indicated by subsequent episodes of the same problem that occurred and the absence of systematic follow-up and monitoring of the problem by management. Based on this continuing pattern, it appears that the current governance of the County health care system by the

Board of Supervisors, and the constraints the Board faces, prevents implementation of measures that are aggressive enough to solve identified problems, or prevents sufficient follow-up on these measures to ensure they are implemented and the problems are solved.

GOVERNANCE STRUCTURES

There are three characteristics that are common among the recommendations made by previous evaluators of the health authority concept in Los Angeles County:

- The recommended governing boards would have been large, totaling anywhere from seven members to as many as 14 members in the proposals where exact membership was specified.

- The recommended governing boards would have encouraged the appointment of individuals with broad interests and/or expertise, either professional – as described in the 1995 and 2003 proposals – or political – as described in the 2001 and 2005 proposals.

- None of the proposals included members who would be appointed from consumer or other stakeholder groups.

Governing boards with a large and diverse membership can be effective, provided the boards do not become so large that they are unable to function effectively. In many instances, when they become large, sub-committees are often formed where much of the board's work is conducted. Boards that do not include opportunities for consumer or other stakeholder involvement can experience difficulties when they are perceived as making decisions which may conflict with the perspectives of the stakeholders. It may be in the interest of the health authority to compose a board that has a core health care business orientation with suitable representation from the healthcare consumer interests that may be present in Los Angeles County. Further consumer representation could be provided through a formal system of regional advisory boards organized around the hospital and health center network.

Several governing bodies have been composed in this manner, and exist in both Los Angeles County and in Alameda County, where a Health Authority was created in 1997. Some of these other governing bodies could serve as models for the Los Angeles County Health Authority. To provide some perspective, some examples are described below.

L.A. Care Health Plan

L.A. Care Health Plan was created in the mid-1990s in response to the State's efforts to create MediCal managed care programs in California counties. Today, the L.A. Care Health Plan boasts that it is "the nation's largest public health plan and also one of California's largest health plans." In a description of its

governance, L.A. Care states that the "model was designed to give all parties involved in the health care process – health plan members, providers, health plan partners, other health care professionals and community groups – a voice in the direction of the organization."

L.A. Care is governed by 13 board members, "representing medical and health care professionals, as well as Medi-Cal consumers." The Board of Governors currently includes:

- One member from the Los Angeles County Board of Supervisors
- One member from the Los Angeles County Department of Health Services
- One member from the Los Angeles County Department of Public Social Services
- One member from the Hospital Association of Southern California
- One member representing Knox-Keene Licensed Pre-Paid Health Plans
- One member representing the Private Essential Access Community
- One physician member who represents Children's Healthcare Providers
- Two physician members who represent public and private physician interests
- One member from the Community Clinics Association
- One member from Federally Qualified Health Centers (FQHC)
- Two members representing L.A. Care Health Plan members

As shown, the L.A. Care Board of Governors has broad stakeholder representation and significant expertise in the fields of health care and health plan system management. In addition, the L.A. Care Board of Governors has created three standing advisory committees, including the Health Care Professionals Committee, the Children's Health Committee and the Executive Community Advisory Committee. This latter committee represents 11 Regional Community Advisory Committees "composed of health plan members, advocates and medical professionals."[6]

Emergency Medical Services Commission

A second similar model has been established for LA County's Emergency Medical Services Commission. This commission fulfills the requirements of the mandated emergency medical care committee defined in Health and Safety Code § 1750, et seq., acting in an advisory capacity to the Board of Supervisors and the Director of Health Services regarding emergency medical services operations and quality.

Los Angeles County Ordinance No. 12.332 - Chapter 3.20 of the Los Angeles County Code, Section 3.20.040 defines the 17 member composition of the Commission, as follows:

- One member who is an emergency medical care physician in a paramedic base hospital nominated by the California Chapter of the American College of Emergency Physicians
- One member who is a cardiologist nominated by the American Heart Association, Western States Affiliate
- One member who is a mobile intensive care nurse nominated by the California Chapter of the Emergency Department Nurses Association

[6] http://www.lacare.org

- One member who is a hospital administrator nominated by the Healthcare Association of Southern California
- One member who is a representative of a public provider agency nominated by the Los Angeles Chapter of California Fire Chief's Association
- One member of a private provider agency nominated by the Los Angeles County Ambulance Association
- One physician member, either an orthopedic general or neurological surgeon, nominated by the Los Angeles Surgical Society
- One psychiatrist member nominated by the Southern California Psychiatric Society
- One physician member nominated by the Los Angeles County Medical Association
- One member who is a licensed paramedic nominated by the California Rescue and Paramedic Association
- Five public members, one nominated by each supervisor, who are prohibited from being a medical professional or affiliated with any other nominating agency
- One member who is a law enforcement officer nominated by the Los Angeles County Peace Officers Association
- One member who is a city manager, nominated by the League of California Cities, Los Angeles County Chapter

The Emergency Medical Services Commission clearly has a broad based membership that includes both professionals in the field of emergency medicine and consumers.

Alameda Alliance for Health

Like the L.A. Care Health Plan, the Alameda Alliance for Health was created under the enabling legislation adopted by the State to create MediCal managed care programs in California counties.[7] Welfare and Institutions Code § 14087.35 defines the composition of the Board of Governors for the Alameda Alliance for Health. Under this State law, the Board of Governors "may include, but is not limited to: a member of the board of supervisors, individuals that represent and further the interests of the perspectives of Medi-Cal provider physicians and other health practitioners, hospitals, and nonprofit community health centers." The code also gives the Board of Supervisors the discretion to include "other perspectives" on the governing board. The specific Board of Governors membership was created by ordinance of the Board of Supervisors and the bylaws for the Alameda Alliance for Health, in accordance with this State legislation.[8] The 11 member Board includes:

- One member from the Alameda County Board of Supervisors
- Two physician members who represent public and private physician interests
- Two members from public and private hospitals
- One member from community clinics
- Two members representing health care consumers
- One member representing the Alameda County Medical Center
- Two members selected at large (presently designated for pharmacies and labor)

[7] Because Alameda County was creating a Health Authority at the time, special legislation was adopted and included in California Welfare and Institutions Code § 14087.35 that merges the enabling legislation to establish a Health Authority and the authority to create the County's MediCal Managed Care Plan.

[8] Alameda County Ordinance 0-94-13

Including a member from the Alameda County Medical Center (ACMC) ensures representation from the Hospital Authority, which was simultaneously created by California Health and Safety Code § 101850. The ACMC includes two medical hospitals, one psychiatric hospital and three freestanding ambulatory care centers that provide services primarily to MediCal, indigent and uninsured patients. Outpatient clinic services are also provided at Highland Hospital, which is the flagship facility managed by the Health Authority.

Alameda County Medical Center

The Alameda County Medical Center is governed by an eleven member Board of Trustees who are appointed by the Board of Supervisors. Required membership includes the Chief Executive Officer of the Medical Center and one member nominated by the medical staff and appointed by majority vote of the Board of Supervisors. With the exception of these two positions, there are no qualifications requirements for Board members. At the time of this report, four of the eleven Board of Trustee seats were vacant. The seven filled seats included individuals with diverse backgrounds in medicine, business and health system management.

COMPOSITION OF LOS ANGELES COUNTY HEALTH AUTHORITY BOARD OF DIRECTORS

The three primary examples that were chosen for this report provide some interesting characteristics to be considered for the Los Angeles County Health Authority.

1. All three of the examples require that the majority of members possess professional skill sets that are consistent with the mission of the organization.

2. All three of the examples ensure that consumer interests are represented by including individuals from the various consumer groups. In the case of the EMS Commission, stakeholder representatives are also nominated by external associations or bodies with a key interest in the appointment.

3. All three of the examples include requirements that representatives of consumers or general members of the public be appointed. In the case of the L.A. Care Health Plan, an extensive community advisory committee structure has been established to ensure that users in the various regions of the County can contribute to the decision-making process.

It is interesting to note that the enabling legislation for the Alameda County Medical Center Board of Trustees had very few requirements regarding its composition. In this instance, the Board of Supervisors was left with complete discretion regarding the composition of the Board of Trustees and chose to keep the requirements very general. It is also interesting to note that in Alameda County, the Board of Supervisors makes all appointments to the Board of

Trustees without the benefit of any nominating process from the Board of Trustees itself or the consumer community.

Preserving Healthcare System Consumer and Consumer Interests

As discussed previously, the lack of designated representation by consumer interests is perhaps the most significant omission in the recommendations that have previously been made regarding the creation of a Health Authority Board of Directors. In private sector models, consumer interests are protected to some extent because patients can choose their health services provider. If a private healthcare provider does not meet consumer needs, it will lose business.

Generally, the same opportunities are not available to indigent and uninsured patients since these individuals must rely solely on medical services offered by public sector health care agencies and other disproportionate share providers within the community. In county-run healthcare systems or in hospital districts, members of the governing board are directly elected so consumer influence can be exerted through the political process.

However, establishing a system where the Board of Directors is elected can present several difficulties which should be considered by the County and the Los Angeles County community as the health authority is designed. It is because of the complexities associated with matching professional expertise with selection through the electoral process that we believe such an approach is inadvisable for the County. This was put succinctly in an analysis of this subject that was performed for the East Maine Healthcare System in 2004.

> "While the 'Corporator' or 'Member' model[9] may provide direct accountability of the trustees to its electorate, it continues to decline as a model of choice in meeting today's needs. One governance consultant estimates that less than 25% of the hospitals across the country have an "elected" (or member) model, and that this number continues to decrease each year. Health care has become so complex and changing that fewer and fewer people can commit the time it takes to absorb and leverage the information they need to make appropriate judgements on issues like trustee selection. Selections are more apt to be based on the popularity of individuals rather than the skills and diversities needed to achieve the strategic plan of the organization." [10]

In organizations where the Board of Directors is not elected, the typical process requires either (a) that members be selected by an external political body, such as the Board of Supervisors; or, (b) that the Board of Directors be self-selecting – that is, that the Board directly select member replacements when vacancies occur. In our view, neither of these alternatives would be appropriate for Los Angeles County in their pure forms. If members are selected by the Board of

---

[9] Defined as a system where boards "are selected by the vote of the people either in a particular geographic area or by members of a particular constituent group. Elected boards are typical among county, district or public hospitals supported by tax dollars.

[10] July 30, 2004, *The Ins and Outs of Governance Modernization,* EMHS News, written by the East Maine Healthcare Systems Community Relations department

Supervisors, the selection process could become highly politicized and defeat one of the key purposes of separating the Health Authority from the County. If the Board of Directors is self-selecting, the ability of the public and the consumers of the services to influence decisions will be weakened.

A preferred alternative which captures the benefits of both approaches would be based on a split selection process. In this model, the Board of Directors would nominate individuals for certain slots and designated consumer groups would nominate members for other slots. All nominations would be subject to confirmation by the Board of Supervisors and appointment by the Board of Directors. This approach provides opportunities for all key consumers to reject nominees, similar to the federal system for Cabinet members and other high ranking officials, where the President nominates and appoints after receiving confirmation from Congress. It is also similar to the Emergency Medical Services Commission model that exists in Los Angeles County, where consumer groups nominate and the Board of Supervisors makes the appointments.

Under this preferred alternative, the interests of principal consumer groups would be preserved. The interests of the Board of Supervisors, and presumably the electorate, would be protected through the confirmation process. And, the interests of the Health Authority would be protected because final approval of all appointments would be made by the Board of Directors. This type of process forces compromise and ensures that the organization reflects the more balanced interests of the community.

Protecting Consumer Interests

In order to ensure that consumer interests are protected, the enabling legislation for the health authority should ensure that Healthcare Consumer Advisory Commissions are established in each of the principal operating regions within the County. Under the current structure, this would require the formation of six advisory commissions in (1) the LAC+USC service region, (2) the Coastal Cluster, (3) the Southwest Cluster, (4) the San Fernando Valley Cluster, (5) the Antelope Valley Cluster, and (6) Rancho Los Amigos National Rehabilitation Center. This advisory commission structure could be modeled after that which has been established for the L.A. Care Health Plan, which has 11 Regional Community Advisory Committees that advise the Board of Trustees through an advisory board executive committee. As discussed previously, the consortium of Healthcare Consumer Advisory Committees would also be responsible for nominating some members of the Health Authority Board of Directors.

RECOMMENDED BOARD OF DIRECTORS COMPOSITION AND NOMINATING PROCESS

Based on this analysis, we believe the enabling legislation for the Health Authority should establish a Board of Directors with a minimum of nine members, as follows.

Exhibit 2.1
Recommended Composition and Nomination Process for Health Authority Board of Directors

Number	Profile	Nominated by:
Five	Expertise in healthcare administration	Board of Directors
Two	Physicians	Medical Director or Physician Staff Representatives
Two	Consumer representatives	Consortium of Healthcare Consumer Advisory Committees

This recommended composition will balance:

- The interests of the physician and consumer members, who would typically bring service quality and access perspectives to the table

Against:

- Business management members who would also be concerned about service quality and access, but would bring management and fiscal perspectives to the table.

Details of the recommended Board of Directors composition, nomination and appointment process are as follows.

To be Nominated by the Health Authority Board of Directors:

- A member with a background in hospital administration;
- A member with a background in ambulatory care/clinic administration;
- A member with a background in health care finance and/or administration;
- A member with a background in human resources and/or labor relations; and,
- A member with a background in risk and/or asset management, preferably in a health care environment.

To be Nominated by the Medical Director or by a Representative Body of Physician Staff:

- Two physician members.

To be Nominated by the Consortium of Healthcare Consumer Advisory Committees:

- Two healthcare consumer members.

All nominees should be subject to confirmation by the Board of Supervisors and appointment by the Health Authority Board of Directors.

This recommended composition for the Health Authority Board of Directors is intended to provide a framework for the minimum numbers and types of members who should be appointed to the Board of Directors. It is not meant to be an inflexible recommendation, since local priorities and interests should be reflected in the final Board composition included in the enabling legislation. However, we believe this preferred alternative provides a strong business perspective for the Board, while preserving the ability of consumers to influence the direction of the Health Authority.

A task force should be appointed by the Board of Supervisors to prepare a slate of nominees for the initial Health Authority Board of Directors. The task force should be comprised of representatives of DHS, the Department's Medical Director, private sector health care professionals and consumer representatives.

Under this proposal members could only be removed for cause. Removal authority would rest with the Health Authority Board of Directors.

CONCLUSIONS

The Board of Supervisors has been criticized for its lack of health care expertise and difficulty balancing its other priorities against the County's hospital and health system needs. In addition, the Board's approach to governance has reportedly created a risk adverse environment that suppresses management innovation. Therefore, creating a Health Authority Board of Directors that is statutorily composed of members with expertise in hospital and healthcare management, finance and other business disciplines could provide an opportunity to strengthen healthcare system governance within the County.

It is important that this governing board not be insulated from consumer groups. For example, patients of the County healthcare system have a limited ability to exercise consumer choice and instead utilize the political process for providing input to the Board of Supervisors. If not elected, the Health Authority Board of Directors should include some consumer representation in its membership.

Because of its unique role, the Health Authority Board of Directors should nominate its members with confirmation by the Board of Supervisors. Further, by incorporating the best attributes of a business model with one designed to protect consumer interests the Health Authority Board will be better able to exercise healthcare system oversight. Consumer interests could be protected by designating some board seats for consumer appointments and establishing a network of regional Healthcare Consumer Advisory Commissions.

RECOMMENDATIONS

The Board of Supervisors, with input from DHS and healthcare professionals, should:

2.1 Develop recommendations for enabling legislation that specifies membership on the Health Authority Board of Directors. At a minimum, the Board of Directors should include nine members, as follows:

- Five hospital and health care professional slots, as follows:
  - A member with a background in hospital administration to be nominated by the Health Authority Board of Directors;
  - A member with a background in ambulatory care/clinic administration to be nominated by the Health Authority Board of Directors;
  - A member with a background in finance and/or administration to be nominated by the Health Authority Board of Directors;
  - A member with a background in human resources and/or labor relations to be nominated by the Health Authority Board of Directors;
  - A member with a background in risk and/or asset management to be nominated by the Health Authority Board of Directors;

- Two physician members to be nominated by the Medical Director or voted on by physician staff;
- Two healthcare consumer members to be nominated by the consortium of Healthcare Consumer Advisory Commissions established in each of the County's major service areas (See Recommendation 2.4).

2.2 Develop recommendations for enabling legislation that requires the Board of Supervisors to appoint a Task Force comprised of DHS representatives and other health care professionals, practitioners and consumer representatives to develop a slate of nominees for appointment to the Health Authority Board of Directors, consistent with the composition outlined in Recommendation 2.1.

2.3 Develop recommendations for enabling legislation that requires the creation of Healthcare Consumer Advisory Commissions in each of the County's regional service areas or networks with one role being nominations to the two consumer representative positions on the Health Authority Board of Directors.

2.4 Develop recommendations for enabling legislation that establishes an ongoing nomination and appointment process for the Health Authority Board of Directors, where: (a) nominations are made by the Board of Directors for the five hospital and health care professional slots, by DHS' medical school affiliates for the two physician members, and by the recommended Healthcare Consumer Advisory Commissions for the two consumer representatives; and, (b) all nominations are confirmed by the Board of Supervisors.

COSTS AND BENEFITS

There would be no direct costs to implement these recommendations, although staff time will be required to provide analytical support to the Board of Supervisors.

The benefits of implementing these recommendations would be that the Health Authority Board would include members who possess appropriate hospital and health care system management, finance and other business expertise, as well as members who represent consumer interests. By segregating ongoing member appointment responsibilities between consumer groups, medical school affiliates and the Health Authority Board of Directors, a less politicized and more balanced organization should be in place, better reflecting the diverse interests of the community.

3. HEALTH AUTHORITY FINANCE AND PERFORMANCE REQUIREMENTS

- **Only 34.2 percent of the Department of Health Services $2.4 billion hospital and ambulatory care net operating budget is funded from direct patient revenues. The remaining 65.8 percent, or $1.6 billion, is funded from intergovernmental transfers from the federal and State governments, designated tax revenues, grants and subsidies received from the County. The substantial portion of income received from the federal, State and County governments are received by DHS to fund health services for the County's medically indigent and uninsured population.**

- **The creation of a health authority will not relieve the County of the significant financial responsibility it bears for the care of the medically indigent and will not alone resolve the fiscal problems facing DHS. While net operating costs could be lowered by implementing service efficiencies and initiatives to maximize revenues, it is likely that a significant operating deficit will continue unless the County redefines service responsibilities presently included in California Welfare and Institutions Code § 17000, case law and policy of the Board of Supervisors. Even with such a redefinition, challenges to the County's ability to fund medically indigent service demand will likely continue as the federal and State governments attempt to reduce their costs through Medicaid reform.**

- **To provide financial stability to the health authority, adequate financial provisions must be incorporated in the operating agreement with the County. A coordinated care approach, using standard rates for each covered patient or episodic treatment category, that can be adjusted each year based on changes in patient population and service profile, is recommended. The rate should incorporate planned cost reductions from efficiency improvements and redefined services, and cost enhancements for investments in areas such as information technology.**

- **To ensure that a desired level of service quality and cost-effectiveness is achieved, the operating agreement should include specific performance and financial goals for the health authority and measurements to use for periodic reports to the Health Authority Board of Directors and the County on actual accomplishments.**

The Department of Health Services is divided into several lines of business. The operations of the hospitals, comprehensive health centers and health centers are grouped as enterprise activities because these parts of the Department resemble business-type services. Other parts of the Department, such as public health, alcohol and drug services, AIDS treatment and others, are referred to as General Fund activities. As discussed extensively in Section 1 of this report, a health authority should be comprised of the enterprise activities because these parts of the Department share a common mission, serve similar clientele and are charged with complementary mandates.

As part of this study, we examined the finances of the DHS enterprise activities to develop broad recommendations regarding the financial relationship that should be developed between the County and the health authority. To accomplish this objective, we examined questions regarding the source of enterprise operating revenues and the major cost drivers for DHS enterprise functions.

ANALYSIS OF DHS ENTERPRISE REVENUES

The Department of Health Services' revenues come from a variety of sources, including patient payments for services and the federal, State and County governments. Many of the revenues received from the federal and State government are categorical in nature, meaning that funding is provided to support specific services that are provided by the Department. For example, the Department receives Healthy Families Program funding from the State and Federal government, which provides health insurance coverage for families with children who would otherwise be uninsured.

Other revenues are received by the Department because it operates public hospitals that serve a high proportion of indigent and uninsured patients. For example, the Department receives net income of approximately $592.3 million by using Intergovernmental Transfer (IGT) funding mechanisms established by the State. IGT payment mechanisms were established by the State to access supplemental federal Medicaid funding for public and private health care organizations that serve a disproportionate share of low income patients. During the past ten years, the Department also received special funding from the federal Medicaid program to finance direct patient care and develop innovative ways to streamline service delivery systems and reduce costs. Known as the federal Section 1115 Medicaid Waiver, this allocation of funding will end in the current fiscal year. In FY 2004-05, DHS received $75.5 million in Waiver payments for services provided by its enterprise departments, including $10.7 million for acute psychiatric services that were provided to Department of Mental Health (DMH) clients.

The Department also receives an allocation of Sales Tax and Vehicle License Fee revenue that is collected by the State and apportioned to counties based on total collections, population and various other factors. Much of this revenue is received by the County to subsidize health services that had previously been the

financial responsibility of the State. When the State decided to shift financial responsibility for these services to the counties, in a major legislative effort known as "Realignment," the Legislature provided general tax dollars to the counties to offset the cost of services. Other taxes are received from Measure B, which was approved by the voters of Los Angeles County to support emergency medical services. For FY 2004-05, DHS budgeted approximately $486.1 million in total tax revenue to support its enterprise activities.

When these major operating revenues and miscellaneous smaller revenues are lower than needed to fund DHS enterprise operations, the Department must take money from fund balance (e.g., savings from prior years) or request additional money from the County General Fund. This latter funding component is known as the General Fund Subsidy. In FY 2004-05, the Department was required to use approximately $115.9 million from the enterprise fund balance and an additional $142.2 million subsidy from the General Fund.

Some of these revenues change with patient service demands. For example, the $827.5 million in patient revenues that are received from Medi-Cal, Medicare, insured and "self-pay" patients will fluctuate each year based on the service demands of these populations. However, most of the Department's revenues – such as taxes – have no direct relationship to service delivery patterns. This can create a dilemma for the County since, when the economy falters and the uninsured population increases, tax revenues used to fund those services typically decline.

The result is that DHS has very little control over its income stream since only a small portion of its total revenues reflect the dynamics of the health care marketplace. Instead, most of the Department's income is more directly affected by the economy or by decisions that are made by external policy makers at the federal and State government levels. These conclusions are supported by the presentation of data contained in Table 3.1, below.

Table 3.1

Analysis of DHS Enterprise Revenues by Total and Percent – FY 2004-05 Final Budget (in millions)

Source of Funds	FY 2004-05 Budget	Percent of Income
Patient Revenues	$827.518	34.2%
Intergovernmental Transfers	592.341	24.5%
General and Dedicated Taxes	486.083	20.1%
Federal Medicaid Waiver	75.449	3.1%
SB 1732/Grants	13.161	0.5%
Miscellaneous Income	65.255	2.7%
TOTAL OPERATING INCOME	$2,059.807	85.2%
Subsidies from County and Enterprise Fund Balance	$358.163	14.8%
TOTAL INCOME	$2,417.970	100.0%

Note: "Enterprise" is comprised of DHS hospitals, comprehensive health centers and health centers.

Using the data contained in Table 3.1, the following observations can be made:

- Only 34.2 percent of operating revenues are derived from public and private insurance programs and collections from patients. These are the Department revenues that are most closely linked to the dynamics of service activity. When service demands from this group of patients increase, revenues increase. When service demands from this group of patients decline, revenues decline. However, it is important to recognize that 55.4 percent of the Department's patient revenue comes from the Medi-Cal program. In his FY 2005-06 recommended budget, the Governor has proposed major changes to the Medi-Cal program that he states will conservatively produce State General Fund cost savings of $139.1 million over the next four years.

- Nearly 25 percent of DHS enterprise revenues are derived from Intergovernmental Transfers related to the two California Disproportionate Share (DSH) funding programs discussed previously. Referred to as SB 855 and SB 1255, these programs provide a mechanism whereby (a) public hospitals transfer money to the State, (b) the federal government matches the contribution with Medicaid funding, and (c) the State redistributes the local money, with the federal match, back to public and private DSH hospitals. Nationally, the costs of Medicaid and Medicare DSH programs have been outpacing expected growth rates. In response, the federal government has changed the program and capped payments to states repeatedly throughout the 1990s and into the 2000s. During the past year, the federal government has been attempting to eliminate the IGT as a

funding mechanism and migrate to an alternative system of Medicaid block grant funding.

- As mentioned previously, the DHS enterprise activities were budgeted to receive $486.1 million in tax revenues in FY 2004-05, which represented approximately 20.1 percent of the total income. The primary sources of these revenues are Sales Tax and Motor Vehicle License Fees. During periods when there is a robust economy, these taxes can produce strong revenues to support health program needs. However, during the prolonged economic downturn, the health portion of Statewide Realignment Sales Tax has been stagnant. The Governor's January budget projects that there will be no growth in this account through FY 2005-06. Motor Vehicle License Fees are projected to produce some modest growth. However, between FY 2003-04 and FY 2005-06, the Governor has projected a three year growth rate for Motor Vehicle License Fees of only 4.1 percent.

- In FY 2004-05, DHS received $75.5 million in Waiver payments for services provided by its enterprise departments, including $10.7 million for acute psychiatric services that were provided to Department of Mental Health (DMH) clients. This amount represented 3.1 percent of the income for the enterprise activities. FY 2004-05 is the last year of this ten year demonstration project (two five year grants) that was intended to finance innovative ways to streamline service delivery systems and reduce costs. Beginning in FY 2005-06, DHS will no longer receive these funds.

The tenuous nature of each of these major revenues has created an unstable income environment for DHS, and in large part has contributed to concerns regarding the looming deficits being faced by the Department. As a result, anticipated gaps in funding from patient revenues, including Medi-Cal, external pressures to reduce or modify disproportionate share revenue, economic factors that affect tax collections and other significant destabilization factors regularly place the Board of Supervisors in difficult budget policy positions. Generally, the Board must either subsidize DHS operations or reduce services to the community. They have done both in recent years. On the revenue side, in FY 2004-05, the Board appropriated enterprise fund balance and General Fund discretionary resources to DHS enterprise activities that amounted to $358.163 million, or 14.8% of DHS enterprise operating income.

Despite the regular uncertainty surrounding these revenues, the Department has been successful in generating increased funding over the past five years. An analysis of net operating revenue and subsidy payments, other than use of enterprise fund balance and General Fund contribution, indicates that DHS enterprise activities have produced a 41.9 percent growth in income since FY 1999-00.

The majority of this growth has occurred in the Medi-Cal and DSH accounts, which represent 48.1 percent of the Department's revenue. These accounts grew by 40.9% over the five year period reviewed. In addition, the Department has

seen significant growth in taxes, particularly after the implementation of Measure B. In fact, tax growth after the implementation of Measure B, equaled 14.2 percent of the total growth realized by the Department.

A summary of this analysis is provided in Table3.2.

Table 3.2

Five Year History of DHS Enterprise Revenues FY 1999-00 through FY 2004-05 (Projected)

Dollars in Billions								
	Operating Income	Other State Hospital	Sales Tax	Vehicle License Fees	Tobacco Settlement	Measure B	Annual Income	Annual Growth %
FY 1999-00	$ 1.219	$ 0.033	$ 0.069	$ 0.201	$ -	$ -	$ 1.522	-
FY 2000-01	$ 1.460	$ 0.033	$ 0.082	$ 0.232	$ 0.045	$ -	$ 1.852	21.7%
FY 2001-02	$ 1.508	$ 0.033	$ 0.089	$ 0.248	$ 0.047	$ -	$ 1.925	3.9%
FY 2002-03	$ 1.470	$ 0.031	$ 0.103	$ 0.277	$ 0.050	$ -	$ 1.930	0.3%
FY 2003-04	$ 1.597	$ 0.012	$ 0.093	$ 0.263	$ 0.047	$ 0.140	$ 2.152	11.5%
FY 2004-05	$ 1.616	$ 0.013	$ 0.088	$ 0.255	$ 0.045	$ 0.143	$ 2.160	0.4%
Cumulative Growth %	32.6%	(61.1%)	27.5%	27.2%	N/A	N/A	41.9%	

Source: DHS Finance Department

Notes: "Enterprise" is comprised of DHS hospitals, comprehensive health centers and health centers.
Operating income includes net DSH revenue. The table also assumes that all Realignment Sales Tax, Vehicle License Fees and Tobacco Settlement revenues that are currently received by the Department will be obligated to the Department and the DHS enterprise activities discussed in this report.

ANALYSIS OF DHS ACTIVITY AND EXPENDITURES

Given this significant revenue growth, DHS has still been faced with annual deficit projections and believes it will be faced with such deficits in the future. Accordingly, the Board has periodically directed the Department to reduce services in an effort to reduce costs. For example, the County June 30, 2004 financial statements make the following observation:

> "In June 2002, the Board adopted a redesign plan that contemplates a System based on four acute hospitals, the closure of an additional 11 health centers, and additional reductions focused on narrowing the deficit . . . The Department's June 26, 2002, Proposed Savings Plan included reducing LAC+USC Medical Center by 100 acute beds and reducing the County's contribution to Rancho Los Amigos National Rehabilitation Center (Rancho) by either implementing an alternative governance structure or, failing that, by closing the hospital. As of June 30, 2004, the Department had been unable to implement either of these plans because of a preliminary injunction issued by the federal district court prohibiting any service reductions at these two facilities."

In fact, reductions that were implemented produced measurable results. Between FY 1999-00 and FY 2004-05, inpatient days in the County hospitals have declined by approximately 12.2 percent, while emergency room and ambulatory care visits have decreased by approximately 23.1 percent and 12.7

percent, respectively. Yet during this same period, costs have increased by approximately 26.9 percent. The reasons for these cost increases are varied, but a large portion of the increase relates to expenses associated with employee salaries and benefits, which represent over 57 percent of the Department's total cost. As discussed in Section 8, a significant reason for employee wage and benefit increases relates to pension funding requirements that have occurred as a result of the economic downturn.

Activity information is displayed in Table 3.3, below. Cost information is displayed in Table 3.4.

Table 3.3

Five Year History of DHS Enterprise Activity FY 1999-00 through FY 2004-05 (Projected)

Annual Activity	Base Year FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	Projected FY 2004-05
Inpatient Days	683,322	673,060	673,060	651,160	602,980	599,695
Emergency Room Visits	385,739	400,618	298,226	301,882	301,570	296,552
Ambulatory Care Visits	2,331,095	2,329,074	2,300,000	2,165,136	2,031,027	2,035,689
Year-toYear Change						
Inpatient Days	-	(1.5%)	0.0%	(3.3%)	(7.4%)	(0.5%)
Emergency Room Visits	-	3.9%	(25.6%)	1.2%	(0.1%)	(1.7%)
Ambulatory Care Visits	-	(0.1%)	(1.2%)	(5.9%)	(6.2%)	0.2%
Cumulative Change						
Inpatient Days	-	(1.5%)	(1.5%)	(4.7%)	(11.8%)	(12.2%)
Emergency Room Visits	-	3.9%	(22.7%)	(21.7%)	(21.8%)	(23.1%)
Ambulatory Care Visits	-	(0.1%)	(1.3%)	(7.1%)	(12.9%)	(12.7%)

Source: DHS Finance Department

Note: "Enterprise" is comprised of DHS hospitals, comprehensive health centers and health centers.

Table 3.4

Five Year History of DHS Enterprise Expenditures FY 1999-00 through FY 2004-05 (Projected)

	Annual Cost ($billions)	Annual Growth %	Cumulative Growth %
FY 1999-00	$ 1.905	-	-
FY 2000-01	$ 2.035	6.8%	6.8%
FY 2001-02	$ 2.063	1.4%	8.3%
FY 2002-03	$ 2.324	12.6%	22.0%
FY 2003-04	$ 2.328	0.2%	22.2%
FY 2004-05	$ 2.418	3.9%	26.9%

Source: DHS Finance Department
Notes: FY 2004-05 is projected.
"Enterprise" is comprised of DHS hospitals, comprehensive health centers and health centers.

Despite the significant revenue growth and the efforts to contain costs, the Department will likely continue to face financial difficulties in the future. In January 2005, DHS projected a "cumulative shortfall" of $1.315 billion through FY 2008-09. The Department also stated that, unless it can successfully reduce hospital capacity, negotiate alternative federal funding mechanisms for some outpatient services and negotiate continued funding of some parts of the Section 1115 Waiver, the deficit projection would grow by $953 million, to $2.268 billion by FY 2008-09, unless there are significant reductions in expenditures. These projections did not include an assessment of impacts from the Medi-Cal Program Redesign proposals that are included in the Governor's proposed budget for FY 2005-06.

We did not analyze the reasonableness of these projections for this report. If they are accurate, the services to the community will likely degrade and drastic measures may be needed to successfully reduce costs. The ability to do so may be complicated by the County's statutory obligations and local policy to provide services to the indigent and uninsured regardless of citizenship.

LEGAL OBLIGATION TO PROVIDE SERVICES

As discussed elsewhere in this report, the County's responsibilities related to Welfare and Institutions Code §17000 should be clearly defined in relation to the mission of the health authority. Welfare and Institutions Code §17000 states:

> "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions."

Section 17000.5 allows boards of supervisors to "adopt a standard of aid, including the value of in-kind aid which includes, but is not limited to the monthly actuarial value of up to forty dollars ($40) per month of medical care." However, Section 17000.51 clarifies that Section 17000.5 "was not intended, and shall not be construed, to do any of the following:

1. Satisfy, in whole or in part, the duty of a county or a city and county to provide health care services to indigent and dependent poor persons under Section 17000.
2. Permit a county or a city and county to cease providing health care services to indigent and dependent poor persons under Section 17000.
3. Affect the eligibility of indigent and dependent poor persons for health care services under Section 17000."

As a result, eligibility for healthcare services has been defined by Los Angeles County as including "General Relief recipients and individuals aged 18 to 64 with income between 100 and 200 percent of the Federal Poverty Level (FPL)."[1]

Other sections of the law and various court decisions have further complicated this definition. Patients and advocacy groups have previously sued counties in California when attempts have been made to reduce benefits, curtail services or significantly redefine the health care delivery systems, using legal challenges rooted in California statute and federal Medicaid regulations. A recent example occurred when the County was challenged in federal court after announcing its intentions to close Rancho Los Amigos Rehabilitation Hospital and reduce the number of beds at the LAC+USC Medical Center.[2]

In its 2002 Strategic Plan, DHS attempted to define the population which the County is legally responsible to serve under the definition previously discussed, and for whom it actually provides services. The Plan stated that, "The legally-mandated population is estimated to be some 700,000 residents of the County. In Fiscal Year 1999-2000, DHS (including the PPP network) provided services to 140,000, or 20 percent of this mandated population. These services included 637,000 outpatient and emergency room visits and 68,000 inpatient days."

It is difficult to measure the proportion of this population that receives services from other community providers or receives no care at all. However, in its Strategic Plan, the Department recognized that in order to reduce the County's costs, the scope of safety net services and service delivery strategies would need to be redefined in addition to reducing costs through improved efficiency. According to the Department, opportunities for reducing costs would involve a range of alternatives that would (a) utilize managed care principles for the "legally-mandated" population, (b) discontinue or discourage service for the non-

---

[1] January 29, 2002, *Department of Health Services Strategic and Operational Action Plan*

[2] Harris v. Board of Supervisors, Los Angeles County, Federal Court of Appeals, Ninth Circuit No. 03-56028, and Rodde v. the California State Department of Health Services and County of Los Angeles, United States District Court for the Central District of California, No. 03-55765.

mandated population (e.g., non-County residents), and (c) redefine the scope of services that would be provided by DHS, based on decisions regarding service emphasis. Under each of the scenarios that were presented, the Department anticipated that there could be legal challenges.

Lastly, it is important to recognize that many of the patients treated by the Department access care through the hospital emergency rooms. These ER visits are typically episodic in nature and, therefore, are difficult to manage because services generally must be provided to any person who presents themselves for care. As a result, many times persons are seen by DHS physicians who might otherwise not meet eligibility requirements established by the County. Therefore, even if these more restrictive policies were adopted by the Board, certain services would need to continue and made available to non-County residents and others that would otherwise not be eligible for services.

DHS is therefore faced with difficult choices in the coming years. While revenues have increased at a reasonable level during the past five years, there is a strong likelihood that there will be reductions in the future. The loss of the Section 1115 Medicaid Waiver, pressures from the federal government to contain DSH funding, and efforts by the Governor to transition from a fee for service to managed care system through Medi-Cal redesign all have the potential of degrading revenues over the course of the next several years. On a more positive note, tax revenues will likely increase as the economy recovers.

The Department's ability to reduce costs has also been made more difficult due to the character of services that are provided, and court injunctions against hospital closures or service reductions. Given the history of efforts by advocacy groups to maintain service levels in the community, pressures to continue at present service levels are likely to continue. Unless the Board can successfully redefine the population to whom the County is legally mandated to provide services, demands on the system of health care will continue. The recommendations made by the Department in the strategic plan recognize the seriousness of the situation and call upon the Board of Supervisors to take the political action necessary to resolve the crisis.We do not believe that these serious service level and financial difficulties will evaporate with the creation of a health authority. In the County of Alameda, the health authority governing board has returned to the Board of Supervisors for additional funding when it has been unable to internally resolve its financial difficulties. Even the experience of Denver Health (DH), which has been pointed to as a successful health authority model, suggests that the key to success is to obtain appropriate funding to meet service demands and improve operations. A report by the National Health Policy Forum (NHPF) made the observation that:

> "In 1991, DH faced a $40 million operating deficit, but a rapid infusion of Medicaid DSH funding in the 1990s was a critical factor in DH's subsequent financial turnaround. Between 1991 and 2000, DH received nearly $320 million in DSH funding. . . In addition to supporting direct care, Medicaid DSH has allowed DH to eliminate its operating deficit, invest in new infrastructure, and reorganize into a vertically integrated

> delivery system that can deliver care in a more coordinated and cost-effective manner."[3]

To be successful, the enabling legislation would need to be designed to permit the health authority to access all of the same funding sources as are currently available to the County. This will require complex strategies and a clearly delineated financial relationship between the two organizations that will permit the County and the health authority to jointly leverage available from the federal and State governments.

FINANCIAL AND PERFORMANCE REQUIREMENTS BETWEEN THE COUNTY AND HEALTH AUTHORITY

Because of the requirements of Welfare and Institutions Code Section 17000 and other factors, the new health authority will need to rely heavily on the County for funding. Accordingly, the operating agreement between the County and health authority will need to clearly define the responsibilities, the financial relationship and expectations of each party. The County will want to make sure that services are appropriately and cost effectively being provided, while the health authority will want to make sure that resources are sufficient to finance the cost of operations.

In addition to the operating agreement, systems and processes should be established to guarantee appropriate funding amounts for specific quality expectations and service levels. These systems would need to:

- Capture key activity, financial and service quality information to measure performance and provide a basis for reimbursement; and,

- Provide regular performance reports to managers and board members from both the County and the health authority, supplemented by periodic analysis of results by an independent party.

An appropriately constructed operating agreement and system of performance-based monitoring is key to the success of the health authority and the County's ability to control the quality and cost of the services that it purchases. Such mechanisms are used by both private and public sector managed care organizations to ensure the quality and cost effectiveness of services, and have reportedly been key to the success of Denver Health and other successful health care organizations.

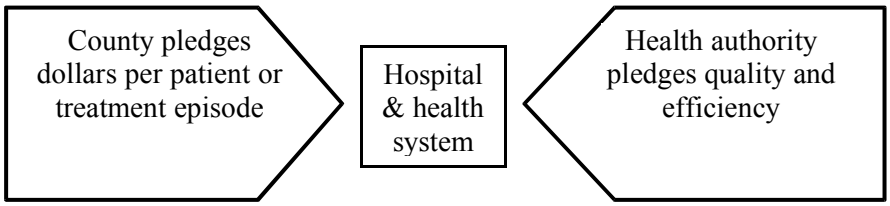
The ability to obtain sufficient funding and invest the resources necessary to operate efficiently is key to success for the health authority. Unless the financial and performance responsibilities of the County and the health authority are clearly defined, and mechanisms are established to effectively measure health

---

[3] Robert E. Mechanic, Consultant, National Health Policy Forum, *NHPF Background Paper, Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments,* September 14, 2004

authority performance, the probability that the health authority will outperform DHS are minimized. Exhibit 3.1 demonstrates the interests that must be balanced in an agreement between the County and the health authority.

Exhibit 3.1
Interests to be balanced between
County and new health authority



There are four key ingredients to a formula for success:

1. The Board of Supervisors must clearly and effectively define the population for whom the health authority will provide services. Recommendations to clarify the definition have been made by DHS to the Board of Supervisors, but a clear and succinct policy has still not been accepted by the Board.

2. The Board of Supervisors will need to commit sufficient resources to the health authority to reasonably finance its operations. The health authority would need to retain all patient revenues and other resources that result directly from the services that it provides. The Board of Supervisors would need to ensure that dedicated taxes collected by the County (e.g., Sales Tax, Motor Vehicle License Fees and Measure B) would be provided to the health authority; and, through maintenance of effort commitments, guarantee appropriate levels of General Fund subsidy to support services not funded through these other mechanisms.

3. An agreement for services between the County and the Health Authority would need to be constructed to provide revenue and cost based incentives for (a) the County to provide sufficient financial resources to the health authority, and (b) the health authority to use those resources effectively. To the extent possible given the transient characteristics of many DHS patients, the contract structure should build on managed care principles, with standard rates per patient or episodic treatment established each year, as has become prevalent in the health care industry and is being pushed forward by the State of California. These rates should incorporate the Department's existing cost structure, reduced by an assumed level of cost reduction each year, and increased by a planned level of investment in areas such as information technology. The target number of patients to be served should be determined based on these three key variables. This approach would provide a rational basis for increases in payment from the County based on increases in projected patient population, offset by net annual cost reductions achieved.

4. Goals and measures should be codified in the operating agreement and a monitoring infrastructure developed to measure operational and financial performance of the health authority, given the substantial resources that the Board of Supervisors will be contributing to the health authority. Examples of areas for which goals and measurements should be established include:

   - Cost reductions as measured annually by average risk adjusted cost per patient
   - Measures of system integration
   - Number of patients served by comprehensive disease management programs and results of the programs
   - Patient outcomes such as mortality rates, complications for patients with diabetes, etc.
   - Patient satisfaction measured through patient surveys, and
   - Others to be determined

DHS' strategic and redesign plans of 2002 provide a framework for defining the health authority's service population, benefits package and performance and financial measurements. The redesign plan of June 2002 calls for: greater integration of Department services; consolidation and elimination of redundant services; defining the Department's services provided; aligning services and patient populations; improving the use of information technology; consolidating administrative and clinical management functions and establishing a performance management system incorporating measurements of efficiency, effectiveness, patient satisfaction and outcomes. The plans include specific proposed reductions in services based on varying assumptions about revenue levels in the coming years.

Using the recommendations of the strategic and redesign plans for the new health authority would cover many of the four ingredients for success identified above. They would help define the population to be served and a corresponding service levels to be provided. The plans could serve as the basis of a standard rate per patient or episodic treatment category, and they provide a suggested framework for a performance measurement system.

Financial and performance measurement reports including key measures such as those presented above should be prepared and regularly provided, such as monthly, to the Health Authority Board of Directors and on a less frequent basis, such as annually, to the Board of Supervisors. Details of the reporting requirements should be included in the operating agreement between the County and the health authority.

CONCLUSIONS

Only 34.2 percent of the Department of Health Services $2.4 billion hospital and ambulatory care net operating budget is funded from patient revenues. The remaining 65.8 percent, or $1.6 billion is funded from intergovernmental transfers from the federal and State governments, designated tax revenues, grants and subsidies received from the County. The substantial portion of income received from the federal, State and County governments are received by DHS to fund health services for the County's medically indigent and uninsured population.

The creation of a Health Authority alone will not relieve the County of the significant financial responsibility it bears for the care of the medically indigent. While net operating costs could be lowered by implementing service efficiencies and maximizing revenues, it is likely that a significant operating deficit will continue unless the County redefines service responsibilities that are presently included in California Welfare and Institutions Code § 17000, case law and policy of the Board of Supervisors. Even with such a redefinition, challenges to the County's ability to fund medically indigent service demand will likely continue as the federal and State governments attempt to reduce their costs through Medicaid reform.

Accordingly, the financial relationship between the County and the Health Authority needs to be carefully defined. Unless adequate financial provisions are incorporated into future operating agreements, the interests of both parties will be at risk.

Performance goals and measurements need to be established and codified in the operating agreement between the County and health authority to ensure that County funds are being spent efficiently and that the quality of care is improving. A consistent set of performance measurements should be provided to the Health Authority Board of Directors on a regular basis such as monthly and the Board of Supervisors on a less frequent basis such as annually.

RECOMMENDATIONS

The Board of Supervisors should:

3.1 Clearly and effectively define a patient benefits package and the population for whom the health authority will provide services, within the context of State law, case law and local priorities, to be included in the operating agreement between the County and the new health authority.

3.2 Direct the CAO to work with the Department of Health Services representatives to establish a funding mechanism that will reasonably finance the health authority’s operations. At a minimum, the health authority should retain all patient revenues and other resources that result directly from the services that it provides, as well as dedicated tax revenues and maintenance of effort guarantees for sufficient County General Fund subsidies to finance its operations.

3.3 Direct the CAO to work with County Counsel and the Department of Health Services representatives on the development of an operating agreement for services that provides revenue and cost-based incentives for (a) the County to provide sufficient resources to the health authority using a coordinated care standard rate per patient or episodic treatment approach, and (b) the health authority to use those resources effectively, as demonstrated by reductions in cost per patient over several years.

3.4 Direct the CAO to work with Department of Health Services representatives to establish baseline costs based on current operations, and to determine the planned timing of cost reductions and efficiency improvements and needed investments in areas such as information technology so that the standard rates used in the agreement between the health authority and County can be adjusted each year, in accordance with this plan.

3.5 Direct the CAO to work with the Department of Health Services to develop (a) hospital and health care system financial and performance goals and measurements, for inclusion in the operating agreement between the County and the health authority; and, (b) systems to measure actual financial and service quality performance of the health authority, including cost measures, patient outcome and satisfaction measures and improvements in efficiency. These goals and measurements should be regularly reported to managers, the Health Authority Board of Directors and the County Board of Supervisors, supplemented by periodic analysis of results by an independent party.

COSTS AND BENEFITS

There will be initial costs to implement the service quality and performance monitoring system, primarily in County staff time. However, we did not estimate that cost within the scope of this study.

The health authority will be provided with greater assurance that sufficient funding will be provided by the County for designated levels of service. The County will have greater assurance that it will receive high quality, low cost services for the indigent and uninsured population that the health authority will be serving.

4. HUMAN RESOURCES

- **The Department's hospitals had a 12.7 percent position vacancy rate for the first five months of FY 2004-05, with even higher rates for key classifications such as nurses and technicians and specialists. These vacancy rates, measured in full-time equivalents, are one indication of potential human resource management problems in areas such as recruiting, hiring and/or compensation. A review of the Department's and County's human resources processes and systems indicates that all of these areas are affecting the Department's ability to hire and retain staff. A fiscal impact of this situation is the use of Registry personnel to fill vacant positions. For Staff Nurses, the Department will spend an estimated $9 million in FY 2004-05 for Registry positions compared to the cost of in-house County employees.**
- **Adherence to County civil service rules means that the Department's recruitment and hiring processes are lengthy and time consuming. Review and approval of job bulletins, selection criteria, position information, and classifications can delay the hiring process.**
- **To address some of these concerns, DHS has begun to reengineer its human resources function, centralizing some functions and obtaining increased authority from the County for compensation and hiring decisions. Much of the hiring process has been automated with the development of an in-house system available to program managers. Despite these achievements, the process is still governed by County civil service requirements and many DHS managers continue to assert that the Department's human resources system is ineffective and cumbersome.**
- **A health authority would not be subject to current restrictions placed upon DHS by the County Charter, Civil Service Rules, and employee bargaining agreements. Compensation levels could be strategically set by the health authority board within the context of the health authority's singular mission and budget, the recruitment and hiring process could be streamlined and made more efficient and the rules associated with employee disciplinary actions could be reconsidered.**

The County of Los Angeles human resources system has evolved over many years in response to the varying needs of the many County departments, and the

various legal requirements and rules embedded in the County Charter, Civil Service System and memoranda of understanding with employee bargaining groups. The evolved system has become inflexible and reportedly unresponsive to the operating needs of many County departments. Throughout interviews for this study, DHS managers expressed frustration with their perceived inability to move salary and compensation change requests through the system, attract qualified candidates, schedule exams or accomplish other hiring activities in a timely manner. Some managers expressed frustration with the employee discipline system, stating that Civil Service rules are confusing and often misinterpreted at the operations level. Further, many believe that the disciplinary process is ineffective and often disruptive to the organization, since the subject employee often continues to work during "the many months or years" that it takes to resolve the matter.

These concerns are recognized throughout the various levels of County government. Although line managers expressed a desire for increased human resources flexibility and greater timeliness, DHS human resources managers, County human resources managers and County Chief Administrative Office human resource managers all expressed concerns that, without standardization and oversight, there would be a greater likelihood that Civil Service rules would be violated and personnel costs would escalate.

HUMAN RESOURCES PROFILE, ACTIVITY AND PROCESS

The Department of Health Services is one of the largest and most complex health organizations in the United States and is bigger than most counties and cities within California. With over 24,300 budgeted positions, the Department is continually immersed in human resources activities. As part of a larger government organization, DHS must conform with general County rules that may not provide the flexibility and autonomy needed to function within a dynamic marketplace for health care workers. In addition, the Department must compete against other County departments for significant amounts of discretionary County General Fund funding to support its operations. As a result, County management has established some layers of checks and balances to provide themselves with assurance that County departments will appropriately contain salary and benefit costs. At 57 percent of total costs, the salaries and benefits of employees represent the single largest cost component for DHS hospitals, comprehensive health centers and health centers.

DHS has a high vacancy rate

Known as the Department's enterprise activities, the DHS hospitals, comprehensive health centers and health centers are budgeted for approximately 18,440 positions, or approximately 75.9 percent of all DHS personnel. Within the enterprise divisions of DHS, there is a constant need to fill vacant positions at all levels within the organization. Between July 1, 2003 and March 18, 2005, 3,369 employees, comprised of 2,566 "new hires" and 803 "rehires" were hired at the hospitals. In spite of this level of hiring, between July

and November 2004, approximately 2,147 of the 16,871 budgeted full-time equivalent positions (FTEs)[1] assigned to just the DHS hospitals were vacant. This represents 12.7 percent of the workforce assigned to the Department's hospitals. This level of vacancy is an indicator of deficiencies in the Department's human resource systems and processes.

The highest vacancy rates at the hospitals, measured in terms of FTEs are in the nurse classifications as shown in Table 4.1. The rate for the Registered Nurses classifications, which comprises most of the nursing staff at the hospitals, is 28.0 percent of budgeted FTEs. After this classification, the next highest vacancy rates are reported for Management and Supervision classifications at 18.2 percent, followed by Technician and Specialist classifications at 16.8 percent of budgeted FTEs. Some classification groups, such as Physician's Assistants and Aides and Orderlies had negative vacancy rates during the period reviewed because more positions were filled than budgeted. This is allowable under County procedures as long as the Department does not exceed its total budget for salaries and benefits.

As one might expect, most of the vacancies fall within the classifications where there are the most authorized positions. As shown in Table 4.1, approximately 46.6 percent of all FTE vacancies at the DHS hospitals are within the registered nurse classifications and another 24.6 percent of all vacancies are within the Department's technical and specialist classifications (e.g., pharmacy technicians, radiology technicians, physical therapists, occupational therapists and respiratory therapists). Other smaller numbers of vacancies exist in management/support and clerical classifications.

[1] A full-time equivalent represents 1,764 hours of productive staff time, the assumed average number of productive hours for which a full-time employee is paid after deducting for paid holidays, vacation, sick leave and other paid leave from the 2,080 hours for which an employee is paid in a year. One full-time equivalent could consist of two half-time positions.

Table 4.1
Vacancy Rates by
DHS Employee Classification Groups
In Full-time Equivalents (FTEs)
FY 2004 - 2005

Code	Classification Group [1]	Budgeted FTEs	Actual Average FTEs	Vacant FTEs	Vacancy Rate	% Total Vacancies
095	Nurse Anesthetist Trainee	2.0	1.1	0.92	46.0%	0.04%
015	Nurse Anesthetist	43.0	27.5	15.50	36.0%	0.7%
020	Registered Nurse	3,576.1	2,576.1	1,000.00	28.0%	46.6%
001	Management & Supervision	954.0	780.7	173.30	18.2%	8.1%
010	Technician and Specialist	3,148.2	2,619.5	528.70	16.8%	24.6%
070	Physicians	729.4	629.6	99.80	13.7%	4.6%
003	Mgt/Sup-Supv Staff Nurse	600.3	523.5	76.80	12.8%	3.6%
093	Phys Post Grad 1st Year	357.0	311.8	45.20	12.7%	2.1%
081	Dentist	3.2	2.8	0.40	12.6%	0.0%
060	Environmental/Food Svs.	1,118.4	986.6	131.80	11.8%	6.1%
094	Phys Post Grad 2nd-7th Yr.	1,256.0	1,121.4	134.60	10.7%	6.3%
090	Other Salaries & Wages	563.4	516.2	47.10	8.4%	2.2%
030	Licensed Vocational Nurse	450.6	422.7	27.90	6.2%	1.3%
050	Clerical & Other Admin	2,889.0	2,778.5	110.50	3.8%	5.1%
005	Mgt/Sup-Nurse Anesthetist	2.0	2.0	-	0.0%	0.0%
011	Dental Specialist	-	8.2	(8.2)	0.0%	-0.4%
080	Non-Phys Medical Practnr	94.6	96.2	(1.7)	-1.8%	-0.1%
092	Dental Resident	12.0	12.3	(0.3)	-2.5%	0.0%
084	Physician's Assistant	89.0	103.0	(14.0)	-15.8%	-0.7%
040	Aides and Orderlies	957.3	1,108.5	(151.2)	-15.8%	-7.0%
091	Dental Intern	15.0	18.8	(3.8)	-25.3%	-0.2%
097	Student Nurse Worker	11.0	76.5	(65.5)	-596.4%	-3.1%
	Total FTE:	16,871.37	14,723.6	2,147.8	12.7%	100.0%

Source: HMR Analysis of (a) *DHS FTE Report by Natural Classification – average FTE for July – November Fiscal Year 2004-2005*; (b) *DHS Registry Report – annualized FTE for July – December Fiscal Year 2004-2005; (c) County of Los Angeles-Department of Health Services Positions by Natural Class as of 3/2/05.*

[1] The Department's classifications are grouped by "Natural Classifications" which is a system designed by DHS to group like classifications for staffing data submitted to the State Office of Statewide Health Planning & Development (OSHPD).

USE OF REGISTRY

One of the impacts of the Department's high staff vacancy rate, particularly for nurses and technician and specialist classifications is that the Department has ended up using more costly Registry personnel to meet its staffing needs. Use of Registry personnel allows the Department to meet its critical

staffing needs at the hospital that would otherwise go unmet due to vacancies, but at a higher cost than if the vacant positions were filled.

The personnel needs of hospitals are unique. In order to meet standards of care, specific levels of staffing are required based on the census, acuity and service requirements of patients. Hospitals operate 24 hours per day – seven days per week. Accordingly, when there are vacant positions in classifications where direct patient care is required, they frequently must be backfilled with overtime, part-time or registry personnel.

Registries are private sector companies that generally provide health care workers for positions that require high-end skill sets. Registries will provide nurses and other technical and specialist positions when needed by hospitals. The hospitals are charged for the cost of the positions plus an administrative and profit mark-up by the Registry.

DHS hospitals use significant levels of registry personnel. As shown in Table 4.2, for the five month period examined in FY 2004-05, approximately 1,126 FTE positions were regularly filled by registry personnel. Again, as one would expect, most registry usage fell within the registered nursing (55.3%) and technical and specialist (30.9%) classifications, where the Department has the greatest need in terms of both total positions and vacancies. Overall, registry use averaged 14.2 percent of the total FTE classifications assigned to the hospitals for whom registry personnel are used. In nursing and technical/specialist fields, approximately 19.5 percent and 11.7%, respectively of all budgeted FTEs, respectively, were filled by registry personnel.

Table 4.2
Use of Registry Personnel by Classification
FY 2004 - 2005

Code	Classification Group [1]	Budgeted FTEs	Actual Average FTEs [2]	Vacant FTEs	Registry FTEs	% Total FTEs for the class	% Total Registry
020	Registered Nurse	3,576	3,199	1,000	623	19.5%	55.3%
010	Technician and Specialist	3,148	2,967	529	348	11.7%	30.9%
090	Other Salaries & Wages	563	549	47	33	6.0%	2.9%
040	Aides and Orderlies	957	1,230	(151)	122	9.9%	10.8%
	Total FTE:	8,245	7,947	1,425	1,126	14.2%	100.0%

Source: HMR Analysis of (a) *DHS FTE Report by Natural Classification – average FTE for July – November Fiscal Year 2004-2005*; (b) *DHS Registry Report – annualized FTE for July – December Fiscal Year 2004-2005; (c) County of Los Angeles-Department of Health Services Positions by Natural Class as of 3/2/05*.

[1] The Department's classifications are grouped by "Natural Classifications" which is a system designed by DHS to group like classifications for staffing data submitted to the State Office of Statewide Health Planning & Development (OSHPD).

[2] Includes average County FTE and Registry FTE.

These statistics are even more dramatic when viewed by hospital. Table 4.3 illustrates the high percentage of registry personnel used to fill Registered Nurse (RN) FTEs in the County's hospitals.

Table 4.3

Use of Registry Personnel to Fill RN Positions at the County's Hospitals FY 2004-2005

Hospital	Filled FTEs	Registry FTEs [1]	Total FTEs	% Registry
MLK/Drew	333	178	511	34.8%
LAC+USC	1,165	405	1,570	25.8%
Olive View	341	33	374	8.8%
High Desert	34	1	35	2.9%
Rancho Los Amigos	148	4	152	2.6%
Harbor-UCLA	555	2	557	0.4%
TOTAL	2,576	623	3,199	19.5%

Source: HMR Analysis of: a) (a) *DHS FTE Report by Natural Classification – average FTE for July – November Fiscal Year 2004-200; and b) DHS Registry Reports*

[1] Registry FTE reflects July 2004 – December 2004, annualized, productive FTE.

While the average RN registry use was 19.5 percent for all County hospitals, usage varied significantly by location. At Martin Luther King – Drew Medical Center, nearly 35 percent of all RN staffing was filled by registry personnel, while at Harbor-UCLA Medical Center, less than one percent of all RN staffing was filled by registry personnel. While we could not conduct this analysis for all registry classifications within the scope of this study, the analysis performed provides a concrete illustration of the operational and financial impacts from the Department's inability to attract and hire qualified personnel in positions filled by registry personnel.

Use of registry personnel has a negative fiscal impact on DHS and the County in that the hourly rate for most registry personnel is higher than the comparable hourly rate for County employees. Table 4.4 presents the comparative costs and estimated fiscal impact of using registry personnel for DHS' Staff Nurse classification and a combination of Medical Record Coders and Medical Record Technicians. As can be seen, use of registry personnel for Staff Nurse positions represents an extra cost to the Department of approximately $9.1 million for FY 2004-05 compared to filling the positions staffed by registry workers with County employees. The comparable amount for the Medical Record Coders and Medical Record Technician I is approximately $2.1 million. While there will probably always be some need for registry personnel due to circumstances such as unplanned staff leave, Department costs could be substantially reduced if a greater proportion of

positions were filled with full-time County employees rather than registry personnel.

It should be noted that the bargaining unit agreements between the County and DHS Registered Nurses and Supervising Registered Nurses were recently amended. Among the changes was a County obligation to create a new 20-step pay scale for these nursing classifications, which will result in increased costs for County employees. Unless registry costs increase proportionately, this will reduce the differential between the two groups, though it is likely that registry personnel will still cost more.

Table 4.4
Comparative Costs of Registry Personnel vs. County Employees FY 2004-2005

Classification	Staff Nurse (5335)	Medical Record Coders/ Techs (1399 & 1401)
Average Registry Hourly Rate	$64 [1]	$38.40 [4]
County Employee Hourly Rate	$46.82 [2]	$29.19 [5]
Estimated Hours Billed by Registry Personnel	529,200 [3]	224,028 [6]
Registry Cost	$33,868,800	$8,602,675
County Employee Cost for Same Hours	$24,777,144	$6,539,377
Difference	$9,091,656	$2,063,298

[1] Based on average of actual rates paid in FY 2004-05 at Harbor/UCLA, Olive View, Rancho Los Amigos and King-Drew Medical Center.

[2] Based on Step 5 salary for DHS' 5335 Staff Nurse classification plus a 40% benefits rate, and assuming 1,764 productive hours per FTE.

[3] Assumes that of the 623 actual Registered Nurse FTEs provided by registry personnel in FY 2004-05, an estimated 327 are Staff Nurses. The estimated 327 Staff Nurse FTEs is based on the proportion of Staff Nurse classification 5335 to Registered Nurses FTEs in the FY 2004-05 budget and applying this ratio to the 623 actual registry Registered Nurse FTEs to arrive at an estimated proportion that represents staff nurses.

[4] Based on average of actual rates paid in FY 2004-05 at King-Drew, Harbor/UCLA, and LCC+USC.

[5] Based on average step 5 salary for classifications 1399 aand 1401.

[6] Based on total Medical Records Coders hours through December 2004 of 112,131 annualized and divided by 1,764 for productive FTE.

EXPLANATIONS FOR DHS VACANCY RATE

The hospitals overall vacancy rate at the hospitals of 12.7 percent, measured in FTE's, is an indicator that the Department has problems recruiting, hiring or retaining staff. In many organizations, these problems are explained by:

- a poor recruitment and/or hiring process;
- total compensation that is not competitive; and/or,
- a difficult or undesirable working environment.

A review of the human resources process at DHS showed that all of these factors appear to be contributing to the Department's high vacancy rate, particularly for the classifications where the highest vacancy rates exist.

Hiring Activity

As part of this study, we analyzed the hiring activity at the Department's hospitals for the period July 1, 2003 through March 18, 2005. During this period, the hospitals hired 3,369 employees, including 2,566 "new hires" and 803 "rehires" (rehires include individuals who may have temporarily left County employment or have returned after retirement to work part-time). Of the 2,566 new hires, 696 were for post-graduate physician positions (i.e., interns and residents). These physician positions are hired through a separate non-Civil Service process in collaboration with the medical schools while they work through their medical rotations. Accordingly, we did not evaluate the hiring process for these classifications.

Therefore, excluding the post-graduate physician positions, the hospitals hired 2,673 positions, including 1,870 new hires and 803 rehires. These employees were hired for a variety of positions within the hospital organizations. However, approximately 59.6 percent, or 1,593 positions were hired for ten classifications in (a) nursing, (b) clerical and (c) physician specialist positions. The distribution of these new hires and rehires by position classification is shown in Table 4.5, below.

Table 4.5
New Hires and Rehires by Classification

DHS Hospitals: July 1, 2003 – March 18, 2005 [1]

Position Classification		All Hires	Percent
5335	Staff Nurse	305	11.4%
5261	Relief Nurse	267	10.0%
5118	Senior, Student Worker, Nursing	195	7.3%
5098	Nursing Attendant I	191	7.1%
5104	Licensed Vocational Nurse I	179	6.7%
5113	Student Worker Nursing	110	4.1%
1138	Intermediate Clerk	96	3.6%
5477	Physician Specialist, M.D.	87	3.3%
2214	Intermediate Typist Clerk	84	3.1%
5422	Senior Radiation Protection Specialist	79	3.0%
		1,593	59.6%
	All Others	1,080	40.4%
	Total Positions	2,673	100.0%

Source: HMR Analysis of *Department of Health Services New Hire Report – 7/1/03-3/18/05.*

1 Total new hires and rehires do not include transfers into the hospitals or promotions.

Despite this level of hiring activity, the hospitals have experienced a 12.7 percent vacancy rate, discussed above, and much higher rates for many critical classifications.

DHS' hiring process is time consuming as it is governed by County civil service requirements

The human resources concerns most expressed during interviews for this study focused on the delays that result from the numerous processing stages and approvals that are required to hire an employee. Particular concern was expressed regarding the external analysis and approval steps that are conducted by the County Human Resources Department and the Chief Administrative Office (CAO) employee compensation and budget units. Some staff were also concerned that the hiring processes recently delegated to the Department by the Chief Administrative Office and County Department of Human Resources for the Department's own classifications are no better than the County's since the Department still has to adhere to County civil service rules.

There is no question that the process for hiring personnel within the County Civil Service system creates a time-consuming process. Depending on the type of hiring, the processing can take anywhere from several weeks to a

year or more. A judgmental sample that we conducted for this study provides some examples of hiring cycle time.[2]

There are five different categories of employees with separate human resources processing and approval requirements. Each of the five categories is described below, including a detailed explanation of the process for Salary Scheduled Classifications, which covers most of DHS' positions.

1. Salary Scheduled Classifications – This category includes all classifications where there is an established salary schedule specifying the compensation that will be paid to employees. If DHS wishes to hire an individual for a vacant position, in accordance with established County policies, then no external processing, review or approvals are required. However, the process is very much influenced by the County system: the role of DHS' Human Resources Department is to administer the Countys' civil service rules within DHS. The process is as follows. Flow charts depicting the processes are included as Attachment 4-1.

   - The hiring process for a salary schedule classification begins when the facility that needs the position enters the Personnel Action Request (PAR) into the automated Item Management System. Next, an internal review and approval process, which is unique to each facility, takes place. Following the lower management internal reviews and approvals the PAR is forwarded to the facility CEO who grants or rejects the request to hire. If the CEO approves the request, the PAR is forwarded to DHS-HR for processing.

   - The major function of DHS-HR is to ensure that the recruiting and hiring process is conducted in accordance with Civil Service guidelines and applicable County Ordinances. To accomplish this, DHS-HR reviews the paperwork to ensure that the position is required and is the right position for the job requirements. If this is confirmed, DHS-HR confirms that a certified list exists for the classification. A certified list is created after candidates take an exam. Candidates are placed in one of five "bands" based on the grade they received and are available to be hired. Facilities can only hire candidates from the certified list associated with the classification[3]. A manager hires from the highest ranking group on the list, except when the highest ranking group does not include at least 5 persons, then the hiring manager may select a person in the next highest band or bands that include at least five persons. If a certified list does not exist a new exam for the position

[2] A judgmental sample is a non-statistical sample conducted to provide general insight into the characteristics of a population. The samples are usually small and are selected based on the judgment of the analyst, rather than through a scientific sampling process. Therefore, the results have little if any statistical relevance, but can provide information that is useful for designing statistical samples or other analysis.

[3] An exception to this rule can be made if the director of personnel finds that the use of another list is in the best interest of the service and the necessary skills and knowledge were adequately tested in the examination.

must be opened and administered and a new certification list developed.

- If a certified list for the position does exist, DHS-HR will provide this list to the hiring office or facility for use in identifying and selecting candidates. Facilities can also access the certified lists online. If a certified list does not exist, DHS-HR must request County HR to open an exam. At this point, the hiring process is put on hold until an exam is open, candidates take the exam, are scored, placed in the appropriate bands, and a certification list is created. DHS-HR administers all exams for DHS positions and County HR administers exams for County positions. The exam process is reportedly very time consuming.

- Once DHS-HR confirms the existence of the certified list they provide the list to the facility. All individuals on the list that are "reachable" may receive a recruitment letter either from DHS-HR or the hiring office. Candidates have five days to respond. If they respond later than this, the facility does not have to hire them. The harder to recruit positions are given more time to respond.

- Candidates that respond are granted interviews by the hiring department within the facility. Once the interviews are completed, the facility notifies DHS-HR of their selection. At this point, DHS-HR will confirm that the specific candidate selected is on a certified list and is "reachable." If DHS confirms they are reachable on an active list they will schedule the candidate for a physical. If DHS determines that the candidate is not on an active certified list or is not reachable they will notify the hiring facility that they must make another selection, or have the candidate tested and added to the list. Candidates who are confirmed take their physical and, if they pass, are hired.

- All new hires to the County start at step one of their classification unless they are registered nurses, in which case they start at step three. Any deviation from this salary rule is considered to be a Special Step Placement and must be separately approved by the CAO.

  - ***Nurses***: Registered nurses, one of the Department's salary scheduled classifications, undergo the same process as any other salary schedule employee described above. However, to simplify the process for recruiting and hiring, registered nurses, as of March 15, 2004, were moved from a multiple band system to a single band system. Additionally, nurses are now subject to continuous exams rather than the annual or semi-annual cycle. Hospitals now have the ability to access candidate lists online. Refer to the attached flow charts at the end of this section pertaining to the Hiring process for Nurses.

DHS appears to recognize the importance of having up to date exams and certified lists available for recruiting. A review of the top 25 classifications hired during the 20 month period reviewed (July 2003 – March 2005) revealed that all had recent exams and all except one, the Medical Technologist I, had a certified list of candidates. The oldest certified list date was May 19, 2004 for the Clinic Nurse II.

2. Management Positions – The hiring process for management employees is the same as for Salary Scheduled classifications except for one additional step: review and approval of all management positions and salaries by the CAO.

3. County Classifications – For clerical and other classifications used by other County departments, the applicant screening and testing eligibility list processes are similar to those described above except they are administered by the County Department of Human Resources (DHR). For these classifications, DHS must rely on DHR for hiring lists and compete with other departments to hire the most qualified candidates.

4. Special Step Placements – This category includes all employment requests where the Department wishes to pay an individual at a level above the amount included in the salary schedule or approved by policy. For example, the Department cannot pay most new hires above the first or third step in the established salary schedule without receiving approval from the Chief Administrative Office compensation and budget units. For nurse managers who are paid within broad bands,[4] CAO approval must be obtained if the prospective employee is to be paid more than 5.5 percent above their current salary in the County or midpoint of the range.

5. 120-Day Rehires – When the Department wishes to rehire a retiree as a temporary employee after the employee has left County employment or retired, additional approvals must be obtained from the CAO.

The matrix in Table 4.6 displays the major human resources processing steps by category of hiring and processing step. Attachment 4.1 provides corresponding flow charts that illustrate the multiple processing and approval stages by major participant in the process.

[4] A broad band classification has a wider salary range than most others, providing the Department with greater discretion on the amount that can be paid to an individual with special qualifications.

Table 4.6

Matrix of Human Resources Processing and Approval Activities Los Angeles County Department of Health Services – April 2005

(Non-DHS responsibility shown in bold italics)

Hiring Category	Applicant Screening	Applicant Exams	Eligibility Listings	Interviews Offerings	Salary Setting	Hiring Approval
Salary Scheduled Classifications	DHS	DHS	DHS	DHS	***PA***	DHS
Special Step Placements	DHS	DHS	DHS	DHS	***CAO***	***CAO***
Countywide Classifications	***DHR***	***DHR***	***DHR***	DHS	***PA***	DHS
Management Positions	DHS	DHS	DHS	DHS	***CAO***	***CAO***
120-Day Rehires	DHS	DHS	N/A	DHS	***CAO***	***CAO***

Key to abbreviations:
DHS = Department of Health Services
DHR = County Department of Human Resources
CAO = County Administrative Office compensation and budget units
PA = Preauthorized by the Board of Supervisors

As shown in the table, DHS has direct responsibility and control over all of the major hiring process steps, with the exception of (a) applicant screening, examinations and eligibility list development for Countywide classifications, which are assigned to County DHR; (b) salary setting, which is retained by the CAO unless preauthorized salary schedules are being used; and, (c) hiring approval, which is retained by the CAO for any special step placement, management position and 120-day rehire.

The result is that DHS has functional control over most hiring activities although their processes must comply with County civil service requirements. DHS' primary role is demonstrated by statistics showing that 2,673 employees were hired[5] at the Department's hospitals between July 1, 2003 and March 18, 2005, and all were processed entirely by DHS, except for thirty-seven 120-day rehires. Included in the 2,673 hired are some management positions.

Even with DHS processing, for new hires at the hospitals, hiring delays appear to be very significant in some situations. In the judgmental sample we conducted of 50 DHS hires we found that delays were often extreme and compounded when external approvals were required. Table 4.7 provides some examples from the review of 50 hires. Some of these sample items were omitted from our analysis because of incomplete data provided. As can be seen, with the exception of one Nurse position, whether the process is administered by DHS or the County, the process takes more than one month and in many instances takes multiple months.

[5] New hires do not include transfers in to the Department or promotions.

Table 4.7
Cycle Time for Selected New Hires
For Selected Classifications

Classification	# in sample	# Days in Hiring Process
Physician	2	47-69
Clerical	5	91-135
Nurse	6	14-314
Patient Resource Worker	1	100

Source: Review of files and timelines for a sample of 50 employees hired between 2003-2005, of which 14 included timelines through employee hire date.

A separate review of 11 management positions that had to be approved by the Chief Administrative Office before they could be hired showed that CAO approval added between 3 and 44 days to the hiring process, with an average of 20 days for review. In all but one of the 11 cases, the CAO approved the proposed position and salary. For the position where the salary was not approved, the CAO recommended a reduction of approximately $1,000 per year. While oversight of Department management positions, salaries and costs are needed, this review lengthens the hiring process and does not appear to be the most effective means of controlling unwarranted growth in management positions and costs.

In instances where there was no current list of eligible applicants, the time that elapsed from the exam posting to promulgation of the list of applicants was extreme. For physician classifications, 39 days elapsed. For nurses, between 207 and 1,256 days elapsed. The long timeframe for nurses is because the exams are now continuously open and the promulgation date reflects the last time a new person was added to the list.

These sample results support the concerns expressed by managers within the Department. Nurse managers from the hospitals and comprehensive health centers indicated that it typically takes six to nine months to hire employees, and that even after a job offer is made, prospective employees must go through a pre-employment physical and other processing that takes a considerable amount of time to accomplish. Instances were described where persons who had initially accepted employment with the Department changed their minds after experiencing frustrations associated with the pre-employment physical and other processing activities.

Under a health authority, County civil service rules would no longer apply and the organization would be able to create their own hiring processes. This could eliminate not only the external steps and reviews such as CAO approval for certain hires, but could also streamline DHS' internal hiring processes. The "band system" and associated time requirements could be eliminated to enable

the Department to hire the most qualified candidates more quickly to avoid losing them to other employers.

CLASSIFICATION AND COMPENSATION

During interviews, many DHS staff expressed frustration regarding the Civil Service classification process that exists within the County. This process, which establishes position classifications and sets salaries based on defined job duties, is performed jointly by DHS, DHR and the CAO compensation and budget units. If the classification effort involves the creation of a new position or redefinition of an existing position, the CAO's Employee Relations personnel must also be involved. Many employee classification decisions are strategic in nature and must be viewed in the context of the larger County organization, agreements with employee bargaining groups and the overall County budget. The complexity of these matters, and the political and financial consequences of some classification decisions, can cause significant delays in implementation. Some DHS managers felt the Department was inappropriately excluded from some major decisions regarding classification and compensation strategies. If DHS' compensation is not competitive with the market place, it stands to reason that qualified applicants will choose to work elsewhere, thus exacerbating DHS' vacancy problem.

The County is continually evaluating its classification and compensation structures. Most recently, major changes were made in the agreement with Service Employees International Union (SEIU) Local 660, regarding the bargaining unit agreements with Registered Nurses (Unit 311) and Supervising Registered Nurses (Unit 312). Under the terms of the agreement, the County is obligated to (a) create three broad range nursing classifications and (b) develop a 20 step pay scale at 2 percent increments. These major changes are the culmination of a long series of negotiations with the union in an attempt to meet some of the management concerns expressed previously, regarding flexibility and the ability to attract the most qualified staff. During the negotiation process, the Department sustained a high vacancy rate for most nursing classifications and made significant use of more costly registry personnel to fill vacant slots.

Other major classification and compensation issues can be impacted by the County's relationship with the unions. For example, DHS recently attempted to create a Flexible Staffing Program (relief per diem pool for non-RN healthcare workers) in an attempt to reduce the high costs of registry personnel. This was a long-term effort that involved the DHS human resource staff, who developed recommendations regarding the included classifications and compensation levels, and the CAO compensation and budget staff.

The compensation required to attract qualified candidates was an issue of concern for the Department. However, the CAO determined that the program would go forward as only a pilot with salaries set at levels below the amounts being recommended by DHS. Therefore, because of uncertainty regarding this decision, the program was proposed as a pilot and the CAO was prepared to go

forward to the Board with a request that he be delegated authority to increase the recommended wages by up to 30 percent, if determined necessary at the end of the pilot program period.

The development of the program reportedly was a time consuming and difficult process. Program development activities were initiated in March 2004, and a package was prepared for submission to the Board of Supervisors in late September of that year. However, just prior to submission, the item was "placed on hold" while concerns regarding the use of part-time and temporary employees were resolved with the affected unions. There has been little forward movement on this matter since that time, and it is uncertain when the program might be implemented. If implemented as designed, the program could save the Department millions of dollars annually in reduced costs for part-time and temporary personnel. Representatives of the Hennepin County Medical Center provided confirmation of the savings that can be achieved through such programs. Since implementing their Flexible Staffing Program, they report that their reliance on registry personnel has been significantly reduced to the point where they rarely rely on registry firms to supplement their staffing needs.

LABOR RELATIONS

As mentioned previously, the Employee Relations function within the County is assigned to the Chief Administrative Office. The unit is responsible for negotiations and the administration of 58 memoranda of understanding (MOU) with over 20 unions. Most of the DHS employees are represented by six bargaining units, primarily SEIU Local 660.

The employee relations function within the County is highly controlled. In general, departments are not permitted to actively participate in the MOU negotiation process or enter into any side letters of agreement with the unions. However, in some cases, DHS staff have attended Bargaining Unit negotiations to represent the County on its behalf. More often, however, the CAO meets with Departments to obtain an understanding of their concerns and suggestions. Otherwise there is no formal mechanism for integrating departments into the collective bargaining process.

Department representatives have expressed concern during this analysis regarding the structure of the Employee Relations function within the County. Specifically, it was felt that the high degree of control exercised by the CAO and low level of involvement by DHS management resulted in an environment where the interests of the Department were not always appropriately addressed.

Although an evaluation of the effectiveness of the County Employee Relations function was beyond the scope of this project, it is reasonable to expect that more direct involvement in the collective bargaining process by a Department's executive management will result in a better agreement for the organization. Further, it stands to reason that agreements with unions that represent employees that work for an organization with a singular mission would benefit

both the organization and the employees. Such a structure would be established with the creation of a health authority.

Labor Relations Transition Issues

Many of the process concerns that we have discussed could be resolved within the County organization. As discussed later in this section, the 1999 study of the DHS *Human Resources Organization Structure and Allocation of Responsibilities* and subsequent action have placed the Department on the right track for improving human resources functions. Further improvements, including development of a more professional DHS human resource staff, full implementation of an internal item control and human resource management system, and redefining delegated authority within DHS will likely enhance the human resource function further.

However, several managers within DHS have stated that they believe little benefit will be gained if the County Civil Service system is merely transplanted to the new health authority organization. The health authority will therefore need to break with a system that is governed by the County's Charter, civil service rules and "one-size-fits all" collective bargaining agreements with the current employee unions.

Discussions with the CAO Employee Relations staff indicate that many of the current restrictions that are placed on the County and DHS' ability to manage within the County environment could potentially be changed with the creation of a health authority. The new health authority could install a Binding Arbitration system for negotiation rather than continuing with the current Civil Service system, providing more management flexibility and opportunity for worker advancement. Further, the new health authority could establish more competitive standards and flexibility for employee salaries and benefits.

However, it is unlikely that such changes could be implemented unilaterally by the new health authority. When the Alameda County Medical Center health authority was created, there was a statutory transition period when existing employee agreements were protected. It was only after a number of years that the health authority was given the authority to negotiate new agreements with its employees. Typically, when these types of organizational splits occur, consideration is given to continuing the total compensation packages (salaries and benefits) that existing employees are receiving at the time of separation. Changes in compensation are typically implemented for new employees and transitioned employees are generally brought along with little or no change in benefits. With regard to retirement benefits, CAO staff indicated that any change impacting current employees may be difficult due to vested rights considerations.

Employee representation would also continue uninterrupted during the transition period. At the end of that period, the current unions would have certain rights to continue representation for the transitioned employees. It may be in the best interest of the existing unions to quickly implement agreements with the new

organization, providing opportunities to modify some of the more troublesome sections of the current agreements. If there is full separation, so that the County terminates existing employees and hires a new workforce for the health authority, many of these concerns would be lessened.

EMPLOYEE DISCIPLINE

Most local government organizations have civil service processes that are governed by explicit rules regarding employee discipline and termination. In most cases, these rules are supplemented by language contained in MOUs with employee bargaining groups. Like other jurisdictions, the County of Los Angeles has established procedures for the review of disciplinary actions by an independent review board. In Los Angeles County, this function is performed by the Civil Service Commission. The Commission is established in the County Charter. The Charter and the County's Civil Service rules govern the activities of the Commission and establish a standard of review.

A major concern expressed by individuals interviewed for this study centered around the structure and process established for employee discipline within the County's Civil Service system. Many managers within DHS stated that the process is ineffective, cumbersome and time consuming. As stated previously, resolution of disciplinary actions can take long periods of time. While awaiting decisions on disciplinary actions, there may be additional actions taken or the employee may return to work. If the employee returns to work, or the recommended discipline or termination is not approved by the Commission, there can be adverse morale or management authority challenges that may arise at the operations level.

Many of the managers stated that they are able to succeed with disciplinary attempts within the Civil Service system. However, they noted that the confusing and time consuming processes often result in managers avoiding the process entirely. Central County management staff indicated that difficulties typically arise when department managers do not successfully document the reasons for discipline or provide an inconsistent record on employee performance.

As with other parts of the human resource functions discussed within this report, the creation of a health authority will provide an opportunity to eliminate or significantly alter the existing disciplinary review process. This should be a focused effort during the transition period.

DHS HUMAN RESOURCES REENGINEERING EFFORTS

The difficulties described in this report have been known by the CAO and DHS management for many years. Efforts have been made to streamline the human resources processes and to provide the Department with more management flexibility. In 1999, the Department commissioned a study of the DHS *Human Resources Organization Structure and Allocation of Responsibilities* that began a human resources redesign process for DHS. Since that time, certain processes and authorities that had previously been assigned to County DHR and the CAO have been delegated to the Department. Functions that had previously been provided at the program or facility level have been centralized in an effort toward standardization. The DHS Administrative Services Division has internally developed a centralized item control and personnel management system that will eventually expedite approvals by creating a common information resource, creating an on-line approval process and reducing paperwork.

During discussions with program managers, there were concerns that the DHS human resources unit was replicating a "broken County system" within the Department. These individuals felt that program level managers need to have greater autonomy and ability to make the key human resources decisions that affect their operations. These are legitimate concerns as the Department has no choice at present but to adhere to County civil service rules and regulations.

However, a review of documentation indicates that the eventual goal of the Department is to provide more authority and control to the operating units such as the hospitals. The human resources information system and other actions by this unit are a beginning. The new system is available to all program managers at the time of this study, but not all CEO's are choosing to implement the system in their cluster or facility. In addition, DHS management is recommending creation of a more professional human resources staff within the Department and transition from a processing unit to a professional support unit for the program managers. With the creation of a health authority, these types of initiatives can potentially be enhanced and developed outside of the County regulatory environment.

CONCLUSIONS

The County's human resources system does not provide the Department of Health Services with the amount of flexibility needed to meet the dynamic service demands of the medically indigent population or to compete in the health services marketplace. The Department had a 12.7 percent position vacancy rate for the first five months of FY 2004-05, measured in FTEs, with even higher rates for key classifications such as nurses and technicians and specialists. These high vacancy rates are an indicator of potential human resource management problems afflicting the Department in areas such as recruiting, hiring and/or compensation. A review of the Department's and County human resources

processes and systems indicates that all of these areas are affecting the Department's ability to hire and retain staff.

Recruitment and hiring processes are lengthy and time consuming. Review and approval of job bulletins, selection criteria, position information, and classifications can delay the hiring process, resulting in the loss of qualified candidates to competing hospitals.

To address some of these concerns, DHS has begun to reengineer its human resources functions. Many responsibilities that had previously been delegated to the programs have been centralized within the Department, in accordance with consultant recommendations made in 1999; the DHS Director has sought increased authority for making compensation and hiring decisions; and, much of the hiring process has been automated with the development of an in-house system that is available to program managers. Despite these achievements, program managers continue to assert that the DHS human resources system is ineffective and cumbersome.

With the formation of a health authority, many of these inefficiencies could be eliminated. Current restrictions placed upon DHS by the County Charter, Civil Service Rules, and employee bargaining agreements could potentially be lifted; compensation levels could be strategically set by the health authority board within the context of the health authority's singular mission, budget resources and operating environment; the recruitment and hiring process could be streamlined and made more efficient by eliminating the need for certain external approvals; and, the rules associated with employee disciplinary actions could be reconsidered.

RECOMMENDATIONS

The Board of Supervisors should:

4.1 Direct the CAO and DHS to collaborate on development of a human resource plan for transition to the health authority, with detailed recommendations regarding timelines and alternatives for addressing the various labor and collective bargaining issues identified in this report.

4.2 Direct the CAO to expedite negotiations with employee bargaining groups to implement the proposed Flexible Staffing Pilot Program, in an effort to immediately reduce outside Registry costs.

4.3 Direct staff to include goals for key human resources measures in the operating agreement between the County and the health authority, including reducing turnover and vacancy rates, improving hiring cycle time and achieving compensation parity with the hospital and health care market, with the results reported annually to the Board of Supervisors.

The Department of Health Services should:

4.4 Continue efforts to improve the internal human resources organization, process, resources and tools for effectively administering human resources processes prior to the date of transition to the health authority.

4.5 Conduct an analysis of the existing classification and compensation system and identify specific changes needed under the new health authority.

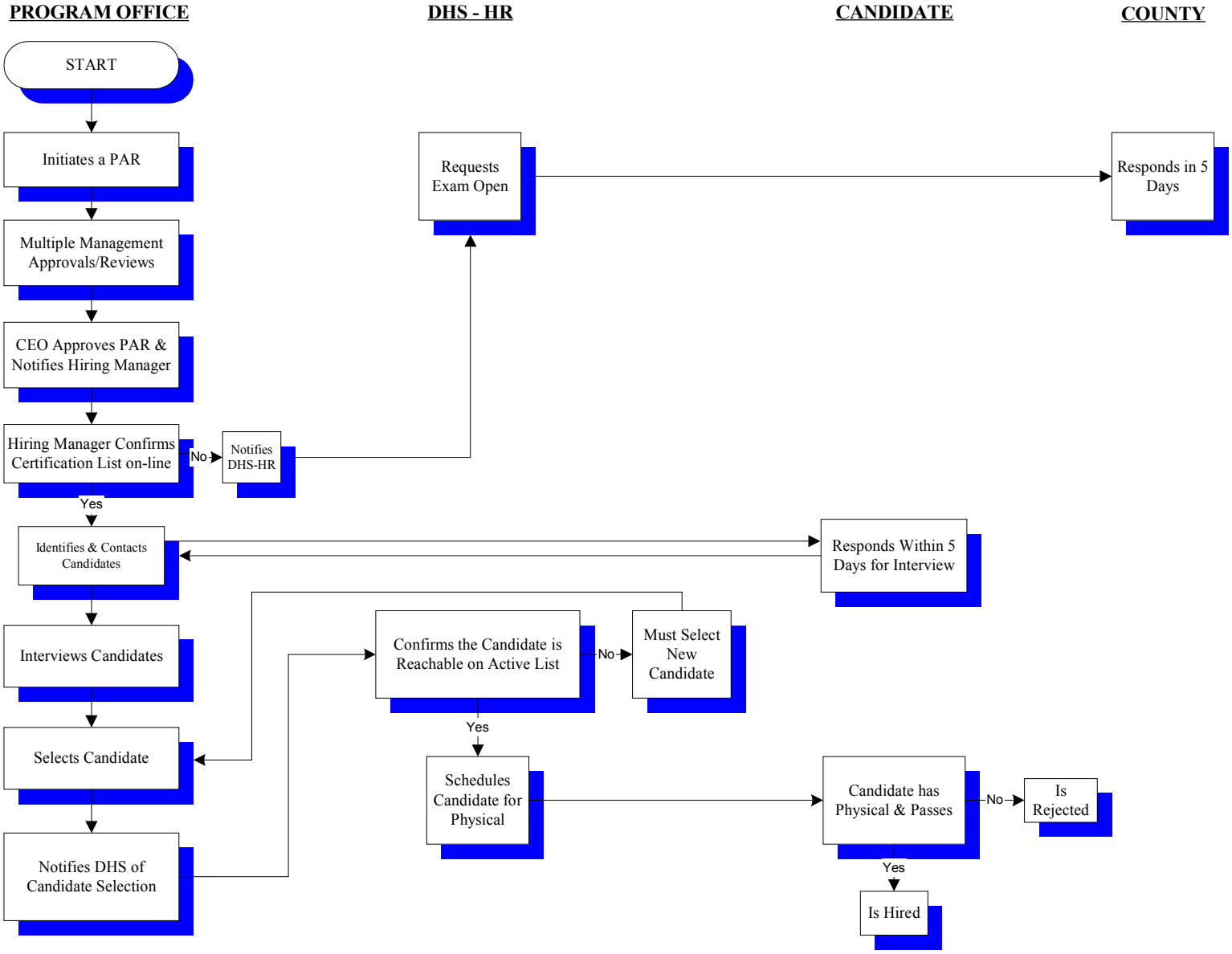
4.6 Develop a proposed expedited hiring system for implementation under the health authority.

COSTS AND BENEFITS

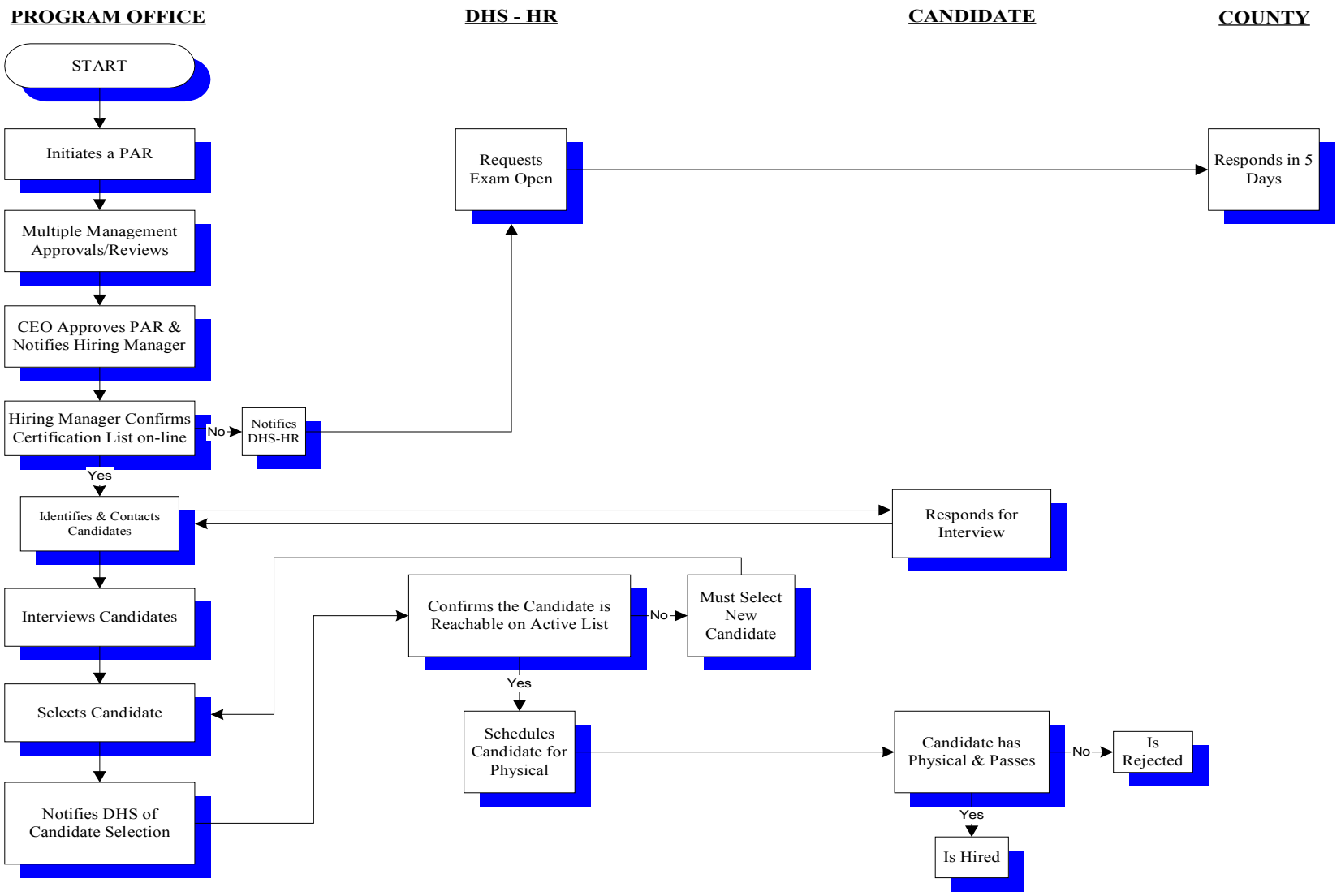
There would be unspecified costs to implement an effective human resources function within the Department of Health Services.

The human resource process within DHS should continue to improve until the health authority is created. The new health authority would be provided with critical information regarding labor and collective bargaining agreements, needed changes to civil service processes and other critical human resource concerns. The net result should be faster and more flexible hiring processes, fewer vacancies and turnover and reduced costs from decreased use of registry personnel.

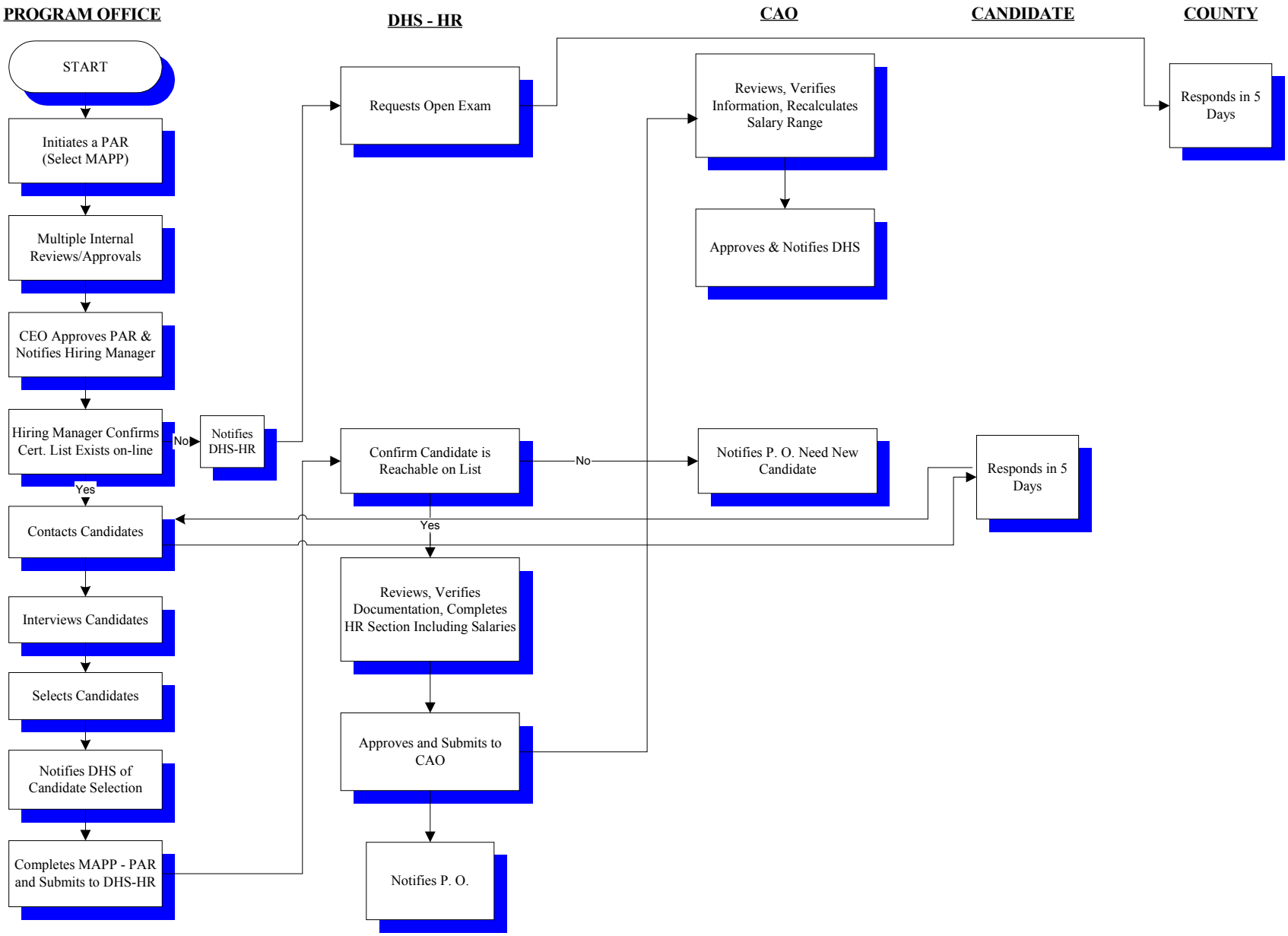
HIRING PROCESS - SCHEDULED EMPLOYEES



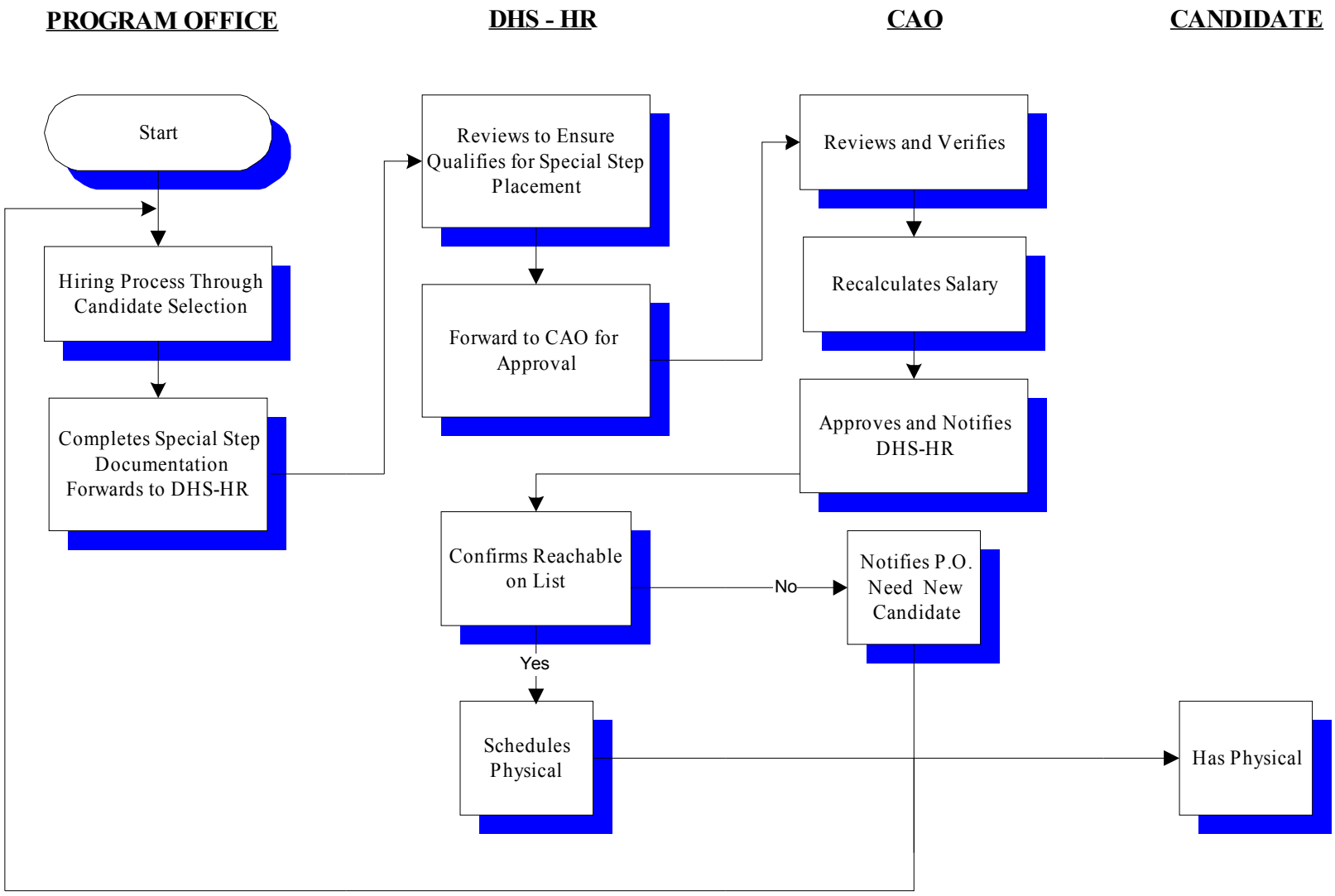
HIRING PROCESS - NURSES



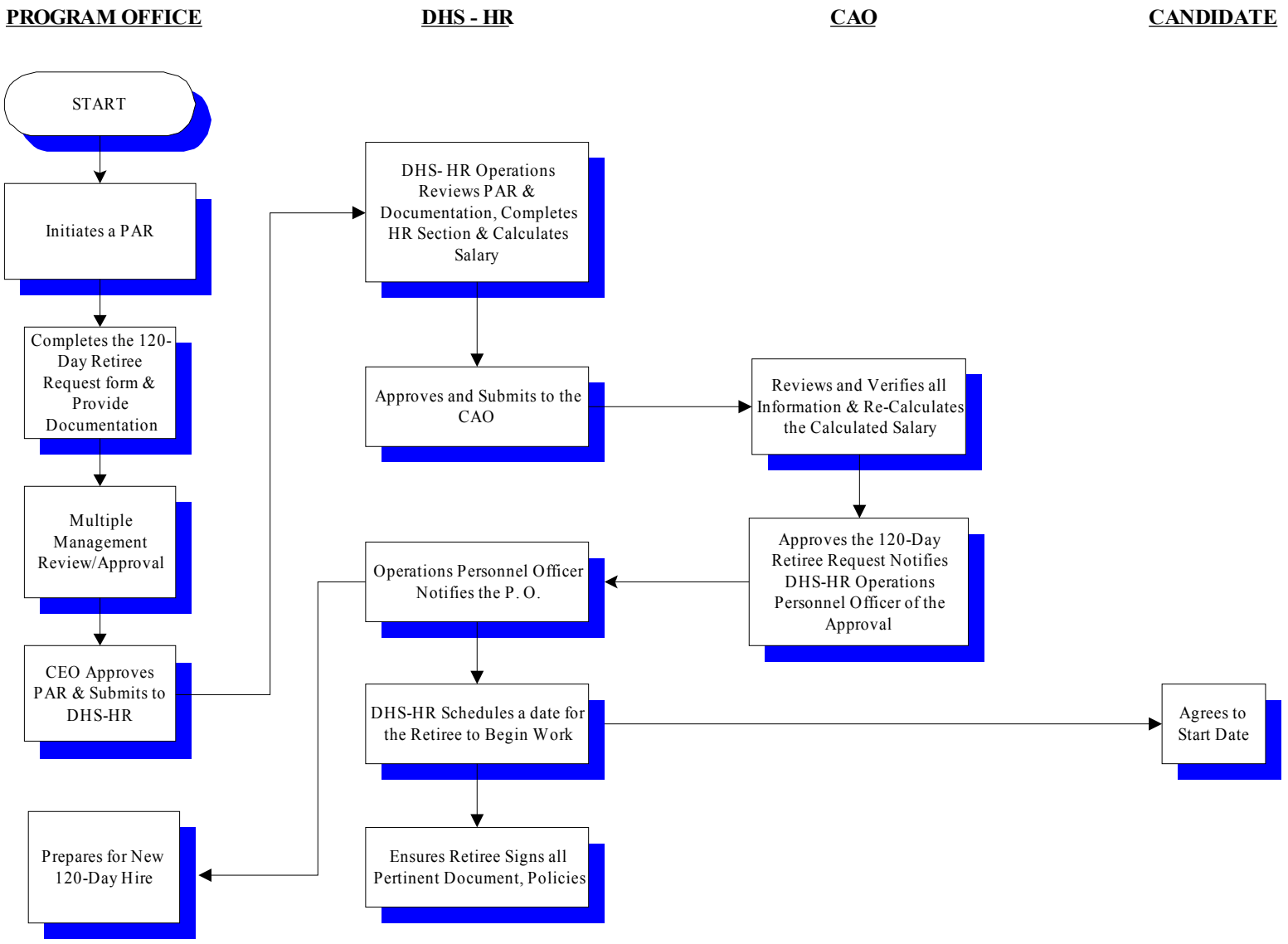
HIRING PROCESS - MAPP



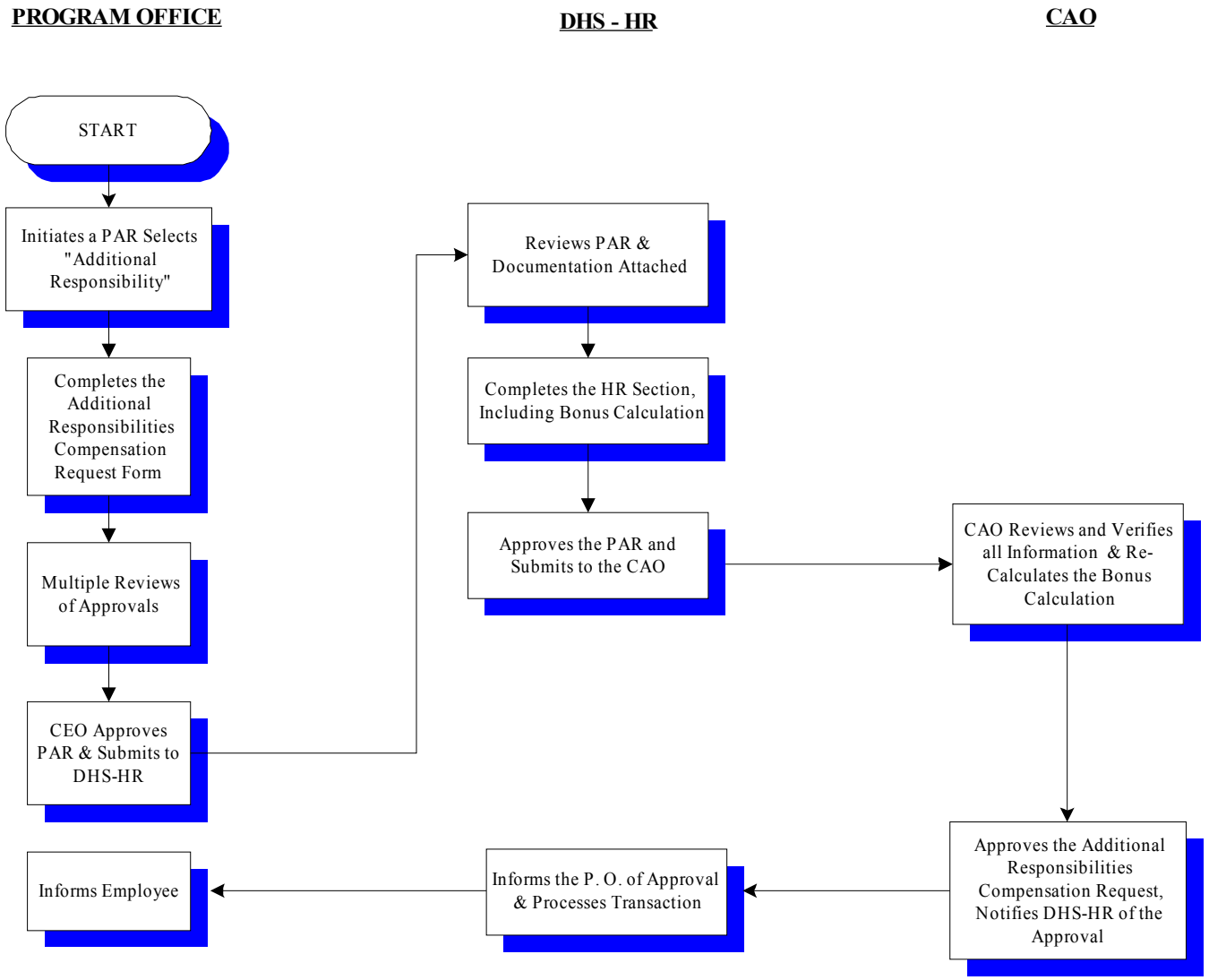
HIRING PROCESS - SPECIAL STEP PLACEMENTS



HIRING PROCESS - 120-DAY RETIREE REQUEST



HIRING PROCESS -ADDITIONAL RESPONSIBILITIES COMPENSATION



5. HEALTH SERVICES PROCUREMENT

- **In FY 2004-05, the Department of Health Services procured goods and services worth up to $1.7 billion. Procurement occurred in a structure featuring formal rules codified in State law, the County charter, County ordinance and Board of Supervisors policies, emphasizing maximum opportunity for vendors to bid to provide goods and services, and focusing on competition as the primary way to achieve the lowest prices.**

- **Department staff criticized the rigidity of this process, complaining that the plethora of rules slows down the procurement process unnecessarily, and does not achieve substantially better prices than could be achieved for lower dollar value items by more informal processes that permit informal negotiations with vendors. In addition to these interview comments, a review of a limited number of service contracts negotiated by the DHS Contracts and Grants unit revealed instances where technical violations of procurement rules led to contract protests, and significant delays in the award of contracts. DHS staff estimates that approximately 80 percent of all service contracts issued are subject to protest over the award and related delays.**

- **Because the rigid procurement system that currently exists is defined in State law, the County charter, County ordinance and Board of Supervisors policies, establishment of a health authority would provide the opportunity to eliminate some of those strictures, establishing a more flexible procurement system, while still providing some centralized control of procurement to prevent abuses.**

BACKGROUND AND LEGAL AUTHORITIES

Budget documents provided by the Los Angeles County Department of Health Services show that in FY 2004-05 the Department is scheduled to purchase between $1.6 and $1.7 billion in goods and services. Items purchased by the Department include medical supplies and equipment, office supplies, food served to hospital patients, consulting contracts for assistance carrying out hospital functions, and other items.

These items are currently acquired using a procurement process that follows various strictures of State law, the County charter, County ordinance and Board of Supervisors policies. Examples of these restrictions include the following:

- The California Government Code authorizes the County to employ a purchasing agent to purchase personal property and supplies that would otherwise have to be purchased directly by the Board itself. Under this authority, the Purchasing Agent, which in Los Angeles County is part of the Internal Services Department, buys all such property for the County, subject to rules that the Board may establish by ordinance regarding requirements for formal and informal bidding and other purchasing requirements. The Government Code also permits the Board of Supervisors to authorize the purchasing agent to hire independent contractors to perform services, when the aggregate cost of the services provided by a contractor does not exceed $100,000, subject to rules and regulations established by the Board.

- The Los Angeles County Code more specifically establishes restrictions and requirements on the purchasing process. For example, Section 2.81.950 states: "Formal bids shall be the preferred method of purchase for all goods, services and leases, with at least three competitive bids obtained wherever feasible. Any other means shall be used only when, in the opinion and discretion of the director, the best interests of the county will be served by using other methods, or that formal bidding procedures are impractical."

- The Board of Supervisors Policy Manual includes a variety of policies related to the contracting and procurement process. For example, Board Policy 5.055 establishes a process for firms submitting proposals on Board of Supervisors-approved service contracts to protest the contract award recommended to the Board by a contracting department. Implementation guidelines for this policy, also approved by the Board, permit a losing proposer to protest to the contracting department, to a special County Review Panel established to hear the protest, and finally to the Board itself.

We analyzed the DHS procurement process based on interviews with the Department's Corporate Director of Purchasing, with materials managers in several of the County hospitals, and with the County Internal Services Department's Purchasing Division Manager and the head of its medical buying unit. We also reviewed files provided by the DHS Contracts and Grants Division related to a limited number of service contract solicitations that office had conducted, and also received numerical data on procurement workloads provided by DHS and ISD.

In interviews, Health Services Administration representatives, materials managers from several Department of Health Services facilities, staff from the Department's Contracts and Grants unit, and staff from the Internal Service Department, described the procurement process as outlined below.

THE PROCUREMENT PROCESS FOR GOODS

- An authorized departmental representative within a hospital department, for example, such as a director of respiratory care, fills out a written form requesting that a good be purchased. The request must be approved by hospital administrative staff, typically someone reporting to the Chief Operating Officer at the facility, verifying that the purchase is appropriate and funds are available.

- If hospital administration approves, the purchase request is forwarded to the hospital's materials management office. Hospital materials management staff determines if there is an existing agreement with pre-established prices in place that can be used to purchase the item. A common source of such agreements is a Group Purchasing Organization (GPO), called Novation, in which the Department of Health Services has joined with other large health and hospital organizations across the country to maximize buying power and negotiate lower prices with medical supply manufacturers for commonly used items, such as bandages, catheters, x-ray film, etc. In addition to the Novation agreements, there are other countywide agreements that have been solicited directly from vendors by ISD for categories of items that the Department of Health Services and all other County departments frequently use. Of more than 800 such commodity agreements established by ISD, ISD reports that 151 are for equipment, supplies and/or related services that are exclusively used by DHS. DHS also accesses commodity agreements available to all County departments for items such as computer equipment and peripherals, janitorial supplies, communications equipment, etc. When such established agreements are in place for items ordered by DHS, an order is placed with the relevant vendor by phone and a confirming purchase order is issued electronically within the County, to serve as a record of the order for purposes of receiving, paying the vendor's invoice, etc.

- If there is no established agreement for purchasing an item, then a so-called "spot purchase" must be processed. ISD, as the County's purchasing agent, has delegated to operating departments, including DHS, authority to complete spot purchases with a value of less than $5,000 on its own without ISD involvement. In the Department of Health Services, Martin Luther King, Jr.-Drew Medical Center has delegated authority to make purchases up to $15,000 on its own though all other facilities are subject to the $5,000 threshold. For purchases valued at $1,500 to $4,999.99, DHS materials management staff must get three quotes, by phone, documenting from whom they were obtained, and the prices and other information received.

- Spot purchases of $5,000 or more are processed by ISD, as the County purchasing agent. Each purchase goes to a buyer in ISD who specializes in the type of item sought. The buyer will review specifications for the item which are provided by the end user. Assuming the specifications are sufficiently detailed, not written to favor one vendor, etc., the proposed

purchase will be posted on a County purchasing web site inviting interested vendors to offer their best bid price on the item. When bids are received from vendors, the lowest bid meeting the specifications is normally awarded the purchase. If the low vendor proposes alternatives to the specifications in the County's original solicitation, the end user seeking the item will be asked if the alternatives are acceptable.

Decentralized DHS materials management staff assigned to the clusters consists of 42 positions department-wide. Internal Services Department staff dedicated to DHS procurement consists of nine positions.

THE PROCUREMENT PROCESS FOR SERVICES

The Department of Health Services currently has approximately 3,064 contracts for service in place. Service contracts are subject to the following procedural requirements.

- The County purchasing agent (ISD) has authority to purchase services through the purchase order process if the value of the contract is $100,000 or less and if the service is: temporary in nature; needed on a part-time or intermittent basis; can't be done by current staff; or, is for audit, evaluation or analytic services. The process is similar to that for purchasing commodities, except that a Scope of Work for the service to be provided takes the place of specifications for the purchase of goods, and the service purchase may be conducted using a Request for Proposal process that awards the contract based on some combination of contractor qualifications, approach to the proposed service, price, and other factors than just price.

- Contracts with a value of $100,000 or more or that don't meet the criteria listed above for ISD purchase order processing, are processed by DHS' own Contracts & Grants Division and must be approved by the Board of Supervisors. Typically an operating unit at a hospital that wants to contract for service contacts the Contracts and Grants Division which works with the end user to develop a Request for Proposal (RFP) so the service can be competitively bid. The RFP indicates what service is being requested, what information must be provided in proposals, and how proposals will be evaluated to award a contract.
- Contracts and Grants issues the Request for Proposal, reviews the proposals that are received to make sure they meet minimum requirements for proposal format and minimum qualifications such as possession of insurance by the proposed contractors.
- Proposals that meet the minimum requirements are forwarded to an evaluation panel, which typically includes County staff familiar with the service being sought, including representatives of the end user. The panel scores the proposals, and the highest score would normally receive the contract. Contracts and Grants then negotiates a contract with the winning firm based on its proposal.

- The contract is forwarded to the Board for approval.

Department of Health Services staff estimated, and Contracts and Grants staff confirmed, that the formal service contract process takes between 18 and 24 months for a single contract.

The procurement process could be streamlined under a health authority

In interviews, DHS materials management and many other staff members were critical of the existing procurement process, stating that it takes longer than necessary, is encumbered by rules and regulations that do not necessarily result in better procurements and does not necessarily result in better prices or superior vendor performance. Common criticisms, corroborated by a review of a limited sample of DHS service contract solicitation files and other DHS and County procurement information, were as follows:

a) The procurement process is geared to adherence to formal rules and regulations rather than efficiency
b) Many County contracting requirements are designed to achieve social policy goals rather than to ensure contractor abilities or performance
c) The Board of Supervisors is overly involved in the contractor selection process.
d) The extensive contract protest process adds time to the majority of service contracts.

a) The procurement process is geared to adherence to formal rules and regulations rather than efficiency

Some DHS staff reported that inefficiencies are built into the procurement process because of the rigid governing rules and regulations. Many described the process as unnecessarily time consuming and not flexible enough to meet the needs of medical facilities. As a result, a number of hospital materials managers said they feel trapped between clinical staff members at their facilities, who demand rapid response to their need for medical-supply items, and the rules that slow down the existing process.

DHS materials management staff believe that it is possible to achieve good prices on medical supplies and equipment with a more informal procurement system that can react more quickly to Department needs. While many of the current County procedures and requirements were established to ensure the lowest prices and to prevent abuses, a review of the process indicates that such protections and reasonable prices could probably be achieved without the extensive and cumbersome set of rules and regulations now in place.

As discussed above, the procurement process for goods with a value of $5,000 or more activates a County requirement for a more formal process, with ISD processing the purchase request rather than DHS staff. While the Department purchases many of its medical supplies through Novation, the Group Purchasing

Organization, which expedites the process and provides favorable pricing, the Department will still purchase an estimated $50 million worth of goods in FY 2004-05 through the regular ISD purchase order process. This process involves extra administrative steps and time as all requisitions over $5,000 for which the GPO or another pre-established agreement is not applicable must be processed by ISD. This entails posting the solicitation on the County web site for a specified period of time and processing all bids submitted. A less formal and less time consuming process, for items with a value of less than $5,000, is administered by DHS procurement employees who must only obtain three quotes by telephone.

The value of the extra time required for the more formal procurement process for many of the Department's purchases is questionable because nearly half of the purchases processed by ISD are for relatively low dollar value amounts. As shown in Table 5.1, 48.2 percent of the purchases for goods processed by ISD, or nearly half, had a value of $15,000 or less and, together, account for only $2.4 million, or 4.8 percent, of the Department's total purchases made through this process. The average value of the estimated 394 purchases with a value of $15,000 or less was $6,006.

Table 5.1
DHS Purchase Orders for Goods
Using Formal ISD Procurement Process
FY 2004-05

	Total	# with Value < $15,000	% Total
Number of Purchase Orders processed by ISD	817	394	48.2%
Dollar value of Purchase Orders processed by ISD	$49,675,235	$2,366,369	4.8%
Average $ Value	$60,802	$6,006	

Source: County Internal Services Department, annualized from actual purchase orders as of April 12, 2005. Excludes purchases made through Novation, the Group Purchasing Organization (GPO).

These spot purchases are in addition to the 151 DHS-specific commodity agreements which are established and maintained by ISD. Under a separate health authority, the hospital and health system would no longer be required to adhere to the $5,000 threshold and the County's policy of using formal bid methods for most purchases. Instead, the new organization could set a threshold based on its own analysis of the savings and other benefits resulting from formalized versus informal bidding. While it is possible for the Department to now obtain permission from ISD to process more procurements itself (such as the current arrangement at Martin Luther King, Jr./Drew Hospital), it would still have to comply with County procurement rules and processes. Under a health authority, the organization could process more of its own procurements in the interest of saving time and alter the formal bidding threshold to an amount that

represents the optimal point between the price advantages of formal bidding and time and staff resources consumed by the process.

As the data in Table 5.1 shows, setting a threshold of $15,000 for formal bidding would enable the Department to make half its spot purchases using informal bidding. This would expedite the process and reduce the costs now incurred for ISD services while retaining some of the price advantages of competition. The additional savings that might result from obtaining more than three bids has to be compared to the time lost and costs incurred in utilizing the more formal spot purchasing process.

Currently ISD has nine staff positions who are dedicated to DHS purchasing and who process spot purchasing requisitions. In FY 2004-05, they will process an estimated 817 such procurements for DHS, 394 of which, or 48.2 percent, will have a value of less than $15,000. If the threshold for formal bidding were increased to $15,000, the staff time needed to formally bid these 394 requisitions would no longer be needed. A portion of these positions, and their overhead charges, could be eliminated as DHS costs, or reallocated to more productive uses. Staff time would still be needed to establish and maintain broader commodity contracts, such as the Novation agreements and other commodity contracts established by ISD.

For service contracts, DHS Contracts and Grants Division staff estimates that the bidding and contract execution process takes an average of between 18 and 24 months. Under a separate health authority, the service contracting process could be expedited as the various regulations and procedures now governing the process could be eliminated or streamlined. It would no longer be necessary to competitively bid all service contracts or to provide contract documentation and obtain contract approval from the Board of Supervisors for every contract over $100,000. The County's bid award protest procedures and the County's many contracting requirements could be abolished. This would reduce the staffing needs and costs of processing service contracts.

Department representatives provided examples of specific procurements that demonstrate how the current process emphasizes adherence to rules often at the expense of efficiency.

Example: Scanner Purchase

An example of the conflict between the need for flexibility and current procurement requirements is a purchase of computer tomography (CT) scanners described by DHS staff. This purchase started out as a procurement of five CT scanners for the new Los Angeles County-University of Southern California (LAC+USC) Medical Center now under construction. A formal procurement process, carried out by ISD, resulted in the selection of Toshiba scanners for the new hospital, at a good price.

After learning of the price available for the new equipment, DHS managers proposed expanding the procurement to buy the new Toshiba scanners not just for LAC+USC, but for all the County hospitals. This would allow the entire system to be standardized on the most current equipment, and would allow staff that uses the equipment to be redeployed among the hospitals when necessary due to workload fluctuations. DHS staff contacted Toshiba, asking if it would agree to further reduce the price achieved during the LAC+USC procurement, based on receiving a larger order.

Toshiba agreed to the reduced price, but ISD representatives refused to permit the expanded procurement, stating that if the procurement was going to be expanded, the formal bidding process needed to be repeated, giving all vendors a chance to bid again, based on the larger procurement now being proposed.

ISD representatives stated that if a competing firm had complained to the Board of Supervisors, ISD then would have been in the position of defending why it did not follow the mandated process. ISD emphasized the statement in the County Code that competitive bidding is the preferred method of procurement, and that the process proposed by DHS for additional scanners would not reflect that preference.

The Department was not able, in this situation, to balance the potential price advantage that may have been achieved with re-bidding the purchase against staff time and delays. Under a health authority, the organization would be able to make business decisions such as this in the best interests of the organization and patient service rather than adherence to rules.

Example: Sterilization Equipment

The Department planned to purchase state-of-the-art equipment to sterilize surgical instruments that use methods other than gas. Because it uses new technology, the equipment can be portable by putting it on wheels. This would permit the sterilization equipment to be brought to operating suites to sterilize a set of instruments in each suite, rather than moving instruments from operating rooms to a central facility and creating a risk of loss, theft or breakage.

The equipment was to be purchased through a County lease revenue program, each purchase of which must be approved by the Chief Administrative Office. While the sterilizing equipment has been purchased in the past from this source, the newest

models of the equipment, because they are portable, are being denied use of the funds, because the CAO believes the portability of the equipment creates an unacceptable risk of loss or theft. Representatives of Harbor-UCLA Medical Center stated that they have decided to buy a sterilization unit and bolt it to the floor in one location, thereby giving up the portability advantage the newest models provide, in order to qualify for the leasing funds and comply with County regulations, as opposed to trying to buy this equipment with some other source of funds.

Sacrificing equipment functionality in the interest of complying with procurement rules, as was done at Harbor/UCLA in this case, would not be necessary under a health authority where more flexible rules would allow for decision-making in the best interests of organizational efficiency and patient service.

Example: Repair services

One hospital sought to obtain repairs for a forklift. Because this service is something that was needed on a one-time basis, rather than ongoing, it was permissible to use a purchase order to pay for it. The forklift manufacturer advised the hospital that the repairs would probably cost no more than $3,000, which was within the Department of Health Services authority to make a purchase on its own without assistance from ISD. However, once a vendor actually examined the damage to the forklift, the estimate for repairs was $6,000. Because this was beyond the Department's delegated authority from ISD, the item was criticized in a review of the hospital's procurement by the Auditor-Controller. The Auditor-Controller also criticized the hospital for not obtaining three quotes on the repair cost. However, hospital staff said to get the one quote that was obtained required partially dismantling the forklift, which would have needed to be done by each vendor. Hospital staff also said they were advised that once one vendor had dismantled the forklift, other vendors would not be willing to work on it.

b) Many County contracting requirements are designed to achieve social goals and policies rather than to ensure contractor abilities or performance

Examples of contractor requirements that are designed to achieve policy objectives through the procurement process include County encouragement that contractors: 1) provide paid time off for employees to serve on jury duty; 2) warrant that all employees comply with court-ordered family and spousal support orders; 3) distribute to employees literature on a program for troubled mothers to voluntarily surrender babies at identified locations; and, 4) interview available workers under the GAIN and GROW welfare programs and laid off County employees for any job openings the contractor may have. The County has strict contract policies to maximally protect its financial interest, including a requirement for damages of up to $100 per day against contractors who exhibit deficient performance, a requirement that contractors whose prices go down, or offer a similar service to another client at a lower price, must also reduce prices to the County, and a requirement that contracts be non-exclusive, allowing the County to get the same service from a different contractor or other source.

While many of the goals of these provisions are laudable, Contracts and Grants Division staff indicate they frequently create conflict with contractors, particularly with nationally known service providers. This necessitates additional negotiation of contract terms, which usually requires involvement of County Counsel, and slows the contracting process. For a recent contract awarded to provide housekeeping services at County medical facilities, for example, one bidder issued a letter listing at least 10 points to be negotiated regarding aspects of the standard County contract it wanted changed. DHS Contracts and Grants Division staff report that these standard terms and conditions by the County frequently must be negotiated with vendors, adding time to the contracting process. Under a health authority, these requirements could be eliminated and the service contract process expedited.

c) The Board of Supervisors is overly involved in the contractor selection process.

Interviews with DHS staff members and review of a sample of contract files indicate a significant interest in and involvement by the Board of Supervisors in the contracting process. For example, at the time a Request for Proposal is issued by the DHS Contracts and Grants Division, a notification of this is sent to the staff member who works on health-related issues for each supervisor. This notification includes a copy of the letter of intent prepared by Contracts and Grants soliciting proposals, and a list of firms to whom the RFP was sent. Similarly a Notice of Contract Information that is sent to potential contractors, informing them of the solicitation conference and any walk-throughs that proposers must attend, provides a list of the locations where services are to be provided under a contract, and the supervisorial district in which each location is found.

A number of DHS staff members report that they have received calls from Board member offices questioning contact awards and inquiring why certain contractors were not included in the solicitation list or were not awarded a particular contract. In such instances, Department staff report that the procurement process is sometimes altered to take the Board members' considerations into account.

Under a separate health authority, the Board of Supervisors would have no jurisdiction over contracting matters and no forum for reviewing contract details. Contract awards and processes should be designated in the operating agreement between the County and the health authority as a management matter for the health authority exclusively.

d) The County contract protest process adds time to the majority of service contracts.

As noted previously, in 2004 the Board of Supervisors adopted a new policy formalizing the protest process. The new policy provides that unsuccessful bidders may protest to the department awarding a contract, then to a review panel set up to hear the protest. Contracts and Grants Division staff indicated that protests may be carried forward to the Chief Administrative Officer and to the Board of Supervisors, if the first two steps do not satisfy a protesting firm.

DHS Contracts and Grants Division staff estimate that approximately 80 percent of Requests for Proposals on service contracts result in protests of the contract award by one or more unsuccessful bidders. It appears that detailed procedural requirements for the bidding process may be making it easier for protests to occur.

Contracts and Grants Division staff acknowledged that the purpose for providing communications to the Board of Supervisors office in advance of contract award is to protect the Division against complaints by contractors to Board of Supervisors that they were not given the opportunity to apply for work. DHS staff said such complaints are typically made by a firm to the supervisor in whose district the firm is located, or in whose district the location of a proposed contract is situated.

Protest example: Landscaping services

As an example of the protest process, in a recently awarded contract for landscaping services, a losing bidder protested, claiming that the winner did not attend a walk-through of a facility where it was to provide services. Attendance at such walk-throughs is mandatory, apparently to prevent contractors from seeking changes or additional payments after contracts are awarded, by claiming they were unaware of conditions at the service site. The winning bidder did make it to the end of the walk-through, having been delayed by traffic. In investigating this

claim, the Contracts and Grants Division also discovered a scoring error in the evaluation of proposals that required a new round of evaluations. Though DHS staff, County Counsel and the Auditor-Controller all concluded that the winning bidders proposal should not be disqualified by what happened at the walk-through, the protest of the contract award went all the way to the Board of Supervisors, and contract award was delayed by four months.

Protest example: Photocopying services

Another hospital representative said several years earlier, a contract to lease photocopying equipment for hospital facilities, which was being let on a cost per copy basis, led to a protest by Xerox, even though Xerox did not bid on the contract. The protest ended being presented to the Board of Supervisors for resolution, delaying award of the contract.

A separate health authority would not be subject to County contract protest procedures. While a set of procedures should be in place to ensure that the new organization obtains high value services from its contractors, the amount of staff time and resources spent dealing with bid award contracts could be largely eliminated.

While the Health Authority Board of Directors should perform a procurement oversight function such as approving contracts over a certain dollar amount and should receive reports from management showing that their procurement procedures are being complied with, the contracting process should be officially delegated to staff. The Board's by-laws should explicitly state this and prohibit acts of interference with the process by members of the Board of Directors.

Some County contract requirements end up creating loopholes that may unfairly benefit certain contractors. For example, the County has a living wage ordinance which requires contractors who are performing lower cost services that otherwise would be performed by County staff (called Proposition A contracts), to pay a wage of at least $8.32 per hour with health benefits, or $9.46 per hour without benefits. However, contractors with less than 20 employees and gross revenue of less than $1 million a year are exempt. In the aforementioned landscaping contract, a winning bidder was exempt. The selection of their proposal hinged primarily on their low cost, which resulted from not having to pay the living wage. A losing bidder protested that the winner was artificially reducing staffing below the 20-person limit, to a level where the proposed service could not be effectively provided, to escape the living wage requirement. Because the proposal review panel could not conclude that the winner's staffing was insufficient, the protest was rejected.

COMPARISONS TO NON-COUNTY HOSPITAL AND HEALTHCARE ORGANIZATIONS

Some DHS staff interviewed said the focus on process by the County was much different than their experience with non-County health care providers. For example, some DHS Materials Management staff stated that they had previously worked at a non-profit hospital, a city-operated hospital, and a large health maintenance organization. Staff said that in those organizations, procurement occurred much more quickly, in as little as four to five days to complete an order for an item that was not part of a master agreement, because those organizations did not require elaborate bidding and specification processes, but simply the acquisition of informal quotations from reputable suppliers.

In the health maintenance organization, staff members reported, hospitals were given a budget, and were judged on their quality of health care and whether they stayed within that budget, not on whether some rigid purchasing process was followed. Department of Health Services staff in other operating functions, who are the end users of purchased items, and also had worked in the private sector, confirmed that in private health care, the focus is on the end product to be provided, good quality health care at a reasonable cost, and not on following a specific purchasing process designed to further other public policy goals.

ORGANIZATION STRUCTURE CHANGES WITHIN DHS TO IMPROVE PROCUREMENT

The organization of the procurement process within DHS is currently fragmented. There is a centralized Purchasing Manager in the Health Services Administration but each hospital has a Materials Manager and staff who do not report to the centralized Purchasing Manager. Instead, the Materials Managers and their staffs report to each facility's Chief Operating Officer.

In addition to the procurement staff, each hospital is assigned a Value Analysis Facilitator who reports to the Department's Health Services Administration Purchasing Manager. The Value Analysis Facilitators are responsible for standardizing medical supplies to make greater use of the Novation commodity contracts. However, even after hospital staff agree that a category of items can be standardized for purchase under a Novation agreement, plans have to be developed by the hospital materials management staff to arrange for training or technical support on use of the new item, the schedule for stocking the new item and removing materials that were formerly used, making sure the new item can be delivered in a timely manner without backlogs, and other issues.

The Contracts and Grants Division within Health Services Administration is separate from these other procurement units. This organizational structure does not encourage standardization of materials and supplies across the entire enterprise, consolidated purchasing for better prices and a consistent policy and management approach to all procurement.

Under a health authority that would have a primary goal of unifying the County's hospital and health services and lowering costs, the procurement function should be consolidated to put more emphasis on the goals of getting needed items quickly at reasonable prices. Hospital materials managers, who now report to the Chief Operating Officer at each hospital, should instead report to the centralized Purchasing Manager for the entire hospital and health system. This manager would be on a par with centralized management level staff responsible for physicians in the health system, for nurses, for pharmacies, etc. The purpose of providing this top-level representative for the procurement process is that when disputes occur at lower levels, such as whether a particular category of medical supplies should be standardized to take advantage of a Novation commodity agreement, the procurement function has an equal voice at the highest levels of the organization to make its case.

Centralizing some procurement staff and establishing new internal controls

The procurement function under a health authority should consist of both centralized and decentralized staff, all reporting to the centralized Purchasing Manager. The centralized staff should be responsible for processing purchases in excess of a certain dollar value, as discussed above. Centralized staff could also be responsible for standardizing and obtaining volume discounts for more medical supply items, as they would have a system-wide perspective and would be insulated from the pressure of clinical staff at the medical facilities. The system-wide perspective would also permit the development of staff expertise that would benefit the entire organization as to where to find items at reasonable prices.

Maintaining a centralized procurement staff would free materials management staff at hospitals from having to spend time getting quotes and arranging purchases for items above a certain dollar amount, and would allow them to focus their time on other aspects of the materials management process for which they are responsible, including receiving goods, managing hospital warehouses and central stores functions, linen management and equipment sterilization. In two hospitals the materials manager is also responsible for processing vendor invoices. Furthermore, because that centralized staff would be in the same organization as the materials managers at hospitals, the current friction described earlier in the process to standardize goods under Novation commodity contracts would be decreased or eliminated.

Internal controls

Another important function for the centralized staff would be to implement internal controls to ensure that the procedures and policies developed by the new health authority are being adhered to throughout the organization. This could be done through periodic random reviews of purchasing and contract records from throughout the system and from analysis of system-wide purchasing data on the organization's computer system. The purpose of these reviews would be to ensure that informal quotes are being obtained where

required, that they are properly documented, and to ensure adherence to all other procurement regulations promulgated by the health authority.

Staff for this centralized procurement function could come from some of the existing nine positions in the medical buying unit in the Internal Services Department, which would no longer be necessary under a separate health authority. ISD agrees that its primary loss under a change in governance would be the staff that now serves the Department of Health Services.

In addition, a key priority of the procurement organization under a new system of health care governance should be to improve the quality of management information generated regarding procurement. During this audit, we asked DHS staff for basic information regarding the number of requisitions (known as "purchase orders" within DHS) filled during the current fiscal year, how many were filled using blanket agreements such as the Novation contracts, and how many were within specific dollar levels.

Despite six weeks of effort, DHS staff was not able to provide data that appeared fully reliable. For example, the total volumes of purchase orders provided was different, depending on whether DHS broke down the data by stock versus non-stock items, by dollar value of the requisition, or by whether the requisition was filled using a blanket agreement rather than a spot purchase through ISD. Furthermore, the Contracts and Grants Division was not able to provide a consolidated data source reporting the number and dollar value of contracts it was responsible for negotiating and monitoring. Instead, the Division provide hard copies of reports from what appeared to be several different data bases, which audit staff was required to count by hand to determine the number of contracts."

CONCLUSIONS

Procurement for the Los Angeles County Department of Health Services occurs in a structure featuring formal rules codified in State law, the County charter, County ordinances and Board of Supervisors policies. These sources emphasize formal processes, maximum opportunity for vendors to bid to provide goods and services, and competition as the primary way to achieve the lowest prices.

Department staff criticized the rigidity of this process, complaining that the plethora of rules slows down the procurement process unnecessarily. A different process emphasizing getting items necessary for medical care quickly, at a reasonable price, could be achieved under a new governance structure for the County medical system, because that governance structure would not be subject to requirements of State law, County Code or Board of Supervisors policy.

If governance of the existing Los Angeles County health system were transferred from the Board of Supervisors to a health authority, a more flexible approach to procurement could be followed. Under such a system:

- The existing requirement of counties under the Government Code to purchase commodities through a purchasing agent would be eliminated and the health authority would no longer need to use and pay for the procurement services of ISD.

- The existing requirement of the Los Angeles County Code that "formal methods shall be the preferred method of purchase" would be eliminated, because the health system would no longer be governed by the County. The policy values enshrined in that requirement, using competition for all purchases and attempting to maximize the number of vendors able to provide goods and services would be de-emphasized, in favor of an emphasis on acquiring the goods and services that the health system needs to serve patients quickly, at a reasonable price. The health authority could raise the threshold for formally bid procurements from the current $5,000 to an amount that allows for more of the lower dollar value items procured by the Department to be accomplished with informal bidding rather than the more time consuming formal bidding process.

- Existing Board of Supervisors policies that emphasize a number of social goals, such as promoting jury service, promoting the surrendered baby law or promoting child support collections, would no longer need to be followed. While these may be laudable goals, pursuing them with vendors may interfere with the ability to get goods and services quickly, at a reasonable price.

- The lengthy protest process available to vendors who do not receive contracts could be shortened or eliminated. Because the Board of Supervisors would no longer be directly involved in management of health services, parochial considerations regarding use of vendors from different areas of the County would be eliminated, as would the ability of vendors to complain to the Board about perceived problems with the procurement process.

- Consistent with its recommended mission, the new health authority would put greater emphasis on consolidating the County hospital and health care system, including standardizing medical supplies and other commodities used across all facilities, financial savings would occur, because greater use could be made of the Novation group purchasing organization commodity contracts. As noted earlier, the cost charged by ISD to the Department of Health Services for processing such purchases is one-third its normal rate, reflecting the reduced administrative costs of group purchasing organizations.

The structure needed to make the changes described should combine some decentralization of authority to the operating units in the hospital and health care system, and some centralization of authority to promote standardization and consolidation of purchases system-wide and adherence to new procedural requirements.

RECOMMENDATIONS

The Board of Supervisors should:

5.1 Direct DHS staff to develop recommendations for enabling legislation that exempts a new system of health care governance from the requirements for a County purchasing agent in State law, and from the procurement requirements of the Los Angeles County Code and Board of Supervisors policies.

The Department of Health Services should:

5.2 Develop procurement procedures and requirements to be implemented under the health authority that eliminates a rigid focus on formal bidding processes and that emphasize maximum vendor access in favor of a more flexible system that focuses on getting goods and services quickly, at reasonable prices.

5.3 Develop procurement policies for the health authority to increase the value of goods and services that individual health care facilities can purchase on their own with less formal bidding requirements based on an analysis of current purchasing amounts and financial risk so that formalized bidding is used only when there will be substantial benefits or price advantages resulting from the additional time and administrative requirements.

5.4 Design a consolidated procurement structure to be established under the health authority that includes a centralized procurement office overseeing all components of the system, including the Contracts & Grants Division, that would process bids above the newly established threshold for formal bidding, provide organization-wide oversight and monitoring of compliance with the Health Authority's new regulations to ensure that procurement abuses are not occurring, and would be headed by a purchasing manager established at the same management level as a health system director of nursing, or director of clinical care.

5.5 Develop a system for ensuring and reporting to management and the Health Authority Board of Directors that competitive bidding is used when appropriate and advantageous to the organization and that procurement abuses are not occurring.

5.6 Determine the number of positions that should be transferred from the Internal Services Department to the new health authority for the new centralized procurement function, recognizing that fewer formal bids will be required in the new system and that more items will be standardized and purchased through a Group Purchasing Organization.

5.7 Determine the number of positions that will be needed for the Contracts and Grants Division under a new more streamlined contracting procedure.

COSTS AND BENEFITS

There would be no costs to implement these recommendations. A new system of procurement, based on a new system of health care governance, would be more flexible, allowing the health care system to get the items needed for patient care more quickly, at reasonable prices, by eliminating rigid bureaucratic rules and processes. Benefits would include reduced cycle time for procurement and reduced administrative costs as fewer staff would be needed to process purchases without all of the procurement rules and regulations and processes with which DHS must now comply. There should be some cost reductions from a reduced need for the current ISD staff that processes DHS purchase orders since fewer procurements would be subject to formal bidding procedures and in the Contracts and Grants division since the service contract procedure would be streamlined.

6. INFORMATION TECHNOLOGY

- **The Department of Health Services' past approach to information technology has been decentralized, with each hospital and department developing its own systems and protocols. As a result, it is not possible to track patient records across the Department as there are no common patient identifiers and no common methods for recording patient transactions.**

- **The Department has recently developed a system for centrally collecting and standardizing some patient data from each cluster after it is entered into each independent system, allowing for better management monitoring of patient outcomes and quality of care across the system, and has been used to develop some new clinical protocols. Further integration of the Department's information systems is a key component to managing the Department as a single system, consistent with the Department's strategic plan.**

- **The Department completed a business automation plan in 2005 that sets its strategic information technology objectives and goals. The key weaknesses identified are the level, mix, compensation, and skills and abilities of the Department's information technology staff. As one indication of staffing limitations, vacancies in the Department's information technology classifications averaged approximately 14 percent in FY 2003-04, and were even higher for core classifications such as Systems Analysts and supervisors.**

- **Under a health authority, the new organization would be free of County constraints on classifications, compensation and hiring processes. The organization could redesign or establish new classifications more appropriate to its needs and adjust compensation accordingly. At the same time, the organization should establish a stronger management function centrally by converting the current Chief, Information Systems in Health Services Administration to a chief information officer, responsible for overall information technology development and maintenance for the entire organization.**

The Department of Health Services' information technology function is staffed by a centralized unit within Health Services Administration and decentralized staff

assigned to each hospital, cluster and major division. Total Department-wide staffing in FY 2003-04 was approximately 500 Full-Time Equivalents (FTEs).

The centralized staff is headed by a Chief, Information Systems-Health Services position who reports to the Director of Clinical Management and Information Systems in Health Services Administration. Decentralized information technology staff at the hospitals and other Department divisions mostly report to Information Systems Managers, referred to as Chief Information Officers at some, but not all, of these units. These managers most often report to the Administrator or Chief Operating Officer for their cluster or organizational unit and not the Chief, Information Systems in Health Services Administration.

The job specifications for the Chief, Information Systems-Health Services position states that the position is responsible for,

> "…directing, managing and administering the analysis, planning, designing, coordinating, implementing and maintenance of department-wide automated information systems that are specific to and support the data requirements of Health Services Administration (HSA) and departmental senior management."

The position is also responsible for identification and integration of long-range automated information systems requirements into departmental strategic plans to ensure that departmental information data requirements are met. What the job specification does not state is that the position has authority over the information systems managers in each of the clusters and other units. In the past, and to some extent to this day, this has meant that each cluster and other division has operated independently and designed systems and protocols unique to their organization. This is reflected in the lack of standardization between clusters found in the QuadraMed/Affinity system, DHS' core health information system.

Each hospital and cluster records patient transaction information in a unique manner. Patient identifiers are different at each cluster and, in some cases, between facilities within clusters meaning that a care provider at one DHS facility cannot easily access a patient's records from another facility. Besides the clinical implications of providers not having a patient's complete records, it also means that a patient has to provide the same information to the provider each time they visit a different facility. Ancillary systems such as Pharmacy and Laboratory are separate systems at each hospital and data on those systems is not linked to the primary health information systems so that complete patient records cannot be accessed from a single system.

The Department has undertaken an initiative in recent years to centrally collect and standardize certain patient data from all clusters to enable system-wide evaluation of patient outcomes and key measures such as length of patient stay and patient diagnoses. The results of this initiative, though still in progress, allow for better management monitoring of the quality of care and patient access to services, both key measures of DHS' effectiveness. Other benefits include collection of data that is enabling development of new clinical protocols and

implementation of the Department's 2002 strategic plan focus goal of treating the Department's operations as a single system, rather than separate silos functioning independently.

Integration and greater utilization of information technology is key to the Department's strategic goal of operating as a single system, as demonstrated by the experience at Denver Health, the safety net public hospital and health care system governed by a separate health authority in Denver. Denver Health is an integrated system comprised of emergency services, a 349-bed hospital, ten community health centers, 13 school-based clinics, the public health function for the city and county, and behavioral health services, all of which share processes, protocols, a single management team and an integrated information system. The organization reports that single image patient medical records are available to all physicians throughout the system, regardless of site and that this level of systems integration has resulted in improved care and greater efficiency. The organization's billing, medical records and patient scheduling systems are all linked and available at all sites.

A key concept behind the level of integration at Denver Health is to better manage patient care and prevent unnecessary hospital visits and duplicate procedures. They report, for example, that the top ten diagnoses at their emergency room do not include asthma, otitis media, and viral infection, which are often in the top ten diagnoses at urban public hospitals[1]. In addition, Denver Health reports an average length of inpatient stay of 4.5 days in 1999, which compares favorably to DHS' average of 6.1 days for FY 1999-00[2]. This approach at Denver Health appears consistent with the goals of DHS.

DHS' Business Automation Plan outlines its information technology future direction

DHS produced a Business Automation Plan in February 2005 that outlines the Department's information technology strategies though FY 2007-08, current and planned information architecture, the alignment between Department goals and County information technology goals, an assessment of the Department's information technology and strengths and weaknesses and proposed projects for the coming years.

The Department's overall information technology direction disclosed in its Business Automation Plan is:

- Integration and coordination of systems across the entire department and discontinuation of separate approaches at each cluster and division

- Use of web-based technology in the future, providing greater functionality and Department-wide access to system-wide data for all end users

[1] "Denver Health: A Model for the Integration of a Public Hospital and Community Health Centers", Annals of Internal Medicine, Volume 138, Issue 2 (January 21, 2003), p. 143.
[2] Ibid for Denver Health. DHS records for DHS.

- Use of system-generated data to measure and assess Department's performance and effectiveness of patient care
- Move to electronic medical records, replacing paper records and related storage and retrieval costs

Strengths of DHS' information technology function identified in the business automation plan include:

- Improving collaboration within DHS and between DHS and external County departments
- Improved information technology infrastructure
- Improved flow of data from hospitals to central repository for standardization and system-wide analyses
- Information technology increasing recognized as key contributor to achievement of Department goals and objectives

Weaknesses of the information technology function are identified as including:

- Lack of a full-time Department-wide chief information officer and senior management team
- Outdated information technology job specifications
- Problems with information technology staffing levels, distribution and skill sets
- Lack of qualified information technology project managers
- Over-utilization of the same staff for implementation of new information technology projects
- Need for technical and security related training for information technology staff
- Procurement processes adding costs and delays to information technology operations
- Lack of a Department-wide patient identifier
- Space constraints for equipment and ergonomic issues

Opportunities identified in DHS' business automation plan include:

- Establish an effective centralized organizational structure with qualified full-time leadership positions delegated responsibility for Department-wide

strategic development and project oversight; decentralized information technology staff to be used for day-to-day operational support

- Realign compensation rates with appropriate skill levels through a reclassification process
- Reduce and focus the number of information technology projects to be aligned with Department's business goals
- Streamline information technology operations
- Standardize applications and data throughout the Department
- Consolidate purchases to leverage buying power
- Enhance information technology staff training
- Assist Human Resources in understanding information technology staffing needs

The plan also identifies threats to the information technology function, which primarily concern funding shortfalls although the impact of the County human resource processes on the Department's ability to hire and retain qualified information technology staff is also identified as a threat.

The plan provides a strong framework for future information technology development in the Department and very specific proposals for improvement. It includes criteria by which proposed projects should be evaluated and lists many of the proposed projects. It does not include cost detail however for the projects, making it impossible to conduct a complete evaluation of the projects and set priorities. The Department needs a detailed multi-year strategic plan with cost estimates to enable Department decision-makers to select projects that would provide the greatest benefits for the costs incurred.

Human resource issues have impact on Department's information technology

Most of the weaknesses detailed in the plan and listed above concern the inability of the Department to attract and retain and rationally allocate qualified information technology staff at DHS. Staffing flexibility and the need for streamlined human resources processes have been identified in Section 4 as a key areas that need to be improved for DHS to perform more effectively overall. As evidenced by the business automation plan, this is particularly relevant for the Department's information technology function. Many of the needed changes identified in the plan would be addressed through creation of the health authority, which would enable the organization to create its own classifications, compensation schedule and hiring processes, as discussed in Section 4 of this report. Similarly, the Department's procurement processes are identified as a

weakness affecting the information technology function; these too could be streamlined under a health authority, as detailed in Section 5.

A review of information technology position vacancies in the Department's enterprise operations and Health Services Administration shows a 14.1 percent vacancy rate for all information technology classifications in FY 2003-04, measured in full-time equivalents (FTEs). Even higher rates were found among the core classifications that comprise the bulk of the Department's information technology staffing: Information Systems Analysts II (42.7% FTE vacancy), Information Systems Coordinators (14.4 percent), Information Systems Supervisors I (35.2 percent) and Information Systems Supervisors II (22.7 percent). High FTE vacancy rates were also experienced for the higher salaried classifications of Information Systems Manager II and Data Elements Coordinator. Offsetting these high vacancy rates in FY 2003-04 were over-filled (i.e., more actual than budgeted FTEs) Information Systems Analyst I and Information System Manager I classifications. The vacancy data appears to confirm the point in the Department's business automation plan about its difficulty in recruiting and retaining information technology staff, particularly at the journeyman level (Information Systems Analyst II) and above.

Table 6.1 provides a summary of the Department's information technology vacancies in the hospital clusters in FY 2003-04. DHS staff report using contract services for some of their information technology initiatives due to the lack of required skills in-house.

Information technology skills within DHS

The vacancy statistics do not reflect the Department's situation concerning information technology staffing as discussed in the business automation plan. That document discusses the mismatch between Department needs for the future and the training and qualifications of staff. In addition, the move in the health care industry to electronic medical records and the growing importance of information technology for clinical operations as opposed to administrative, has some industry observers predicting increased demand for information technology workers in the health care industry in the coming years and accordingly, greater upward pressure on salaries. This will likely mean that DHS will need to make changes in its job descriptions and salaries to attract and retain the staff needed to achieve its strategic goals related to use of information technology to achieve greater system-wide integration.

Table 6.1
Information Technology Classification Vacancies
DHS Hospitals, Clusters & Administration
in Full-time Equivalents (FTEs): FY 2003-04

ITEM #	ITEM NAME	BUDGETED FTEs	ACTUAL FTEs	# VACANT FTEs	% VACANT FTEs	FY 04-05 SALARY
2591	INFO. SYSTEMS ANALYST II	93.8	53.7	40.1	42.7%	$63,528
2593	INFO. SYSTEMS COORDINATOR	73.0	62.5	10.5	14.4%	$77,371
2595	INFO. SYSTEMS SUPERVISOR I	16.0	10.4	5.6	35.2%	$77,731
2596	INFO. SYSTEMS SUPERVISOR II	23.5	18.2	5.3	22.7%	$87,955
2624	DATA ELEMENTS CRD, HLTH SRVS	6.0	1.0	5.0	83.3%	$107,062
2657	DATA CONTROL CLERK	10.0	7.0	3.0	30.4%	$29,772
2585	SENIOR SYSTEM AID	7.0	4.0	3.0	43.0%	$45,130
2520	PROGRAMMER ANALYST I	3.0	-	3.0	100.0%	$60,319
2526	PRINCIPAL PRGMMR. ANALYST	3.0	-	3.0	100.0%	$86,231
2597	INFO. SYSTEMS SUPERVISOR III	4.0	1.0	3.0	75.0%	$94,476
2525	SENIOR PRGMMR. ANALYST	3.0	1.0	2.0	66.7%	$72,749
2574	INFO. SYSTEM SMANAGER II	4.0	2.8	1.2	29.8%	$112,285
2490	COMPUTER SYSTEM OPERATOR	12.0	11.0	1.0	8.4%	$37,685
2537	SUPVISNG INFO. SYSTEMS SUPPORT ANALYST	3.0	2.0	1.0	33.3%	$73,286
2672	DATA CONVERSION EQUIPMENT OPR I	2.0	1.0	1.0	50.0%	$31,791
2536	SENIOR INFO. SYSTEMS SUPPORT ANALYST	-	-	-		$86,231
2660	SPVSNG DATA CONTROL CLERK II	2.0	2.0	-	0.0%	$36,605
2674	SENIOR DATA CONVERSION EQUIPT OPERATOR	-	0.5	(0.5)		$35,376
2588	INFO. SYSTEMS ANALYST AID	16.5	17.3	(0.8)	-4.6%	$49,521
2489	COMPUTER EQUIPMENT OPERATOR	15.0	15.9	(0.9)	-6.2%	$32,422
2673	DATA CONVERSION EQUIPMENT OPERATOR II	-	0.9	(0.9)		$35,376
2569	INFO. SYSTEM SPECIALIST I	-	1.0	(1.0)		$102,219
2584	SYSTEMS AID	8.0	9.0	(1.0)	-12.5%	$38,427
2658	SENIOR DATA CONTROL CLERK	2.0	5.0	(3.0)	-150.0%	$32,979
2573	INFO. SYSTEM MANAGER I	18.0	22.9	(4.9)	-27.4%	$102,219
2590	INFO. SYSTEMS ANALYST I	13.2	40.4	(27.2)	-206.6%	$59,136
	TOTAL	**337.9**	**290.3**	**47.6**	**14.1%**	

Source: HMR Analysis of (a) DHS FTE Report by Natural Classification for Fiscal Year 2004-2005; (b)County of Los Angeles-Department of Health Services Positions by Natural Class as of 3/2/05.
Note: FY 2004-05 salaries are at the highest step.

The Department's business automation plan proposes conducting an inventory of information technology staff skills and comparing them to the skills required to

achieve the vision of DHS' information technology future. To the extent there are mismatches, the plan proposes staff training, or, new staffing configurations.

The plan also identifies DHS' procurement system deficiencies including the absence of basic functions such as end user catalog-based on line requisitions and self-service requisition tracking. Integration of ordering with services and supplies budget information has also not occurred, according to the plan. The plan recommends that DHS correct these deficiencies to help streamline the procurement process and improve management oversight of Department expenditures.

DHS' organization structure and need for a chief information officer

The Department's business automation plan addresses the lack of an information technology governance structure and a centralized information technology leader for the Department. This is a key need for the Department, particularly as it implements its strategic plan goals of greater integration of the Department's components. Many organizations the size of DHS would have a chief information officer position in place, responsible for the development and maintenance of information technology across the entire organization.

The roles of a chief information officer in an organization such as DHS would be: to ensure that all hospitals and operating units are held accountable for achieving desired results; to coordinate Department-wide information technology activities; and, to develop standards for Department computer systems. The role of the current Chief, Information Systems-Health Services is not defined this way.

If DHS were to create a chief information officer position and realign reporting relationships between this position and decentralized information technology staff, the new position would have the authority to hold the hospitals/clusters accountable for development and implementation of their technology plans, consistent with a broad Department-wide vision. Such a position should also be responsible for development of a Department-wide strategic plan, which would provide the framework for all information technology initiatives throughout the Department. This function would also serve as the point where information technology priorities are set, consistent with the Department's overall strategic plan, and where information technology funding priorities are determined.

Implementation of the proposals in the DHS business automation plan would be greatly facilitated if the Department were able to redesign existing classifications, set competitive salaries in cases when they are not at parity with the marketplace, assess skill levels of existing staff and provide training to achieve the skill sets needed to implement the Department's strategic plan vision. Accomplishing all of this would be greatly enhanced by transferring the Department's personal health services function to a separate health authority as the organization would no longer be subject to County restrictions on classification changes and compensation restrictions.

Currently, funding for information technology projects are subject to review by the County's Chief Administrative Office and Chief Information Officer. Both can curtail planned projects based on Countywide cost issues or technical matters such as compatibility with County standards. Under a health authority, these levels of review would no longer be necessary and project funding decisions could be made by the organization itself. Cost and standardization would still be important considerations for new projects, but the health authority perspective would be costs versus benefits for health authority operations and compatibility with health authority systems and standards, rather than conforming to County-wide standards.

As discussed in Section 3, the financial relationship between the County and the health authority should be performance based, so that health authority compensation from the County is driven by the health authority's ability to contain costs and provide enhanced quality of care to patients. Accordingly, it is important that the County suitably participate in the development of a comprehensive and integrated information technology system for the health authority, so that the County's ongoing contributions to the cost of health authority operations are protected. If such a system is not funded and successfully developed with the County's assistance, the health authority will lack one of the most essential tools for managing patient care and costs, and the County will be unable to monitor key indicators of the health authority's performance. In fact, during interviews for this study, we were advised that the Office of Managed Care (OMC) is currently unable to effectively monitor services provided by DHS to OMC clients because of the difficulty extracting key data that is necessary for this purpose. Replicating this ineffective system within a health authority would therefore be inappropriate, and place the County's investment in health authority operations at risk.

CONCLUSIONS

Information technology at the Department of Health Services has evolved in a decentralized fashion, with each hospital and operating division designing unique systems and protocols. As a result, sharing data between facilities and monitoring Department-wide performance has not been possible in the past, resulting in inefficiencies in operations and an inability for the Department's central management to monitor and compare key aspects of patient care and cost-effectiveness.

Health Services Administration maintains a centralized information technology staff and a Chief who report to the recently created Director of Clinical Management and Information Systems. These positions do not have management authority over information technology staff at the hospitals or other operating units.

The Director of Clinical Management and Information Systems has been instrumental in the recent development of a centralized repository where data from all operating facilities is transmitted and standardized to allow for measuring

Department-wide performance and tracking patient outcomes. Some regular reports of this sort are now being produced. These early stages of centralized data compilation and integration is consistent with the Department's strategic direction to operate as a single system. Use of information technology to accomplish this goal will continue to be key, as demonstrated by the experience at Denver Health, which operates an extremely integrated system of primary care clinics, a hospital and other medical facilities, all operating on the same computer system with access to the same patient data at all sites.

The Department's business automation plan calls for greater system integration and use of web-based architecture in the future. It also points out that current information technology staff is deficient in many of the skills needed to implement the plan. It blames this in part on out-of-date County job specifications and impediments to hiring and retaining qualified information technology staff in the County. Vacancy rates among information technology classifications at the hospitals and clusters are high, particularly for core systems analysts, Information Systems Coordinators and supervisors.

Transferring the County's hospital and personal health care system to a separate health authority would enable creation of new or redefined information technology classifications and compensation schedules and a more flexible hiring process to enable the organization to make better use of information technology to implement its strategic plan. Creation of a chief information officer for the new organization and changes in the reporting structure between Health Services Administration and the hospitals and operating units would allow for more consistency across the organization and more accountability for decentralized information technology staffing and expenditures.

RECOMMENDATIONS

The Board of Supervisors should direct the Department of Health Services to:

6.1 Expand the current business automation plan into a five year strategic information technology plan for the health authority linked to the priorities and principles of the 2002 DHS strategic plan and detailing current hardware, software and utilization throughout the Department, future priorities, proposed projects, costs and benefits of projects, funding sources and project selection criteria.

6.2 Determine the unit cost for the highest priority, most cost-effective information technology projects to include in the payment rate that the health authority will receive from the County.

6.3 Design and implement a skills assessment process for current information technology staff and compare results to skills needed as detailed in the five year strategic information technology plan.

6.4 Begin preparation of new or redesigned job specifications for information technology positions for the health authority, including creation of a chief information officer classification.

6.5 Conduct or obtain existing information technology salary survey data to determine market rate compensation levels for new or redesigned classifications.

6.6 Prepare a formal plan, including an implementation schedule, for restructuring the information technology function under the health authority with a centralized chief information officer responsible for overall direction and priority setting for the function and overseeing centralized and decentralized staff, with the latter responsible for day to day operations at hospitals and other facilities.

6.7 Participate in the funding for a fully integrated, comprehensive information technology system for the health authority, that will be able to provide cross-system data on patient care and costs that will be necessary to monitor health authority performance.

COSTS AND BENEFITS

The primary cost of implementing these recommendations will be staff time. One-time direct costs could be incurred if an appropriate salary survey cannot be obtained and needs to be commissioned to assess current salaries for information technology positions. Benefits of the recommendations would include preparation of a plan to guide future information technology investments under the health authority, consistent with the 2002 strategic plan, a more consistent approach to information technology across the organization, an improved information technology staffing plan that will enable the organization to achieve its goals and improved information to assess performance and patient outcomes.

7. COUNTY SUPPORT SERVICES

- **The FY 2004-05 Countywide Cost Allocation Plan (CCAP), allocates nearly $1.4 billion in County costs to departments for services that are provided centrally, such as payroll, accounting, building maintenance, facility rent and use, utilities, insurance, legal and other general support activities. DHS was charged approximately $203.9 million for these services in the current year plan. Approximately $185.6 million was direct charged and the balance was allocated to the Department using a variety of allocation methods.**

- **A separate health authority would not be required to use County support services, but would likely continue to use many of them at little or no cost savings. In addition, many of the costs presently charged to DHS such as rent, facility use and utilities would still be incurred even if the services are no longer provided by the County. In some instances the combined cost for both the health authority and the County could increase because the County would be unable to sufficiently lower its costs to offset losses in income from the health authority.**

- **Nonetheless, some County overhead costs charged for support services provided to DHS could be eliminated, by providing the services in-house or through less costly contractors. Costs for some external County oversight and control services that would no longer be required under a separate health authority could also be eliminated.**

- **Conservatively estimating reductions in overhead costs for some County support services, savings could amount to an estimated $10.8 million per year. However, this is a relatively small amount of savings when compared with the projected cumulative DHS operating deficit of over $1.3 billion.**

- **After an initial transition period, the health authority should be given the option to (a) continue to purchase services from the County, (b) purchase services from contractors, or (c) provide services in-house. Each alternative should be fully analyzed for the potential to produce savings for the health authority and the County, but should primarily be chosen based on business considerations for the health authority.**

As a department within the larger County organization, the Department of Health Services (DHS) receives a wide array of services from other County departments to support its operations. Consistent with governmental accounting principles, these costs are either charged back to DHS on a direct charge basis or allocated to DHS using an allocation methodology that is regulated by the federal government and the California State Controller.[1]

IDENTIFICATION AND COST OF SERVICES

To conform with these accounting principles and requirements, the County Auditor-Controller prepares a Countywide Cost Allocation Plan (CCAP) for purposes of billing federal and State grants. It is also the basis for internal charges between departments within the County. Allowable costs are defined in an agreement between the County and the State Controller. The agreement establishes the allocation basis year and the specific services for which the County can bill the grants. For FY 2004-05, the State approved and the CCAP included the following group of centralized services based on FY 2001-02 actual costs:

1. Employee Fringe Benefits
2. Insurance
3. Rental Expenses
4. Utilities
5. Affirmative Action
6. Auditor-Controller
7. Board of Supervisors
8. Chief Administrative Officer
9. County Counsel
10. Internal Services Department
11. Human Resources
12. Public Safety
13. Treasurer-Tax Collector
14. Employee Benefits - General

In order to fairly allocate these costs, the State Controller assesses the County's procedures by asking the following questions:

- "Do the total costs accumulated for a service department reasonably reflect the value of services provided by that department?" and,
- "Do costs that are distributed and/or billed to each operating department reasonably reflect the value of the services received by these departments?"[2]

The County's Cost Allocation Plan is regularly audited by the State Controller, reviewed internally and adjusted to reflect any changes in allocation methodology or the treatment of cost information between years (i.e., roll forward adjustments). Accordingly, the document serves as a reasonable basis for identifying those services and costs that would need to be organized and funded to support the operations of the proposed health authority, but which are not currently part of DHS. Because the health authority would not be a subdivision of the County, it would not need to purchase these support services from the County. Instead, the health authority could provide many services internally, or purchase services from public or private entities. However, opportunities to do so

[1] *Federal Office of Management and Budget Circular A-87*; and, *Handbook of Cost Plan Procedures for California Counties,* California State Controller

[2] *Handbook of Cost Plan Procedures for California Counties,* California State Controller

are limited and our analysis suggests that potential savings are small when compared with the cumulative $1.3 billion DHS deficit.

COSTS IDENTIFIED IN THE CCAP

The FY 2004-05 CCAP allocates the FY 2001-02 costs of 68 different programs that reside within 14 County departments. In FY 2001-02, DHS was either directly charged or allocated costs that exceeded $203.9 million.[3]

In a memorandum to the Board of Supervisors dated August 29, 2001, the Chief Administrative Officer (CAO) reported that County departments were expending approximately $145.8 million to support the operations of DHS. At that time, he noted that "based on their experience, ACMC (i.e., the Alameda County Medical Center) believes that there are cost savings by purchasing services elsewhere or by providing the services in-house. They continue to purchase services from private providers since they found that the other county departments are not as competitive due to higher overhead costs compared to the private providers. ACMC estimates that overhead costs represents approximately 25 percent of the total cost to purchase services from other county departments." The CAO's report further suggested, as a preliminary estimate, that "40 percent or $58.3 million" of the $145.8 million reported amount in DHS' support services costs may be "associated with overhead charges", or costs other than the direct costs for services, such as for supervisors, managers and support services within the service providing department. The CAO noted that any loss in income to support the overhead costs incurred by the service departments would either need to be absorbed by the General Fund or reduced from the departments' budgets in whatever way is feasible.

Our analysis of current data suggests that the Chief Administrative Officer's presentation of the cost data may have provided unrealistic expectations regarding opportunities for cost savings. Many of the existing support services costs such as rent and facility maintenance, utilities, and insurance would still be incurred under a health authority. An analysis of the FY 2004-05 CCAP suggests that while there are some opportunities to reduce elements of these costs, particularly some overhead costs for County support services and the costs for some direct services such as County control and oversight functions that would not be required under a health authority, such savings will not approach the 40 percent estimate made by the CAO.

The FY 2004-05 CCAP shows that $203.9 million was charged to DHS for County support services. Of that amount, a portion of an estimated $40.5 million in costs potentially could be reduced under a health authority by providing the services with in-house staff or by purchasing services from a lower cost contractor. Exhibit 7.1 at the end of this section provides a detailed analysis of

[3] Includes direct charges of $185.6 million and allocated costs of $18.3 million. To arrive at this amount, direct charges were increased by approximately $80.4 million to offset prior year adjustments for unallowable facility construction loan interest (fuller explanation included in Exhibit 7.1). The amount used in this report provides a better estimate of the annual costs incurred by DHS than either the direct charge amount or the total amount reported in the CCAP.

the Department's support services costs and identifies areas where potential savings could be realized.

FIXED COSTS AND AREAS OF POTENTIAL COST REDUCTION FOR SUPPORT SERVICES OVERHEAD

The following are some of the areas that contain substantial fixed costs that would still be incurred under a health authority, but which also contain opportunities for some cost reductions by reducing overhead costs or improving performance. The costs identified are based on data in the FY 2004-05 CCAP.

- The $203.9 million in support service costs charged to DHS in the FY 2004-05 CCAP includes over $80.4 million for rental expense associated with the facilities that the Department occupies. These expenses include property management, labor, leasing services, architecture and design and certain costs associated with borrowing. While rental expenses are initially administered by the Chief Administrative Officer, they are eventually charged back to the departments that occupy the facilities. It is improbable that the health authority would be able to avoid most of these costs if it continued to occupy County owned facilities after formation.

- DHS was charged over $29.4 million in costs for electricity, natural gas, and water utilities used at DHS occupied facilities. These costs are administered by the County Internal Services Department and then allocated back to the departments based on actual utility usage or square footage of the buildings that the departments occupy. It is unlikely that most of these costs could be avoided by a health authority that would be occupying the same space presently occupied by DHS. However, over $3.9 million in administrative costs are included in these costs, and it is probable that some amount of overhead costs could be eliminated by moving utility related functions now performed by the County to the new health authority operation.

- DHS was charged approximately $33.4 million for the cost of judgments, damages and insurance paid by other County departments on behalf of DHS. A better managed Department or health authority should be able to reduce liability exposure, and thus produce insurance and claims settlement cost savings, though such savings are speculative without conducting an in-depth review of DHS insurance and claims experience. Overhead costs for the County's insurance related services, however, potentially could be reduced by moving legal and claims administration services from the County to the health authority.

- DHS presently contracts with a private company to provide security services at some of its facilities. The reported FY 2004-05 CCAP cost of the contract was $14.0 million. Without a change in the level of security, or changes in policies surrounding security services at the hospitals, comprehensive health centers or clinics that would be operated by the health authority, the core costs for these services would be retained. But a portion of these costs are

for contract administration and overhead and potentially could be reduced if these contracts were managed by the health authority instead of the County.

Taken alone, these four major programs represent $157.2 million of the $203.9 million in costs charged by County departments to DHS (77.1 percent), a substantial portion of which would still be incurred by the health authority. For example, the health authority would continue to be charged the full amount of $80.4 million for facility rental expense. However, we estimate that at least $2.2 million, or 1.4 percent of these costs represent overhead that could be reduced (as opposed to the 40 percent overhead estimated by the CAO and 25 percent estimated in Alameda County). Of course, actual savings would be dependent on a number of factors specific to the services being provided.

Cost Savings from External County Verifications and Reviews that could Potentially be Discontinued

Some other support services now provided to the Department of Health Services offer greater opportunities for cost reductions. There is opportunity for the health authority to reduce costs by eliminating many of the external verifications and checks and balances that the County has established for civil service, information systems and budget control purposes. In some areas, such opportunities could be significant. For example, a health authority would not be required to obtain salary survey data or approvals from the County prior to establishing new classifications or setting salaries for new classifications, special step placements, temporary employees or other categories of workers. The following are examples of cost savings opportunities that would become available under the health authority.

- DHS presently contributes over $4.4 million to the County annually for the Human Resources Department (HRD) costs associated with examinations and recruitment, classification and salary setting, training and other Countywide costs incurred by HRD. As discussed extensively in Section 4 of this report, many of these activities either supplement or duplicate services that are provided internally by DHS and would no longer be needed as presently provided under a health authority

- DHS presently receives over $865,000 in services from the County's Chief Information Officer (CIO) for information systems support. This is in addition to hundreds of Department staff and contractors dedicated to this function. While some of the information systems services provided by the CIO might need to be replicated under a health authority, savings should be achieved by discontinuing payment for review and verification of the Department's information systems, plans and procurements for consistency with County policies, procedures and protocols by other County departments.

- Approximately $6.3 million was allocated to DHS for the cost of accounting, auditing, claims processing, payroll and other services provided by the County Auditor-Controller. If these functions were directly assumed by the

health authority or a contractor for the health authority (e.g., some auditing services and payroll), some of these costs could potentially be reduced. However, without conducting a detailed analysis of the services that are provided by the Auditor-Controller, a reliable estimate of the potential cost savings in this area cannot be prepared. While we think some small amount of savings could be achieved, we have not estimated any in this analysis.

- Approximately $3.7 million was allocated to DHS for the cost of finance and budget, employee relations and other management services provided by the Chief Administrative Office. Many of these functions could be provided internally by the health authority at little or no additional cost, or discontinued entirely. For example, many of the finance and budget functions performed by the CAO are intended to provide checks and balances against County policy, or to integrate DHS into the overall County financial framework and budget. Many of these activities would no longer be necessary with a separate health authority. In addition, similar activities that would have to be developed to support internal finance and budget requirements could be implemented at little or no additional cost, since activities related to communication and coordination with the CAO would be discontinued.

The cost for the services described above and some others, could be discontinued or significantly reduced under a health authority. In total, these services amount to $16.7 million in charges to DHS through the County's FY 2004-05 CCAP. Based on our review, we believe an estimated savings of nearly $8.6 million could be achieved in these specific support service areas, with the creation of a health authority. When combined with the $2.2 million in potential overhead cost savings estimated previously, total savings would be $10.8 million.

Given the limited scope of this review, the types of detailed analysis required to estimate the potential cost savings to the health authority could not reasonably be performed. Accordingly, the Board of Supervisors should direct the CAO to conduct a thorough analysis of current County costs to support DHS services. The analysis should include:

- A comprehensive accounting of costs, such as rental expenses, utility charges, judgments and damages, insurance and security services, that would likely offer little opportunity for health authority savings;
- An analysis of services, such as information systems development and support, where some limited health authority savings could be achieved; and,
- An analysis of services, such as auditing, accounting, budgeting, financial management and employee relations, where more substantial savings might be possible.

SUPPORT SERVICE COSTS NOT LIKELY TO BE REDUCED OR TO POTENTIALLY INCREASE

In other areas, the health authority may have more difficulty achieving savings. For example, DHS is presently charged nearly $700,000 for legal services provided by the Office of the County Counsel. It is highly reasonable to expect that these legal services would need to be replicated in the separate health authority with little or no cost savings. In addition, the County would still require the services of County Counsel to oversee the agreement with the health authority. While this would represent a great reduction from the level of service now provided by County Counsel for DHS matters, it would still represent an ongoing cost in addition to the health authority's costs for legal services, probably representing an increased cost.

In his August 29, 2001 memorandum, the CAO stated that, "If the governance structure that is established determines to purchase services (personnel, legal, accounting/payroll, etc.) from providers other than County departments, the County will need to address the impact to these departments regarding the loss of revenue from DHS." Also, the CAO suggested that unless County overhead costs could be reduced, such a decision by the health authority governing body "may result in further curtailments in the impacted County department if additional County funding is not provided to mitigate this loss of revenue."

These are important observations that were made by the CAO. First, the County could lose revenue from a health authority decision to no longer purchase support services from County departments. Second, because the County would no longer receive income to offset indirect – or overhead – costs of the services being provided, the County may be forced to consider staffing reductions and other cost savings measures for more than the direct cost of the discontinued service.

This situation could result in increased costs to the taxpayer because: (a) the County may be unable to reasonably reduce its costs in direct proportion to the loss in revenue from the health authority, and (b) the health authority may reasonably need to replicate the service and costs internally or with contract services. For example, in a hypothetical situation the County may lose $1.0 million in revenue when the health authority decides to no longer purchase a particular support service, because the health authority finds that it can internally replicate the services by spending only $900,000. Accordingly, the health authority would realize $100,000 in savings. However, because the allocated cost for this service reflected economies of scale achieved by centrally pooling resources, the County finds it can only reduce costs by $800,000. As a result, the County would incur $200,000 in ongoing costs. Combined, the two departments would be paying $100,000 more than prior to the health authority decision to discontinue the use of the County service.

This is an important consideration for both the County and the health authority, since it is likely that the County will continue to substantially fund the activities of the health authority after legal separation. In the example, the health authority would realize savings as a result of its independent action. The County would realize a cost increase because it would be unable to reasonably adjust to the

loss in income. Because a substantial portion of health authority operations would be funded by the County, in this instance the taxpayers would essentially be paying a premium for health authority autonomy.

This situation could benefit both organizations. The health authority would be provided with opportunities to reduce the cost of health care delivery, while the County would be forced to reconsider the cost effectiveness of its centralized support services operations. Even if the decision by the health authority to discontinue the use of County services results in increased overall costs, flexibility should be given to the health authority to make such decisions. This flexibility will result in opportunities for efficiency and beneficial tension when the health authority and the County negotiate the terms of their business relationship.

In preparation for the creation of the health authority, the CAO should be requested to conduct a thorough analysis of County cost impacts that might result from possible health authority decisions to discontinue the use of County services. As part of this analysis, the CAO should estimate the net cost or savings to the taxpayer (e.g., the combined finances of the County and the health authority) that might be achieved with the creation of a health authority. Lastly, so that the County is able to appropriately plan for the possible loss in funding for some support services, the enabling legislation for the health authority should require that the health authority purchase support services from the County during a transition period lasting no longer than two years. After the two year transition period, the health authority should be required to give a one year notice to the County when it intends to discontinue the use of County support services.

After the initial transition period, the health authority should be given full authority to (a) continue to purchase services from the County, (b) purchase services from contractors, or (c) provide services in-house. Each alternative method of service should be fully analyzed for the potential to produce savings for the health authority and should be chosen based on business considerations for the health authority enterprise. In each instance, the financial impact on the County should be considered as part of contract negotiations between the County and the health authority to minimize the cost impact on the taxpayer.

CONCLUSIONS

The FY 2004-05 Countywide Cost Allocation Plan (CCAP), allocates nearly $1.4 billion in costs to departments for services that are provided centrally, such as payroll, accounting, building maintenance, facility rent and use, utilities, insurance, legal and other general support activities. DHS was charged approximately $203.9 million for these services in the allocation basis year. Approximately $185.6 million was direct charged and the balance was allocated to the Department using a variety of allocation bases.

The costs for some of these services are charged to departments based on actual amounts. For example, DHS was charged $1.4 million in costs for specific audit services provided directly to DHS programs. However, other costs are allocated to departments using various bases for estimating the relative benefit that each program receives from the service. For example, DHS was allocated $127,715 of the County's outside financial audit cost of $549,640, based on the DHS share of total county wages.

It is likely that many of the costs that are presently allocated to DHS will continue as separate health authority expenses, even if the related services are not provided by the County. Further, while the health authority could potentially achieve savings if it no longer uses County services, in some instances the combined cost for both the health authority and the County could increase because the County would be unable to sufficiently lower its costs to offset losses in income from the health authority. This is an important consideration for both the County and the health authority, since it is likely that the County will continue to substantially fund the activities of the health authority after legal separation.

Cost reductions could be realized, however, for overhead costs charged for County support services provided by departments such as the Internal Services Department if those services are provided in-house at DHS or contacted out to a lower cost contractor. Further cost reductions should be realized under a health authority for costs now incurred for oversight and reviews of DHS operations by external County departments such as the County Department of Human Resources, the Chief Information Office and the Auditor-Controller.

Nonetheless, the health authority should be given the option to (a) continue to purchase services from the County, (b) purchase services from contractors, or (c) provide services in-house. Each alternative should be fully analyzed for the potential to produce savings for the health authority and should be chosen based on business considerations for the enterprise. The financial impact on the County should be considered as part of contract negotiations between the County and the health authority.

RECOMMENDATIONS

The Board of Supervisors should direct the Chief Administrative Officer to:

7.1 Conduct a thorough analysis of current County costs to support DHS services. The analysis should include:

- A comprehensive accounting of costs, such as rental expenses, utility charges, judgments and damages, insurance and security services, that would likely offer little opportunity for health authority savings;
- An analysis of services, such as legal and information systems, where some limited health authority savings could be achieved; and,

- An analysis of services, such as auditing, accounting, budgeting, financial management and employee relations, where more substantial savings may be possible.

7.2 Conduct a thorough analysis of County cost impacts that might result from possible health authority decisions to discontinue the use of County services and possible offsets under the health authority.

7.3 Estimate the net countywide cost or savings (i.e., the combined finances of the County and the health authority) that might be achieved with the creation of a health authority, considering fixed support services costs that the County might still incur even if the health authority no longer uses the support service.

7.4 Work with the Department of Health Services to identify and report back support service overhead costs that could be eliminated by DHS providing the services in-house or contracting to a lower cost contractor for services now provided by County departments, and, to identify other cost reductions that would be achieved for external verification and monitoring of DHS operations that would no longer be needed under a separate health authority and is now performed by departments such as County Human Resources, the Chief Administrative Office and the Auditor-Controller.

The Board of Supervisors, with input from the County Counsel, the Department of Health Services and other County departments, should:

7.5 Develop legislative provisions that ensure the most cost effective partnership between the County and the health authority. At a minimum, these provisions should require that:

- The health authority be required to purchase support services from the County during a transition period lasting no less than two years; and,
- The health authority be required to give a one year notice when it intends to discontinue the use of County support services.

COSTS AND BENEFITS

There would be no direct cost to implement the recommendations, although staff would be required to conduct the recommended analyses and report to the Board.

Taxpayer interests would be protected, while providing the health authority with the eventual autonomy that would be required to operate in an efficient and effective manner. The County would be provided sufficient notice to plan for transition when the health authority determines that County services are no longer required. While further analysis is recommended for more precise quantification, annual savings to be realized by the health authority for reduced overhead costs for support services and reduced oversight and monitoring by

external County departments could amount to as much as $10.8 million per year.

EXHIBIT 7.1

FY 2004-05 Cost Allocation to DHS – By Program

Program	DHS Allocated Costs	Opportunity for Cost Savings	Little or No Opportunity for Cost Savings
Auditor-Controller			
Accounting	1,141,292	1,141,292	-
Auditing	1,449,613	1,449,613	-
Financial Auditing	138,245	138,245	-
Payroll	2,392,836	2,392,836	-
General Claims	1,025,714	1,025,714	-
Systems Development	73,697	73,697	-
Welfare Financial Services	95,732	95,732	-
TOTAL AUDITOR-CONTROLLER	6,317,129	6,317,129	-
Affirmative Action			
Affirmative Action	1,116,148	1,116,148	-
TOTAL AFFIRMATIVE ACTION	1,116,148	1,116,148	-
Chief Administrative Office			
Countywide Support	401,235	401,235	-
Employee Relations	968,814	968,814	-
Finance	1,697,673	1,697,673	-
Rent	10,014	10,014	-
Service Integration	539,548	539,548	-
Urban Research	73,143	73,143	-
TOTAL CHIEF ADMIN. OFFICE	3,690,427	3,690,427	-
Outside Auditors			
Outside Audit Cost	127,715	-	127,715
TOTAL OUTSIDE AUDIT	127,715	-	127,715
Rental Expenses			
Administrative Costs	91,767	91,767	-
Direct Costs	80,724,857	-	80,724,857
TOTAL RENTAL EXPENSES	80,816,624	91,767	80,724,857

EXHIBIT 7.1

FY 2004-05 Cost Allocation to DHS – By Program

Program	DHS Allocated Costs	Opportunity for Cost Savings	Little or No Opportunity for Cost Savings
Utilities			
Utility Costs	23,997,360	-	23,997,360
Utilities Specially Identified	5,419,942	-	5,419,942
Utilities Services Support	3,937,861	3,937,861	-
TOTAL UTILITIES	33,355,163	3,937,861	29,417,302
Board of Supervisors			
Civil Service Commission	358,417	358,417	-
Services and Supplies	1,205	1,205	-
TOTAL BOARD OF SUPERVISORS	359,622	359,622	-
Chief Information Officer			
Chief Information Officer	864,829	864,829	-
TOTAL CHIEF INFORMATION OFF	864,829	864,829	-
County Counsel			
Children's Services	397	397	-
General Litigation	12,123	12,123	-
Management Services	(4,175)	(4,175)	-
Probate	(1,817)	(1,817)	-
Public Services	714,947	714,947	-
Public Works	(13,985)	(13,985)	-
Special Services	(11,161)	(11,161)	-
Workers Compensation	(294)	(294)	-
TOTAL COUNTY COUNSEL	696,035	696,035	-

EXHIBIT 7.1

FY 2004-05 Cost Allocation to DHS – By Program

Program	DHS Allocated Costs	Opportunity for Cost Savings	Little or No Opportunity for Cost Savings
Insurance			
Insurance Administration	718,219	718,219	-
Judgments and Damages	33,251,814	-	33,251,814
Fidelity	57,745	-	57,745
Fiduciary	42,089	-	42,089
Hospital Liability	258,274	-	258,274
Children's Legal Services	171,844	-	171,844
Property Damage	411,537	-	411,537
TOTAL INSURANCE	34,911,522	718,219	34,193,303
Internal Services			
Computer Services	1,463,942	1,463,942	-
Direct Auto Contract	34,521	-	34,521
Extraordinary Maintenance	132,221	132,221	-
Facility Services	(3,404)	(3,404)	-
Materials and Mail Management	45,728	45,728	-
Office Systems	(178,061)	(178,061)	-
Parking Services	438	438	-
Purchasing and Printing	(905,777)	(905,777)	-
Telecommunications	(154,582)	(154,582)	-
Telephone Utilities	(129,663)	-	(129,663)
Telephone Utilities Other	297,748	-	297,748
TOTAL INTERNAL SERVICES	603,111	400,505	202,606

EXHIBIT 7.1

FY 2004-05 Cost Allocation to DHS – By Program

Program	DHS Allocated Costs	Opportunity for Cost Savings	Little or No Opportunity for Cost Savings
Public Safety			
Facilities Contract	116,163	116,163	-
County Facilities	64,134	64,134	-
Health Facilities Contract	14,028,073	-	14,028,073
Health Facilities County Staff	17,340,149	17,340,149	-
TOTAL PUBLIC SAFETY	31,548,519	17,520,446	14,028,073
Human Resources			
Appeals	151,653	151,653	-
Examinations and Recruitment	9,322	9,322	-
Classification and Salary	293,720	293,720	-
Countywide Costs	3,772,421	3,772,421	-
Department Support	169,665	169,665	-
MAPP Special Programs	62,683	62,683	-
Training Academy	15,449	15,449	-
TOTAL HUMAN RESOURCES	4,474,913	4,474,913	-
Employee Benefits			
Retirement Administration	66,429	66,429	-
Long Term Disability	53,535	53,535	-
Employee Benefits	70,050	70,050	-
Workers Compensation	101,105	101,105	-
TOTAL EMPLOYEE BENEFITS	291,119	291,119	-
Treasurer			
Deferred Compensation	44,389	44,389	-
Collections	3,885,275	-	3,885,275
Bank Charges	92,664	-	92,664
Public Health	744,572	-	744,572
TOTAL TREASURER	4,766,900	44,389	4,722,511
TOTAL ALLOCATED COSTS	$203,939,776	$40,523,409	$163,416,367

EXHIBIT 7.1

FY 2004-05 Cost Allocation to DHS – By Program

Note: The DHS Allocated Cost amount reflects adjustments that were necessary due to the identification of significant "unallowable costs," identified by the Auditor-Controller when constructing the CCAP. According to the notes for "Rental Expenses" (Schedule 2.001), "the 2001-02 rent appropriation included lease purchase expenses of $102,044,658 which has been allocated to 'All Others.' The cost applied for these leases is $172,547,138 and is credited to the receiving departments. *This created an overbilling for several departments."* In addition, the document states that "several departments had been charged interest for loans which were generated to pay for the development of lease purchase properties. However, we determined that these buildings were never built. Therefore, the interest is unallowable. We discovered that we had included this interest as an allowable cost in prior years. We identified the facilities involved, *and calculated the unallowable interest costs and have made negative adjustments to the departments affected"* (emphasis added).

8. TRANSFER OF COUNTY ASSETS AND LIABILITIES TO THE HEALTH AUTHORITY

- **The County has invested significant resources in facilities and equipment used by DHS to provide hospital and health services. Many of these facilities are in need of significant rehabilitation or replacement. For example, the County is presently involved in a major construction effort to replace the LAC+USC Medical Center, which will cost an estimated $820.6 million. As a result, complex legal and financial decisions need to be made as part of creation of a health authority regarding asset ownership, responsibilities for debt repayment and the ongoing maintenance and improvement of the County's infrastructure.**

- **The County has significant long-term unfunded liabilities for employee retirement obligations and prior workers compensation, general liability and medical malpractice self-insurance program claims against DHS. These obligations amounted to nearly $920 million as of June 30, 2004, and do not include unfunded liabilities for retiree health care benefit costs which are in the billions of dollars.**

- **Since these unfunded liabilities are the result of policies and decisions made by the County over the years, they should be retained as an ongoing County expense, not an expense of the new health authority, until they are fully paid. In fact, some of the County's self-insurance policies reflect exemptions from State Controller insurance guidelines to ensure federal grant reimbursement to local agencies and therefore would probably not be allowable for new health authority. As a result, the health authority will most likely have to fully fund the insurance liabilities that it incurs starting the day of its inception. The operating agreement between the County and the health authority should be structured and external approvals obtained to ensure that all existing and future liabilities are fully funded and that the County can effectively leverage federal and State funding. Unless the County can successfully obtain such external approvals, there is a risk that the substantial unfunded liability that exists at the time of separation would become a General Fund cost and would not be considered eligible for reimbursement from federal and State grants.**

The County of Los Angeles has invested significant resources in hospital and health system assets and incurred significant liabilities that have been necessary to support DHS operations. Included have been investments in land, facilities and equipment; borrowings to fund employee retirement obligations; and, policies that have resulted in a lack of funding for long-term retiree health and self-insurance liabilities. The County and a new health authority share interests in ensuring that the complex financial and legal issues that have resulted from the financial inter-relationship between general County operations and DHS are clearly understood and recognized. The County needs assurance that it either retains ownership or obtains suitable payment for its significant investment in health and hospital assets; and, the health authority needs assurance that it will not be saddled with significant financial obligations that the County has incurred before health authority formation.

CAPITAL ASSETS

The County of Los Angeles has invested significant resources in the facilities and equipment used by DHS to provide health and hospital services to the Los Angeles County community. As a very conservative indication of the value of these assets, the County's financial statements as of June 30, 2004, reported that DHS had land, buildings and equipment valued at $1.35 billion.[1] The major County owned facilities used by DHS include multiple hospitals and medical centers, comprehensive health centers, outpatient clinics, administrative buildings, and support buildings throughout the County. Many of these facilities have been operated by DHS for decades; and, the original construction, renovation and repair costs have been financed with an array of local, State and federal funds.

Because of the age of many of these facilities and other factors, the County is continually investing resources in new construction or the replacement and rehabilitation of its facilities. During the next five-year period, DHS is projecting that approximately $676.7 million will be spent on various capital project needs of the Department. A summary of DHS capital expenditure projections is provided in Table 8.1 below. Funding has been requested but is not secured for these projects at the time this report was prepared other than the LAC+USC replacement project, which is funded.

As shown, the major area of expenditure will occur in the Northeast Cluster, where $426.4 million will be spent on a variety of projects. By far, the most costly of the projects in the Northeast Cluster will be the completion of the new LAC+USC Medical Center, for which construction is currently underway. This project has a budget of $820.6 million, of which $407.3 million had been expended through January 2005. In the Coastal Cluster, another major project is

[1] The value for buildings and equipment represents the original value prior to depreciation. The cost to replace the buildings and equipment would be significantly greater than the amount reported. Therefore, the $1.35 billion reported amount can only be used as a broad indicator of the facility and equipment value at the time of purchase.

the construction of the new Harbor-UCLA Surgery and Emergency Room annex, which will cost approximately $147.2 million.

TABLE 8.1

Anticipated DHS Facility Construction Expenditures Fiscal Years 2005-06 through 2009-10

NORTHEAST CLUSTER		**RANCHO LOS AMIGOS**	
LAC+USC Replacement*	413,017,562	Rancho Los Amigos Improvements	2,925,000
LAC+USC Interim Improvements	3,810,000	TOTAL	2,925,000
H. Claude Hudson CHC	2,322,000		
Edward Roybal CHC	257,000	**SAN FERNANDO VALLEY CLUSTER**	
El Monte CHC	200,000		
La Puente HHC	6,774,000	Olive View Improvements	7,305,000
TOTAL	426,380,562	TOTAL	7,305,000
COASTAL CLUSTER		**ANTELOPE VALLEY CLUSTER**	
Harbor/UCLA Surgery & ER	147,229,000	High Desert Hospital Improvements	615,000
Ambulatory Care Study	246,000	Antelope Valley Rehabilitation Centers	1,839,000
TOTAL	147,475,000	TOTAL	2,454,000
SOUTHWEST CLUSTER		**TOTAL ALL FACILITIES**	**620,355,562**
		FY 2004-05 Supplemental Budget Request	**56,336,000**
MLK/DREW Improvements	33,816,000		
TOTAL	33,816,000	**GRAND TOTAL ALL FACILITIES**	**676,691,562**

* Balance of project expenses through February 2005. Original budget for the LAC+USC replacement project was $820,558,000.

Certainly, expenditures over the next five year period are generally going to be higher than they will normally be in future years because of the significant cost to replace the LAC+USC Medical Center. But these cost estimates are indicative of a large healthcare system that is continually presented with financial decisions to expend resources to modernize and rehabilitate its facilities, and retrofit buildings to meet changing healthcare and regulatory needs (e.g., seismic updates).

As a result, the formation of a health authority presents several concerns that would need to be addressed by the County and the health authority:

- There are complex questions related to legal title, ownership and use requirements imposed by the original funding source that was used to purchase or develop the asset, and from debt financing conditions. If the asset is to be transferred, these complex questions will need to be resolved by the County's legal counsel. Based on our limited review, we believe these complicating factors strongly suggest that asset ownership should be retained by the County and that facilities should be leased back to the health authority as part of the more comprehensive operating agreement discussed in other sections of this report.

- As shown in Table 8.1, the County expends considerable resources on capital projects related to DHS operations. Such expenditures will continue for the health authority in the future. The detailed information for the projects that DHS has included in its next five-year plan show that (1) some project costs are funded from non-County sources of revenue, and (2) many larger projects are debt financed. Because the health authority would not have

independent taxing authority or own assets that can be presented as collateral, it may have difficulty securing financing for major construction projects. Again, these factors support a conclusion that ownership of the land and buildings should be retained by the County. However, as part of the comprehensive operating agreement between the County and the health authority, responsibilities related to facility maintenance and minor rehabilitation should be specifically defined. For the reasons stated previously, major expansion, replacement and rehabilitation responsibilities should remain with the County, while more minor maintenance and repair responsibilities should be assigned to the health authority. This alignment of duties would ensure that appropriate federal and State funding can be leveraged, and financing secured for major construction projects, while ensuring that the health authority has the capacity to perform day-to-day maintenance duties that affect services.

With such a structure, the interests of the County and the health authority could be preserved. To support the proposed alignment of duties and responsibilities, the operating agreement between the County and the health authority should specifically describe the County's obligations related to:

a. providing the land and facilities for use by the health authority;

b. performing major rehabilitation and maintenance on the facilities to ensure they conform with industry and regulatory standards; and,

c. expanding or replacing the facilities, when required.

The health authority should be required to share in the cost of facility expansion, replacement or renovation; and, provide regular and ongoing facility maintenance out of its operating budget.

PENSION LIABILITIES

The County's Pension Plan is administered by the Los Angeles County Employee's Retirement Association (LACERA), which was established under the County Employee's Retirement Law of 1937. It provides benefits to the County and some small special districts within the County. DHS employees who would be transferred to a new health authority are currently members of this system.

LACERA is a defined benefit retirement plan. That means that the benefits that employees are to receive upon retirement are predefined based on the plan, their age at retirement and the number of years of service the retiree worked with the County. The annual contribution requirements to be made by plan members and the County are determined based on total current and future plan costs, as determined by independent actuaries, and then "discounted" (or lowered), by applying current and future fund interest earnings against current and future fund liabilities.

As of June 30, 2004, LACERA had net assets held in trust for pension benefits that amounted to $29.5 billion. This was a $3.3 billion improvement from June

30, 2003 when LACERA reports that the plan held net assets for pension benefits of $26.2 billion. Most of these gains resulted from improvements in investment returns.

At the time of this report, LACERA had not yet completed its actuary report for FY 2003-04. However, when conducting interviews for this study, we were advised that the pension plan was only 82.8% funded on June 30, 2004, which was a degradation since June 30, 2003. On that earlier date, the LACERA actuary estimated that the plan was 87.2% funded and was carrying an unfunded liability of over $3.9 billion.

Although this unfunded liability is significant, it will likely dissipate as the investment market corrects and LACERA investment earnings improve. Through June 30, 2003, the plan was not fully funded in only four of the previous 10 years; and, in all years except FY 2002-03, it was over 99 percent funded. Accordingly, the current deficit status of the fund is probably transient. For example, in FY 2003-04, LACERA reported that the fund earned interest of approximately 16.5 percent compared with the actuarially assumed earnings rate of 8.0 percent. Although these gains were substantial, the County will not immediately realize the benefit of the excess earnings because of rate smoothing (i.e., averaging investment gains or losses over multiple years to prevent dramatic rate fluctuations).[2] LACERA has a policy of smoothing rates over three years.

Pension Obligation Bonds

The current status of the LACERA fund does not fully describe the County's financial obligations regarding the funding of employee pensions. According to the County's June 30, 2004 financial statements, in FY 1994-95, the County sold approximately $1.97 billion in par value pension bonds to fund LACERA. The outstanding principal balance of the bonds as of June 30, 2004 was approximately $1.6 billion. In addition, a smaller borrowing of $481.5 million in pension obligation certificates was made by the County in 1986 to purchase annuity contracts to provide pension benefits to a specific group of LACERA members. For the year ended June 30, 2004, the combined principal and interest payments for both the bonds and certificates were $249.5 million and $66.6 million, respectively. Altogether, the financial statements indicate that the total outstanding principal on both bonds and certificates, was approximately $1.8 billion as of June 30, 2004.

This County obligation represents a significant ongoing liability for all County departments and is the equivalent of an unfunded liability on the portion of LACERA benefits that were pre-funded by the County. An analysis of the Statement of Net Assets for the six DHS enterprise funds shows that the Department is presently carrying a pension obligation bond liability that amounted to $399.6 million as of June 30, 2004, or 67.2 percent of the

[2] LACERA indicates that due to its current smoothing policy, approximately $1.0 billion in net assets were not recognized as part of the most recent rate analysis.

Department's cumulative deficit on that date (using financial statement reporting).

Since this significant pension-related debt represents decisions and policies made by the County, it should not be transferred to the new health authority. The County's unfunded pension obligations and the amount of the outstanding debt incurred for DHS employees should remain with the County. This debt would therefore represent a continuing County cost and not an obligation of the health authority. At the same time, the County's payment to the new health authority should include sufficient funding to cover the County's share of employee retirement costs incurred by the health authority, starting the day the health authority is established.

Post-Retirement Health Care Benefits

In addition to regular pension benefits that are paid by LACERA to Los Angeles County retirees, the County provides funding for health care benefits for all retired employees and their eligible dependents or survivors. The cost of retiree health is recognized when the County makes payments to LACERA. For FY 2003-04, such payments were approximately $260.5 million[3].

As stated in the financial statements, and presented above, this amount represents the current costs of the program only. Although we are not aware of any actuarial studies that have been conducted by either the County of Los Angeles or LACERA, the unfunded liability to pay future post-retirement health care benefit costs is surely much greater. In one county with which we are familiar, the total plan liability is presently 36 times the amount of that county's annual cost. A similar ratio in the County of Los Angeles would mean that the County would have an unfunded liability for post-retirement health care benefits of approximately $9.4 billion. At this magnitude, DHS would be sharing in as much as $2.0 billion of the total amount.

Impact of Pension Obligations on Ongoing County Cost

The significant County pension obligations, including debt on the pre-funded portions, will present significant financial challenges for the County in coming years. After formation of the health authority, the County will need to pay (a) principal and interest payments on the 1986 and 1994 borrowings, (2) the costs associated with the unfunded portion of LACERA pension obligations, and (3) the costs associated with the unfunded liability associated with post-retirement health care benefits for DHS employees. In addition, the County would be required to fully fund its share of the health authority's pension costs, including amounts sufficient to finance both current and long-term obligations, through the operating agreement rate for services that the County would pay (see Section 3).

[3] This amount is comprised of $167.1 million for governmental activities, $34.3 million for business type activities and $59 million of LACERA excess earnings reserves to offset a portion of total funding requirements.

This situation would make it advisable for the health authority to fully segregate its pension plan from the County's and create a new plan for its employees.

The health authority would likely have three alternatives regarding retirement systems:

1. The health authority could negotiate with LACERA to administer a new plan. The plan structure would be subject to the requirements of the enabling legislation that created the health authority and collective bargaining agreements with employee groups (questions of employee seniority, vesting rights and other related matters are discussed more fully in Section 4 of this report).

2. The health authority could create its own pension plan for employees. Under this structure, employees who would choose to move from County employment to the new health authority would terminate active membership in LACERA and become members of the new plan. Again, consideration would likely need to be given to seniority and vesting rights within LACERA and the long-term impact it might have on employee retirement benefits.

3. The health authority could join the Public Employees Retirement System (PERS) and sever all pension related obligations with the County and LACERA.

Under any of these alternatives, the health authority would be free to reconsider its post-retirement health care benefits, at least for employees hired after the health authority is established. However, the County would remain obligated for the unfunded liability for post-retirement health care benefits for employees working while the hospital and health system was part of the County.

It is beyond the scope of this study to determine which of the three alternatives above might be most advantageous for the County and the health authority. However, whichever alternative is chosen, distinctions should be made between the County's pre-existing unfunded liability and debt that exists at the point of separation and new obligations to which the health authority will commit itself.

INSURANCE OBLIGATIONS

The County of Los Angeles has several self insurance programs that it administers for DHS, including (1) workers compensation, (2) medical malpractice, and (3) general liability insurance programs. For catastrophic hospital general liability, the County purchases insurance. Otherwise, the County is self-insured, or retains the risk itself for all other loss exposures.

The liability for these self insurance programs is significant. At the end of FY 2003-04, the County reported total liabilities of approximately $3.163 billion. During the year, it made estimated claims payments of $561.7 million. In addition to the $3.163 billion stated liability, the County has identified approximately $204 million in additional exposure from lawsuits and other pending claims

settlements. Based on discussions with the County's risk manager and a review of documents made available for this study, the County has not established reserves to fund these significant self insurance liabilities or potential claims settlements. Instead, expenditures are paid on a current basis from the fund that incurred the loss in the year that the expense was paid.

The County's absence of full reserves to cover insurance payouts have a significant effect on DHS. On average, DHS made annual payments for workers compensation, medical malpractice and general liability self insurance of $69.2 million per year during the past three years. But in addition to these payments, as of June 30, 2004, the Department was carrying long-term insurance liabilities of $518.8 million. These liabilities represented 87.2 percent of the Department's cumulative deficit of $594.6 million that was reported in the financial statements as of that date.

The County's self insurance policies run counter to State Controller guidelines, which have been developed so that California counties comply with federal regulations designed for determining indirect costs that may be charged to federal and State grants. In the Controller's *Handbook of Cost Plan Procedures for California Counties,* the Controller clearly requires that counties which choose to establish self insurance programs create reserve accounts to pay all current and future claims liability.[4] Section 4410 (2), states,

> "If a county chooses either a) not to purchase insurance, or b) not to establish a self-insurance program but to finance any losses through special budget appropriations, bond issues, or other spur-of-the moment public financing, this is considered a system of 'no insurance.' Payment of losses under such a system are not eligible for grant reimbursement purposes, unless specifically provided for in a grant agreement."

If enforced in Los Angeles County, these requirements could have serious financial consequences. However, discussions with the State Controller on previous studies of California self insurance programs, indicates that the County of Los Angeles is operating under a long-term general exemption to these rules. It is not certain, but seems unlikely, that this same exemption would carry forward to a separate health authority. In any case, the County's approach to funding its insurance liabilities is not an advisable practice and would add an element of fiscal instability to the health authority. A preferred approach would be for the County's payment to the health authority to include sufficient monies to fully fund its share of the health authority's current insurance costs and future liabilities. As with the unfunded pension obligations discussed previously, the County would also need to continue to pay for the self insurance unfunded liabilities that exist at the time of legal separation. In the near term, this would increase the County's overall costs as it pays down unfunded liabilities and simultaneously pays the full apportioned cost of the health authority's insurance program.

[4] *Handbook of Cost Plan Procedures for California Counties,* Section 4250, Reserves for Incurred Losses

CONCLUSIONS

The County has invested significant resources in the facilities and equipment used by DHS to provide health services to the community. Many of these facilities are in need of significant rehabilitation or replacement. For example, the County is presently involved in a major construction effort to replace the LAC+USC Medical Center, which will cost an estimated $820.6 million. As a result, complex legal and financial decisions need to be made regarding asset ownership, responsibilities for debt repayment and the ongoing maintenance and improvement of the County's infrastructure.

In addition, the County has significant long-term unfunded liabilities for employee retirement obligations and prior workers compensation, general liability and medical malpractice self-insurance program claims against DHS. These obligations amounted to nearly $920 million as of June 30, 2004, and do not include unfunded liabilities for retiree health care benefit costs which could be in the billions of dollars.

The County's significant retirement and insurance liabilities should not be transferred to a newly formed health authority since they were incurred by the County based on polices and decisions made prior to health authority creation. Accordingly, this unfunded liability should be retained by the County and considered an ongoing County expense until the obligations are fully paid. The operating agreement between the County and the health authority should be structured and necessary external approvals obtained prior to formation, to ensure that the County can effectively leverage federal and State funding to offset a portion of these costs. Unless the County can successfully obtain such external approvals, there is a risk that the substantial unfunded liability that exists at the time of separation would become a General Fund cost and would not be considered eligible for reimbursement from federal and State grants.

RECOMMENDATIONS

The Board of Supervisors should direct the Chief Administrative Officer, the Auditor-Controller and County Counsel to collaborate to:

8.1 Develop strategies and recommendations for either (a) transferring ownership of health and hospital facilities to the health authority; or, (b) retaining ownership of all health and hospital facilities, but defining rights and obligations regarding facility use, rehabilitation, maintenance, expansion and replacement.

8.2 Determine federal and State requirements regarding the funding of retirement and insurance liabilities under the health authority that must be complied with for the County to be able to leverage all available federal and State funding for the health authority.

8.3 Seek authority from the federal and State governments to permit the County's unfunded liability to be partially financed by federal and State grants made to the health authority.

8.4 Develop estimates and report back on the financial implications to the County of (a) fully funding the LACERA pension plan, (b) repaying pension obligation borrowings, (c) establishing appropriate post-retirement health care benefit reserves, and (d) fully funding the unfunded liabilities for the County's self insurance programs. This analysis should assume that the County would be required to proportionately fund its share of all current and future pension and insurance costs through its operating agreement with the health authority.

8.5 Include a reduction in hospital and health system insurance costs, including general liability, medical malpractice and workers compensation, as a goal in the operating agreement with the new health authority, to be measured and regularly reported back to the Health Authority Board of Directors and the Board of Supervisors.

The Department of Health Services should:

8.6 Determine the costs and impacts of alternatives to the current post-retirement health benefits that could be established under a new health authority.

8.7 Establish systems and reporting mechanisms to be established under the new health authority that would track and report insurance costs, including liability, medical malpractice, and workers compensation.

COSTS AND BENEFITS

Although there are no direct costs associated with the implementation of these recommendations, staff time will be required to perform the analysis and report on the results to the Board of Supervisors.

The County Board of Supervisors would have a clear understanding of the significant financial consequences related to the formation of a health authority. Health authority representatives would have a more comprehensive understanding of the financial obligations that should be retained by the County and assumed by the new entity.

9. HEALTH AUTHORITY LEGISLATION AND TRANSITION PROCESS

- **The Department of Health Services, the Chief Administrative Office and County Counsel will all be very involved in the analysis and preparations for implementation of a health authority to govern Los Angeles County's hospital and health care system. To formalize and facilitate these efforts, the Board of Supervisors should appoint a health transition team comprised of representatives of those departments, health care professionals from within and external to the County system and consumer representatives. The main task of the transition team should be preparation of a health authority implementation plan. This approach, used in other jurisdictions, would bring cross-departmental cooperation, accountability and continuity to the process.**

- **The transition team's tasks should also include development of draft State legislation needed to authorize creation of the health authority. The legislation authorizing creation of a health authority in Alameda County should be used as a model, with some modifications specific to the needs and principles of a health authority in Los Angeles County. The Alameda County implementation plan could also be used as a model, though it was prepared after the enabling State legislation was adopted, so should be expanded for Los Angeles County to include tasks that the County should perform to prepare for drafting the legislation.**

Many sections of this report contain recommendations regarding aspects of health authority operations to be formally addressed in the operating agreement between the County and the health authority or in the health authority's operating policies and procedures. However, before the agreement can be executed and policies and procedures implemented, the health authority needs to be created by State law. The reason for this is that there is no general State law at this time under which creation of this entity is authorized. Whereas there is a basis for creation of cities, counties and school districts in State law, no comparable statute exists for health authorities. Once State legislation is adopted authorizing creation of a health authority in Los Angeles County, the Board of Supervisors would need to amend the Charter and County Code, the County would need to execute an operating agreement with the new entity and the health authority would need to establish bylaws and policies and procedures and consistent with the enabling State and local legislation.

ESTABLISHMENT OF A TRANSITION PLANNING TEAM TO PREPARE AN IMPLEMENTATION PLAN

In some other jurisdictions that have converted to an alternative form of governance for their public hospital and health care systems, transition plans have been developed by inter-departmental teams generally comprised of representatives of the health departments, county administrators, labor representatives and health care providers. Establishment of such a team in Los Angeles County would provide accountability, coherence and continuity to the process and greater assurance that key issues have been addressed and resolved prior to initiation of the health authority.

This report contains numerous recommendations for assessments and analyses to be conducted by County staff and key stakeholders to resolve issues involving creation of the health authority. The departments and organizations most frequently recommended for involvement in preparing for the health authority are: Department of Health Services (DHS); Chief Administrative Office; County Counsel; consumer representatives, employee organizations; and, health care professionals. By organizing representatives of these departments and groups in to an appointed team, the transition process would be formalized and individuals would become accountable for achieving the desired results in a specified time frame.

Alameda County prepared an implementation plan after State legislation was adopted authorizing its health authority but before the County's Administrative Code was amended by the Board of Supervisors to create its Hospital Authority. Though the Alameda County enabling State legislation was very specific in many areas, many administrative matters were worked out and codified in the County Code or Master Service Contract between the County and the Hospital Authority after the legislation was adopted.

The Alameda County implementation plan was divided in to three phases: 1) establish the Hospital Authority and develop its infrastructure; 2) transfer of operations; and, 3) transfer of Medical Center personnel. The concept in Alameda County was to work on all three phases simultaneously though much of the first phase needed to be completed before the second and third phases could be undertaken.

Another key concept of the Alameda County implementation plan was ongoing communications with Health Care Services Agency personnel regarding the transition and implementation progress. The plan specifically called for a regularly published employee newsletter and quarterly staff briefings. This should be a key component of the transition in Los Angeles County as well as employees will be understandably concerned about the transition and their status in the new organization.

A health authority transition team for Los Angeles County should be appointed by the Board of Supervisors and assigned responsibility for preparing an implementation plan to address issues to be resolved prior to and after implementation of the health authority. Unlike the Alameda County approach, the Los Angeles County transition team should be involved in analyzing and resolving issues pertaining to the enabling State legislation as well as issues to be resolved after the statute is adopted.

Issues to be addressed by the transition team should be assigned to one of the following categories:

1. Issues to be resolved prior to drafting of enabling legislation

2. Issues to be resolved prior to drafting of necessary County Code and Charter amendments

3. Issues to be resolved prior to transfer of authority to the health authority

4. Issues to be resolved after transfer of authority to the health authority

The Board of Supervisors should develop a timeline and assign individual responsibility for each task in the plan.

PREPARING STATE ENABLING LEGISLATION

While health authorities have been established throughout the country, there is presently only one other in California similar to the proposed model for Los Angeles County: the Alameda County Medical Center. The enabling legislation and implementation plan for Alameda County provide useful models to be considered in creation of a health authority in Los Angeles County. While many of the details of the health authority's operations should be specified in the County Code, the operating agreement between the County and the health authority, and the health authority's operating policies and procedures, the enabling State legislation should be specific enough so that key principles of authority operations are ensured.

Areas addressed in the Alameda County enabling legislation included the following, all of which should be considered for inclusion in legislation for Los Angeles County. Many of these issues are addressed in the other sections of this report. Exhibit 9.1 presents key elements from Alameda County's enabling legislation statutes and recommendations, where applicable, for how each topic should be treated in Los Angeles County's health authority enabling legislation.

Exhibit 9.1
Elements of legislation enabling Alameda County's health authority and recommended treatment of element for Los Angeles County

Components of Alameda County Statute	Recommended for Los Angeles County Statute
Statement that County will establish a health authority separate and apart from the County to administer, manage and control the County's hospitals and personal health centers.	As recommended in Section 1, legislation should specify that the health authority would not include DHS' divisions of Public Health, Alcohol and Drug Services, Managed Care, Juvenile Court health services and emergency medical services. County's Department of Mental Health also recommended to remain separate.
Mission of the health authority: to comply with Welfare & Institutions Code Section 17000 and operating facilities cost-effectively.	As recommended in Section 3, compliance with Section 17000 should be explicitly stated and a benefits package and the population to be served should be defined by the Board of Supervisors. If not defined as the legislation is adopted, the statute should refer to the fact that the County will be defining a benefits package and population. The statute should reference the fact that the County will provide funding to the health authority using standard rates for each covered patient or episodic treatment category, based on cost components agreed to by the County and health authority and that improvements in cost-effectiveness will be monitored and reported to County by health authority.
Statement that the County will remain responsible for County's compliance with Welfare & Institutions Code Section 17000.	Include similar language in Los Angeles County statute, consistent with Section 1 recommendations.
Establishment of health authority as a governing body in compliance with State law.	Include similar language in Los Angeles County statute.
Statement that health authority will be a public agency as defined in State law and for purposes of eligibility for federal and State funding.	Include similar language in Los Angeles County statute.

Components of Alameda County Statute	**Recommended for Los Angeles County Statute**
Identifies composition and role of Hospital Authority Board of Trustees.	As recommended in Section 2, statute should identify that the Los Angeles County Health Authority Board of Directors will have designated slots for individuals with health care and finance backgrounds, health care professionals and community/consumer representatives. Also, appointment and confirmation process outlined in Section 2 should be referenced in statute.
Requires creation of bylaws for the health authority.	Include similar language in Los Angeles County statute.
Requires conflict of interest policies for Health Authority Board of Directors.	Include similar language in Los Angeles County statute.
Authorization for health authority to apply for medical licenses.	Include similar language in Los Angeles County statute.
Definition of specific facilities and programs for which the health authority will be responsible.	Section 1 of this report defines components of DHS that should be transferred to health authority. Transfer of facilities should be linked to final composition of organization, with responsibility for ownership, maintenance and improvements between County and health authority defined, as recommended in Section 8.
Statement that health authority can employ personnel, enter into contractual agreements, and be sued.	Include similar language in Los Angeles County statute.
Provides authority for County Board of Supervisors to revoke agreement if health authority is not meetings its obligations.	Section 3 recommends that the Board of Supervisors identify goals for health authority service quality and financial performance and that accomplishment of those goals be regularly measured and reported back to the County by the health authority. Revocation of agreement should be allowed if the health authority is not fulfilling its contractual obligations including meeting performance goals over time.

Components of Alameda County Statute	**Recommended for Los Angeles County Statute**
Requires Hospital Authority's baseline and ongoing management reporting requirements to the County in areas such as: patient census; inpatient days; outpatient visits; emergency room visits and others.	Sections 3, 4 and 8 of report identifies areas of service quality and financial and operational performance that should be measured and regularly reported back to the County. These areas, emphasizing outcomes and efficiency improvements rather than just workload, should be referenced in statute for baseline and ongoing management reporting.
Statement that the health authority is not subject to County Charter or operational rules in areas such as personnel and procurement.	Include similar language in Los Angeles County statute. Details of changes recommended in Sections 4 and 5 of this report should be left to operating agreement and health authority operating policies and procedures.
Statement that health authority can contract for services without a competitive bidding process.	Include similar language in Los Angeles County statute. Details of changes recommended for procurement in Section 5 of this report should be left to operating agreement and health authority operating policies and procedures.
Identification of process, compensation and other arrangements for County facilities and assets to be transferred or leased to health authority.	Section 8 details recommendations for County to determine if it will retain or transfer ownership and maintenance responsibility for facilities and land and to define rights and obligations of health authority for their use.
Statement that obligations and liabilities of each entity will be separate and distinct.	Include similar language in Los Angeles County statute, as recommended in Section 8, stating that the Hospital Authority's responsibility starting on the day of its inception, and the County retaining obligations and liabilities incurred prior to establishment of the health authority on behalf of DHS.
Statement that transfer of responsibility for hospital and health care to the health authority will not affect the County's eligibility for: funding programs currently available to the County for hospital and health care services.	Include similar language in Los Angeles County statute, as recommended in Section 3.

Components of Alameda County Statute	**Recommended for Los Angeles County Statute**
Requires recognition of existing employee organizations representing classifications of employees transferred to the health authority.	Depending on results of DHS' human resources transition plan, recommended in Section 4, and meet and confer processes held prior to adoption of State legislation, consistent language should be included in Los Angeles County statute regarding recognition of employee organizations.
Requires County retirement system continuing to be available to health authority employees at point they become health authority employees.	Depending on results of DHS' analysis of retirement options included in its human resources transition plan, as recommended in Section 4, and meet and confer processes held prior to adoption of State legislation, language should be included in Los Angeles County statute regarding retirement system(s) that will be available to health authority employees. If the specific program has not been defined at time of adoption of State legislation, it should reference the fact that there must be a system available to employees when they become health authority employees.
Statement that health authority is subject to existing memorandum of understanding for employee organizations until they expire, at which point new agreements can be negotiated by the health authority.	Depending on results of meet and confer processes prior to adoption of State legislation and DHS' human resources transition plan recommended in Section 4, language should be included in Los Angeles County statute regarding status of existing memorandum of understanding.
Requirement for personnel transition plan covering: communications to employees and meet and confer process with employee organizations on : timeframe for transition to new organization; option for employees to remain County employees in other departments, and time frame for being reinstated as County employees; compensation for vacation leave and compensatory time off; transfer of sick leave from the County to the hospital authority; and, possible preservation of seniority, pensions and other benefits.	Include similar language in Los Angeles County statute incorporating human resource transition plan recommended in Section 4. Requirement should be included that health authority plans are regularly communicated to employees, whether before or after adoption of State legislation.

Components of Alameda County Statute	**Recommended for Los Angeles County Statute**
Health authority to identify number of employees, classifications, compensation, job descriptions for its labor force.	Include similar language in Los Angeles County statute.
Statement that employees are public employees, as defined in State law.	Include similar language in Los Angeles County statute.
Statement that health authority shall indemnify County in operating agreement.	Include similar language in Los Angeles County statute.
Statement that health authority may borrow from the County.	Include similar language in Los Angeles County statute.
Allowance for health authority to engage in promotion of marketing of hospital and health services.	Include similar language in Los Angeles County statute.
Requirement that patient information and records will remain confidential.	Include similar language in Los Angeles County statute.
Statement regarding whether or not the health authority will be subject to Brown Act public disclosure requirements.	Include similar language in Los Angeles County statute. Include language determining whether health authority will be subject to Beilenson hearing requirements in the event of facility closures.
Requirement that health authority will carry general liability insurance.	Include similar language in Los Angeles County statute.

Source: California Health and Safety Code §101850

The statute will provide the official framework for the health authority and should be specific enough so that key elements of the health authority are ensured in the new organization, but flexible enough to allow the organization to make changes in operations over time in the best interests of cost-effectively fulfilling its mission.

Many of this issues identified in Exhibit 9.1 above should be determined in advance of State legislation being drafted; others can be finalized after the legislation is adopted but before responsibility for the County's hospital and health system is transferred to the health authority. Key issues to be resolved prior to adoption of the State legislation are: 1) components of the new organization; 2) Board composition and appointment; 3) the extent of retained representation and compensation for current DHS employees who transfer to the new health authority; and, 4) rights, ownership and responsibility for County hospital and health facilities.

Outside counsel and probably other expertise will be needed to assist the County in addressing many of the financial, human resource, liability and other issues related to implementation of a separate health authority, as identified in this report. Use of outside counsel will entail additional direct costs for the County of an amount that cannot be determined at this time.

Areas addressed in Alameda County's implementation plan including the topics presented in Exhibit 9.2. For each task, responsibility was assigned to an agency or team member along with a due date. This plan was developed after the enabling State legislation was adopted so it does not include tasks for some of the key areas that were resolved in advance of the legislation such as the rights of employees to stay with the County or transfer to the new Hospital Authority and the fact that existing employee organizations were to be recognized for negotiations by the Hospital Authority. However, it still serves as a useful reference for tasks that should be addressed by the recommended Los Angeles County Transition Team.

Exhibit 9.2
Elements of Alameda County's
Hospital Authority Implementation Plan

Phase 1: Creating the Authority and its infrastructure

- Organization and medical staff bylaws
- Adoption of County ordinance amending Administrative Code
- Filing with Secretary of State and obtaining tax identification
- Determination of date of transfer
- Obtaining tax identification, filings with Secretary of State, securing insurance
- Development of code of ethics and operating procedures for board of trustees
- Adopting a personnel system and human resource policies and procedures (this included initiation of the meet and confer process)
- Execution of all necessary employee benefit contracts such as health, retirement, dental, Social Security, etc.
- Development of an action plan to address changes needed for Hospital Authority infrastructure including human resources, payroll, procurement, general accounting, claims processing and management, budget, management information systems and others.
- Adoption of medical staff bylaws and Medical Center policies and procedures

Phase 2: Transfer responsibility for general operation

- Preparation of leases for land and facilities
- Transfer of equipment and assets
- Development of debt financing and lease agreements
- Preparation of Master Service Contract
- Preparation of inventory of all notices, contracts, licenses, leases, etc. that need to be processed
- Development of a memorandum of understanding between County and health authority regarding County funding of operations and dedication of certain revenue sources
- Finalize arrangements for Hospital Authority to purchase County support services
- Establish fiscal and equipment inventory baseline for transfer of assets
- Convene Beilensen hearings
- Notify all funding sources, service providers and others of change in governance

Phase 3: Transfer of personnel

- Complete meet and confer process
- Determine effective date of transfer of personnel
- Process all new hires, transfers and promotions as Hospital Authority employees
- Provide all employees the option of accepting transfer to the Hospital Authority
- Board of Supervisors approve layoff order for Alameda County Medical Center positions with a simultaneous transfer to the Hospital Authority

Source: Alameda County Hospital Authority Plan, January 7, 1998

One area not addressed in the implementation plan highlights shown above that should be part of the transition plan for Los Angeles County involves licensing during the transition process. Specifically, the transition team should plan for transfer of licenses between the County and the health authority so that there is no interruption of licensure of hospital and health system facilities as the transition occurs.

CONCLUSIONS

Many of the recommendations in other sections of this report call for inter-departmental analyses and resolution of various issues regarding DHS and County operations in preparation for transition to governance of the County's hospital and personal health care system to a separate health authority. Appointment of a transition team responsible for preparing a transition plan would bring accountability, consistency and continuity to the process. A transition team comprised of representatives of DHS, County Counsel, the Chief Administrative Office, health care providers from within and outside the County and consumer representatives would ensure participation by the key parties that should be involved in most of the analytical work needed to prepare for implementation of a health authority in Los Angeles County. Transition teams and implementation plans have been developed in other jurisdictions that have created separate health authorities, notably Alameda County in California, and Hennepin County in Minnesota, which is currently creating a separate governance structure.

The implementation plan should consist of specific tasks, each with its own timeline and individual or department assigned chief responsibility. The timelines for each task should depend on whether it needs to be completed for the State enabling legislation, for amendments to the County Charter or Code, prior to creation of the health authority, or after the health authority is created. The Alameda County implementation plan can be used as a model for Los Angeles County, though it was prepared after the State enabling legislation. In Los Angeles County, work on the transition plan should occur in advance of and after adoption of the State enabling legislation.

State legislation enabling creation of a health authority in Los Angeles County will require resolution of a number of topics identified in this report. The legislation that created the Alameda County Medical Center can be used as a model for Los Angeles County though some important distinctions should be made.

RECOMMENDATIONS

The Board of Supervisors should:

9.1 Appoint a health authority transition team comprised of representatives of the Department of Health Services, County Counsel, the Chief Administrative Office, health care professionals from within and external to the County system, consumer representatives and other County representatives as needed, responsible for preparation of a detailed transition plan needed for implementation of a separate health authority in Los Angeles County.

9.2 Direct the transition team to identify the areas where outside counsel or other expertise will be needed to assist with certain implementation issues and report back to the Board of Supervisors with the estimated costs and timelines for procuring such services.

9.3 Assign responsibility and due dates for each implementation plan task and classify each as one of the following: 1) issues to be resolved prior to drafting of enabling legislation; 2) issues to be resolved prior to drafting of necessary County Code and Charter amendments; 3) issues to be resolved prior to transfer of authority to the health authority; and, 4) issues to be resolved after transfer of authority to the health authority.

9.4 As part of the implementation plan, direct the transition team to prepare draft State legislation to enable creation of a health authority in Los Angeles County, including each of the components outlined in Exhibit 9.1 of this report.

9.5 Determine a sponsor in the State legislature to introduce the proposed legislation.

COSTS AND BENEFITS

The primary costs of implementing these recommendations will be County staff time for participation on the transition team. The use of outside counsel and possibly other experts needed to assist in this effort will result in direct County costs of an amount that cannot be determined at this time. The benefits of implementing these recommendations will include a process for transition to a new health authority that is well planned and executed, with all key areas addressed and decided on based on thorough analyses of all key issues. This will assist the health authority smoothly begin it operations and start achieving its mission as soon as possible: the cost-effective provision of high quality health care services to the indigent and medically needy.

HEALTH AND SOCIAL SERVICES COMMITTEE

HOMELESS COMMITTEE

BACKGROUND

The most commonly cited definition of a homeless person is from Section 11302 of the McKinney-Vento Homeless Assistance Act. The act defines a homeless person as an "individual who lacks a fixed, regular, and adequate night time residence or a person who resides in a shelter, welfare hotel, transitional program or place not ordinarily used as regular sleeping accommodations, such as street, cars, movie theatres, abandoned buildings, etc."[1]

The U.S. Department of Housing and Urban Development's definition of homelessness includes a "person who has no place to go, no resources to obtain housing, and is either being evicted within a week, discharged within a week from an institution, such as a hospital, or is fleeing domestic violence".[2]

The U.S. Department of Education uses a more expansive definition that includes children and youth "who are sharing the housing of other persons due to loss of housing, economic hardship, or similar reason…or are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations".[3]

METHOD

Visits to, and interviews with, the Los Angeles Homeless Services Authority, Weingart Access Center, and the Justiceville/Homeless, USA, Dome Village revealed efforts within the community to address the homeless situation. Interviews with Department of Social Services personnel were also beneficial in defining the problem of homelessness in Los Angeles County. Further interviews with the Weingart Access Center revealed a 10-year plan called "Bring LA Home". Phase one of the plan was the focus of the 2004-2005 Civil Grand Jury.

[1] McKinney-Vento Homeless Assistance Act, Section 11302
[2] U.S. Department of Housing and Urban Development, ESG Deskguide, Section 4.4
[3] McKinney-Vento Homeless Assistance Act. Section 725

FINDING

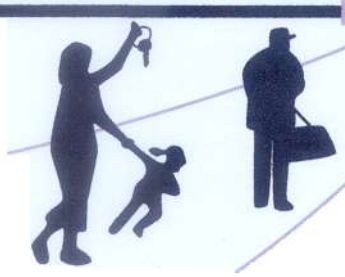
Over the course of one year, an estimated 243,000 men, women and children experience homelessness in Los Angeles County. Los Angeles has a higher rate of homelessness than most other U.S. cities and counties. South Los Angeles and Metro Los Angeles have the greatest number of homeless people in the county.

RECOMMENDATION

The Los Angeles County Civil Grand Jury of 2004-2005 Homeless Committee recommends that the County Board of Supervisors support the Los Angeles Homeless Services Authority (LASHA) mission to end homelessness as specified in goal one of the ten year Strategic Plan to End Homelessness in Los Angeles County.
(See Attachment)

Bring Los Angeles Home!

The Partnership to End Homelessness



DRAFT FRAMEWORK for the 10-Year Strategic Plan to End Homelessness

"Partnership is the key to ending homelessness"

Approved by and released on behalf of
The Blue Ribbon Panel

Bring LA **Home!**
The Partnership to End Homelessness

October 4, 2004

Goal 1: Decrease the number of people on the streets and in shelters.

Homeless services are highly concentrated in the urban center of Los Angeles but sparse in the area of greatest need -South Los Angeles, and acutely underdeveloped in the Antelope and San Gabriel Valleys. More specifically, there is a wide disparity in providing emergency shelter beds and affordable housing regionally. Many cities have not acknowledged the reality that they are part of a regional housing and economic market that gives rise to homelessness.

To bring an end to homelessness we must preserve the existing hard-won facilities and programs, and create new facilities and programs where there are unmet needs. This includes ensuring that emergency shelter beds are available to serve subpopulations of homeless people with specialized needs, such as unaccompanied youth, two parent families, inlcuding families with teenage male children, persons with physical disabilities, hearing or visual impairmen, individuals, seniors, people with pets and women in the third trimester of pregnancy or with very young children.

Given the current rates of homelessness, a countywide total of 7,000 additional shelter beds are needed to bring each region up to the countywide average of 13 annual homeless public assistance recipients per shelter bed.

Ending street homelessness will require an increase in outreach services so that they are available seven days a week in all areas of the county. Further, it is critical to enhance the effectiveness of the outreach effort by standardizing outreach team composition to include members with professional level skills in mental health, substance abuse, and health care as well as street-wise workers with excellent skills in approaching, engaging, and bringing people into shelter. It is imperative that these outreach teams have the resources they need, such as housing with minimal entry requirements, and substance abuse and mental health treatment programs, to provide timely assistance to their clients.

Keys to Success The keys to success are critical for achieving each goal. Each key will be operationalized by specific detailed recommendations, with timelines, milestones, projected resources, and responsible parties.

Key 1: In the short-term, increase the number of emergency shelter beds by 7,000 taking into account the needs of homeless youth, disabled people, seniors, families and pregnant women, and people with pets. Adjust the number of beds downward as additional permanent housing is created and there is less need for shelter beds.

This plan must complement current City and County of Los Angeles planning efforts to ensure that LAHSA's year round shelter program in fact operates as a 24-hour, 365 day program. Equally important, is a fair share commitment from all cities in the county to site these facilities. Over time, in order to decrease reliance on shelters, we must begin to create more permanent supportive housing, service-enriched housing, and housing that is affordable for extremely low- income households.

Strategy 1:	TBD
Timeline:	TBD
Milestone:	TBD
Projected Resources:	TBD
Responsible Parties:	TBD

Key 2: Reduce the number of "system resistant" homeless people on the streets through a combination of appropriate and accessible services and high tolerance programs.

Strategy 1:	TBD
Timeline:	TBD
Milestone:	TBD
Projected Resources:	TBD
Responsible Parties:	TBD

Key 3: Adopt a countywide “Housing First” approach to service delivery.

"Housing first" refers to moving homeless persons into permanent housing as quickly as possible, and then providing time-limited transitional or longer-term services to help support them in housing. This model both minimizes the duration of homelessness and helps prevent recidivism by ensuring that formerly homeless individuals and families are connected to community-based resources and services that are responsive to their particular needs. In this way, problems can be addressed before becoming crises which might lead to a recurrence of homelessness. The services provided will depend on the client's individual situation, but may include childcare, money management, household management, employment services and counseling.

Strategy 1:	TBD
Timeline:	TBD
Milestone:	TBD
Projected Resources:	TBD
Responsible Parties:	TBD

Key 4: Reconfigure existing outreach teams and create new regional multi-disciplinary outreach teams.

The composition of street outreach teams should be reconfigured to include mental health and substance abuse professionals in order to bring professional skills and provide immediate assistance in the field. The effectiveness of the multi-disciplinary outreach teams can be enhanced through increasing the number of minimal entry requirement shelter programs as well as programs for co-occurring disorders including mental illness, substance abuse, and health issues such as tuberculosis, cancer, and HIV/AIDS.

Strategy 1:	TBD
Timeline:	TBD
Milestone:	TBD
Projected Resources:	TBD
Responsible Parties:	TBD

JAILS COMMITTEE

Beverly Clemence, Chairperson

Clairene Almond
Dennis Brusseau
Hal D. Hichborn
Wayne Hunt
William R. Jackson
Mary Alice King
Alfred Rucker
Geneese Simmons
Oscar Warren

JAILS COMMITTEE

BACKGROUND

California Penal Code Section 919 (a) and (b) directs that the Grand Jury shall inquire into the condition and management of the public prisons within the county. The Jails Committee was formed to carry out this mandate.

Los Angeles County has 88 cities and an unincorporated area of 2299 square miles. The Los Angeles County jail system is the largest in the nation with an average daily population of some 17,000 inmates in Los Angeles County Sheriff's Department (LASD) facilities. This number does not include State facilities that were not inspected.

Detention facilities fall into three categories:

- Long term - characterized by county jails and state prisons
- Short term - characterized by city jails or other holding facilities
- Juvenile facilities – characterized by probation camps, juvenile halls, and California Youth Authority

ADULT DETENTION FACILITIES

Most local police departments include jails. These facilities are short term, indicating a stay not to exceed 48 hours, prior to a detainee's transfer to a central facility such as Twin Towers. Courthouses are equipped with holding cells for keeping detainees secure while awaiting their court appearances.

Los Angeles County Sheriff's Department manages all court holding units and the large detention facilities. Overcrowding is a constant complaint and budget constraints appear to be the main cause. Early release of inmates, work release programs and electronic monitoring procedures are used to alleviate some of the overcrowding.

JUVENILE DETENTION FACILITIES

The Los Angeles County Juvenile Probation Department is responsible for the management and operation of all juvenile detention centers and camps within the county. Eastlake, Los Padrinos and Barry Nidorf house minors awaiting prosecution as adults, as well as those arrested for misdemeanors, and those awaiting assignment to foster care, group homes, camps or mental health care. Probation Department programs are offered to aid young people before and after they become involved in the juvenile justice system. County probation camps provide an alternative to incarceration in the California Youth Authority, and offer a highly structured environment designed to enhance academic training for elementary, middle and high school youth. Juveniles

assigned to a camp are required to attend three hundred minutes of classroom training per day provided by the Los Angeles County Office of Education.

METHOD

The Jails Committee devised a form to collect common data from each facility (see attachment). Committee members used specific inspection criteria and recorded their findings for inclusion in the final jury report.

A minimum of two grand jurors per visit inspected fifty-three adult and eight juvenile detention facilities for compliance with State health and safety regulations. The entire jury inspected Twin Towers, Pitchess Honor Camp, and Men's Central Jails.

FINDINGS

Of the sixty-three detention facilities inspected, we found nine to be outstanding: Alhambra Police Department, Arcadia Police Department, Culver City Police Department, East Los Angeles Sheriff's Department, Inglewood City Police Department, Long Beach Police Department, Monterey Park Police Department, Pasadena Police Department, and Santa Monica Police Department. They were in good repair, clean, and well run. Each had complaint forms readily available, some in several languages reflective of the population served. All three major jails, Men's Central Jail, Pitchess Honor Camp (North County Correctional Facility), and Twin Towers met or exceeded criteria we considered. We found three facilities, Harbor Community, 77th Street Station, and Foothill Community non-compliant with our inspection criteria. These Los Angeles Police Department facilities were found to be in need of cleaning, improved sanitation, new paint and miscellaneous repairs.

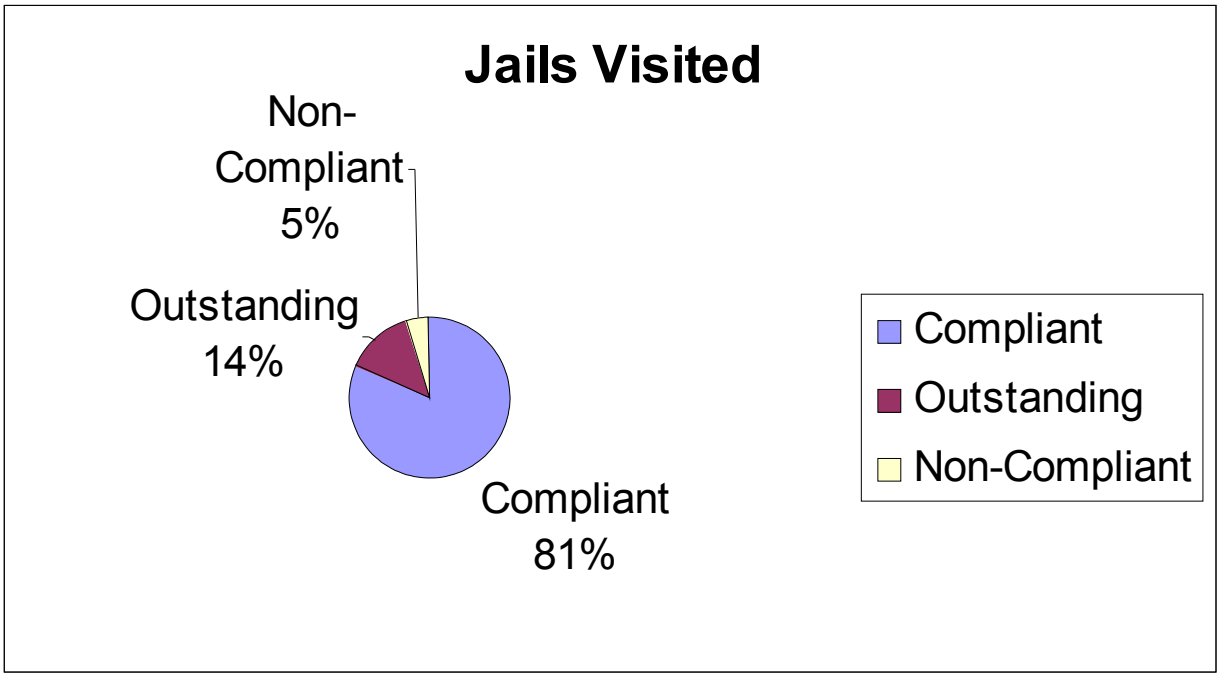
The availability of breathing apparatus and oxygen monitoring equipment was inconsistent in the jails visited. Thirteen adult facilities representing 21 percent of jails visited had no oxygen equipment. With the increased awareness of potential terrorist activity, the immediate availability of oxygen and self-contained breathing apparatus is critical to the survival of staff as well as inmates. Many of the jails are located adjacent to fire departments whose emergency equipment is assumed available. This may be adequate in a local emergency, but not in a state of national emergency. Availability of self-contained breathing apparatus is essential for the survival of First Responders in order to reach their assigned staging areas.

The 1998-1999 Grand Jury recommended that all Sheriff's and LAPD stations be equipped with self-contained breathing apparatus (SCBA). As of this date, this had not been accomplished. The Pasadena City Police Department has equipped its jail with affordable, disposable, self-contained breathing apparatus (SCBA) that could be useful for other departments.

We noted inconsistency in availability and content of citizen's complaint forms. In some locations, forms were exceptionally good; in others, inaccessible or non-existent. An example of good public accessibility of forms is the Monterey Park Police Department. Their forms are provided in English, Spanish, and Chinese. The department has bi-lingual staff to assist in the completion of the forms.

Juvenile facilities were found to be well managed and maintained despite budget constraints, lack of personnel, and the increasing number of juveniles entering the system.

Of the 63 detention facilities visited, the following is a breakdown of compliance with standards.



RECOMMENDATIONS

Based on the findings of the jail study, The Civil Grand Jury recommends the following:

- Each LAPD detention facility be equipped with enough self-contained breathing apparatus to assure the safety of all key responsive personnel.

- Both the Los Angeles County Sheriff Department and Los Angeles City Police Department establish a uniform standard for the display and dissemination of citizen complaint forms and their processing procedure at the stations and jails.

- The LAPD Chief report on the steps being taken to correct conditions at the three facilities cited to be non-compliant.

DETENTION FACILITIES INSPECTION REPORT
BY THE
JAILS COMMITTEE OF THE 2004-2005
LOS ANGELES COUNTY CIVIL GRAND JURY

DATE:_____ ARRIVAL TIME:_____am/pm DEPARTURE TIME:_____am/pm

FACILITY NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

Type of facility: _____MANAGED BY: _____

CAPACITY: _____POPULATION: _____

INSPECTED BY: (1)
(2)
(3)

RATINGS: COMPLIANTor NON-COMPLIANT

	COMPLIANCE	NON-COMPLIANCE
C.P.R. AND OR OTHER SAFETY INSTRUCTIONS POSTED		
FIRE EXTINGUISHER CERTIFICATE CURRENT?		
OXYGEN TANKS/ANY HAZ.MAT. EQUIPMENT?		
SANITATION		
TELEPHONE		
NUTRITION REFRIGERATION/TEMP		

GENERAL APPEARANCE & COMMENTS:

_____
_____
_____
_____
_____
_____
_____

PUBLIC INTEGRITY AND LAW ENFORCEMENT COMMITTEE

Oscar Warren, Chairperson

Robert Dobson
Hal D. Hichborn
William R. Jackson
Rita Kleinman
William Korb
William Noble
Alfred Rucker
Elyse Ruth

PUBLIC INTEGRITY AND LAW ENFORCEMENT

COMMITTEE

INTRODUCTION

The 2002-2003 Civil Grand Jury examined the policies and procedures of several law enforcement agencies within Los Angeles County to determine if they were conforming to California Penal Code 832.5, which requires, ”That all law enforcement agencies in the State of California must establish policies and procedures to receive, investigate, and resolve citizen’s complaints concerning their particular agency.”

The 2004-2005 Civil Grand Jury received Citizen complaint letters alleging: 1) the inability to secure forms and/or instructions; 2) the inability to file forms at some agencies; 3) the inability to find out the resolution of the complaint; 4) dissatisfaction with resolution of complaint, and 5) feelings of being intimidated by some officers against whom complaints had been filed. The committee did not investigate specific cases but investigated the policies and procedures of agencies operating within Los Angeles County. Based on these letters, the committee on Public Integrity and Law Enforcement committed to visit five law enforcement agencies within Los Angeles County to examine their policies and procedures for filing, investigating, and resolving citizen complaints.

METHOD

The Civil Grand Jury received citizen complaint letters alleging problems with filing and the resolution of complaints filed at Hermosa Beach PD and Long Beach PD. Following approval by the entire jury the Public Integrity and Law Enforcement Committee decided to examine the policies and procedures a private citizen must follow to file a citizens complaint at the following agencies: Redondo Beach PD, Torrance PD, Manhattan Beach PD, Hermosa Beach PD, and Long Beach PD. The committee determined the availability of forms and instructions for filing complaints upon entrance to each facility. Question and answer techniques were used to understand the process each agency follows in receiving, investigating, and processing complaints.

HERMOSA BEACH PD

The committee met with a Commander who was unable to contact anyone from the Internal Affairs unit, which is responsible for receiving and compiling information on citizen complaints. Forms and instructions were not visible at the entrance but were made available upon request.

REDONDO BEACH PD

The committee met with a Sergeant from the Professional Standards Unit who provided detailed documentation of citizen complaints from files located in his office. He is responsible for receiving and reviewing each complaint filed. Citizen complaint forms and instructions for filing are available at the entrance to the station. After the investigation and findings, the compiled data is forwarded to the Chief of Police who makes the final decision. One officer had been required to take sensitivity training as a result of a citizen complaint filing and investigation.

LONG BEACH PD

The committee met with Internal Affairs officers, and with members of The Citizens Complaint Commission of Long Beach. Forms for filing and instructions for filing were available in the lobby of the downtown station as well as in the public libraries, and on the city website. Internal Affairs receives and investigates all complaints filed. After their investigation is completed a recommendation is made to the Chief of Police who is responsible for final disposition. The Citizens Complaint Commission automatically reviews each filing of citizen complaints resolved by Internal Affairs. The commission has its own investigators who act independently of the police department.

TORRANCE PD

The committee found brochures in the lobby of the station for filing citizen complaints. Posted signs indicated that a complainant must first speak with the Watch Commander. Officers indicated that this procedure allowed complaints to be screened to determine their validity. Officers indicated that they were in the process of revising their complaint forms and procedures. Following investigation of complaints by Internal Affairs, recommendations are made to the Police Chief who makes the final resolution of each complaint.

MANHATTAN BEACH PD

This department is currently in a temporary location while a new facility is being constructed. The Chief and a Captain explained the complaint process and made available all information regarding filing and resolution of complaints. The chief has final say in the resolution of investigations of citizen complaints. Complaint forms are available on the city web site. The committee was assured that once construction of the facility is complete forms and instructions will be available in the station.

FINDINGS

- Hermosa Beach PD and Torrance PD required that potential complainants talk with a police supervisor prior to receiving and or filing a complaint form

- Only the Long Beach PD has an independent review process for individuals who may feel the resolution of a complaint was unfair

- Three of the five agencies visited were in the process of reviewing and/or revising complaint procedures

- Manhattan Beach PD and Long Beach PD make complaint forms and procedures for filing available on the City web site

- Long Beach PD complaint forms and filing instructions are available in public libraries

RECOMMENDATIONS

Based upon the findings, the committee makes the following recommendations:

- Torrance PD and Hermosa Beach PD should make citizen complaint forms and instructions for filing available to the general public without requiring the citizen to speak with an officer prior to receiving the forms and instructions

- The Hermosa Beach PD should establish lines of communication between shifts so that each officer responsible for investigating citizens complaints has access to the current status of each investigation

- Long Beach PD should make the general public more aware of the existence of the independent police commission and that it automatically reviews all citizens complaints resolved by Internal Affairs

- Many cities within Los Angeles County have established Independent Citizens Complaint Review Boards such as the Long Beach model, which has proven to be effective. Hermosa Beach, Manhattan Beach, Redondo Beach, and Torrance should consider establishing a similar board

- Torrance PD, Hermosa Beach PD, Manhattan Beach PD, Redondo Beach PD, and Long Beach PD should identify and make sensitivity training a requirement for all officers, especially those who interact with the public in potentially volatile situations on a regular basis

COUNTY COUNSEL PROCEDURE FOR USE OF OUTSIDE COUNSEL

INTRODUCTION

Several news articles in late 2004 regarding the contracting of outside attorneys by the Los Angeles City Attorney indicated possible abuses involving selection, retention, billing, and general oversight of these private entity contractors. This resulted in an audit by the Los Angeles City Controller's Office.

The 2004-2005 Civil Grand Jury elected to review the system Los Angeles County Counsel used in its outside counsel contracting.

The Office of County Counsel provides legal advice and representation to the Board of Supervisors, County departments and employees, other public officers and agencies relating to the operation and management of the County.

METHOD

We interviewed representatives from the Office of County Counsel and reviewed its policies and procedures used in contracting with outside counsel.

We reviewed the amounts paid to outside counsel by Los Angeles County, including a summary detailing the activity from fiscal year 1998-1999 to fiscal year 2003-2004.

FINDINGS

The current policy of the Office of County Counsel is to contract private counsel:

- where it is cost effective
- where necessary expertise is unavailable
- for short-term lawyer-intensive matters.

Outside counsel is warranted for specific matters involving potentially long term, high cost, important policy considerations, or where a conflict of interest precludes County Counsel representation.

The private law firms are selected based on:

- competence
- quality
- price
- necessary expertise

The Law Enforcement, Litigation and Labor Services Practice Group, which is part of the County Counsel's Office, is responsible for the supervision and litigation of most civil lawsuits involving the County of Los Angeles and its employees.

The Office of County Counsel in 2003 created the position of Litigation Cost Manager. Figures for the fiscal year 2003-2004, the only year for which figures are available after that position was created, show a substantial decrease in fees and costs associated with outside counsel compared with figures for the preceding four fiscal years. There was also a substantial decrease in judgments and settlements involving outside counsel for the preceding five fiscal years. While we recognize that one year does not constitute a trend, our inquiry indicates that the County is reducing the outflow of taxpayer dollars in matters relating to its use of outside counsel.

The Office of County Counsel requires case plans, budgets, and closely reviews invoices from outside counsel. Similarly, the Office of County Counsel has done a good job in negotiating attractive, below-market hourly rates from outside attorneys. Our investigation showed that County Counsel attorneys are closely monitoring legal services provided by outside counsel. Each outside law firm is required to sign a standard contract setting rates and requiring budgets and strategy plans. Status reports and prior approval for major expenses are required and guidelines limit costs that can be charged.

The Office of County Counsel uses multiple forms and procedures to track and monitor litigation handled by outside counsel. It effectively manages outside litigation in terms of both strategy and cost. The Division Chief and team leaders meet with outside counsel to assess pending litigation. They decide upon strategic matters and discuss controlling the cost of outside services. Representatives of the client in litigation (for example, the Sheriff's Department) and the Chief Administrative Officer also attend these meetings.

The Division Chief and/or other County Counsel attorneys attend some court hearings and conferences to monitor the litigation and to assess the performance of contract lawyers. A team leader sits in on all settlement conferences where the issues being litigated are of political importance to the County, or are otherwise sensitive. County Counsel attorneys also attend settlement conferences. They are authorized to settle cases up to $20,000. The County Claims Board has authority to settle cases up to $100,000. Higher settlements require approval by the Board of Supervisors.

CONCLUSION

We found that the Office of County Counsel does an excellent job selecting and managing outside counsel based on its policy and procedures used in selecting and contracting with outside law firms. The Office of County Counsel also uses effective strategies for monitoring the costs and cost effectiveness of outside counsel.

REAL ESTATE ASSET COMMITTEE

Larry Silk, Chairperson

Robert Dobson
Wayne Hunt
William R. Jackson
Charles H. Parks

INVESTIGATION OF OPPORTUNITIES TO ENHANCE REAL PROPERTY COLLABORATION

TABLE OF CONTENTS

INVESTIGATION OF OPPORTUNITIES TO ENHANCE REAL PROPERTY COLLABORATION

INTRODUCTION

The 2004-2005 Civil Grand Jury of Los Angeles County conducted, with KH Consulting Group, an investigation into the degree of collaboration and coordination among selected government executives responsible for the management of real estate assets within Los Angeles County. Based on the results of this investigation, the Grand Jury has determined that there are opportunities to improve the acquisition and disposition of real estate assets by governmental agencies within the County. Coordination and collaboration among agencies can benefit all participants.

Objectives and Scope: The purpose of this report is to identify workable models for collaboration among government agencies responsible for the acquisition, sale, and management of real estate assets in Los Angeles County. The primary focus of the investigation was publicly owned and leased real estate devoted to operational and headquarters activities, e.g., office space, public space, and warehouse space, as contrasted with public housing, public schools, roadways, or economic development.

The Grand Jury identified five city departments or municipal entities within the County of Los Angeles as appropriate venues for the review of a spectrum of approaches to collaboration. These agencies included:

- ❑ The County of Los Angeles
- ❑ The City of Los Angeles Asset Management Division (AMD) in the General Services Department, (for Council-controlled Departments)
- ❑ The City of Los Angeles, Department of Water and Power (LADWP) (as an example of a Proprietary Department)
- ❑ The City of Long Beach, (as an example of an Independent City within Los Angeles County)
- ❑ The Metropolitan Water District of Southern California (MWD)

The Los Angeles Unified School District (LAUSD) was considered and not included because of the breadth and complexity of their property holdings, and the uniqueness of their needs.

To develop collaboration models, the Grand Jury:

- ❑ Reviewed processes for acquisition and disposition of property in the five agencies
- ❑ Assessed the completeness and structure of the databases used by the agencies, focusing on opportunities to share data
- ❑ Conducted a review of private and public sector entities to identify models for collaboration that hold the promise of reduced costs, increased effectiveness and economic efficiency in the provision of real estate services
- ❑ Identified key incentives and benefits which could attract agencies to a collaborative system

METHOD

In completing this study, the Grand Jury:

1. Discussed areas where the lack of collaboration and shared information has led to inefficiencies
2. Reviewed relevant documents. See the Appendix for a list of documents reviewed
3. Conducted interviews with real estate asset managers in the identified agencies
4. Researched approaches and models used by other governmental and private sector agencies, including the following:

a. Alberta, Canada
b. Chicago, Illinois
c. San Bernardino County
d. A web-based multiple listing service available by subscription

5. Facilitated a discussion of models for collaboration with the participating agencies
6. Evaluated with participants the advantages and disadvantages of various approaches and models

GOVERNMENTAL APPROACHES TO REAL PROPERTY MANAGEMENT

All governmental agencies cope with difficult and sometimes conflicting priorities in the management of their real estate assets. Facilities must be located in places that maximize accessibility, safety, and convenience of residents and service beneficiaries. Public real estate asset managers must also ensure that workers and visitors are secure; that they can easily and safely access the facility; and that the location, construction and operation of the facilities do not violate sound principles of environmental management and protection. Where appropriate, public real estate assets should support economic development and revitalization. Services and corresponding needs for space can grow or shrink based on external factors that are not always easy to predict. Budgets are subject to changes from year to year. Acquisition, leasing and sales policies and practices must reflect the values of the agencies in which they reside. With all these elements to consider, it is not always possible to ensure that creative cost reduction is of primary interest in public real estate decisions.

The organizations employed a range of acquisition and disposition approaches and practices, reflecting their specific needs. Important factors included the number of properties held and the primary use of them. There is a significant difference in the management of property intended for long-term operational use, such as a reservoir or electrical substation, and property needed for office space.

Even so, there was substantial common ground. The State of California has enacted codes covering the disposition of surplus property by governmental entities, which are followed by the agencies we evaluated. California Government Code Sections 54220-54232 require agencies with non-exempt surplus property to assess the suitability of that property for various governmental purposes, and to offer them first to the appropriate agencies. Most reviewed agencies complied with these codes, except as otherwise noted in Tables 1 to 5. They do not require asset managers searching for property to first consider whether any other governmental entities have suitable parcels or buildings to be considered for lease or sale.

Although collaboration on a professional level was of significant interest to participating agencies, there was a consistent concern about the value of collaboration in the context of the political environments. Real estate transactions are highly visible to elected officials and the general public. They require multiple levels of approval, and involve powerful local interests. In this environment, it does not appear that the advantages of collaboration are compelling enough to affect the political consensus that supports most decisions to buy, sell, or lease real estate assets. One specific example cited as an impediment to collaboration was that the Los Angeles County Supervisors have approved a lawsuit against the City of Los Angeles over the planned modernization of Los Angeles International Airport (LAX). The Supervisors support a more regional approach to handling air traffic, and have raised issues about lack of adequate public hearings. This complicates the

relationship of the real estate professionals in the two jurisdictions, as legal staff on both sides may establish restrictions on exchanging information.

The following tables outline the different priorities and approaches to acquiring, disposing, and leasing property. The tables also include salient points about the structure of the databases maintained by each organization.

Table 1: County of Los Angeles	
Property Managed	The Real Estate Division is the County's Real Estate agent for all Departments except the Community Development Commission (CDC), the Department of Public Works, and the Department of Beaches and Harbors. These three large public agency landholders manage their own real estate holdings.
Acquisition/ Disposition	When property is deemed to be surplus by the Board of Supervisors and ready for disposition, the County generally follows California Government Code Sections 54220-54232. The County posts information on unfilled leasing needs and available surplus property on its web site. The Office of the Chief Administrative Officer (CAO) also maintains a list of potentially surplus property by Supervisorial District. Generally, when the County needs to lease or purchase property, it advertises its needs on the internet, through the office of the CAO, among other methods.
Leasing	As of FY 2003-04, the County CAO was managing 491 office leases with a total of 8.6 million square feet. Generally, the County does not have excess useable space for lease.
Database	The Real Estate Management Information System (BDR) holds all County property information except raw land and CDC properties. The new system is being implemented by the CAO with expanded web-based and GIS capabilities with full implementation scheduled for August 2005.
Collaboration Efforts	Formal and Informal; County participates in Statewide groups and with local Cities and Agencies.

Table 2: City of Los Angeles, Asset Management Division	
Property Managed	Properties owned or leased for Council-controlled Departments (excluding Harbor, Airports and Water & Power) are handled by the Asset Management Division (AMD) of the General Services Department. The City owns more than 2,800,000 square feet in Council-controlled facilities. This includes a $25 million lease portfolio. When leases managed by all City departments are included, there are over 200 locations, and an annual lease cost of over $35 million. In addition to its leasing responsibility, AMD manages more than 2,500 parcels of City-owned land. AMD has limited responsibility for office space and improvements on City-owned properties after they have been acquired. The Division ensures that the office space is fully occupied.
Acquisition/ Disposition	AMD is responsible for the acquisition of property and buildings for bond-funded City capital projects. The Division typically uses real estate brokers to assist with the location and negotiation of property to be acquired When property is deemed to be ready for disposition, the City follows California Government Code Sections 54220-54232. AMD is actively implementing the MORE (Maximize Our Real Estate) program, which is designed to recommend the best way that the 2,400 parcels of surplus property can serve the City's priorities of increasing affordable housing stock, creating more open spaces, and facilitate job creation. City uses are of first priority.

Leasing	As noted above, AMD manages a substantial inventory of leased facilities. Staff members in the Division either identify available property themselves, or use pre-selected brokers to negotiate terms for property. AMD is subject to a policy established by the City Council which calls for the City to meet its downtown space needs by leasing in the Historic District. It is also subject to a variety of social responsibility requirements imposed by the City on all contractors.
Database	AMD's Lease Information System (LIS) stores lease information files on approximately 700 properties arranged by Right-of-Way Number. The LIS provides all necessary information about the property, along with complete terms and conditions associated with the underlying lease documents and a chronological record of any changes. The LIS provides the Division with all information necessary to remit lease payments and receive lease revenue. AMD is working to develop a City-wide database of real property, including property held by Proprietary departments.
Collaboration Efforts	AMD has leased property from the County of Los Angeles, and has attempted to establish a "Civic Center Authority" – an intergovernmental planning cooperative for office space needs in the Los Angeles Civic Center area. AMD also worked on the consolidation of State and City transportation responsibilities within one building at the new CalTrans Office Building.

Table 3: City of Los Angeles, Department of Water and Power	
Property Managed	The Real Estate Business Group acts as an internal real estate brokerage for LADWP. Water and Power are distinct as customers. The Power business groups rely more heavily on Real Estate for property management services. Water Service, on the other hand, wants to exercise more control over their real estate holdings, in part because they are more sensitive about uses near water supplies. LADWP has extensive real estate holdings in and near the Owens Valley, which are used as watersheds, reservoirs, and hydropower generating stations. It also owns the canal system that transports water from the Owens Valley to Los Angeles. All of the Owens Valley land is administered by LADWP staff in the local area, and is not the responsibility of the Real Estate Business Group. LADWP is in a "steady state" mode. It is neither expanding nor contracting. Because of this, acquisition efforts are rare. Much of the unit's work consists of disposing of property and, to a lesser extent, leasing property to meet shorter-term needs.
Acquisition/ Disposition	When property is deemed to be ready for disposition, LADWP follows California Government Code Sections 54220-54232.
Leasing	The Real Estate Business Group leases property at the request of its internal customers, primarily through brokers. This is not a major activity at LADWP – there have only been four to five significant lease transactions in the past 4 years. LADWP owns most of its facilities, reducing the need to lease major sites.

Database	The current property database at LADWP is based on the structure maintained by the County Tax Assessor's Office. A project is under way, however, to convert LADWP's database to one that matches the database implemented by the General Services Department, including GSD's GIS system. LADWP is in the process of preparing contract documents that would allow it to retain the consultant used by GSD to perform the migration.
Collaboration Efforts	LADWP Real Estate has not extensively collaborated with other agencies, beyond following the requirements of the California Government Code. It recently sold a significant parcel of land in the San Fernando Valley to the Los Angeles Unified School District. It is open to collaboration, however, if it would benefit the Department or help the City.

Table 4: City of Long Beach	
Property Managed	The City of Long Beach currently owns approximately 1,003 parcels of real property primarily held for public purpose and open space, which are catalogued in an Access database. This includes property owned, leased or managed by the Port of Long Beach and Long Beach Municipal Airport. Property owned by the Long Beach Redevelopment Agency is not included. The Long Beach Redevelopment Agency has a substantial acquisition program in progress, funded through a recent bond issue totaling approximately $200 million. The Redevelopment Agency does not normally hold property as an asset. It seeks out development partners and transfers the assets into the private sector as expeditiously as possible.

Acquisition/ Disposition	Long Beach complies with Section 54220 of the Government Code, which requires notification to the State of California of all surplus property sales. Long Beach currently has 13 surplus properties that appear to have at least some market value. These properties are being actively marketed. Long Beach also engages in the sale and leaseback of property that may be underused. As an example, the City is near conclusion on the sale of a parcel that includes a Police warehousing facility in a manner that allows the Police to use the property at no base cost, while providing $400,000 to the City's General Fund.
Leasing	Long Beach does not lease extensively. It owns most municipal facilities, including its primary office locations. If leasing is required, Long Beach generally utilizes the services of local brokers.
Database	Long Beach maintains a GIS database of the entire City that indexes to the Assessor's Parcel Number (APN). This allows City staff to access the information on the parcel that is contained within the Assessor's database. All publicly owned property (City, RDA, County, State or other municipalities) can be queried and identified through this system.
Collaboration Efforts	Long Beach has not participated in collaborative efforts before. It is open to such efforts, however, especially with the County of Los Angeles, which operates several facilities within the City.

Table 5: Metropolitan Water District of Southern California	
Property Managed	The Metropolitan Water District of Southern California (MWD) currently manages approximately 160,000 acres of land comprised of over 8,000 individual properties throughout Southern California, including a large volume of property in Los Angeles, Riverside, and San Bernardino Counties.

Acquisition/ Disposition	With regard to property acquisition, MWD is largely project oriented. When property is deemed to be ready for disposition, the MWD follows California Government Code Sections 54220-54232.
Leasing	MWD is currently leasing a small number of offices in Southern California. There is some leasing of space in its headquarters building to State entities, such as the Office of the State Architect.
Database	MWD's Asset Information System is an Access based property information and management system created to meet unique needs and descriptors. The system cannot wholly rely on Assessor's Parcel Numbers because much of the property is tax-exempt and/or easements.
Collaboration Efforts	Most of MWD's property is permanently located within Southern California. MWD currently collaborates extensively with city, county, and other public agencies regarding the location of its pipelines, treatment plants, reservoirs and reserve lands. MWD continues to encourage any opportunity to participate in collaborative efforts, both formal and informal.

BENCHMARKED ORGANIZATIONS

The Grand Jury contacted several organizations, and conducted a web search to identify best practices in the area of governmental collaboration involving real estate acquisition, disposition, and leasing. There appear to be a wide variety of approaches, including the following:

- ❑ Formal organizations that plan and acquire properties together
- ❑ A shared listing service
- ❑ A unilateral effort to publicize available and needed property to other governmental organizations

The Grand Jury also contacted a proprietary multiple listing service to determine opportunities for private sector support of a potential municipal collaboration model.

The results of the benchmarking effort are summarized below.

Chicago, Illinois – Shared Purpose: The City of Chicago has established a multi-agency cooperative effort called Chicago *CitySpace* that includes:

- ❑ Cook County Forest Preserve District
- ❑ Chicago Public Schools
- ❑ City of Chicago
- ❑ Chicago Park District

Those responsible for real estate planning, acquisition, and operations of those governmental organizations jointly plan for and acquire parcels to achieve specific purposes. Specific sub-programs include:

- ❑ *NeighborSpace* program for pocket parks and gardens
- ❑ *CampusPark* program for grass replacement of pavement
- ❑ Chicago River program for riverbank development

Alberta, Canada – Shared Municipal Database: Alberta, Canada has the most comprehensive and structured shared database model found during this investigation. AlbertaFirst is a consortium of 170 municipalities and Economic Development Agencies located within the Province. In collaboration with the Alberta Real Estate Association, they share a property database that is updated twice a week and includes information on property that is for sale or lease. Other municipal organizations have access to the data on the properties, as do community based, not for profit, and private sector organizations. The image below shows a page of the website describing available property owned by a municipality.

San Bernardino County – Available Information: The County of San Bernardino displays information on available and needed property on a website targeted to other municipal organizations. The Real Estate Services Department website has extensive links to cities, all County agencies, and Federal agencies, and provides information on available and desired property.
The images below offer glimpses of what is available on this site.

County of San Bernardino
REAL ESTATE
SERVICES DEPARTMENT

For information on county space needs click here

For information on property for sale click here

County of San Bernardino
REAL ESTATE
SERVICES DEPARTMENT

(909) 387-7832

The Real Estate Services Department maintains a list of Land for Sale for the County of San Bernardino. If you are interested in any of the following items call the assigned agent or email the Real Estate Services Dept.

Be advised that the information listed below is subject to change, and furthermore, that all sales transactions are not final until the Board of Supervisors approves a sales contract.

The information below is as up to date and accurate as possible, however it is up to the indiviual to verify all data Please note the following abbreviation TBA=To be announced.

Click each title to sort.

ID	Date Posted	Location	Address	APN	Type	Minimum Bid	Auction Date	Contact	Department	Comments
1								Place Holder		Place Holder
12	5/2/2005	Baldwin Lake Area	NEC of Kickapoo & Wilson Drives	0314-382-06	BV-RL - Bear Valley Rural Living	$223,000.00 - deposit to bid $22,300.00	Tuesday, May 31, 2005 - 10:30 am	Tom Dustin	Transportation Div.	11.24 +/- gross acres/10.6+/- net acres

Top ← Prev Next → Bottom Color

Web-Based Multiple Listing Service: There are private sector exchanges that are subscription-only, web-based commercial property listing services that facilitate buying and selling of property. They permit the listing of properties to targeted markets, such as municipalities and brokers. The City, County and MWD currently have access to such services, and use them to obtain relevant information on leases and sales. There is not yet, however, a subscription service devoted solely or primarily to municipally owned properties.

COLLABORATION OPTIONS: MODELS FOR CONSIDERATION

As the benchmarked examples demonstrate, opportunities for collaboration cover a wide range of possibilities. The simplest form of collaboration involves informal conversations among professionals, addressing common issues and transactions that may be of mutual interest. Another simple mechanism is to make information available to a variety of locations. At the other end of the spectrum, the most involved and complex options involve the development of formal structures to plan, acquire, construct, and operate facilities for joint use. The Grand Jury has selected five models to consider, as set forth below. The analysis of these models includes an assessment of the advantages and constraints of each.

Model 1: Sharing Common Issues, Plans, and Concerns among Real Estate Asset Managers: Model 1 is the simplest way to begin collaborative efforts. There are significant benefits, and relatively little risk. The primary barrier to successful realization of this possibility is the mutual mistrust that sometimes develops between government agencies. Political differences between governments can also be a restraint. As already mentioned, the City of Los Angeles and Los Angeles County are currently in dispute over the City's plans to expand LAX. Such developments can make it difficult for professional staff to publicly cooperate with each other. Consequences of not cooperating can be serious; disagreements over routine transactions can escalate prematurely, threatening service delivery. It is essential to ensure that such informal meetings offer value to all participants, and that the effort is supported by top agency executives. Unless this is the case, competing commitments encourage members to send representatives who cannot, by the nature of their positions, speak freely and with authority. This quickly makes the effort irrelevant, and ultimately results in dissolution.

As with many professionals, governmental property managers realize that they have common interests and can learn from and support one another in the conduct of their duties. Currently there is a California Counties Real Estate Group that meets regularly to discuss Statewide issues; there have been efforts to establish similar groups focusing on more local issues. While the advantages are clear – ability to learn from one another about strategies, successes, and issues of common interest – there have been difficulties in sustaining interest. Among the problems cited were:

- ❑ Difficulty in making such efforts a priority among competing demands
- ❑ Difficulty in assuring continuity in top-level staff participation
- ❑ Difficulty in establishing an agenda of interest to all members

Despite these difficulties, there is considerable interest in pursuing this simple opportunity for collaboration. Real estate asset managers seem to welcome the chance to work together on subjects of common interest; and it appears that they might be willing to renew their efforts at informal collaboration.

The City of Los Angeles has tried to sponsor a Civic Center Authority of decision-makers about governmental properties, including elected officials as participants. The Authority was short lived, however, and had difficulty sustaining the interest of elected officials.

Model 2: Sharing Resources, e.g., Property Valuation Experts, to Help Handle Peak Workloads: One more concrete area of collaboration could be the joint use of service agreements, brokerage arrangements, and other contracts. In this type of collaboration, one agency accepts the bidding process of another, issuing contracts with the same terms and conditions, and at the same prices. This in turn saves substantially on the administrative overhead required to draft, clear, approve, and issue a contract. It also increases the pool of available resources by raising the number of firms and individuals available to carry out the tasks of appraisal, lease valuation, property inspection, and property management.

There are a number of institutional barriers to be overcome in implementing this option. One important barrier is the contract specifications. As an example, the City of Los Angeles includes clauses in many contracts that require contactors to:

- pay a living wage (which is defined independently from other jurisdictions' living wage clauses),
- promise to assist local authorities in making child support claims against employees, and
- arrange for specific insurance assignment.

Contractors who wish to work for the City of Los Angeles (and who have not already done so) must register for the City Business Tax. These terms are not identical to the terms and conditions of, for example, the County of Los Angeles or the City of Long Beach. The interpretation of similar City and County requirements to set-aside a percentage of costs to provide for the arts has complicated collaborative efforts. Each governing body, if it has not already done so, must pass enabling ordinances that allow one jurisdiction to use the contract of another, waiving any terms and conditions unique to its jurisdiction. This is a practice that has been done on a number of occasions in the U.S, and is not in that sense the breaking of new ground. Once that is done, however, it will be possible to increase the speed with which agencies can act, and reduce the overhead costs of contracting.

At this model's most sophisticated level, two or more agencies could combine their needs and contract jointly for services. This would be especially effective if the model of a Master Contract, currently in use by the Los Angeles City Controller's Office and Los Angeles County Auditor-Controller, CAO, and Internal Services Department were adapted. Under this arrangement, several contractors are qualified to work, including reviews of all financial, insurance, and social responsibility requirements. Once a specific need is identified, the contracting agency solicits informal proposals from two to three of the pre-qualified firms, and issues a contract to the most desirable responder. Master Contracts can be issued for terms as long as three years. This approach, applied across several jurisdictions, could attract high quality contractors, and reduce the time effort and expense of engaging needed professional services.

Model 3: Cooperating on a Shared Listing Database of Needed and Available Property: Private Sector asset managers consistently use multiple listing services to help them acquire and dispose of properties on the open market. The services are typically paid for, at least in the first instance, by sellers and lessors. Potential buyers or renters access the information about available properties. This is a long-established process that has been revolutionized by the development of the Internet. Where once multiple listing services were printed on paper and available almost exclusively to brokers, they are now available on the Web with sophisticated search engines and almost instant access to information. Multiple listing services for commercial property are still limited to subscribers, but are much more broadly available than was once the case.

In its simplest form, a municipal multiple listing service would require the establishment and maintenance of a listing database, updated regularly, which would identify properties in governmental property inventories that are available for lease or sale. Benefits associated with such a listing database are that it would provide:

- A single location to search for available governmental property, increasing the possibility of identifying available property that might be rented at favorable terms by other agencies
- A way to solicit proposals for underutilized property
- An opportunity to acquire or lease property at lower cost
- Expanded search options for needed space
- A potentially more efficient means of addressing notice requirements specified in the Government Code for disposition of property
- A collaborative effort that can be built on for future projects or issues.

Countering those advantages are some constraints such as the following:

- Agencies contacted could not readily identify significant amounts of underutilized property that would be of interest to other governmental agencies. It is possible that this trend will be repeated in other jurisdictions, and the amount of property available for lease or purchase will not be significant
- It would take a significant number of transactions to justify the expense and difficulty of establishing and maintaining the database
- There are barriers to consummating agreements between municipalities with differing policies regarding the disposition of property

This approach seems attractive at first glance, perhaps because it reflects the tremendous success achieved by commercial multiple listing systems. When one considers the constraints, however, it is not so clear that this option is as beneficial as it might seem. Municipal governments do not always have large inventories of property that are of interest to each other. Beyond that, local governments may not have a large stock of excess property.

Model 4: Collaborating on Shared, Joint, or Adjacent Facilities: There have been some successes in partnering to plan for the use of individual parcels. These

collaborations can take the form of informal conversations aimed at better meeting community needs. One example of this would be the locating of related government services near each another – preferably in the same building or complex. In some cases, this may result in the acquisition of property near existing governmental services, or consolidation of services into one or more new facilities. An excellent example of this model is the Chicago CitySpace project, already described. In that instance, formal agreements to support the development of pocket parks and riverfront economic improvement were instigated.

These collaborative efforts can have significant impacts. By pooling resources, it is possible that common needs can be better met, and the overall interests of the community can be more quickly, economically, and effectively served. In contrast, they limit the ability of agencies to act autonomously. Unless the agreements are carefully constructed, there can be legal concerns raised by participants. More formal and long-term agreements cannot be quickly established – development and negotiation of terms is a time-consuming process. Finally, these agreements may limit the ability of asset managers to respond to requests by elected officials seeking to address constituent demands.

This option seems particularly applicable to cooperation between Los Angeles County and the 88 municipalities organized or chartered within it. The County frequently maintains facilities within some of its constituent cities, through which it provides a wide range of government services. Coordination of plans for these facilities with the cities, possibly including the establishment of common facilities or local government complexes, could benefit all parties, as well as the general public. On a less ambitious scale, coordination between the County and cities could be helpful to the cities as they plan for the orderly development of their municipalities.

Model 5: Establishing a Formal Entity or Structure to Plan, Acquire, Develop, and Operate Facilities to Address a Common Need: This model is the broadest option, envisioning the establishment of a new structure such as a Joint Powers Authority or municipal corporation that would provide a wide range of property acquisition, development, management, and disposition services to participating entities. This type of structure is more typically used for transportation – the Grand Jury has not found a current operating example of such an entity to address property asset management issues.

In May 2003, the CAO/ Director of Real Estate for the County of Los Angeles authored a feasibility analysis and proposal for the delivery of public real estate services through a municipal corporation entitled: "*Regional Government Real Estate Service Delivery."* The specific recommendation advocated the consolidation of the real estate operations of the County, its Department of Public Works, and the Department of Beaches and Harbors within this corporation. While this proposal considered only County departments, it could serve as a model for intergovernmental structures. The analysis and proposed organization structure could readily be adapted to further a proposal to create a municipal corporation for real estate and property management services on a broader scale.

There are advantages that could make the development of such an entity attractive. It would:

- ❑ Allow for collaborative planning to achieve joint goals of participating members
- ❑ Provide greater flexibility to participating members in meeting property needs
- ❑ Allow for greater use of private sector tools and approaches to the development and management of property
- ❑ Reduce fluctuation in funding for preventive maintenance of buildings during tight economic times
- ❑ Attract private sector capital and expertise to the development and management of municipal real estate assets

The Grand Jury does not envision that all property needs of participating members would be fulfilled by the authority or corporation. Rather, participants would identify classes or types of needs – e.g., parks or office space, or health and welfare facilities – that would be provided by the authority or corporation. Most of the disadvantages cited for Model 4 would also apply to this model. These authorities cannot be quickly established – development and negotiation of terms is a time-consuming process, and they may limit the ability of individual asset managers to respond to requests by elected officials seeking to address constituent demands.

FINDINGS

Finding 1: There is a wide range of opportunities for jurisdictions to collaborate to improve the effectiveness and efficiency of real estate acquisition and disposition.

Agencies can share information on common problems and challenges. They can undertake joint efforts to make constructive changes in County ordinances and State laws. They can share resources to save money and time. They might even consider collective efforts to establish government service centers that include an array of municipal, county, and special district services. These would allow more residents to undertake "one-stop shopping."

As a long term goal, agencies could plan to establish a Joint Powers Agreement that would allow them to acquire the highly paid negotiators, expert real estate attorneys, and lease analysts that would give their clients a more level playing field when attempting to "make deals" with commercial owners and brokers.

Finding 2: Other municipal jurisdictions provide examples of working examples of collaboration.

As cited in earlier sections of the report, the City of Chicago and Cook County, the Province of Alberta, Canada, and San Bernardino County have all found ways to collaborate successfully in the acquisition and disposition of property. Their examples show that effective collaboration is possible, and that it can carry substantial benefits.

Finding 3: Collaborative efforts undertaken simultaneously by the professional and elective members of government are stronger and more lasting.

Although it can be a challenge to achieve, joint efforts between elected officials and career staff members will produce the most effective and lasting cooperation between government agencies. In planning these efforts, it is critical to obtain the support of senior elected and appointed officials.

Finding 4: There are legislative, political, legal and institutional barriers to collaboration.

In some cases, state or local legislation will need to be changed to support efforts at collaboration. Disputes between different governments or distrust between them can make it difficult to build bridges of trust and cooperation that are essential to the kind of collaboration that can make a significant positive difference to real estate asset management.

Not all of the agencies understand each others' missions. Some of them do not understand the motives that drive their colleagues. In other cases, there are policy or other disagreements that limit the ability of career staff to openly collaborate. On a more mundane level, information systems are likely to have differing structures, or to

utilize incompatible technology. And there is always the "not invented here" issue to overcome, as is the case for almost all proposals for change. Collaboration initiatives must be carefully designed to overcome these obstacles, and those who wish to establish genuine collaboration must be both persistent and patient.

Finding 5: Collaborative efforts will work best if they begin with voluntary efforts to discuss areas of common interest, with specific actions being developed from those discussions.

One of the more effective ways to overcome the obstacles described earlier is to begin where there is a consensus, and where the smallest number of people can make the largest difference. In the area of real estate asset management, that critical point appears to be regular voluntary coordination meetings between senior real estate asset managers from the major municipalities and agencies within Los Angeles County. This appears to be feasible, and it can be done voluntarily. More important, it is a step upon which further, more complex forms of collaboration can be built.

Initially, such meetings could be set up so that they include those agencies willing and able to participate. As time goes on, membership can be expanded to include a wider cross-section of agencies. The cost of the meetings can be kept low, especially if one or more organizations agree to act as host. Benefits should accrue within a reasonable period, as one agency learns about the plans of others, or is able to take coordinated action.

Finding 6: There are significant opportunities to use technology to reduce the administrative effort needed to comply with the existing Government Code notification requirements.

All of the agencies we examined were diligent and professional in meeting the requirements of the law and the dictates of their mandate. They did report some concern about the best way to ensure that all of the cognizant individuals in all appropriate agencies were notified about the availability of surplus property. It is not always easy to determine whether a property is of interest, without consulting a broad range of agencies which might want it. Further, it is not always easy to be certain that the notification process has penetrated the "noise" of the flood of incoming communications. The most significant effect of this requirement is that the notification must be published 60 days before other action is taken. This builds in an automatic delay in the disposition process that adds to the time and effort required to complete the disposal transaction. At the same time, there is a small but lingering doubt – even when all of the prescribed actions are taken – as to whether the appropriate agencies have in fact been notified.

Current law and practice may not include a number of agencies in the notification process such as special purpose districts and authorities e.g., the Metropolitan Transportation Authority (MTA), The Metropolitan Water District of Southern California, and the Southern California Regional Rail Authority (Metrolink). All

involved recognize that there is no single place to look for available municipal property, so that an agency interested in acquiring land would necessarily need to find the appropriate real estate asset manager in several jurisdictions to complete a search. The challenge is made more demanding by the fact that in most agencies there is a relatively small turnover of property. It is, in fact, difficult for most jurisdictions to divest themselves of real estate, in part because there is an extensive review process.

If there were a central repository for this information, it would provide a single point for the posting of notifications of surplus property and a convenient, “one stop shop” for agencies that are both interested in acquiring such property and eligible to do so. Current technology strongly suggests that this could be accomplished through the establishment of a jointly supported website. At minimum, this website would include in its scope the properties either wanted or needed in Los Angeles County. Given time, it should be extended to cover the entire State.

RECOMMENDATIONS

While acknowledging the potential value of all of the models, the Grand Jury recognizes that some of them will require additional research and definition before recommendations and decisions can be made. Specifically, the last model discussed – a formal structure that develops, acquires, and operates facilities – deserves serious consideration as a long-term direction because:

- Insulating property transactions from the immediate political process could offer greater assurance of integrity and a faster, more transparent transactional process.
- It would allow for more sophisticated planning and the inclusion of a wider range of needs in the development of these key assets.
- It would allow sufficient concentration of assets to support better-trained, more experienced asset managers who could more successfully negotiate with their powerful and sophisticated counterparts in the private sector
- It would provide the possibility of cost savings through more cost-effective service delivery.

Immediate action can be taken with the other models by the governing bodies – the Board of Supervisors, the City Councils and Mayors of the Cities, the MWD Board – of the organizations included in this review. Specifically:

Recommendation 1: Governing bodies responsible for policy and oversight relating to Real Property issues should instruct and encourage Asset Managers to pursue opportunities to increase collaboration. All of the models for collaboration could positively affect real property management by governmental entitles located within the County. The governing bodies responsible for giving direction to real property asset management – especially the Los Angeles County Board of Supervisors and the City Councils of Los Angeles and Long Beach – should encourage these collaborative efforts by directing the managers to investigate and pursue increasingly formal opportunities for collaboration. Specifically:

- ***Begin with formal quarterly meetings.***

  Managers and Directors responsible for Real Property management of large jurisdictions should meet quarterly to discuss common issues, and to inform one another of major real property strategic directions for their areas. In this fashion, it will be possible to consider formal and informal ways of collaborating on projects in the early development stages.

- ***Evaluate and introduce policies which foster intergovernmental cooperation for Real Property management.***

Governing bodies should consider implementing policies such as:

- Requiring their responsible departments to request comments from other entities on proposals for specific transactions that would benefit from intergovernmental cooperation

- Authorizing joint use of service agreements, brokerage arrangements, and other contracts

- Holding annual public meetings with counterparts in other jurisdictions to discuss and review common real estate strategic and property management issues and directions

Recommendation 2: Governmental Real Property managers should share information about needed and available property.

- ***Governing bodies responsible for policy and oversight relating to Real Property issues should direct their Real Property Managers to investigate and submit a report on the potential of a Statewide multiple listing service.***

While a multiple listing service is the industry standard for sharing with qualified buyers information on available property, it is not clear that there is sufficient volume and traffic in the Los Angeles governmental market to justify the expense of setting up and maintaining the listing service. Nevertheless, it would be valuable to investigate whether a Statewide service, including the property owned by the State of California would provide a sufficient volume to justify such a listing database. A potential forum for the start of this investigation might be the California Counties Real Estate Group.

- ***Governing bodies responsible for policy and oversight relating to Real Property issues should establish policies requiring asset management professionals to:***

- List properties available for lease or sale
- Check the listings of other localities for availability of property as a part of the standard procedures for acquiring, disposing of, or leasing properties

Even without implementing a formal multiple listing service, some of the same benefits can be achieved by establishing policies that encourage real estate departments to display property needs and availability for

other municipalities. This practice follows the lead of the County of San Bernardino as described in the Benchmarked Organizations section. The County of Los Angeles already displays surplus property and space needs on the website of the Real Estate Division. Other governmental agencies have the capacity to display this, as well, with minor changes. What's missing is a requirement that these sites be checked before entering into lease or purchase arrangements.

It is not the intention of the Grand Jury to introduce onerous and pointless steps into an already difficult process. For example, this should not be required before minor changes or additions to existing leases. It should be, however, an added first step before considering a significant new acquisition or lease.

- ***Governing bodies responsible for policy and oversight relating to Real Property issues should seek to amend the Government Code to recognize that posting the availability of property will satisfy the notice requirement.***

  The City and County of Los Angeles should take the lead in advocating that the State of California revise the Government Code to consider that Internet postings under specific policies would satisfy the various notification requirements. Such changes would allow the local government agencies that must meet the requirement to do so quickly and cheaply, raising compliance and transparency. It would also allow government agencies which are charged with acquiring property to determine whether other agencies might be seeking to divest properties of interest.

APPENDIX
LIST OF DOCUMENTS REVIEWED

Regional Government Real Estate Service Delivery, May 2003, Chuck W. West, CCIM, Esq., County of Los Angeles Chief Administrative Office, Real Estate Division

Asset Management Strategies for the Los Angeles County Real Estate Portfolio, September 1995, The Los Angeles County Citizen's Economy and Efficiency Commission

Five-Year Productivity Report, Real Estate Division, Chief Administrative Office, Los Angeles County July 1999 through June 2004, November 2004, Prepared by Real Estate Division, County of Los Angeles

TRIRIGA Real Estate & Facilities, Facility Center 8i Implementation, May 19, 2003

Municipal Full-Service Design/Build Lease Structures for County Programs in California, June 19, 2001, revised July 11, 2003, Chuck W. West, CCIM, Esq., County of Los Angeles CAO Real Estate Division

Real Estate Activities-Quarterly Reports for 2004, Metropolitan Water District of Southern California, Corporate Resources Group

MORE: Maximizing our Real Estate: Presentation: Presentation by Reginald Byron Jones-Sawyer and David Mora, City of Los Angeles

GLOSSARY

AMD: Asset Management Division, City of Los Angeles
APN: Assessor's Parcel Number
CAO: County of Los Angeles Chief Administrative Officer
CDC: County of Los Angeles Community Development Commission
GIS: Global Information System
GSD: General Services Department, City of Los Angeles
LADWP: Department of Water and Power, City of Los Angeles
MORE: Maximize Our Real Estate, City of Los Angeles
MTA: Metropolitan Transportation Authority,
MWD: Metropolitan Water District of Southern California
RDA: Regional Development Agency

SPEAKERS AND EVENTS COMMITTEE

David Amitai, Chairperson

Robert Dobson
Jane A. Grossman
William R. Jackson
Mary Alice King
Larry Silk
Geneese Simmons

SPEAKERS & EVENTS COMMITTEE

BACKGROUND

A Speakers and Events Committee was established early in the term to coordinate speakers and educational tours for the Civil Grand Jury. These opportunities heightened the knowledge and awareness of jurors to the challenges and needs facing Los Angeles County.

METHOD

Suggestions for speakers and tours were submitted for consideration to the committee for approval. Speakers were invited to the Grand Jury chambers to discuss a specific issue or issues and given the opportunity to raise issues they believed important and relevant. Transportation for educational tours and visits was made through the Los Angeles County Sheriff's Department.

GRAND JURY SPEAKERS

Michael Antonovich	Los Angeles County Supervisor, Fifth District
Rick Auerbach	Los Angeles County Assessor
Margaret Avila	Nursing Director, Public Health, Los Angeles County Department of Health Services
Leroy D. Baca	Los Angeles County Sheriff
Cynthia Banks	Chief Deputy, Los Angeles County Department of Community and Senior Services
Daphne Bell	General Manager, Purchasing and Control, Los Angeles County Internal Services Department
Fr. Gregory Boyle	Executive Director, Homeboy Industries
Yvonne Brathwaite-Burke	Los Angeles County Supervisor, First District
William Bratton	Los Angeles City Chief of Police
Laura Chick	Los Angeles City Controller
Stephen Connolly	Office of Independent Review
Steve Cooley	Los Angeles County District Attorney
Kitty Felde	KPCC Radio
Dan Finkelstein	Captain, Transit Services Bureau, Los Angeles County Sheriff Department
Michael A. Ford	Captain, Los Angeles County Sheriff Department
Ray Fortner	County Counsel, Los Angeles County
P. Michael Freeman	Los Angeles County Fire Chief
Gunther Frehill	Public Affairs, Los Angeles County Office of AIDS
William Fujioka	Los Angeles City Administrative Officer
Thomas Garthwaite	Director, Los Angeles County Department of Health Services
Michael Gennaco	Office of Independent Review
Russ Gviney	Chief Deputy, Los Angeles County Department of Parks and Recreation
Ted Hayes	Homeless Activist
Henry Hearns	Vice Mayor, City of Lancaster
Charles Henry	Director, Los Angeles County Office of AIDS Programs and Policy
Anthony Hernandez	Director, Los Angeles County Department of Coroner
Kenn Hicks	Parole Agent and Domestic Violence Counselor
Garacia Hillman	United States Election Commission
William Hodgman	Head Deputy, Sex Crimes Division, Los Angeles County District Attorney
Kim Hubbard	Council on Aging
David Janssen	Los Angeles County Chief Administrative Officer
Don Kanabe	Los Angeles County Supervisor, Fourth District
Alan Kerstein	Chief, Los Angeles Unified School District Police Department
David Lambertson	Director, Los Angeles County Internal Services Department
J. Tyler McCauley	Los Angeles County Auditor-Controller

Conny McCormack	Registrar-Recorder/County Clerk
Kevin McCarthy	Captain, Los Angeles Police Department
Alexia McNab	Urban Plunge, Faith-Based Organization
Daniel Medrano	Section Manager, Contracting Division, Los Angeles County Internal Services Department
Gloria Molina	Los Angeles County Supervisor, First District
Patt Morrison	Los Angeles Times
Emmett Murrell	Executive Director, Murrell's Community Service Agency
Mitchell Netburn	Executive Director, Los Angeles Homeless Services Authority
James Noyes	Director, Los Angeles County Department of Public Works
Beverly O'Neill	Mayor, City of Long Beach
Bud Ovrum	Director, Los Angeles Community Development Agency
Robert Philibosian	Chairman, Los Angeles County Citizens' Economy and Efficiency Commission
Flora Rostamian	Deputy Compliance Officer, Los Angeles County Office of Affirmative Action Compliance
David Sanders	Director, Los Angeles County Department of Children and Family Services
Richard Shumsky	Los Angeles County Chief Probation Officer
Charles Sophy	Medical Director, Los Angeles County Department of Children and Family Services
Marvin Southard	Director, Los Angeles County Department of Mental Health
Bruce Stanisforth	Executive Director, Los Angeles County Citizens' Economy and Efficiency Commission
Floraline I. Stevens	Educational Consultant
Robert Taylor	Director, Los Angeles County Department of Ombudsman
Violet Varona-Lukens	Executive Officer, Los Angeles County Board of Supervisors
Dien X. Vuong	Long Beach Water Department
Diane E. Watson	U.S. Rep (D-CA)
Kevin Wattier	General Manager, Long Beach Water Department
George Weir	Director of Contracts, Alcohol and Drug Program Administration, Los Angeles County Department of Health Services
David Wesley	Supervising Judge, Superior Court
Harriette Williams	Chair, Los Angeles County Commission for Children and Families
Bryce Yokomizo	Director, Los Angeles County Department of Public Social Services
Zev Yaroslavsky	Los Angeles County Supervisor, Third District

GRAND JURY TOURS AND FIELD TRIPS

Board of Supervisors
California Science Center
Cathedral of Our Lady of the Angels
Office of Coroner
Disney Concert Hall
LAC+USC Medical Center
LAPD Scientific and Investigations Division
LAX
Long Beach Water Department
Los Angeles Public Library
Natural History Museum of Los Angeles County
Marina del Rey Marina
Oath of Office Ceremony for Supervisor Yvonne Brathwaite-Burke (Dorothy Chandler Pavilion)
Pasadena Rose Bowl
Port of Los Angeles
Port of Long Beach
Rancho Los Amigos National Rehabilitation Center
Sheriff's Academy graduations (Sheriff's Academy and Pasadena Civic Auditorium)
Skirball Cultural Center
Thirty-Sixth Annual Los Angeles County Peace Officers' Memorial Ceremony (Sheriff's Academy)